PROPOSED PHASEOUT OF PSRO'S AND UTILIZATION REVIEW REQUIREMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

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PROPOSED PHASEOUT OF PSRO'S AND UTILIZATION REVIEW REQUIREMENTS

MONDAY, MARCH 23, 1981

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman of the subcommittee) presiding.

Present: Senators Durenberger, Dole, and Baucus.

[The press release announcing this hearing, a background paper prepared by the health staff and the opening statement of Senator Dole follows:]

[Press Release No. 81-115 of U.S. Senate Committee on Finance, Mar. 12, 1981]

SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO'S), UTILIZATION REVIEW REQUIREMENTS, AND ALTERNATIVE METHODS OF MONITORING UTILIZATION OF HEALTH CARE SERVICES PAID FOR BY MEDICARE AND MEDICAID

The Honorable Dave Durenberger (R., Minnesota), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold a hearing on Monday, March 23 to review the administration's proposal to phase out the Professional Standards Review Organizations, and the current utilization review requirements.

The hearing will begin at 9:30 a.m. in Room 2221 of the Dirksen Senate Office Building

Senator Durenberger noted that "over the last several years, the PSRO review system has evolved sufficiently to merit reexamination of its objectives, accomplishments, and potential. This hearing will provide us an opportunity to examine the necessity of the current medicare and medicaid review requirements, as well as possible alternatives."

Senator Durenberger further expressed an interest in private sector initiatives in the area of quality and cost control.

It is anticipated that public witnesses will include representatives of Federal and State agencies, private organizations we well as the PSRO's themselves.

Requests to testify.—The Subcommittee requested that persons desiring to testify during this hearing make their requests to testify in writing to Robert E. Lighthizer, Chief Counsel, Committee on Finance, Room 2227, Dirksen Senate Office Building, Washington, D.C. 20510, not later than Wednesday, March 18, 1981. Persons so requesting will be notified as soon as possible after this date whether they will be scheduled to appear. If for some reason a witness is unable to appear at the time scheduled, he may file a written statement for the record in lieu of the personal appearance.

Consolidated testimony.—The Subcommittee urged all witnesses who have a common position or with the same general interest to consolidate their testimony and designate a single spokesman to present their common viewpoint orally to the Subcommittee. This procedure will enable the Subcommittee to receive a wider expression of views than it might otherwise obtain. The Subcommittee urges very strongly that all witnesses exert a maximum effort to consolidate and coordinate their statements.

Legislative Reorganization Act.—The Subcommittee observed that the Legislative Reorganization Act of 1946, as amended, and the rules of the Committee require witnesses appearing before the Committees of Congress to file in advance written statements of their proposed testimony and to limit oral presentations to brief summaries of their arguments.

The Subcommittee stated that all witnesses who are scheduled to testify must comply with the following rules:

(1) All witnesses must include with their written statements a one-page summary of the principal points included in the statement.

(2) The written statements must be typed on letter-size (not legal size) paper and at least 100 copies must be delivered to Room 2227, Dirksen Senate Office Building, not later than noon of the last business day before the witness is scheduled to appear.

(3) Witnesses are not to read their written statements to the Subcommittee, but are to confine their oral presentations to a summary of the points included in the statement.

(4) Not more than 10 minutes will be allowed for the oral summary.

Witnesses who fail to comply with these rules will forfeit their privilege to testify.

Written statements.—Persons requesting to testify who are not scheduled to make an oral presentation, and others who desire to present their views to the Subcommittee, are urged to prepare a written statement for submission and inclusion in the printed record of the hearing. Statements submitted for inclusion in the record should be typewritten, not more than 25 double-spaced pages in length and mailed with five copies to Robert E. Lighthizer, Chief Counsel, Committee on Finance, Room 2227, Dirksen Senate Office Building, Washington, D.C. 21510, not later than Monday, April 6, 1981.

Background Information Relating to Professional Standards Review Organizations (PSRO's)

(Prepared by the Staff of the Senate Committee on Finance)

A. BRIEF LEGISLATIVE HISTORY

The original 1965 medicare-medicaid legislation sought to monitor hospital utilization through three devices:

(1) A requirement that a physician certify in certain cases that the services for which reimbursement will be sought are medically necessary.

(2) The private insurance organizations that served as medicare's fiscal agents ("intermediaries" and "carriers") were responsible for reviewing benefit claims and denying payment for unnecessary care.

(3) Hospitals and skilled nursing homes were required to maintain utilization review committees as a condition for their participation in medicare. These were staff committees of the institution, composed of physicians, that were to review the medical necessity for the care that medicare patients received in the institution. Provision was made for the intermediary to deny claims of patients whose hospitalization was determined to be unnecessary.

The cost of medicare and medicaid increased sharply during its first few years of operation. The 25-year cost projections that were made in 1970 were $240 billion higher than those made only three years earlier. To a degree, these increases were due to unexpected increases in the cost of a day of hospital care and other units of health care. A number of provisions designed to limit reimbursement for health care costs determined to be unreasonably high were developed and eventually enacted.

The second factor that contributed to the increase in medicare-medicaid costs was a substantial increase in the volume of services that beneficiaries received. In commenting on this increased utilization in its report* on the PSRO provisions, the Committee on Finance stated that it had for several years:

". . . focused its attention on methods of assuring proper utilization of these services. That utilization controls are particularly important was extensively revealed in hearings conducted by the subcommittee on medicare and medicaid. Witnesses testified that a significant proportion of the health services provided under medicare and medicaid are probably not medically necessary. In view of the per diem costs of hospital and nursing facility care, and the costs of medical and surgical procedures, the economic impact of this overutilization becomes extremely significant."

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*Senate Report 92-1230, Report of the Committee on Finance to Accompany H.R. 1, the Social Security Amendments of 1972, page 254.

The utilization safeguards then in effect had been inadequate for a number of reasons. The fiscal agents experienced difficulty identifying instances of hospital misuse from the limited information on the hospital bills that were submitted to them for payment. Also, hospitals, physicians and patients were often highly critical of the fiscal agents' decisions concerning the appropriateness of a patient's stay. It was argued that there insufficient physician participation in the fiscal agents' review process and that the agents often either were unfamiliar with, or insensitive to, the individual patient's unique needs.

With respect to the performance of hospital utilization review committees, the Finance Committee stated in the same report:

"The detailed information which the committee has collected and developed as well as internal reports of the Social Security Administration indicate clearly that utilization review activities have, generally speaking, been of a token nature and ineffective as a curb unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. The present situation has been aptly described by a State medical society in these words:

"'Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token.'"

To remedy these shortcomings, provisions, for the establishment of PSRO's were included in the Senate-approved version of the Social Security Amendments of 1970. The 1970 legislation was not enacted because the House and Senate were unable to confer on the bill prior to the end of the 91st Congress. However, the PSRO provision was again approved by the Senate as part of the Social Security Amendments of 1972 and was accepted, after certain changes were agreed to, by the House conferees. The President signed the bill into law on October 17, 1972.

The new legislation directed the Secretary of HHS to divide the country into areas that would be of an appropriate size for the review of health services provided under the Medicare, Medicaid, and Maternal and Child Health programs. The Secretary was also directed to enter into an agreement with a nonprofit physician organization in each area to conduct these reviews. These Professional Standards Review Organizations determine whether services provided to patients in hospitals and long-term care facilities are (1) medically necessary, (2) provided in accordance with professional standards, and (3) provided in the appropriate setting.

B. DESIGNATING PSRO AREAS

Section 1152 of the Social Security Act directed the Secretary of HHS to designate PSRO areas throughout the country for the purpose of establishing a Professional Standards Review Organization within each area. It was intended that these areas be large enough to ensure that there was broad, diverse, and objective representation of physicians, yet small enough to allow efficient and manageable operation. Several controversies, including the desire of many large States to be a single, Statewide PSRO area, delayed area designation until March 1974.

There are currently 197 PSRO areas. The following table shows the number of PSRO's within State borders.

States with single PSRO area	*32
States with two PSRO areas	5
States with three to five PSRO areas	5
States with more than five PSRO areas	11
Total	53

*Total includes the District of Columbia, Puerto Rico, and the Virgin Islands.

An October 12, 1978 Comptroller General Report concerning opportunities to reduce PSRO administrative costs stated that:

". . . it would seem that the potential for eliminating duplication and realizing the resulting savings could be significant if the total number of organizations can be consolidated even on a limited basis, or if sharing of basic administrative support services such as data processing and data management could be accomplished."

C. ESTABLISHMENT OF PSRO'S

PSRO's generally developed in three stages—referred to as the planning, conditional, and fully designated stages. In the planning stage, PSRO's are expected to establish an acceptable organizational structure, recruit physician members, and formulate plans for undertaking review activities. In a conditional stage, the PSRO determines the norms and standards of medical practice that are accepted as appropriate and typical in its areas, e.g. typical lengths of hospital stays for patients

in different age groups and with various diagnoses. These norms and standards serve as benchmarks in identifying potential utilization problems that warrant review by a PSRO physician. The conditional PSRO also initiate review activities, medical care evaluations and profile analysis studies (see Section E below). Once a conditional PSRO has met HSS's organizational requirements and is shown to be capable of fulfilling its responsibilities, it can become fully designated.

In March 1974, HHS made its first request for proposals from physician organizations interested in becoming PSRO's. In June 1974, it awarded 11 conditional contracts. By September 1977, there were conditional contracts with 120 PSRO's. As of October 1, 1980, PSRO's have been established for 189 of the 194 PSRO areas, including 142 conditional PSRO's and 47 fully designated PSRO's.

In addition to the delays in establishing PSRO's, implementation of the PSRO program was delayed because of chronic budget shortages and, according to a 1978 GAO report, because of "organizational shortcomings, inadequate authority and fragmented responsibility" within HEW. The innovative character of the program also precluded speedy implementation.

Five years ago, PSRO review was in operation in only 360 hospitals with less than 200,000 discharges under review. Today PSRO's have implemented review in more than 4,750 hospitals, and by the end of fiscal year 1980 PSRO's were reviewing at an annual rate of more than 11 million discharges.

	Number of medicare-medicaid discharges in fully designated and conditional PSRO areas	Number of discharges reviewed	Percent
Fiscal year:			
1975	1,006,000	173,000	17
1976	4,498,000	1,240,000	28
1977	10,844,000	4,610,000	43
1978	11,900,627	7,207,489	61
1979	12,533,333	9,400,000	75
1980	13,439,533	11,517,973	85

D. PHYSICIAN PARTICIPATION

Active physician involvement in PSRO activity is critical to the program's overall success. Although HHS believes that some of the initial opposition to PSRO's has been dissipated, lack of physician support has continued to impede PSRO development in some areas.

The PSRO legislation requires that HHS give preference to physician organizations when establishing PSRO's. Originally, HHS was barred from designating an organization as a PSRO prior to January 1, 1976, unless at least 25 percent of the practicing physicians in the area were members of the organization. Legislation enacted in December 1975 extended the period of preference for physician organizations to January 1, 1978.

As of June 1977, 17 areas in the country, including the States of Nebraska and Georgia, still did not have PSRO's because of lack of physician support. Currently, 5 areas (including the State of Nebraska) are still without a PSRO. In addition, 5 areas (including three of Louisiana's four areas) are served by physician organizations that do not meet the 25 percent physician-membership test. On the average, about one-half of the practicing physicians in areas that have a PSRO have agreed to be members. Now that almost every area has a PSRO, it can be said that almost one-half of the Nation's practicing physicians are PSRO members.

	Number of physicians in fully designated and conditional PSRO areas	Number of physician members in PSRO organizations	Percent
Fiscal year:			
1974	27,000	13,000	48
1975	130,000	64,000	49
1976	144,000	80,000	55
1977	245,000	123,000	50
1978	286,000	148,000	52

	Number of physicians in fully designated and conditional PSRO areas	Number of physician members in PSRO organizations	Percent
1979	294,580	153,920	52
1980	316,342	160,358	51

E. FORM OF PSRO REVIEW

In addition to inpatient hospital review, PSRO's were also authorized to review care in other health care settings. However, budget limitations and other factors generally limited PSRO review to inpatient hospital services.

The "Omnibus Reconciliation Act of 1980" (P.L. 96-499) narrowed the scope of activities PSRO's are required to perform prior to receiving full (as opposed to conditional) designation. As a result, these ogranizations now need only conduct reviews of routine inpatient hospital services and services in alcohol detoxification facilities. (Review of diagnostic tests, drugs, and other ancillary hospital services is not required.)

The legislation also directed the Secretary to establish a program for the evaluation of the cost-effectiveness of review of health care services outside the inpatient hospital setting. PSRO's will be required to review these services only where it has been found to be cost-effective or yields other significant benefits.

To date, the major focus of the PSRO program has been on the concurrent review of inpatient hospital services. Concurrent review has two components—review at the time of admission and review of atypically long stays. PSRO's conduct reviews in a variety of ways. Generally, a nurse carries out the initial screening and refers questionable cases to a PSRO physician advisor, who reviews the medical record, and, where necessary, discusses the case with the attending physician. A determination that an admission or continued stay is inappropriate is communicated to the patient, attending physician, and the hospital, all of whom have appeal rights. In the case of PSRO denials, Medicare grants one to three days for patients to arrange for post-discharge care before payment for further days of care is to be denied. In the case of Medicaid denials, each State determines whether payment will made for any days following notice of denial.

In recent years, the PSRO budget has not kept pace with the program's expansion, and the program has been under increasing financial pressure. As a result, PSRO's are now moving from concurrent review of all cases toward focused review, a system in which only some cases are reviewed. The ideal focusing system would select for review only those kinds of cases where overutilization is most likely to occur. It is estimated that PSRO's are presently focusing on about one-half of their cases.

There are two other components of hospital review: (1) medical care evaluation studies which involve peer review of selected medical topic areas, and (2) profile analysis in which aggregated patient care data are subject to pattern analysis.

Review of impatient hospital services may be performed directly by the PSRO or it may be delegated to a large extent to a hospital review committee where the PSRO finds the hospital to be willing and able to carry out acceptable reviews. Currently, about three-quarters of the reviewed discharges are reviewed by the hospital rather than the PSRO.

F. PSRO PROGRAM IMPACT

The cost effectiveness of PSRO's has been the subject of several evaluations. In a 1979 PSRO evaluation by HHS (based on calendar year 1978 data) it was estimated that PSRO review for medicare cases resulted in a net savings of approximately 20 percent over the review cost, though widely varying results were reported in different parts of the country. No comparable estimates were provided for medicaid. The Congressional Budget Office has generally agreed with these estimates insofar as medicare savings are concerned. However, CBO further suggests that because of the fixed nature of about 60 percent of hospital costs, any savings in medicare outlays are passed on in part to private patients and that the net effect is to slightly increase health costs overall.

There are many examples of local experiences of PSRO success. Some examples follow:

One Statewide PSRO used patient data to identify overusers of habituating drugs who were receiving these drugs from a variety of providers. The PSRO was able to curtail this misuse simply by informing all providers of the patient's patterns.

A PSRO found that the rupture rate on primary appendectomies was 44 percent for one hospital compared to an areawide average of 11.4 percent. Through an intensive newspaper campaign in this hospital's catchment area advising readers of appendicitis symptoms as well as the risks involved with a ruptured appendix, the need for quick medical attention was emphasized. As a result the rupture rate has decreased from 44 percent to 15.6 percent.

A third PSRO discovered a problem concerning the overutilization of physical therapy services in two hospitals. A peer review conference was held at which the PSRO requested the hospital to submit a specific plan of corrective action. When the plan of correction was not received by the PSRO, it began deleting charges for unnecessary services in cooperation with the fiscal intermediaries. In one hospital a corrective plan is still being implemented. In the second hospital, however, a 50 percent reduction of the physical therapy patient load, and a 38.6 percent reduction in the number of procedures per patient, was achieved.

Another PSRO noted that there was a lack of documentation in hospital medical records to justify the surgical procedures of tonsillectomy and adenoidectomy. This problem was discovered through profile analysis and a quality review study. Action to correct the problem entailed a peer review conference with individual physicians and the implementation of a second opinion certification. Data now shows a 51 percent decrease in the number of tonsillectomy and adenoidectomy procedures done statewide.

One PSRO found that many patients with head injuries received an excess of skull X-rays. Seven hospital emergency room physicians and one acute hospital were involved. Letters were sent to the physicians requesting careful consideration of whether skull films are indicated. Also, guidelines were developed. This resulted in virtual elimination of unnecessary skull X-rays. Deficiencies were reduced by 94 percent (from 16 percent to 2 percent).

A Statewide PSRO discovered that many of its rural hospitals lacked any form of discharge planning. The PSRO conducted Statewide seminars which have resulted in the development of discharge planning throughout the State.

Another PSRO identified a pattern of inappropriate usage of a certain type of antibiotic by a particular physician. PSRO physicians discussed this problem with the physician and provided information on appropriate usage. The physician's inappropriate practice stopped completely.

A PSRO identified inappropriate utilization of routine blood tests. The PSRO initiated two actions to correct the problem. PSRO physicians reviewed with hospital personnel and attending physicians which blood tests should be performed for different types of cases. The PSRO also began to review concurrently all patients for whom these blood tests were performed. The hospital has now stopped routine performance of these blood tests. Such tests are performed only with a physician's order and if necessary for a patient's symptoms or diagnosis.

G. USE OF PSRO'S BY PRIVATE ORGANIZATIONS

It is noteworthy that private organizations are increasingly contracting with PSRO's.

As of February 1979, forth-nine PSRO's were performing private review. Some of these were in the process of expansion and additional PSRO's were negotiating similar agreements. Another survey will be take in fiscal year 1981 to determine more current activity. Those requesting private review ranged from self-insured corporations such as John Deere, Caterpillar and Continental Airlines, to local unions, to insurance carriers like Blue Cross, Blue Shield, State Farm, Prudential, Aetna, etc. In addition, Government-sponsored programs such as CHAMPUS and the Indian Health Service are contracting for PSRO review.

In a recent presentation to the National Professional Standards Review Council on PSRO private review, the director of health care services at one self-insured corporation stated that during the past two years a 30 percent decline in hospital days per thousand population of this corporation was recognized in one PSRO area. Length of stay declined by nearly a day and admissions per thousand declined by 17 percent in this area. Although the corporation has undertaken other initiatives, including HMO development, leading to these lower utilization figures—"the single most significant endeavor undertaken, which has produced significant results in our estimation during the past two years, has been the implementation of private utilization review under the auspices of the PSRO."

STATEMENT OF SENATOR BOB DOLE

Mr. Chairman, I am pleased to join you in welcoming today's witnesses.

Over a century has passed since Ralph Waldo Emerson told an audience, "The first wealth is health." Emerson's maxim remains true, the health of a nation is intimately related to the wealth of its economy. America is a rich nation, whose people are nonetheless strained by the cost of an enormous governmental structure. She is a nation proud of her achievements in the medical field, yet there are still problems with this system of ours. The practice of medicine is one of the most critical elements in determining the quality of life in any country. Without competent, effective, and accessible medical care to assure good health, no people can fully utilize their goals for achievement in their economic, social and political arenas. No nation, however wealthy, can hope to become or remain great without a good foundation or basic good health for its citizens.

FUTURE OF HEALTH

With these points in mind, the United States has, for many years, pursued a wide variety of programs to deal with the need for improving the health standards of its citizens. I believe we can take immense pride in our achievements which have raised the standards of health in America to a level which we take for granted today. But regardless of all our efforts, there will still be instances where we will need to care for the sick. In doing so, we will want to make sure that the care that they receive is the most appropriate, effective and cost efficient care that is available. For although there have been those in the past who have led us to believe that the health care dollar in America is endless, we have all come to realize that the escalating cost of health care has put all health care services in jeopardy. So we must look at both quality, quantity and cost.

POSITION ON PSRO'S

Medicare and medicaid probably stand out as among the most ambitious, expensive, and controversial health care programs in this Nation. And within these two programs, perhaps no aspect has been of greater concern to the physicians and surgeons of America than the professional standards review organizations established by Public Law 92-503.

The professional standards review organization legislation was recommended by the Senate Finance Committee as a partial solution to what it viewed as the dual problems of rising health care costs and the high incidence of medically inappropriate services rendered to medicare and medicaid patients.

I was one who, in 1970, voted against this legislation. I did so because I had doubts about the wisdom of placing bureaucratic and administrative burdens on the medical profession. It is because of this that I have a very special interest and welcome these hearings by the Health Subcommittee.

NEED FOR HEARINGS

I believe it is vitally important that a full and detailed understanding of this program's implementation be available for study and for the information of the general public.

I have a special interest in having fresh, factual knowledge of the programs operation; and those who supported this legislation have a responsibility for monitoring their proposals effect, performance, and development.

Numerous studies have told differing tales as to the success of the PSRO program. I hope that we will address the differences in opinion between the Congressional Budget Office and HEW with respect to the studies prepared outlining the results of the PSRO efforts.

CONCERN FOR HEALTH CARE

Regardless of our original positions on the program, however, I believe each member of the subcommittee has a sincere and genuine concern for seeing that the interests of patients, physicians, hospitals, and tax payers are well served by this and other Federal health programs. And, therefore, I am hopeful that these hearings will help explain some of the questions that have arisen, clarify areas of misunderstanding and confusion, and provide a sound basis for assessing the need to enact changes, revisions, or safeguards to the present statute.

VIEW OF KANSAS PHYSICIANS

To be quite candid, the PSRO concept was not one that was popular among the physicians of Kansas. Some years ago when hearings were held on the PSRO program, I contacted a large number of physicians across the State to solicit their first hand views on the programs. Out of more than 100 busy physicians who took the time to respond, only some 5 or 6 could be said to be favorable, while the remainder expressed varying degrees of doubt, reservation and hostility towards the concept.

In recent conversations with members of the Kansas Medical Society, I detect a change in feeling with respect to the PSRO and sense that they are more favorable towards its concept and are participating very actively and positively.

Mr. James Agin, the executive director of KFMC, believes that the PSRO program can be an effective method of quality assurance which will serve the intent of the PSRO law. He believes that the Kansas PSRO program has been, and continues to be, successful in the accomplishment of their stated goals and objectives. Future success, however, he believes can only be accomplished through appropriate funding for the PSRO program, consistency in the rules and regulations and the flexibility to allow Kansas to structure its programs according to the inherent characteristics of the Kansas health care delivery system.

CONCLUSION

Unfortunately, much of the enthusiasm for the program began to fall off just when it was at its peak—due to an inordinate delay in receipt of funding. For that, I am afraid, we must assume responsibility for not keeping faith—and also recognize that it takes a long time to rebuild interest and support once it is not given timely response.

Mr. Chairman, I would observe that the physicians in Kansas are concerned about the quality and economy in their practices and in the health care programs of the Government. They are worried, as is the Reagan administration, about their practices being burdened by regulation, redtape, and the possibilities for harrassment, but they are willing to contribute to an appropriate and well organized effort to honestly review and evaluate their services. I am hopeful that these hearings will help explain some of the questions and help us seek out solutions which will provide us with such a system. Perhaps there is a substitute for PSRO's which would be more efficient and effective. I for one am keeping an open mind, and am anxious to hear from today's witnesses.

Senator DURENBERGER. The hearing will come to order.

Today the Subcommittee on Health will hear testimony on the administration's proposal to phase out the Professional Standards Review Organizations, the PSRO program, and eliminate provider base utilization review requirement.

The PSRO program was designed to afford practicing physicians at local levels an opportunity on a voluntary and publicly accountable basis to undertake review of the medical necessity and quality of care provided under our Social Security Act, health care financing programs, medicare, medicaid, and maternal and child health programs which will cost taxpayers about $65 billion during the current fiscal year.

There has been much controversy over the effectiveness of the PSRO program, and the administration apprently believes that competition in the health care industry will replace the need for PSRO and utilization review.

Of course, I applaud the administration's goal of restraining health care cost by stimulating competition since it is a goal that I personally share. But I think it also must be recognized that competitive mechanisms are not in place at this time, and it will take several years to begin to see the effects of competition even if we pass a competition bill this year.

Moreover, there may well be a need to maintain some form of appropriateness review and quality assurance activity as part of a competitive strategy.

It should further be recognized that the PSRO program was a legislative response to runaway health care cost, and the failure of various review mechanisms that were in use prior to the enactment of the program, mechanisms that some are now proposing as alternatives to PSRO.

The hearing today will provide critics and supporters an opportunity to express their views on whether PSRO's and associated utilization requirements should be eliminated.

I am hopeful that we will be able to leave this hearing with sufficient information to permit the Finance Committee to make an informed decision on the administration's proposal.

Due to the large number of witnesses, which I think we all appreciate, the 10-minute rule on presentations of oral statements will be applied with a qualifier that that applies to panels.

And I had to inquire on the first panel because Jay Constantine, a former health professional staff member with the Finance Committee is on that panel, as to whether or not he could limit his statement to a proportional part of 10 mintues, and I am assured that he can. [Laughter.]

And you can smoke your pipe. That is legitimate. [Laughter.]

The full text of all of the witnesses' statements will be included in the record.

My colleague from Montana, who is the ranking member of this subcommittee, is here, and I think other members of the subcommittee will be here during the morning.

Max, do you have an opening statement you would like to make?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Chairman, we are approaching the question of eliminating the PSRO's with far more unanswered questions than is normally the case when we begin hearings on legislation that has been proposed by the executive branch.

In fact, I am not sure at this point exactly what the administration is proposing. Some of the unanswered questions that should be addressed at this hearing, in my judgment are:

First, is the PSRO program sound in concept;

Second, should the cost of benefits of PSRO's be measured? How should they be measured?

Third, if there are effective PSRO's, as is generally conceded, should they be retained until a better utilization review mechanism can be put in place?

Fourth, if some PSRO's are doing a good job, why cannot the others be upgraded at the same level of performance? At what point should the persistent nonperformers be dropped from the program?

Fifth, are there legislative changes that would make PSRO's more effective than they now are?

Sixth, what alternatives are available to monitor medicare utilization? When could they be made effective? And how sure can we be that they will work as well as PSRO's?

The Congress, as trustees of our Nation's $80 billion medicare/medicaid programs, would be acting irresponsibly if we were to eliminate PSRO's before having answers to these questions.

The testimony we will hear today will be helpful, I hope, in addressing these questions. And I welcome the witnesses' testimony. And, Mr. Chairman, I look forward to an interesting session of hearings.

Senator DURENBERGER. Thank you very much.

The first witness is Dr. Carolyne K. Davis, Administrator, Health Care Financing Administration, Department of Health and Human Services. Welcome.

STATEMENT OF DR. CAROLYNE K. DAVIS, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. DAVIS. Thank you, Mr. Chairman.

I would like to introduce the people with me. On my left is Edward Kelly, the Acting Director of the Health Standards and Quality Bureau. And to my right is Dr. Judith Lave, the Director of the Office of Research, Demonstration and Statistics.

Senator DURENBERGER. You may proceed.

Dr. DAVIS. I am pleased to discuss with you today the Professional Standards Review Organization program in the context of the President's proposed program for economic recovery.

As part of the general effort to restrain health care costs by stimulating competition in the health care industry, the administration is proposing to phase out the PSRO program over the 1981 to 1983 period.

During this period, grants will be renewed with only the PSROs judged most effective in controlling health care costs and assuring a high quality of medical care.

All direct Federal support will expire at the end of 1983.

In conjunction with the phaseout, we will propose legislation to eliminate the requirements for utilization review committees in providers that are not covered by PSRO review.

Federal regulations will be replaced by health care financing reforms which will promote competitive incentives to control utilization.

Over the longrun, requiring PSRO's and other review entities to compete for contracts in the marketplace without Federal subsidy should insure a more efficient use of our health care resources.

When the PSRO legislation was enacted in 1972, it was because the existing methods of utilization review and control were not doing the job of assuring that medicaid and medicare patients received only medically necessary care.

The PSRO program was designed to correct this situation and to control the costs resulting from overutilization of health care services.

In terms of PSRO program evaluations, in 1977 the Department began annual evaluations of the impact of PSRO review on the utilization and cost of health services. The 1977 evaluation was inconclusive because only a few PSRO areas were active.

Both the 1978 and 1979 evaluations of the PSRO program showed a modest reduction in hospital days used by medicare patients.

However, there have been very wide variations in individual PSRO's performance, with some PSRO's showing little or no effect on utilization while others demonstrated a more positive impact. So, that overall, the evaluations found that the PSRO's were only marginally cost beneficial.

The Congressional Budget Office, using the Department's data, performed its own analysis of the 1979 PSRO evaluation. And while they agreed that PSRO review reduced medicare utilization, the CBO noted that a lack of information exists as to the effect of PSRO review on Medicaid utilization.

Furthermore, they found that the reduced Medicare outlays resulting from PSRO review were partly being transferred to private patients whose charges have risen accordingly.

In consequence then, the CBO concluded that PSRO review cost society as a whole substantially more than it saved.

The overall control of health services utilization and cost has been ineffective through the regulatory approaches that are provided by PSRO review and utilization review.

We will propose to remove these Federal requirements and support only the most effective PSRO's for a 2-year transition period. During this time, other health care financing reforms will be developed to promote competitive ways of controlling utilization in the health marketplace.

In addition to capping the Federal funds provided to the States for medicaid, competition may be stimulated by actions such as instituting alternative reimbursement systems, providing incentives for outpatient care, and encouraging increased enrollment in health maintenance organizations.

After the Federal funding of the PSRO's expires at the end of 1983, we would anticipate that the effective PSRO's could become a component of the competitive market by contracting their services to private health care systems.

This concludes my prepared remarks, but I would be pleased to answer any questions that you may have.

Senator DURENBERGER. All right. Thank you very much, Dr. Davis.

We will probably try to limit our questions here so that all the witnesses have an opportunity to testify before we break for dinner tonight.

My first one relates to the Veterans' Administration, which has established utilization review requirements for care provided in VA medical centers, in part to assure that these Government health resources are efficiently used to provide only needed services to veterans.

The VA has had some notable success in reducing average length of stay in recent years.

Do you think that it is wise for the Government to eliminate utilization review requirements under medicare and medicaid when they have proved beneficial in the Government's own hospitals?

Dr. DAVIS. I think in the Government-owned hospitals there is a different incentive system in place than there is in the system that we have been working with in the PSRO's, which review for medicaid and medicare.

Where the hospital system is the for-profit or the voluntary system, I think the work ethics of the providers are perhaps somewhat different than they are within the veterans system, sir.

Senator DURENBERGER. So, it is no problem for you to recommend that we eliminate PSRO's for medicare/medicaid in the private sector hospitals while continuing a successful review program in Government hospitals?

Dr. DAVIS. Our data for the PSRO's have indicated that we have only a marginal benefit-to-cost ratio in our PSRO reviews. And it is because we have seen so little benefits related to the cost that we are recommending the program's closure.

As you well know, the fiscal situation in the United States today demands, we think, prudence in terms of looking at which programs can be retained in the longrun. And this, obviously, we felt was a candidate for phasing out simply because of its lack of effectiveness.

Senator DURENBERGER. The argument has often been made—an argument that is applicable to other than PSRO implementation—that if you do not adequately fund a good idea you are not going to know whether it is a good idea or a bad idea.

And quite a number of people who have been involved with PSRO have indicated that lack of funding has been a hindrance to the development and effectiveness of PSRO.

Now one obvious measure of inadequate funding is that three-fourths of the review work is being done by hospitals under delegated review rather than by direct PSRO review.

In your opinion, on the basis of what you know about the programs, has inadequate funding of the PSRO program limited its effectiveness?

Dr. DAVIS. I do not believe that that would be the case.

I would like to ask Mr. Kelly, who has been more directly involved in this over longer periods of time, if he would care to comment on that.

Mr. KELLY. The slow implementation over the first 2 years because of funding may have held the program back. But in the last few years the funding has been sufficient to both fund the PSRO's administrative costs and the hospital review costs. Since we have come into focused review and gone away from the 100-percent concurrent review system, there has been sufficient funding to allow us to review the cases that were necessary, to collect the data that is necessary, and then profile the hospitals, the doctors and the various cases that we are involved in so that we make good decisions about where there seem to be patterns of utilization that are not correct, or even some quality patterns are not correct.

Senator DURENBERGER. So it strikes me that your answer is yes or no. Up to 2 years ago the answer would be yes, inadequate funding stood in the way, and in the last 2 years, no, it did not.

Mr. KELLY. No. I would say it was in 1973-74 that inadequate funding held the program back from immediate growth. From there on in, we have been able to expand, starting in the 1975-76 period, into long-term care and to other parts of the review system because the funding was there.

Senator DURENBERGER. As you know, Dr. Davis, utilization review and medical care appraisal are requirements of the Joint

Commission on Accreditation of Hospitals. The majority of hospitals participating in medicare are JCAH accredited.

In your opinion, will the administration continue to recognize as a reasonable cost the expenses of utilization review and medical care appraisal activities that are carried out in JCAH-accredited hospitals?

Dr. DAVIS. We have long recognized the fact that the JCAH has been involved in this type of quality assurance. And, obviously, until we have other measures, we will certainly consider that a reasonable cost.

Senator DURENBERGER. Do you believe that as a matter of public policy the Government should discourage such activities in hospitals?

Dr. DAVIS. As a matter of public policy, should the Government discourage the JCAH type of activities?

Senator DURENBERGER. Right.

Dr. DAVIS. No, sir, I would not think so, because the JCAH is in a sense a voluntary type of professional peer review at the local level. And it is my belief that the voluntary local level is where such activity should be.

Senator DURENBERGER. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Davis, one thing that strikes me is that if the Administration wants to keep some PSRO's that are allegedly effective and discontinue those that are not, does not that at least argue that possibly it makes better sense instead of phasing out the PSRO's that are ineffective, to make those ineffective PSRO's more effective?

I mean, if you concede that some are effective—and that certainly is a premise and a conclusion of your statement—then it seems to me that one should at least be intellectually honest to address the question of whether or not one should make the ineffective more effective.

Has the administration looked into that course of action?

Dr. DAVIS. That has been considered, sir. We have had, as you know, since 1973 a significant period of time to try to work with a number of the PSRO's to try to make them more effective.

The point is that we have not yet achieved that. It is our belief that if, in keeping with the administration's philosophy of deregulation and lack of governmental controls, we stimulate the procompetitive system, that will inherently provide the incentives for changing physicians' behavior and providers' behavior.

Senator BAUCUS. Does the administration know why some PSRO's are effective and why some others are ineffective? The reason for the difference.

Dr. DAVIS. Some of our data would indicate that where the physicians have taken a very active role in the entire decisionmaking process in their local PSRO and are solidly behind it, that has seemed to be one of the factors—but it is only one of the factors that can be identified.

I think the important point is that we do not feel that the Federal Government ought to try to intervene in a professional review system which might better be stimulated from the peer review mechanisms that are the alternative that could be provided.

Senator BAUCUS. But in addition to physician involvement which apparently is the factor that determines whether some PSRO's are effective and some ineffective, what are some of the other factors?

Dr. DAVIS. I beg your pardon.

Senator BAUCUS. What are some of the other factors that bear upon the effectiveness of PSRO's, other than physician involvement?

Dr. DAVIS. Again, it is the hospitals' involvement for those that are delegated review. I don't know if we have complete data on some of the other areas. Mr. Kelly?

Mr. KELLY. Well, the real basis for the effective PSRO is the total involvement of the physicians in those communities and the hospital's acceptance of the process in working with the PSRO to carry it out.

Where that does not exist, you cannot really regulate or mandate that the hospitals or the physicians will cooperate.

Over the 3 or 4 years that we have had PSRO's implemented we have tried technical assistance, we have tried conferences back and forth, we have used the examples of the good PSRO's. We have worked constantly with the poorer PSRO's.

The AAPSRO, a national organization, has worked——

Senator BAUCUS. So if I understand, you are saying those doctors that have accepted the concept and worked with it, then generally that PSRO is more effective in saving necessary costs. Is that correct?

Mr. Kelly. Yes.

Senator BAUCUS. As I listen to you though it sounds like it is irrelevant whether PSRO's are effective or not. The real criteria is whether or not there is sufficient competition. Is that a fair statement?

Dr. DAVIS. No. I think that at this particular time, with the administration facing severe fiscal constraints, prudence would dictate that if we have a program that is only marginally cost beneficial, and you look at the variety of programs that one would assess in terms of priorities, this would be a very low priority as opposed to keeping some other programs.

Prudence would simply dictate that if you have a marginally cost beneficial activity that PSRO's would be one of the items that should be slated for elimination.

Senator BAUCUS. I see the amber light. Let me ask one more question.

As I understand the CBO conclusion, which the administration relies on, PSRO's should be phased out because even though there might be slight savings in medicare/medicaid, those savings are transferred to private patients and there is a resultant increase in total health care cost. Is that not roughly the CBO conclusion?

And if it is, it seems to me, logically, that that argues for more PSRO's to be more active in the private area, in addition to looking at medicaid and medicare patients.

Because if CBO argues that, yes, it concludes that yes, there are savings in medicaid/medicare patients, that those savings probably would exist in nonmedicaid/medicare patients, since, as we all know, that most hospital bills are paid for by third parties anyway, that is insurance companies.

Does not that logically follow, that is, if there are savings in medicare/medicaid patients, there probably would be savings in private patients as well?

Dr. DAVIS. The CBO study, I think, did not indicate that there significant savings in the medicaid/medicare patient population.

The overall philosophy which I would like to go back to, is that we do not believe that the Federal Government ought to try to mandate behavior patterns.

We are hoping that procompetitive incentives will be in place as the PSRO's are phased out, and that those incentives will be the ethic that will control utilization and cost.

Senator BAUCUS. Thank you.

Senator DURENBERGER. I am not sure I know who, and I don't want to ask you who in the administration is making these recommendations, but I am going to say to you now in public what I have said to you in private, and that is I think it is ridiculous to say that we can abandon any effort to control costs just because competition is coming in 1983. That is a lot of bunk.

I mean, competition has been in the Twin Cities for 7 or 8 years, and competition is not yet controlling health care costs in the Twin Cities. It just does not come that fast.

And so I think the kinds of questions that Max asked you are very appropriate and will be at the heart of all of the questions I hope that are asked by those of us who believe in competition. We think competition is going to come. It has to come. It is the ultimate cost constraint in the system.

But I am just afraid that unless HHS can do a better job of answering the questions relative to what the world is going to look like—or cost constraints are going to look like in 1983, please do not tell us that competition is going to be there and solve these problems.

Do you have any further comments you would like to make?

Dr. DAVIS. No.

Senator DURENBERGER. Do you have any further questions, Max?

Senator BAUCUS. No.

Senator DURENBERGER. Thank you very much, Dr. Davis.

[The prepared statement of Dr. Davis Follows:]

STATEMENT OF DR. CAROLYNE K. DAVIS, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

I am pleased to appear before the subcommittee today to discuss the Professional Standards Review Organization (PSRO) program in the context of the President's proposed program for economic recovery. As part of a general effort to restrain health care costs by stimulating competition in the health care industry, the administration is proposing to phase out the PSRO program over the 1981-83 period. During this period, grants will be renewed with only those PSRO's judged most effective in controlling health care costs and assuring a high quality of medical care. All direct Federal support would expire at the end of 1983. In conjunction with the phase-out of the PSRO program, we will propose legislation to eliminate the requirement for utilization review committees in providers not covered by PSRO review.

Federal regulations in this area will be replaced by health care financing reforms which promote competitive incentives to control utilization. Over the long run, requiring PSRO's and other review entities to compete for contracts in the market place without Federal subsidy should ensure a more efficient use of health care resources.

BACKGROUND

The PSRO legislation was enacted in 1972 because the existing methods of utilization review and control were not doing the job of assuring that medicare and medicaid patients receive only medically necessary care. The PSRO program was designed to correct this situation and control costs resulting from overutilization of health care services.

PSRO PROGRAM EVALUATION

In 1977, the Department began annual evaluations of the impact of PSRO review on the utilization and cost of health services. Results of the 1977 evaluation were inconclusive as only 18 PSRO areas were active. Both the 1978 and 1979 evaluations of the PSRO program showed a modest reduction in hospital days used by medicare patients. However, there were wide variations in individual PSRO performance. Some PSRO's showed little or no effect on utilization while others demonstrated a positive impact. Overall, the evaluation found that PSRO's were only marginally cost beneficial.

Using the Department's data, the Congressional Budget Office (CBO) performed its own analysis of the 1979 PSRO evaluation. While agreeing that PSRO review had reduced medicare utilization, the CBO noted that a lack of information exists on the program's effect on medicaid utilization. Furthermore, CBO found that the reduced medicare outlays resulting from PSRO review are partly transferred to private patients whose charges rise accordingly. In consequence of this, CBO concluded that PSRO review costs society as a whole substantially more than it saves.

CONCLUSION

Overall control of health services utilization and cost has been ineffective through the regulatory approaches provided by PSRO review and Utilization Review Committees. As I indicated earlier in my testmony, we will propose to remove these Federal requirements and support only the most effective PSRO's for a two-year transition period. During this time, other health care financing reforms will be developed to promote competitive ways of controlling utilization in the health market place. In addition to capping the Federal funds provided to States for medicaid, competition could be stimulated by instituting prospective reimbursement systems, providing incentives for outpatient care and encouraging increased enrollment in health maintenance organizations. After Federal funding of PSRO's expires at the end of 1983, we would anticipate that the effective PSRO's will become a component of the competitive market by contracting their services to private health care systems.

This concludes my prepared remarks. I would be pleased to answer any questions you may have.

Senator DURENBERGER. Our next witness is Mr. Gregory J. Ahart, Director, Human Resources Division, General Accounting Office, accompanied by: Robert Iffert, Jr., Assignment Manager, Human Resources Division; and Donald Baiardo, Senior Evaluator, Human Resources Division.

If I am not correct in those, you can correct me.

STATEMENT OF MR. GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT IFFERT, JR., ASSIGNMENT MANAGER, AND DONALD BAIARDO, SENIOR EVALUATOR

Mr. AHART. Thank you, Mr. Chairman.

With me this morning is Mr. Iffert from the Human Resources Division, and Don Baiardo, also of that Division.

I have a rather lengthy statement. I will try to stay as close to the 10-minute allotment of time as I can and summarize it.

We are pleased to be here today to discuss the administration's proposal to phase out the professional standards review organization program and repeal the requirement for institutional utilization review committees for providers not covered by PSRO review.

You have asked us to discuss five areas which we will take up in turn.

First, however, I would like to summarize that we are unable to support the administration's proposal at this time, at least until some alternative is postulated which would clearly be more effective.

Turning to the history of the program, it shows that the Congress was concerned that the medicare program be carried out in a manner which would provide necessary hospital care to beneficiaries, but the beneficiaries would stay in the hospital only as long as necessary.

To this end, the law required hospitals and skilled nursing facilities to establish in-house utilization review committees to review the medical necessity of admissions, durations of stay, and any professional services rendered.

The medicaid law was amended in 1967 to require utilization review in that program.

As experience grew with the utilization review programs, dissatisfaction with the performance also grew. In response, this committee developed legislation establishing the PSRO program.

The Senate initially approved the program in December 1970, but the 91st Congress adjourned before it could be enacted.

The amendment was again approved in the 92d Congress and was enacted in October 1972.

Before PSRO's, the utilization review consisted of a review of medical necessity by the facilities' utilization review committees, review of claims by medicare intermediaries and carriers, or by medicaid State agencies, and, third, certification and recertification by the patient's physician that the care provided was medically necessary.

Congressional dissatisfaction centered on four aspects of this mechanism.

First, it was perceived that the title 18 Utilization Review Committees focused on form rather than substance. This perception was reinforced by data which showed the hospitalization utilization was increasing at a higher than anticipated rate.

We brought along a chart this morning, Mr. Chairman, which is over on my right, which provides some historical perspective on the unanticipated increase in hospital utilization that the Congress was attempting to deal with in the early years of the program.

Our work also tended to support these perceptions. A review of medical records by our consultant physicians of a random sample of 1969 extended duration medicare cases suggested the significant amounts of care provided was either unnecessary or of a higher level than necessary.

We reported also that while review committees tended to focus on extended duration cases, for hospitals the length of stay criteria for determining when the committees would review such cases ranged from 7 to 90 days. Thus, many beneficiaries who remained in hospitals for relatively long times did not have their cases reviewed.

Further, we reported that institutions were not complying with the legislative requirements regarding the frequency of committee

reviews, the sample of admissions and the certification by physicians that the care provided 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 what they called insurance company clerks.

Also, reviews by medicare intermediaries resulted in retroactive denials of payment after services had been rendered. This was considered onerous and manifestly unfair by the medical profession as well as by the institutional providers most directly affected.

Third, this 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, finally, dissatisfaction arose from the lack of professionally developed and accepted norms and criteria for carrying out the then existing utilization review requirement.

In light of these shortcomings, the Congress 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 program was slow. In March 1974, the Department designated 203 PSRO areas, 28 of which were statewide areas.

PSRO's were developed in three stages: planning, conditional, and fully designated.

By June 1977, 174 PSRO's were in place. A year later the number had increased to 190, 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 PSRO's, 3 planning PSRO's, and 6 areas not yet covered.

According to program officials, between July 1980 and January 1981, 47 conditional PSRO's became fully designated.

Briefly stated, the impediments to implementation over the first 5 years of the program involved fragmented authority and program responsibility within the Department, less than anticipated financing, delays in issuing regulations and program guidance, lack of aggressive administration of contracts with PSRO's, and, lastly and perhaps most important, lack of physician support in many areas of the country.

In summary, the program can be viewed as an attempt by the Congress to build a better mousetrap in response to evidence of significant increases in medicare hospital utilization and dissatisfaction with the utilization control mechanism that existed.

Despite problems in implementing the program, by 1979 there were 186 conditional PSRO's with about half the eligible physicians participating, which indicate that some of the early problems have been overcome.

Turning now to studies that have been made of the effectiveness of the program, I think, first, 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 in short-stay hospitals under medicare increased from about 88 million to 98 million.

In terms of the common denominator principally used in the evaluations, however, which is total days per 1,000 aged beneficiaries in short-stay hospitals, the changes from 1 year to the next became relatively small, with total swings of less than 3 percent during the 4-year period and a net difference of less than 1 percent.

The table at the bottom of page 9 in my statement gives some of this data.

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 cost effectiveness of PSRO's has been the subject of three comprehensive studies by HHS and numerous estimates of cost savings computed by individual PSRO's.

We have looked at some of these studies, and CBO has looked at some of these studies, and we have both found certain problems that exist with respect to the accuracy of the data used and the methodologies employed to compute savings.

I will not take time to go through what those studies show and what the findings were. I would just like to summarize and say that the rather inadequately measurement, I think, and the very difficult measurement, showed that the program was marginal at best to the extent that it could be measured.

But at the same time there is so much a problem with trying to measure such small changes in such large numbers that I would not put too much credence in those studies in terms of measuring the effectiveness of the program.

Let met move over to page 16 of the statement and just talk briefly about the extent to which private health insurers and other private parties have bought into the PSRO program.

Some of them have, both third party payors, private companies and some providers, have contracted with PSRO's or sister agencies to review the quality of care, or the necessity of care for which they reimburse or which they provide.

Most recent information available indicates that at least 30 PSRO's are associated with private review programs.

Nationally, private patient review is reported for no less than 24 hospitals, 8 health maintenance organizations, 63 insurers, 8 employers, and 11 other private entities.

In a January 1980 study by the American Association of PSRO's, 29 PSRO's reported that their private review programs involved an estimated 426,000 hospital discharges.

A complete picture of the extent to which PSRO's are involved with the private review, however, is not available.

Turning now to what we think about the administration's proposal, first of all, as Senator Baucus pointed out, we really do not know what the administration proposes to take its place or what forces they expect will be able to work to accomplish this same objective.

We assume that the effect would be the elimination of requirements for utilization review at the time medicare and medicaid patients are being treated on an inpatient basis.

We assume that the States would be able to establish any type of utilization control program they wish for medicaid, including no program if they wish, and that medicare intermediaries would be responsible for some form of utilization review for medicare in connection with their determinations of whether services were covered under the program.

We do not know what utilization control mechanisms might be substituted by the States or the intermediaries, 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 mechanisms gone, we cannot even speculate about the impact on medicare utilization rates.

Now I might add, as has already been pointed out, the Joint Commission on Accreditation of Hospitals now includes internal utilization review as a part of their accreditation standards. To the extent that this will stay in place, we are not sure.

Based on 1980 costs, Federal payments under medicare and medicaid for inpatient hospital care were about $25.6 billion. The funding for the PSRO program amounted to $155 million, or about 0.6 percent of such costs, of which 97 million, or about 0.4 percent, was assigned to the concurrent review activity.

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 at this time.

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 reliably 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 well be 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 will clearly be more effective.

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

Turning to the alternatives, one thing that bothers us is the fact that the administration proposes to fund for a short period of time the most effective PSRO's.

We do not know how this is going to be done. The studies that have been made so far do not validly assess which ones are the most effective.

We have over the past several years done studies of different parts of the program, including: One, the post-payment monitoring program; and two, the work that the HHS does itself in monitoring the program.

We think that both of these systems could be improved, and we have made recommendations to this effect which would better help improve the effectiveness of the programs that are there and also

help in identifying those that are most effective and perhaps they could be emulated.

Also we are a little bit concerned with the fact that a lot of the programs do not cover full States. In some States, there are as many as 28 areas, others 17. In Maryland, for example, they have 54 short-stay hospitals but have 7 PSRO areas.

We feel that administrative costs could be cut if you consolidated some of these. And we think there is an opportunity there to marry, in effect, some that are less effective, by whatever measure, with those that are more effective and perhaps upgrade the program itself.

Finally, we have often in our office recommended that when the Congress takes some initiative, where, we have many unknowns involved, to do a demonstration first.

We really do not see why this would not be equally applicable to dismantling of a program as to one that is being set up.

We do not know just how this kind of a demonstration might work. We note that in the South the studies have indicated that there may be some increase in utilization as a result of the PSRO program. This is unexplained and we cannot explain it. But that might be an area where with a properly controlled study, discontinuance of the program in some areas with some effective way to measure it might dispell the unknown answers at this time to questions as to what would happen if you discontinued PSRO's.

I might just pick up on a note which was brought out in the questioning of the previous witness.

It does seem to me—let me make two points that are not included in my statement—that it is a little bit inconsistent for the Federal Government, as one of the largest purchasers of health care services, to disband a program and expect that program to be picked up by the private sector, by other third-party payors and providers outside that program. There is an inconsistency there it seems to me.

Second, the big unknown—and if you look at the chart over here, it illustrates a big unknown—and what most studies really did not attempt to measure and which I do not think you really can measure, is what has been the effect on utilization and cost of the mere fact that the program is there?

The studies to try to compare the statistics are very shaky. Just the fact that somebody is going to be there looking at this, I just do not know. We do not know how to measure what that would be and I do not think any attempt has been made.

That summarizes our message here this morning, Mr. Chairman. And we would be happy to respond to questions.

Senator DURENBERGER. Thank you. I will just ask a couple of brief ones because your testimony was valuable and I am sure anticipated some of our questions, so we did not jump on you with the red light.

Mr. Kelly, in response to a question from Dr. Davis by Senator Baucus, talked about the total involvement of physicians, hospitals, all of the providers in this program being essential to make it work.

You make a strong point that perhaps the most important impediment to implementation of PSRO's has been the lack of physician support for the program in many areas of the country.

Do you see that the consequence of abandoning the so-called ineffective PSRO's is facilitate the emergence from the provider community of their own form of a review, or is it just to abandon the system and say that that has finally gone away. Now we can go back to doing our own thing? What is the most likely to occur?

Mr. AHART. Well your question really asks for me to speak to motivation, and I really would not want to do that here this morning.

I would say this though on the point that you are making. I think that we have had quite a history over the past 8 or so years of, to some degree, turning the medical profession around and getting involvement, the active involvement of doctors in this program.

As I referenced in my statement, we now have 186 PSRO's that are active. We have participation by about one-half of the physicians that are eligible to participate. And I think that says we have gone quite a long ways.

I would have some concern, and we would have some concern, about whether that situation might reverse itself a little bit if the Federal Government, in effect, withdraws its support of this type of quality assurance and cost control mechanism.

And that is about the best I can respond, I think, Mr. Chairman, to your question.

Senator DURENBERGER. On the issue of analyzing of a program like this, your statement—not the part that you read but the one that you submitted for the record—contains a rather detailed examination of a lot of very expensive studies that have been going on during a period of time when it appears that this whole program was just evolving. I imagine similar kinds of analyses have been undertaken at the State or local level as well.

Are you aware, from your work at GAO, of any other program in the health care area that has been subject to the same kind of rigorous, so-called cost benefit analysis as PSRO has?

Mr. AHART. No; Mr. Chairman, I am not. And I think because of the difficulties in measuring these types of things, I am not sure how valid these kinds of studies can be.

For example, we have just taken a look at the medicaid fraud control units which are established at the State level.

I think it is fair to say that at this point in time that program would not stand the same kind of a test which these studies try to apply here, that is, whether they save more than a buck for every buck that is spent on them.

But at the same time I would add to that the other point I made: To what extent is the system influenced by the mere fact that they are there and people know that they are there? In the same way as to what extent is that downward curve on the chart, influenced by the mere fact that the Congress was considering the PSRO legislation and the kinds of controls which we now have in place?

And I do not think there are ever going to be any answers to these kinds of quetions.

Senator DURENBERGER. Thank you very much.

Max?

Senator BAUCUS. Mr. Ahart, one question that concerns me is how the ratio of cost, that is, 0.6 or 0.4 tenths of a percent to the total cost of the program, compares with other monitoring activities in the Government or in the private sector, that is, where some agencies try to monitor whether their program falls within the range of the potential payout or is it not within the range, compared with other similar functions?

Mr. AHART. Yes; I would view it as a relative small cost to pay for this type of thing.

Again, you do not know what effect it has. To some degree, I think you are kind of flying blind in expecting—and I think you have a reasonable expectation—that the mere presence of this kind of program is going to have some effect, and that that effect is going to be in the right direction.

The point we tried to make in our statement was that it is so small, and the variability of data is so wide, that if it has any effect at all, it probably pays for itself, irrespective of what these very expensive studies have shown.

I understand that you will have some people that are from private outfits that are actually paying for this kind of service. Perhaps they could help in what their perspective is on whether or not—whatever percentage they pay of their health care cost for this type of service—whether or not that is worth it in their minds.

Senator BAUCUS. You said that the effectiveness of some PSRO's depend upon the acceptance by physicians. What in your experience and according to your studies are the reasons why some communities of physicians accept PSRO's and some do not?

Mr. AHART. Well, I think that is a difficult question to answer, Senator.

I am sure that early on in the program and probably to a large degree today for those people that resist this type of program, it is a question of not wanting to be second guessed, to have somebody else come in and make the judgment as to whether what I have decided is a matter of my professional judgment was reasonable.

And I think that really gets down to the kernel of it. Nobody likes GAO to come audit them. Nobody likes the Internal Revenue Service to check over what they reported. I don't think the medical profession is different in that regard. They don't like to have people come and check on a formal basis and particularly one where a payment depends on whether or not that judgment is evaluated as being a correct judgment.

Senator BAUCUS. So it would depend more upon whether a physician is being second guessed or whether the mechanism of the second guessing is what affects acceptability?

Mr. AHART. Well, I am sure there are some types of mechanisms that might be more acceptable than others. But I think the kernel of it is whether or not you are being second guessed.

Senator BAUCUS. Thank you.

Senator DURENBERGER. Thank you very much, Mr. Ahart.

[The prepared statement of Gregory J. Ahart follows:]

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION

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 amd (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 beneficiaries, 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 (Public Law 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 opccupany 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: 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. Futhermore, 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 by the institutional providers most directly affected.

Third, aside from the economic impact of the perceived overutilization, 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 implementing the PSRO legislation was slow.[2] 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 actually implement or delegate to hospitals their concurrent review activities.[3] The fully designated stage was to be reached when HHS considered that a conditional PSRO was capable of fulfilling its resonsibilities, 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 planning stage. A year later, the number has increased to 190—37 planning and 153 conditional—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

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

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

[3] 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.

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 responsiblity within the Department involving the health financing agencies and the public health service, (2) less than anticipated financing because of Office of Mangement 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 PSRO'S

Before discussing the various studies aimed at assessing the cost effectiveness of PSORs, 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 beneficaries 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.[4]

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 1974-78		+.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 deductible and coinsurance amounts which are the responsibility of the beneficiaries.

Thus, relatively insignificant errors in the data of 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 certin problems that exist with respect to the accuracy of the data used and with the methodologies employed to compute savings.

OPEL STUDY OF 1974-76 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 PSRO's were making concurrent reviews of hospital utilization. The utilizations 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.[5] The study concluded that in the aggregate, PSRO review had no significant effect on the days of Medicare hospital

[4] 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.

[5] In the non-PSRO areas, utilization review committees were operative.

utilization. The study also concluded that seven of the PSRO's 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 PSRO's. Most of these were done by the PSRO's 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 PSRO's.

In this effort we selected nine estimates of cost savings for individual PSRO's. 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 reviewed.

Also, because of deficiencies in the methods used by the PSRO's 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 PSRO's.

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 evauluation 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 studies 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 beneficiaries. 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 the 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 PSRO'S

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 acitve. 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 mechanisms 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 reliably 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 PSRO'S

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 discussed, both the 1978 and 1979 HCFA evaluations associated PSRO concurrent review in the South [6] 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 existing utilization control mechanisms will not result in a corresponding increase in unnecessary benefit

[6] 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.

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 advantage 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.[7] 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 to inpatient admissions reviewed by a PSRO to identify cases where intermediary physicians questioned the medical necessity of days approved by the PSRO.[8] 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.[9] 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 recommendations 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.

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

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[7] Opportunities to Reduce Administrative Cost of Professional Standards Review Organization, HRD-78-168, October 12, 1978.

[8] Need to Better Use the Professional Standards Review Organization Post-Payment Monitoring Program, HRD-80-27, December 6, 1979.

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

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.

Senator DURENBERGER. Our next witness is Mr. Paul B. Ginsburg, Chief, Income Security and Health Unit, Congressional Budget Office.

STATEMENT OF PAUL B. GINSBURG, CHIEF, INCOME SECURITY AND HEALTH UNIT, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION, CONGRESSIONAL BUDGET OFFICE

Mr. GINSBURG. Mr. Chairman, I would like to introduce to you Daniel Koretz, on my right, who is an analyst in the Human Resources and Community Development Division of CBO and is the author of the CBO report on PSRO's.

The Congressional Budget Office is pleased to have the opportunity to testify on the subject of the cost effectiveness of Professional Standards Review Organizations (PSRO's) and the administration's proposal to phase out the program. As you are aware, CBO has studied the issue of PSRO effectiveness for some time and has issued a number of reports, the most recent of which appeared in January of this year. Since there has been much discussion of the topic during the past year, I will give only a brief summary of our latest study, which has been submitted to the committee, and I will then concentrate on the administration's proposal to phase out the program.

The CBO study examined the effect of PSRO's on hospital utilization and costs in 1978, the last year for which data are available. The study assessed only the program's efforts to restrain hospital use. I will refer to these activities as PSRO review. Limited data prevents our evaluating PSRO's quality assurance activities in general or assessing any incidental impacts of PSRO utilization review on quality. Accordingly, the costs and effect of PSRO's quality-assurance activities were excluded from our evaluation.

The CBO study reached three basic conclusions. First, PSRO review does reduce medicare days of hospitalization by about 1.5 percent. And notwithstanding remarks made by the witness from the General Accounting Office, this conclusion includes any deterrent effects of the program. There is no good information, however, concerning the program's effect on hospitalization of medicaid recipients.

Second, PSRO review of medicare patients costs more than it saves society as a whole. Since PSRO's are themselves part of the health care system, this means that, as a result of PSRO review, society devotes slightly more resources to health care than it otherwise would.

Nonetheless, PSRO review of medicare patients saves the Federal Government slightly more than it costs. In 1980, the net savings to the Government from such review were about $18 million—less than one-tenth of 1 percent of medicare outlays for hospital care.

PSRO medicare review generates a small net savings to the Federal Government while producing a net loss to society as a whole because some of the savings to the Government are costs that have been transferred to private patients. This transfer occurs because of the way the medicare reimbursement system treats

fixed costs. When a medicare day of hospitalization is avoided because a PSRO has had a patient discharged earlier, some of the hospital's costs that medicare would have paid for remain. Interest on the hospital's mortgage debt, for example, remains unchanged. The medicare reimbursement system apportions these remaining—or fixed—costs proportionately among all patients, and since private patients account for about two-thirds of all patient days, they are charged for most of these costs.

I would like to turn now to the administration's proposal for the PSRO program and to assess the effects that proposal would have.

The administration is proposing a phaseout of Federal support for PSRO's, beginning in the current fiscal year and ending in 1984. Individual PSRO's could continue some review activities if they were able to obtain private funding for them, but their role in the medicare and medicaid programs would be terminated. PSRO's quality assurance activities would be terminated along with their utilization control efforts. At the same time, the administration proposes to eliminate the requirement under titles XVIII and XIX of the Social Security Act that providers not under PSRO authority conduct their own utilization review. Without those legislative changes, utilization review of that sort—usually called UR—would resume when PSRO's terminated their activities.

The administration proposes fiscal year 1981 funding for the program of $135 million, which would be $39 million, or 22 percent less than the level in the continuing resolution. The administration's 1982 request is for $70 million, which is $104 million below both the 1981 continuing resolution and the Carter administration request for 1982.

To accomplish this reduction, the Reagan administration would stop funding a large number of PSRO's, rather than cut funding across the board. The administration suggests that they will be able to select the least effective PSRO's to stop funding first, giving the most effective PSRO's time to develop the private funding that they would need in order to continue operation.

The effect of the administration's proposal on the Federal budget would be quite small. Total elimination of both the program and the UR requirements would save about $60 million relative to the 1981 continuing resolution. The administration's smaller reductions in 1981 and 1982 would save somewhat less, depending on the administration's success in selecting the effective PSRO's for earlier termination. It might be reasonable to expect a net budgetary savings of about $20 million in 1981 and perhaps $50 million in 1982.

There is one unknown factor that might make these estimates of budgetary savings too large. While we have estimated the cost of UR and PSRO review, and we have estimated the impacts of PSRO review on utilization, we are not aware of any reliable estimate of the effects of UR on utilization and costs. There has been a widespread consensus—though not based on firm data—that UR has little or no effect. Both our budget estimates and those of the administration assume this to be the case. If, however, UR has some effect, eliminating it would further increase utilization and costs, offsetting some or all of the estimated savings from the administration's proposal.

Two aspects of these estimates warrant some discussion.

First, changes in funding for the PSRO program, without changes in the UR requirement, have only negligible effects on the Federal budget. The small net savings to the Federal Government generated by PSRO review are roughly offset by the cost of PSRO quality-assurance activities. Thus, the net budgetary effect of eliminating the entire PSRO program would be, for all practical purposes, zero. It is the additional elimination of the UR requirements that causes us to estimate budgetary savings, and that estimate is a very soft one.

Second, CBO's estimates take into account the fact that it is not feasible to reduce the program to the extent proposed by the administration without denying funding for some moderately effective PSRO's. In contrast, the administration's budget estimates assume that the proposed 60 percent funding reduction in 1982 would be accomplished by denying funding only to PSRO's that are completely ineffective in reducing hospital use.

There are two reasons why the Administration's assumption is unrealistic: First, there is no evidence to suggest that so many PSRO's are totally ineffective; second, there is no entirely reliable way to sort out the most and the least effective PSRO's, and, consequently, any group of PSRO's that the administration selects for termination is likely to include a number that are, in fact, moderately effective.

The limited ability to distinguish effective from ineffective PSRO's stems in large part from limitations in the available data about individual PSRO's. Much of the data that the Department of Health and Human Services (HHS) has collected consists of so-called process data—that is, measures of the activities that PSRO's have engaged in, but not of their effects on utilization and cost. Examples of process measures include information on whether PSRO's are following regulations and have worked out agreements for fiscal intermediaries.

Unfortunately, HHS still lacks some of the most important process measures, such as the proportion of cases that PSRO's actually review or the criteria they use in selecting cases for review. Nonetheless, it is likely that PSRO's that fail in terms of the available process measures are, in fact, relatively ineffective, and HHS has been able to use these data to weed out a handful that were not doing even a minimally acceptable job. The problem is that many of the remaining PSRO's may still be relatively ineffective.

To weed out ineffective PSRO's further, it is necessary to have "outcome" measures—measures of actual PSRO impacts—that are more reliable than those that are currently available. Many of the available outcome measures represent PSRO's self-evaluations. Among other problems, these data are often incomplete—for example, sometimes reporting changes in length of stay without reporting possibly offsetting changes in admission rates. While high quality outcome data have been developed by HHS for the national evaluations of the program, these are not suited to evaluating the effectiveness of individual PSRO's, and past attempts to use them for that purpose have been highly misleading.

ALTERNATIVE METHODS FOR REDUCING THE PROGRAM

The administration's proposal to terminate the funding of a substantial number of PSRO's within the next 6 months raises two issues about alternative ways of phasing down or eliminating the program; first, whether a phase-down could be structured to allow evaluations of alternative methods of utilization review, and second, whether certain parts of the program should be retained.

If the Congress agrees with the administration that the PSRO program should be phased down, a process could be used to test out alternative, possibly more cost-effective methods of review. As an example, the Western Massachusetts PSRO has for some time been experimenting with an alternative review system in which cheaper retrospective review is coupled with the potential sanction of removal of hospitals' waivers of liability. The PSRO system could provide a reliable test of the cost effectiveness of this or other alternatives, provided that the system was scaled down in the appropriate manner. For example, the process of selecting which PSRO's would be terminated would be crucial, and it would be necessary to have a stable, even if reduced, level of funding for a period of at least 2 years.

Should PSRO review be terminated, a decision would have to be made about whether data collection or quality assurance activities should be continued. PSRO's currently collect detailed data that can be used to generate profiles of the medical-care practices of individual physicians and hospitals. At least one PSRO—Baltimore City—in an effort to enhance the competitive pressures on hospitals, is making public detailed information about lengths of hospitalization for specific diagnosis at various hospitals.

Although the effectiveness of the Baltimore approach has not been well tested, it might be worth maintaining PSRO's data-collection capacity and testing it further as part of the strategy to increase competition in health care.

Comprehensive data on the effectiveness of quality assurance activities are not yet available. Such activities might be continued, however, at least in some PSRO's, in order to assess their effectiveness or to improve them.

CONCLUSION

At past hearings on the PSRO program, CBO and the previous administration debated the cost effectiveness of PSRO review. Despite these disagreements, it is clear that the program has had only a small impact on the budget and on society's expenditures of resources for health care. Changes in the level of funding for the program would have an even smaller net effect. Accordingly, in deciding the future for this program, the Congress might want to give weight to other considerations.

I would be pleased to answer questions now.

Senator DURENBERGER. Thank you very much.

Let me explore briefly the motion of the societal costs that have accumulated as a result of PSRO.

Does the Congressional Budget Office have a process, a general budget process, for determining what might be called off-budget societal cost? For example, do you have a model for measuring

societal cost involved in certain air quality legislation? Do you have a model for measuring societal cost if we switch from cacine to alternative milk products?

You apparently have one here for what is called the cost shifts, from Medicare to private patients.

Is there a model available that you use to estimate these costs?

Mr. GINSBURG. I cannot speak about the specifics of some of the issues you raised. But, in general, CBO attempts to measure effects other than budgetary impacts whenever possible.

One particular area in which we have many inquiries is the effects of various federal actions on the budgets of state and local governments. That is the area we work on hardest to find other effects. But when costs to the private sector tell a different story from the effect on the federal budget, we try whenever possible to measure these costs and bring them to light.

Senator DURENBERGER. Is it possible that with regard to some PSRO activities that the review process operating on Medicare has a societal plus with regard to private patients? In other words, the process gets incorporated into a provider's method of reviewing procedures and costing procedures so that there is a substantial benefit rather than a detriment, financial detriment, to a private patient utilizing a particular provider.

Mr. GINSBURG. Yes. The effects on private patients can go either way. The mechanism you point out certainly can be the case—that by demonstrating a concern with lengths of stay that are too long, one could influence physicians in their decisions about private patients. But, it could go the other way, as in the so-called Roemer effect, which suggests that when you empty beds of Medicare and Medicaid patients, there is a tendency to fill those beds with private patients.

Senator DURENBERGER. Do you want to answer that, Mr. Koretz?

Mr. KORETZ. Yes. Mr. Chairman, the Health Care Financing Administration tried, about a year or a year and a half ago, to test out both of those propositions and found that, on average, they were not able to find any positive or negative effect of PSRO medicare activities on private patients. So if those two effects exist, they appear to cancel each other out.

Senator DURENBERGER. So would it be fair to say that your statement on the bottom of page 2, that there is a net loss to society, may not necessarily hold true?

Mr. GINSBURG. We feel it does hold true.

Mr. KORETZ. If I could elaborate, There are two separate issues here. One is whether PSRO activities, in attempting to restrain Medicare hospitalization, have an impact on private utilization. And as far as we know, the answer seems to be no, it does not, at least not to a large extent. However, even if there is no impact on private utilization, there is still a transfer of costs. And that is the basis for our conclusion.

We are assuming, in the numbers that we mentioned today, that there are no effects on private use whatsoever. All of the negative effects are simply transfers of costs.

Senator DURENBERGER. Let me ask you a question relative to the process issue that is described in the middle of the statement: "HHS still lacks some of the most important process measures,

such as the proportionate of cases that PSRO's actually review or the criteria they use in selecting cases for review."

In the whole issue of process there has been some suggestion—and maybe some of them are—to move the PSRO's from concurrent review of all cases toward a more focused review.

It seems that some of the successful models over in the occupational safety and health area focus their efforts on the SIC code, for example, to make a comparison, in which it is most likely that incidents of safety or health violations might occur.

Is that focusing, in your opinion, an appropriate direction for review process to move?

Mr. KORETZ. We have taken the position that focusing has a great deal of potential. It certainly seems logical to focus review money and review activities on cases where they are most needed. But, unfortunately, we have no idea of how it is being done.

The Office of Research in the Health Care Financing Administration is now beginning to collect information, for example, on the criteria that individual PSRO's are using in selecting which cases to review. But up until now, the problem has been a black box, and it still is. And we do not have any reason to believe that they have been focusing in a way that has increased cost effectiveness.

We are also concerned that if the level of review is too low—or if too large a percentage of cases are focused out—that the system could lose its deterrent effect; hospital administrators and physicians might reach the point of realizing that their odds of being caught are very low. The system might become ineffective at that point. But so far, we lack the data to test this assumption.

Senator DURENBERGER. Thank you. Max?

Senator BAUCUS. Mr. Ginsburg, one thing that strikes me is the question of the degree to which CBO has expertise in this area. Since I have been in the Congress, and not very long, I have always thought that CBO was more involved in macroeconomics and economic-effective budgets on the economy, and so forth, and I always thought GAO was more the investigating arm of the Congress to see whether certain programs work.

Would you just enlighten me and tell me how many health studies that you have conducted and the number of man-hours that you devote to this area, and outline the kind of studies you have undertaken? I mean, you could not possibly just look at studies and then have written up your statement and given us your opinion, at one extreme. The other extreme you could have thousands of people who are the world's greatest experts and all this and have the definitive study.

So I am just trying to figure out on that spectrum where you are.

Mr. GINSBURG. Certainly. Within CBO there are four analysts who work on health care issues.

Senator BAUCUS. Four?

Mr. GINSBURG. Four. Most of our work tends to be studies to assist the Congress in thinking about proposed legislation—what is background of the issue, and what would be the effects of alternative proposals. There is an emphasis on budgetary cost, but our analysis is not limited to that.

The study of PSRO effectiveness is not the typical CBO study, which tends to focus on new programs rather than on evaluating

existing programs. We do not do program evaluations at CBO. We do not have the capability to get into the field. You are right, GAO tends to do that.

[The above mentioned CBO study is in the committee files.]

Mr. GINSBURG. What we were asked to do on the PSRO program was to comment on the existing evaluations. In this case we found that the Health Care Financing Administration (HCFA) had done an outstanding job in collecting a very extensive data base to study this issue. But we had some real methodological differences with them. So an important part of our work in this study consisted of asking HCFA to redo their analysis according to our methodology. That is really the substance of CBO's reports on PSRO's.

Senator BAUCUS. So you did not send out teams of people across the country to the hospitals and interview physicians, trying to determine what the so-called societal cost is going to be?

Mr. GINSBURG. No. Basically, the data that were used were on rates of utilization by medicare patients. Essentially, what we did was to look at differences over time in rates of utilization by medicare patients in areas that had PSRO's and compare them to differences in areas that had no PSRO activity.

The adjustment for societal cost was based on studies of fixed costs in hospital care. Our reasoning was that, if a certain proportion of hospital costs are fixed, the workings of the medicare reimbursement system would cause this transfer.

Senator BAUCUS. Does not that suggest that there are additional problems. I mean, should we not have savings because as a result of fixed costs, there is additional total cost? And maybe that suggests that the fixed cost should be reduced.

Mr. GINSBURG. Well, yes. In the very long run, you might be able to expect that a continuation of PSRO-caused reduction would actually eliminate those fixed costs also. But you are talking about a very long-run process there.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. Thank you very much for your testimony.

[The prepared statement of Mr. Ginsburg follows:]

STATEMENT OF PAUL B. GINSBURG, CHIEF, INCOME SECURITY AND HEALTH UNIT, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, the Congressional Budget Office is pleased to have the opportunity to testify on the subject of the cost-effectiveness of Professional Standards Review Organizations (PSROs) and on the Administration's proposal to phase out the program. As you are aware, CBO has studied the issue of PSRO effectiveness for some time and has issued a number of reports, the most recent of which appeared in January of this year. Since there has been much discussion of the topic during the past year, I will give only a brief summary of our latest study, which has been submitted to the Committee, and will then concentrate on the Administration's proposal to phase out the program.

The CBO study examined the effects of PSROs on hospital utilization and costs in 1978, the last year for which data are available. The study assessed only the program's efforts to restrain hospital use. I will refer to those activities as "PSRO review." Limited data prevented our evaluating PSROs' quality-assurance activities in general or assessing any incidental impacts of PSRO utilization review on quality. Accordingly, the costs and effects of PSROs' quality-assurance activities were excluded from our evaluation.

The CBO study reached three basic conclusions:

PSRO review does reduce Medicare days of hospitlization—by about 1.5 percent. There is no good information, however, concerning the program's effect on hospitlization of Medicaid recipients.

PSRO review of Medicare patients costs more than it saves society as a whole. Since PSROs are themselves part of the health-care system, this means that as a result of PSRO review, society devotes slightly more resources to health care than it otherwise would.

Nonetheless, PSRO review of Medicare patients saves the federal government slightly more than it costs. In 1980, the net savings to the government form such review were about $18 million—less than one-tenth of one percent of Medicare outlays for hospital care.

PSRO Medicare review generates a small net saving to the federal government while producing a net loss to society as a whole because some of the savings to the government are costs that have been transferred to private patients. This transfer occurs because of the way the Medicare reimbursement system treats fixed costs. When a Medicare day of hospitalization is avoided because a PSRO has had a patient discharged earlier, some of the hospital's costs the Medicare would have paid for remain. Interests on the hospital's mortgage debt, for example, remains unchanged. The Medicare reimbursement system apportions these remaining—or fixed—costs proportionately among all patients, and since private patients account for about two-thirds of all patient days, they are charged for most of these costs.

THE ADMINISTRATION'S PROPOSAL

I would like to turn now to the Administration's proposal for the PSRO program and to assess the effects that proposal would have.

The Administration is proposing a phase-out of federal support for PSROs, beginning in the current fiscal year and ending in 1984. Individual PSROs could continue some review activities if they were able to obtain private funding for them, but their role in the Medicare and Medicaid programs would be terminated. PSROs' quality-assurance activities would be terminated along with their utilization-control efforts. At the same time, the Administration proposes to eliminate the requirement under Titles XVIII and XIX of the Social Security Act that providers not under PSRO authority conduct their own utilization review. Without those legislative changes, utilization review of that sort—usually called "UR"—would resume when PSROs terminated their activities.

The Administration proposes fiscal year 1981 funding for the PSRO program of $135 million, which would be $39 million, or 22 percent, less than the level in the Continuing Resolution. The Administration's 1982 request is for $70 million, which is $104 million below both the 1981 Continuing Resolution and the Carter request for 1982.

To accomplish this reduction, the Administration would stop funding a large number of PSROs rather than cut funding across the board. The Administration suggests that they will be able to select the least effective PSROs to stop funding first, giving the most effective PSROs time to develop private funding that they would need in order to continue operation.

The effect of the Administration's proposal on the federal budget would be quite small. Total elimination of both the program and the UR requirements would save about $60 million relative to the 1981 Continuing Resolution. The Administration's smaller reductions in 1981 and 1982 would save somewhat less, depending on the Administration's success in selecting the least effective PSROs for earlier termination. It might be reasonable to expect a net budgetary savings of about $20 million in 1981 and perhaps $50 million in 1982.

There is one unknown factor that might make these estimates of budgetary savings too large. While we have estimated the costs of UR and PSRO review, and we have estimated the impact of PSRO review on utilization, we are not aware of any reliable estimate of the effects of UR on utilization and costs. There has been a widespread consensus—though not based on firm data—that UR has little or no effect. Both our estimates and those of the Administration assume this to be the case. If, however, UR has some effect, eliminating it would further increase utilization and costs, offsetting some or all of the estimated savings from the Administration's proposal.

Two aspects of these estimates warrant some discussion.

First, changes in funding for the PSRO program—without changes in the UR requirements—have only negligible effects on the federal budget. The small net savings to the federal government generated by PSRO review are roughly offset by the cost of PSRO quality-assurance activities. Thus the net budgetary effect of eliminating the entire PSRO program would be, for all practical purposes, zero. It is the additional elimination of the UR requirements that cause us to estimate budgetary savings, and that estimate is a very soft one.

Second, CBO's estimates take into account the fact that it is not feasible to reduce the program to the extent proposed by the Administration without denying funding

to some moderately effective PSROs. In contrast, the Administration's budget estimates assume that the proposed 60 percent funding reduction in 1982 would be accomplished by denying funding only to PSROs that are completely ineffective in reducing hospital use.

There are two reasons why the Administration's assumption is unrealistic. First, there is no evidence to suggest that so many PSROs are totally ineffective. Second, there is no reliable way to sort out the most and the least effective PSROs, and consequently any group of PSROs that the Administration selects for termination is likely to include a number that are in fact moderately effective.

The limited ability to distinguish effective from ineffective PSROs stems in large part from limitations in the available data about individual PSROs. Much of the data that the Department of Health and Human Services (HHS) has collected consists of so-called "process" data—that is, measures of the activities that PSROs have engaged in, but not of their effects on utilization and costs. Examples of process measures include information on whether PSROs are following regulations and have worked out agreements with fiscal intermediaries. Unfortunately, HHS still lacks some of the most important process measures, such as the proportion of cases that PSROs actually review or the criteria they use in selecting cases for review. Nonetheless, it is likely that PSROs that fail in terms of the available process measures are in fact relatively ineffective, and HHS has been able to use these data to weed out a handful that were not doing even a minimally acceptable job. The problem is that many of the remaining PSROs may still be relatively ineffective.

To further weed out ineffective PSROs, it is necessary to have "outcome" measures—measures of actual PSRO impact—that are more reliable than those that are currently available. Many of the available outcome measures represent PSRO's self-evaluations. Among other problems, these data are often incomplete—for example, sometimes reporting changes in length of stay without reporting possibly offsetting changes in admission rates. While high-quality outcome data have been developed by HHS for the national evaluations of the program, these are not suited to evaluating the effectiveness of individual PSROs, and past attempts to use them for that purpose have been highly misleading.

ALTERNATIVE METHODS OF REDUCING THE PROGRAM

The Administration's proposal to terminate the funding of a substantial number of PSROs within the next six months raises two issues about alternative ways of phasing down or eliminating the program: Whether a phase-down could be structured to allow evaluations of alternative methods of utilization review, and whether certain parts of the program should be retained.

If the Congress agrees with the Administration that the PSRO program should be phased down, the process could be used to test out alternative, possibly more cost-effective, methods of review. As an example, the Western Massachusetts PSRO has for some time been experimenting with an alternative review system in which cheaper, retrospective review is coupled with the potential sanction of removal of hospitals' waivers of liability. The PSRO system could provide a reliable test of the cost-effectiveness of this or other alternatives, provided that the system was scaled down in the appropriate manner. For example, the process of selecting which PSROs would be terminated would be crucial, and it would be necessary to have a stable—even if reduced—level of funding for a period of at least two years.

Should PSRO review be terminated, a decision would have to be made about whether data collection or quality-assurance activities should be continued. PSROs currently collect detailed data that can be used to generate profiles of the medical-care practices of individual physicians and hospitals. At least one PSRO—Baltimore City—in an effort to enhance the competitive pressure on hospitals, is making public detailed information about lengths of hospitalization for specific diagnoses at various hospitals. Although the effectiveness of the Baltimore approach has not been well tested, it might be worth maintaining PSROs' data-collection capacity and testing it further as a part of a strategy to increase competition in health care.

Comprehensive data on the effectiveness of quality-assurance activities are not yet available. Such activities might be continued, however, at least in some PSROs, in order to assess their effectiveness or to improve them.

CONCLUSION

At past hearings on the PSRO program, CBO and the previous administration debated the cost-effectiveness of PSRO review. Despite these disagreements, it is clear that the program has had only a small impact on the budget and on society's expenditures of resources for health care. Changes in the level of funding for the

program would have an even smaller net effect. Accordingly, in deciding the future of this program, the Congress might want to give weight to other considerations.

Senator DURENBERGER. Our next witness will be a panel consisting of Dr. Helen Smits, senior research associate, health policy program, The Urban Institute, Washington, D.C., and Mr. Jay B. Constantine, former chief, health staff, Senate Finance Committee.

STATEMENTS OF DR. HELEN SMITS, SENIOR RESEARCH ASSOCIATE, HEALTH POLICY PROGRAM, THE URBAN INSTITUTE, WASHINGTON, D.C., AND MR. JAY B. CONSTANTINE, FORMER CHIEF, HEALTH STAFF, SENATE FINANCE COMMITTEE

Mr. CONSTANTINE. Mr. Chairman, this is an unrelated panel. We have met before, but Helen is here doing her thing and I guess I am doing mine.

Senator DURENBERGER. Thank you.

Dr. Smits, would you like to proceed then with that introduction?

Dr. SMITS. Thank you. I thought I knew him.

Senator DURENBERGER. It hardly speaks in total to your qualifications. Or maybe it does.

Dr. SMITS. Mr. Chairman, I am very pleased to appear before the committee this morning. I should note that in addition to being at The Urban Institute, I am a physician and practice in the District of Columbia and a member of the local PSRO.

I am also, as you know, the former director of the bureau in which the PSRO program is located. And I presume it is on the basis of that experience that you wish to hear from me.

I would like to make two major points this morning. One is on the topic that you have already heard a great deal about, so I will not stress it, that is, in the present, cost effectiveness of the PSRO program. The other has to do with the future, which is something I think we need to talk about a good deal more than we have so far.

In terms of the cost-effectiveness of the program, I would simply like to remind you that all of the numbers you were talking about tend, as most of the analysts agree if you really talk to them, to seriously underestimate the cost effectiveness of the program.

First of all, all the evaluations, all the numbers you are talking about, look only at reductions in total hospital days of care per thousand population. PSRO's do a lot of other things. They review physician services, they review ancillary services. The smallest additional savings from those activities will dramatically improve the cost effectiveness number.

The second problem is one point that I think I am beginning to win because it sounded like other people were acknowledging it more this morning than they have in the past. That is known as the marginal benefit total cost problem. And that is very simply that what we measure in the evaluation is the marginal effect of the program over utilization review, but we do not know what UR costs.

As a matter of fact, if you take the figures which appeared in the 1977 HCFA—then not HCFA—the OPEL evaluation of the program, use standard inflation figures to project them forward to this year, you will find that utilization review is significantly more expensive than PSRO.

And I would note that if UR is eliminated as a mandated Government activity then obligations laid on hospitals by the JACH or local insurance carriers will probably mean that we will go on carrying those costs. And that, therefore, the net savings from eliminating both PSRO and UR will be even less.

But perhaps the most important thing I would like to mention this morning has to do with the future. I was interested to hear that this administration appears to believe that PSRO's do not do anything but save money, and that once you have competition you can simply make them go away since you will not need them any more.

I think exactly the opposite is true. What attracts physicians into PSRO work is often the quality assurance activities rather than just the cost savings. We are getting more interested in cost savings all the time, but quality assurance is often where the heart really is. And that is the work you will need if you have a more competitive system.

There is a great deal of evidence that the consumer in health simply cannot choose as accurately about the quality of care as he can in many other fields. And even if he can choose well at the beginning of an episode of illness, he certainly cannot choose in the middle of an episode of illness. You cannot pack your monitor and move from one hospital to another the same way you can pack your bag and move from one hotel to another when you do not like the service.

The fact is that the Federal Government and State governments will retain an obligation to let consumers know that an approved health plan in a competitive system is going to provide them with satisfactory service. You have only two ways to meet that obligation. You can develop a series of elaborate structural and process oriented measures exactly like the ones I had to administer for hospitals and nursing homes, or you can develop a far more creative and exciting system based on physician review of the actual quality of services delivered.

And I think that that second choice is, interestingly enough, a great deal more consistent with this administration's general position about regulation than the first choice is.

I believe, therefore, that if you take the PSRO program down in 1981 you are going to be in the business of putting it back up in 1983 or 1984.

But I would like to say that from my own personal perspective—and I think this is shared by many physicians—that going through the rather embittering process of taking down an organization into which we have put a great deal of time and effort will leave a lot of us who have been the most active pretty disinterested in participating the next time around.

I would like to finish by saying that I think there are some different things that could be done with the PSRO program. One of the great pleasures of speaking as a private citizen is I do not have to have my ideas approved by 15 people. [Laughter.]

Dr. SMITS. And one of the areas that I think would be very interesting would be to allow States to contract directly with PSROs and get the Federal Government out of the middle of that relationship.

It has been a very difficult business for everybody and I really have a lot of sympathy for both the States and the PSRO's in that setting.

Frankly, I think you would be surprised at how many States would contract with PSRO, and you would be very surprised at the price they would be willing to pay.

One of the bitterest State complaints right now is that they do not believe the work of review can be done at the current Federal price.

I think the relationship between the Federal Government and the PSRO's could also be moved very much in the direction of a simpler contracting arrangement rather than the kind of indirect management of the whole program, which was a responsibility placed on me.

Finally, I certainly think, since there seems to be some enthusiasm for it, that encouragement of private contracting could be vastly increased and that small inducements could be offered to PSRO's to increase their private activity.

I think all of these would tend to move PSRO's in the direction of what I see the original concept as being and that is of being genuinely independent professional organizations which contract with and are not servants to the Federal Government.

Senator DURENBERGER. Thank you very much for that statement.

Mr. Constantineis one who no longer needs 15 people to approve your statement. Would you proceed?

Mr. CONSTANTINE. You left out the "AA's" and the "LA's"

Mr. Chairman, I guess I go back a long way on this. I was hired in 1966 to watch dog medicare by this committee, and we found a lot of problems in the program starting about 1968 when we had data.

John Williams, who was the ranking Minority member, introduced a resolution which the committee approved directing the staff to undertake a complete investigation, which we did with the help of an awful lot of people. And it resulted in this report a year later, called Medicare/Medicaid—Problems, Issues and Alternatives.

We found a lot of problems, among other things, with UR. The Finance Committee held 12 days of hearings following that, or more, and many of the changes, including PSRO, resulted from those hearing and were enacted as part of H.R. 1 in 1972.

I had principal staff responsibility for working with Senator Bennett in the development of the PSRO legislation.

It was not born in a vacuum. It was born, as GAO pointed out, out of the absolute failure of those entities which people with no institutional memory or perspective are now proposing to replace PSRO's, namely, the State medicaid agencies, the hospital UR committees, the carriers and intermediaries.

I brought with me some of the program validation surveys we had and the contract performance reviews, citing the specific failure of intermediary after intermediary, and so on, and what it was costing us. The system was blowing up. The actuarial increases in Medicare cost estimates were almost semiannual. And the Finance Committee had to vote the taxes.

Now against that background I guess I watched the PSRO program and then identified with it, and would be one of the first to say dump it if you have got something that is better, believable, and workable. But I have not seen anything.

If you want to ask me about the specific failures of each of the alternatives, I will be very glad to point them out to you, but let me give you just one example.

If you let a State agency review medicare you are going to see medicare costs go out the window because in many cases the older people are also on medicaid. And the longer the State can keep them on medicare the less the State has to put up under medicaid.

In the cost evaluation of PSRO's—this is apart from the lack of expertise and the fact, for example, that in Pennsylvania before PSRO they had a doctor in Harrisburg making decisions on care in Philadelphia, a couple of hundred miles away. Those are the kinds of realities and the complaints that poured in, plus the complaints concerning retroactive denials that filled every Senator's office. On the cost evaluation, I think CBO does not know what the hell it is doing. I think that their evaluation is a combination of faulty methodology, mythology, and just an abosolute lack of experience.

They is their "shifting" thesis. Their idea is that if PSRO's save medicare 100,000 or half million hospital days it doesn't really save money because if shifts that to the balance of the population just ignores the fact that the PSRO's are supposed to determine whether the care we pay for under medicare and medicaid is appropriate.

If they applied that shifting thesis to other programs, such as revenue sharing or your medicaid cap, the Reagan medicaid cap, there is no way you could save Federal funds; there couldn't be any Federal budgetary savings resulting from termination of revenue sharing because under the CBO approach the State and local governments and other entities would have to increase their taxes. That is the thesis they are applying to PSRO's.

In the case of the medicaid cap, the State and local governments, hospitals, and others, would have to pick up the difference. There is no way the Government could ever be a prudent buyer under the CBO thesis. I think it is one of the most naive, damned things that I have encountered in long time. And the President was right in his criticism of CBO for different reasons. [Laughter.]

Mr. CONSTANTINE. The problems in evaluating the cost effectiveness of PSRO's, Mr. Chairman, are several. I have argued for years, from the beginning, on behalf of the committee staff to get rid of, dump and replace the poor ones, but the good ones are very, very good. And if I or my family needed care any day in the week, I would prefer to get care in an area with a good PSRO than one without.

There is a pretense at precision and measurement which is not justified.

The national averaging approach in evaluating PSRO performance inflates the performance of the poorer PSRO's and devalues the good ones.

Also, they include in that averaging a lot of new PSRO's.

A lot of the PSRO's did not get off the ground. Hell, the AMA and everyone else was fighting the program including the Council of Medical Staffs and the Association of Physicians. PSRO's spent

more time trying to survive for the first several years than doing any kind of review. So it is too soon to tell.

I went into the macrocosmic view, the world view of the gurus at CBO. There is no evaluation of PSRO's effect on medicaid. And they have had significant effects on medicaid. I do not know how to quantify the dollar effect. But you cannot really evaluate PSRO's without looking at what they have achieved in medicaid.

There are other savings that are very difficult to measure that are real, where we cut out a lot of hospital days, save a lot of hospital days—a lot of physicians' visits are not made and a lot of procedures are not performed. Where the PSRO's are moderating ancillaries in the area of inhalation therapy, for example, that has not been measured.

Where they are requiring preadmission workups or restricting routine workups to only those tests which are reasonably related to the patient's diagnosis rather than giving a complete workup for a broken toe, that is not evaluated in there.

Where the PSRO's have moderated occupancy levels in hospitals, as they have in Minneapolis, where they reduced, in the first 2 years, medicare days per thousand, I believe, by 13 or 14 percent, now that is a tremendous decrease. New beds are not built, or fewer beds are built than would otherwise be constructed. The cost effect of that has not been evaluated, and I do not pretend we know how to do it. But you cannot ignore it.

Finally—or two finalies—there is the "Catch 22" aspect of PSRO's.

They spend a very substantial proportion of their budgets to determine wheter patients need a hospital level of care.

Now they are finding many thousands of medicare and medicaid patients in hospitals who do not need hospital care, who need long-term care or home health care. But those resources are not available.

So the PSRO cannot get credit for saving those hospital days at the same time it has to incur the expense of making the determinations. That is not evaluated by CBO or HEW.

There is another unmeasured thing, which is a gut feeling on my part and needs to be evaluated. In 1970, according to the Secretary's Commission on Malpractice, the medicare patients, the aged, accounted for 17 to 18 percent of malpractice suits.

I really believe that it really is worth taking a look at the effects on malpractice, both the incidence of malpractice and the malpractice suits in the areas where you have had PSRO's in operation for a period of time.

And, finally, if you dumped review, any kind of effective review, within 12 months, you would have the greatest surge you have ever seen in this country's health care costs, in my opinion.

The hospitals are humping for money. They are going to fill those beds and provide those services to restore a lot of their funds. A lot of them do not have much endowment left. They also would want to build their base for the next level of controls which they know will be coming, because this just snaps back like a rubberband.

I really think the question you have to ask of those who advocate change—and I have not seen anything—is what have you got that

is better believable and workable? Because I have not seen anything. With all the faults, they are the best we have got. And we are not going to get these doctors out of the woodwork again. They are not going to be jerked around on a string.

Thank you.

Senator DURENBERGER. That was the longest 5-minute green light. That is the kind you used to give Herman, I think. [Laughter.]

Let me ask Dr. Smits if you would comment at least in part of what you have just heard. I think you can actually detect some strong feelings about the purposes of PSRO on cost containment on this side.

I was impressed by your commitment to quality assurance, in using the PSRO's for quality assurance.

Is there a way to do both, and is there a point of transition to get from one to the other? What, in your opinion, would take a successful cost control mechanism and convert it into both a cost and quality assurance process?

Dr. SMITS. I think there is less conflict between the two goals than a lot of the early commentators in the program thought.

The heart of PSRO work, after all, is data. When you talk about something like focusing review, it does not mean you do not pay attention to all the cases. It means you do active review on the cases that look like they are a problem. You are continuing to look at the data on the whole set of cases.

When you look at data it is very hard often to separate cost and quality issues. For example, when you have problems with long surgical lengths of stay in a particular hospital in the community, you are as likely to find that that hospital is having trouble with post-op infection as you are to find out that it has a stubborn set of surgeons.

Although in the early days of the program, in theory, there was a lot of discussion about how you could not do both cost and quality, I think in fact the work has proved to meld very well.

PSRO's will need to change their technology. If right now they are paying a lot of attention to how long the length of stay is, and you get into a procompetitive system, they may have to drop that. But the PSRO's in New Jersey, working with the diagnostic-related groups, have not really had much trouble doing that. They just focus on different activities.

I would say that it is because these are a professionally managed set of organizations that they really are very responsive to changes in the system. And it is relatively easy to adopt staff and review mechanisms to say you do not have to worry about admission rates any more. Once there is a lot of competition in health care, PSRO's are really going to have to put a lot more time and money into quality assurance work.

Senator DURENBERGER. Jay, would you address the quality assurance?

Mr. CONSTANTINE. Yes. Senator, we had that question raised from the beginning of the PSRO program; that is, is this a cost or a quality control program? Well, it is both.

At no point, expressly or implicitly, did any of the advocates of the program ever suggest that a patient be denied appropriate care to save medicare bucks.

The other thing is that if a patient does not need those 3 avoidable days in the hospital, where he is exposed to infection, embolism, and so on, is that cost or quality if you save those days? If he does not need the procedure, is that cost or quality? It is both; they are entwined.

But the key thing, it seems to me, is that a fair number of the States have often applied limits on care which are much more related to straight cost without consideration of medical need.

The PSRO's are to approve care based on medical appropriateness, not to save a buck. I mean, it is a result of that.

Senator DURENBERGER. Thank you.

Max?

Senator BAUCUS. I want to thank both of you coming today with your statements. I think they are very good, very comprehensive.

A question I have though, looking down the road, is that the administration's proposal assumes later development in some work prepared in theorical models. In your analysis of competitive models that you have heard of or seen, do you see any which not only theoretically have certain cost benefit features that seem to be attractive but also which have the quality assurance provisions that we are talking about? That is, have you seen some comparative models which give us both the cost savings as well as the quality assurance?

Mr. CONSTANTINE. I do not know what the competitive model is. I think that there is a basic flaw in the whole thesis of the competition approach, and that is the assumption that the health care market is a normal economic market and responds to normal stimulus, as opposed, for example, to the fact that you may have one hospital in a given town with two doctors who comprise the staff of that hospital. Where is the competition?

The competition proposals do not acknowledge differential in quality. Let me give you a potential test of competition. One of the greatest complaints we get—we used to get—are from the medicare beneficiaries complaining that medicare does not pay their doctors' bills, that medicare, for many, pays less than the 80th percentile of charges.

Well medicare certainly pays at least the 50th percentile, Senator, of charges. That is, if all charges for appendectomies range from $400 to $1,000, maybe 50 percent of those billed charges come in at $600 or less.

Well if you really wanted competition—and wanted to watch the world blow up—why don't you put out a schedule of allowances giving all medicare beneficiaries up to $600 for their appendectomies and so on, and then, according to the competition advocates, watch all the high doctors come down, and those people shop around to see the low bidders. It just will not work.

Senator BAUCUS. Dr. Smits?

Dr. SMITS. Well certainly many HMO's clearly have developed good internal quality assurance mechanisms, both spontaneously and in response to the current rules from the Federal Government.

But one of our problems is that, as you try to generalize that experience, you do not always know quite why it happened.

In California, for example, when you did have experience with medicaid HMO's, it was quite clear that there was some substandard care being delivered. There isn't anything magic about the HMO model that makes doctors behave well.

In the few places in the country where good competition exists, that is, where the market is really dominated by HMO-or IPA-type organizations' big health plans, I don't know enough about the local quality assurance mechanisms to know how they work.

My experience with for-profit medical care in general, say with the shared health facilities, medicare and medicaid mills, is that the quality is extraordinarily variable. We cannot generalize and say they are all bad. Some of them give quite good care.

But they are extremely variable. Some of the care is very bad. And the consumers do not seem to know. And at least before they get in there and get that one set of bills charged to them, don't seem to choose wisely.

Senator DOLE. That is the problem though. I am an attorney, and I know there are some good attorneys and some pretty bad attorneys.

I have talked to some doctors who will tell me—and I am sure this is the case—there are some very good physicians and there are some very bad physicians.

It is difficult for patients to choose. I think all of us want the lowest cost/best quality health care. That is our goal here. And in pursuing that goal, I think we have to ask some of these questions.

To my mind, when those who advocate competition say that is going to help cut down costs, is the study that apparently occurred in San Francisco. I understand why a lot of physicians like to go to San Francisco, and there are a lot of physicians in San Francisco. They like to go there and their wives like to live in San Francisco, or their husbands like to live in San Francisco. [Laughter.]

Senator DOLE. And the argument was, well, with all of the physicians in San Francisco, the fees are going to go down. Well, a study I know about shows the exact opposite occurred, that is, the fees went up, because the doctors, instead of lowering their fees to get the business, just upped their fees for the less business that they had to provide.

And the same might occur with hospitals. I mean, the more you have competition, the hospitals might just increase their fees. I don't know, but I think that we have to move in this direction very, very carefully so that we know what we are doing.

And, frankly, I have not yet seen good reasons for the degree of change in that direction that the administration so far advocates.

Thank you very much.

Senator DURENBERGER. Thank you, Senator Dole.

Senator DOLE. I just want to ask Jay one question. I never did get to ask him a question when he was on the staff. [Laughter.]

As I understand the numbers the Budget Committee has finally agreed upon, in fiscal 1982 this committee is going to have to make cuts of about $9 billion. Now if we don't do it here, do you have another little program in mind that we might save a hundred million on?

Mr. CONSTANTINE. Senator, I have been in touch, you know, as an alumnus, with the staff over the past several months and have given them quite a few suggestions which would save considerably more than the costs of the PSRO program.

It is debatable whether this program is costing money. I do not believe it is. I think it is saving considerably more. There is a problem in measurement. But there are quite a few other areas of potential savings, and I made some suggestions to the staff. Some of them were, I think, incorporated into the budget document, you know, author anonymous.

Senator DOLE. But if we run out of those, do you have other reserves?

Mr. CONSTANTINE. Oh, yes, sir. We can always come up with some winners. [Laughter.]

You might not get reelected. [Laughter.]

Senator DOLE. I think it is important, because I know you have a lot of ideas on how we can save money. And, of course, I read some of the distortions in the press, you would think that every poor American, every student, is going to be denied opportunities for college or attrition programs. And it is really not. I think we have jurisdiction, this committee, over $380 billion. We are talking about $8 billion. They think we would pull the rug out from every American around.

I think you understand the importance of it. You were always giving us recommendations where we might save money without having any adverse impact on people.

Mr. CONSTANTINE. It is becoming tougher. And I will be very glad to continue to do what I can as I draw my pension. [Laughter.]

Senator DOLE. That is right. We cannot pay you for your advice.

Senator DURENBERGER. He does not want to be paid for it. [Laughter.]

Senator DOLE. And I will not charge you for mine. [Laughter.]

Senator DURENBERGER. Thank you very much, Dr. Smits, and thank you, Jay.

[The prepared statements of Dr. Smits and Mr. Jay B. Constantine follow:]

STATEMENT OF HELEN L. SMITS, M.D.

Elimination of the Professional Standards Review Program will increase, not decrease, costs to the Federal Government.

The various cost-benefit analyses discussed this moring contain serious errors; the conclusion that the program doesn't pay its way is an erroneous one.

First of all, the PSRO program does far more than reduce hospital days. It reviews physicians' services, reviews ancillary costs contained within the hospital days, and conducts quality assurance work, which in many instances, also serves to reduce costs. Yet all analyses of the Program are based on the false assumption that all program costs are spent on hospital review and the only program benefits are to be reaped in hospital review. Since the arguments are always quite close—that is, we are always debating whether the Program does or does not fully pay its way—the addition of even modest extra savings will significantly alter the final conclusion. Yet no evaluation, even the most favorable, has ever attempted to look at the costs and benefits of all PSRO activities.

There is, however, a far more serious flaw in the existing cost-benefit studies. In technical terms we are measuring a marginal benefit and balancing it against a total cost. This is not an appropriate use of the cost-benefit methodology and to illustrate my point I would like to use a very simple analogy. Suppose you rent a fleet of cars, the "U" cars, and are considering transfering to the "P" Company. While continuing your "U" lease in some divisions you also try out the "P" folks. We'll have to allow that you don't have much of an accountant and that even the

department that buys gasoline is a little vague as to what's actually going on. As a result, the only information you have is the following:

	"U" company	"P" company
Rental cost	Unknown	$2,000/year.
Gas cost per year	Also unknown	$100 better than "U".

Is the "cost-benefit" ratio of "P" 1/20?

Would you conclude from this that the P car isn't very cost effective? Not at all; you'd be sensible enough to know that, since your gas mileage figures are based on the difference between U and P, you will need the two prices to draw any conclusion. In fact, the cost of the U lease will be the deciding factor in determining which company to purchase from. Yet none of the PSRO evaluations since the first one in 1977 have provided any estimate of the price of utilization review. Opponents of the PSRO Program have tried to get around this problem in various ways including the fairly remarkable claim that UR doesn't really cost anything. In fact it does cost a great deal; those 1977 figures projected forward to 1981 give you a price of Utilization Review which is significantly greater than the price of PSRO. I therefore submit not only that the CBO re-evaluation of the HCFA evaluation is incorrect but that the 1978 and 1979 HCFA evaluations are misleading. They do, indeed, discuss in their text this problem of "marginal benefits and total costs" but they still go ahead to produce a cost/benefit ratio. I believe that the presentation of any such ratio in this setting is misleading and that such figures simply should not be calculated at all unless some estimate for the cost of UR can be included.

But enough of the present. PSRO's deserve to survive not just because it would be wasteful to eliminate them in our current circumstances but because they will be badly needed as our health care system changes. In New Jersey, for example, an experiment in hospital reimbursement is being conducted known as the Diagnostic Related Group (DRG) experiment. This involves paying hospitals on the basis of the mixture of cases they care for rather than on the basis of the actual costs incurred. After some initial discomfort between the State and the PSROs it has become apparent that the PSROs have a crucial role to play in validating the accuracy of the diagnoses submitted for reimbursement. Such a task demands physician participation on an area-wide basis. If there hadn't been PSROs, New Jersey would probably have invented them.

The same administration that wants to eliminate PSRO also wants to put more competition into health care. There is a good deal of existing evidence to show that consumers have some difficulty in evaluating the quality of medical services they receive. Equally important is the fact that one simply cannot exercise consumer choice in the middle of most episodes of illness; you don't pack up your monitor and move to another coronary care unit quite the same way you pack your bag and move to a new hotel. The responsibility of the Federal government to guarantee the basic quality of care will be markedly increased in a competitive system where the incentive is to save money by reducing quality in areas not immediately apparent to the consumer. The choice for the Government will be a fairly simple one: it can certify health plans with the same relatively cumbersome structural and process measures now used for hospitals and nursing homes or it can develop a physician-based system to examine the quality of care. I believe that if PSROs are taken down in 1981 they will inevitably be reinvented in 1983 or 1984. I would like to note right now that if such is the sequence of events I wouldn't expect to participate much the next time around. My personal enthusiasm for voluntary cooperation between the profession of medicine and the government will, to put it mildly, be dampened by the elimination of the PSRO Program into which so many of us have put so much effort. And I don't expect to be alone in that attitude.

I do not mean to suggest that the PSRO Program should be left exactly as it is. I believe, for example, that serious consideration should be given to the possibility of allowing States and PSROs to contract directly with one another with States allowed the option of obtaining review in some other fashion. I believe that such an arrangement would be simpler and far more attractive to both parties than the current arrangement where Congress sets the price of review and HCFA sets the conditions and all the State gets to do is comment. I believe that a large number of States would choose to enter into contracts with PSROs and that these contracts would be at a higher price than the Federal Government has been willing to pay. The possibility of an equally straightforward contract between PSROs and the Federal government should also be explored as an alternative to the indirect management of PSROs which is the current Federal practice. I should note here that

"allowing" PSRO's to subcontract with Medicare intermediaries and carriers is not the sensible way to manage such an arrangement since what you are aiming for is a clarification of the goals and expectations of review. The intrusion of another set of organizations into the Federal-PSRO relationship would be confusing, not clarifying. Finally, PSROs should be actively encouraged to seek private review in order to complete the process of becoming what they were first intended to be: independent professional organizations.

SUMMARY OF THE TESTIMONY PRESENTED BY JAY CONSTANTINE

The PSRO program was established as a direct result of the failure of carriers, intermediaries, state agencies and hospital utilization review committees to deal with widespread inappropriate usage of costly health care services.

The Federal government has had, from the inception, full authority and discretion to replace poorly performing PSROs and to "beef-up" support of effective PSROs. That authority has been exercised in extremely limited fashion.

Evaluation of PSRO cost-effectiveness (excluding qualitative considerations) has been, at least, certainly inadequate and incomplete, and at worst naive and distorted. Significant factors in cost-effectiveness measurement are not made or are not capable of being made at present.

Abandonment of the PSRO program would be disastrous. The alternatives to remedy any present shortcomings in some PSROs are no review or a return to precisely those entities whose failures were so complete and generic in the past.

STATEMENT OF JAY CONSTANTINE

From February, 1966 to January, 1981, I had principal staff responsibility within the Finance Committee for the Medicare and Medicaid programs. Prior to that, I was, for four years, Research Director of the Senate's Committee on Aging as well as staff director of its Subcommittee on Health.

Medicaid commenced operations on January 1, 1966 and Medicare began on July 1, 1966. From the beginning, both programs were plagued with major problems unforeseen or politically difficult to provide for during the formulation of the legislation.

Unfortunately, detailed information on a scale sufficient for Congressional evaluation and possible legislative reform was not available during the first two years of operation. When that information began surfacing, however, the Finance and Ways and Means Committees acted.

In view of the actuarial imbalance created in only the first two years, and in recognition of widespread reports of lax administration, non-compliance with the statute, and program abuse, Senator John Williams of Delaware, ranking Minority Member, offered a resolution directing the staff to undertake a complete investigation into the status and operations of the Medicare and Medicaid programs. That resolution was approved unanimously.

The inquiry, development and writing of the report took a full year. It was issued in February, 1970 under the title: "Medicare and Medicaid—Problems, Issues and Alternatives".

The staff was extensively assisted in its work by the Congressional Research Service, the General Accounting Office and agencies and individuals both in and out of government.

During the preparation of the report and immediately following its publication, the Finance Committee held some 12 days of hearings.

The staff report and the Committee hearings dealt extensively with the failure of utilization review in Medicare and Medicaid. Apart from testimony, there were hundreds of "Program Validation Surveys," undertaken by review teams from Social Security, and "Contract Performance Reviews" prepared by the H.E.W. Audit Agency.

These reports documented, in chapter and verse, the clear failure of the carriers, intermediaries, hospital utilization review committees and Medicaid State Agencies to control widespread, costly and inappropriate utilization of health care services. A selection of those reports is in the stack in front of me.

In January 1972, a summary of the program review team findings was prepared for the staffs of the Committee on Finance and the Committee on Ways and Means. The sections dealing with utilization review included the following:

The review teams examining utilization review at providers and intermediaries found that at most of the providers visited, utilization review was a pro forma activity. Many intermediaries had deficiencies in their UR activities.

There are serious problems with the operations of the UR committees in the providers. They apparently stem from the decision of the provider personnel (possi-

bly reinforced by the intermediary and State agency contacts) that UR activities are just another bureaucratic requirement to be honored more in the breach than the observance.

We believe that many of the problems evident in providers' UR activities are the result of the intermediaries laissez faire attitude. Many intermediaries do not have copies of the UR plans of the providers they service.

Most intermediaries have made little effort to realistically and systematically evaluate the performance of the UR committees.

The surveys which I brought with me are specific as to hospitals, nursing homes, carriers, intermediaries, and State agencies involved and specific with respect to detailed findings. These reports do not represent generalized assumptions and opinions. They are real.

All of this, mind you, in addition to complaints from beneficiaries that where denials of medical necessity were retrospective—after the fact—leading to attempts to recover thousands of dollars from elderly citizens. In contrast, PSRO review is prospective or concurrent. Further, physicians and hospitals complained of the "insurance company clerks" and "bureaucrats" reviewing and judging their professional practices. All of this, apart from what was obviously care of poor quality detailed in the reports.

It was precisely those entities whose documented failure led to introduction and enactment of the PSRO legislation—the carriers, intermediaries, hospital review committees, and State agencies—who are now being touted as alternatives to PSROs! I have seen no evidence whatsoever from the advocates of this changeover that they have the remotest awareness of the previous failures of those they now recommend take over the job of review. Historical perspective and institutional memory are completely lacking.

In fact, few people seem aware that the PSRO statute itself provides a remedy for poor performance by a given PSRO—namely, replacement.

The legislative intent and the law, itself, make clear that an appropriately constituted representative group of practicing physicans have priority in establishing and operating a PSRO. But, that does not constitute an exclusive franchise. The intent of the law was to give practicing physicians an opportunity to establish and apply professional criteria of performance. Where that was not forthcoming or where poor operation was not corrected, an alternative PSRO was to be established. Replacement might be by an adjoining PSRO but if that was not feasible then the Secretary would turn to groups or agencies with professional medical capacity, such as State or local health departments or voluntary groupings of hospital medical staffs. Failing all else, the Secretary could utilize carriers or intermediaries.

The point I want to stress is that evaluation of PSRO performance lies with the Secretary of HHS. The responsibility for replacing a poor PSRO and the authority to do so are also lodged with the Secretary. That responsibility and that authority should be assumed and asserted with discretion and sensitivity, to be sure, but also with decisiveness. That has not been the case to date. Until the last year or so, there has been no major effort by the Federal government to differentiate among PSROs—to insist upon improvement or to terminate those performing poorly and to adequately support and "beef-up" the effective PSROs.

Let me discuss briefly some of the failings of each of the "newly-discovered" alternatives to PSRO review:

State Agency. State review has been uneven, often of poor quality and sometimes non-existent. Findings are not accepted by the medical community. The standards and criteria, to the extent present, are often applied by non-professional personnel remote from the scene of care. In the case of hospitalized Medicare patients, the State has an incentive to approve care for as long as possible because it is paid for entirely with Federal dollars, (the reason being that many of these patients are also Medicaid-eligible and if transferred from the hospital to a nursing home, the State would have to put up its share of the cost). Further, the agency's determination may be influenced more by straight budgetary pressure than legitimate medical need.

Hospital Utilization Review Committees. Have an inherent conflict-of-interest in terms of asking them to act in a manner which may be contrary to the economic interests of the hospital and associates on the medical staff. There is an in-house incentive to use the facility's beds and services. The reference points on which judgments are made are often too narrow and requisite expertise lacking (as opposed to areawide parameters and expertise).

Carriers and Intermediaries. Often fearful of antagonizing medical community and hospitals because of dependence on their goodwill. In the case of given Blue Cross plans, there may be, explicit or implicit control or domination by hospitals. There is an implicit conflict of interest in that beds filled with Medicare and Medicaid patients help spread a hospital's overhead reducing the charges or costs

that would otherwise be required of intermediaries such as Blue Cross. Review is generally retrospective, not concurrent—the result, denial of payment after care has been provided. This is a computerized rather than professionally-sensitized approach. Often remote from practitioners and hospitals who are sensitive to the decisions of "insurance company clerks".

Back to the history.

The American Medical Association, feeling the Congressional "heat" expressed in terms of legislative proposals such as that of the Administration to establish Statewide program review teams and similar efforts to deal with the demonstrated need for effective utilization review, brought a counterproposal in early 1970 to Senator Wallace Bennett. That proposal, the AMA's "Professional Review Organization" (PRO) plan, was the genesis of the PSRO legislation.

The virtue of the AMA plan was that it conceded the problem. Its failing was that the solution was totally self-serving—in effect, turning responsibility for review over to State medical societies with virtually no accountability.

Senator Bennett requested the staff to evaluate the AMA's proposal. Following that evaluation, he asked us to work with him in turning it into a viable, responsible legislative initiative which made full use of practicing physicians while incorporating safeguards designed to assure full public accountability.

During the more than two years that followed the announcement of the Bennett Amendment, an enormous amount of refinement occurred. Senator Bennett, himself, was involved on a daily basis in the work—spending more time on the improvement and advocacy of his approach than any Senator I have ever been associated with on any amendment or any bill. Literally hundreds of individuals and organizations contributed to the work on PSRO. Practicing physicians, medical foundations, medical societies, hospitals, Federal and State agencies and many other participated in the process.

When the hospitals and doctors realized that Wallace Bennett was serious and had serious Congressional support, they got serious. The American Hospital Association and the Joint Commission on Accreditation of Hospitals introduced their "QUAP" and "HAP" programs of hospital utilization review.

The American Medical Association, after preliminary negotiations, decided that they couldn't accept a proposal which didn't mandate State medical societies as the administrative mechanism. Their opposition, stimulated by the virulent attacks on PSRO by the Council on Medical Staffs and the American Association of Physicians and Surgeons, became active and heavy. On the other hand, most of the medical specialty groups, such as the internists and the surgeons were generally supportive of the Bennett approach. Prior to Congressional approval of the PSRO legislation, the Administration also endorsed the Bennett Amendment.

What happened after enactment has been a combination of infighting, bungling and achievement.

The first several years saw a battle between the health side of H.E.W. and Social Security's Bureau of Health Insurance for administrative control of the program. The Health people won, but at the expense of almost fatally flawing the PSROs. We believed that the statute clearly provided for the expenses of PSROs to be incurred and then allocated, just as previous utilization review costs were, among the Medicare Trust Funds and Medicaid. These were to be part of the regular expenditures of the programs. Unfortunately, the Health people included PSRO as a line item in the H.E.W. budget—the net effect being that most PSROs were initially underfunded. The result: widespread indiscriminate delegation to hospitals of review responsibility instead of, as intended, delegation of in-house review responsibility only to those hospitals which "in fact" demonstrated that they were carrying out effective review. The PSROs themselves could not undertake to review many hospitals whose deficiencies, required external review because the line item budget limited their capacity to conduct outside review no matter how deserving.

During the first several years, the AMA, the AAPS and the Council of Medical Staffs exerted themselves, but without success, to have PSRO repealed. The effect of this was to divert PSRO energies to survival tactics instead of substantive work.

But also, during those years, many thousands of physicians joined PSROs and the PSROs themselves went to work. Subsequently, there was broad support and general acceptance by practicing physicians of the concept and program.

PROBLEMS

1. There is a pretense at precision in measurement which is not justified.

2. The national averaging approach to evaluating PSRO performance results in good performance being diluted and poor performance enhanced. This same averaging approach to PSRO evaluation does not distinguish between the performance of mature PSROs as opposed to newer organizations just getting off the ground.

3. The Congressional Budget Office attempt at evaluation of cost-effectiveness of PSROs is a hodge-podge of faulty methodology and mythology and inadequacy. Their thesis is that PSROs save very little money even though they reduce Medicare and Medicaid hospital usage by many thousands of days. The gospel, according to CBO, is that while Medicare and Medicaid indeed save money, other taxpayers as patients have to pick up those continuing standby and other hospital costs (which hospitals cannot moderate according to CBO) and which Medicare and Medicaid, through PSRO review, have so ungraciously avoided incurring. This is the famed CBO "macrocosmic" view—their so-called "shifting" thesis—which is applied by CBO to no other program. They don't apply it elsewhere for very good reason. Applying the CBO doctrine for PSROs to other Federal expenditures would leave virtually no room for the Government to ever reduce expenditures or be a prudent buyer. Applying the "shifting" CBO line to, for example, termination of Federal revenue sharing, would result in no savings because presumably State and local taxpayers would have to make up the shortfall. The CBO "shifting" doctrine can perhaps be rebutted in another way. To the extent that Medicare and Medicaid, through PSROs—shifts costs to others by not paying for unnecessary or avoidable care and services—those costs are shifted back to where they belong, namely, the patients who legitimately need and use the care and service. How, the gurus at CBO can maintain that effective PSRO review of Medicare and Medicaid utilization results in virtually no savings is a mystery—apart from the question their stubbornly-held thesis raises with respect to analytical competence.

4. Of great significance is the fact that no overall evaluation of PSRO cost-effectiveness in Medicaid has been undertaken leaving a major gap in any attempt to conclude that PSROs are ineffective.

5. There are other savings to Medicare and Medicaid (as well as non-Federal patients) which are real but difficult to quantify in dollar terms:

a. The savings in Part B of Medicare for routine physician visits not made or procedures not performed simply because the patient has been discharged from the hospital in timely fashion—or not admitted in the first place—as a result of PSRO review.

b. Where PSRO review has moderated hospital occupancy levels—the need for costly new hospital construction is avoided or reduced.

c. The savings in ancillary hospital costs (x-ray, laboratory, pharmacy and inhalation therapy) where review has led to more discriminate usage is not calculated.

6. There is the "Catch 22" aspect of evaluating PSRO cost-effectiveness. A substantial proportion of PSRO budgets are expended to make "level of care" determinations—that is, does the patient belong in a hospital bed. Many PSROs regularly identify many thousands of Medicare and Medicaid patients in hospitals who do not belong there. But, the PSROs cannot be credited with any savings for identifying those situations unless the patients are actually discharged. In many of these situations, the patients need long-term institutional or home care services which are not available to them. Unless the PSRO goes into the nursing home or home health agency business it is just out-of-luck when it comes to being credited with doing the job it is supposed to do!

7. There is another unmeasured and unevaluated area where PSROs may well have moderated Medicare expenditures, as well as those of the general public, and that is with respect to malpractice. According to the Report of the Secretary's Commission on Medical Malpractice, between 17 and 18 percent of the 12,000 patients represented in medical malpractice claim files closed in 1970 were over age 65. The extent to which PSRO review activity may have positively affected the incidence of malpractice claims is not known but should certainly be studied.

Mr. Chairman, the PSRO program was not conceived and enacted in a vacuum. It constitutes a real attempt and has made real progress toward solution of real problems. It has a long way to go but it has come a long way.

The expenditure of some $80 billion in taxpayer dollars for Medicare and Medicaid continues to require accountable trusteeship and prudent payment of those funds for the care of the poor and the elderly.

Reasonable controls—such as professional review—are integral to fulfilling those responsibilities. A poor PSRO should be promptly replaced—but you should not, because of individual poor performance, condemn the group or the concept.

I am reasonably confident that abandonment of review requirements would contribute to a great surge in health care costs. As a matter of fact, abandonment of review and similar prudent constraints, might even ultimately result in national health insurance—not primarily to cover the population—but as, perhaps, the only means of getting a possible handle on runaway costs.

It seems to me that given our experience thus far, the question for the broad-brush, penny-wise and pound-foolish critics of professional review is to answer: What have you got that's better, believable and workable?

Senator DURENBERGER. Our next witness is Dr. Joseph Boyle, vice chairman, Board of Trustees, American Medical Association, Los Angeles, Calif. He will explain to us the difference between 104 and 100, right? [Laughter.]

STATEMENT OF DR. JOSEPH BOYLE, VICE CHAIRMAN, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, LOS ANGELES, CALIF.

Dr. BOYLE. Actually, Senator, that number has very little meaning.

The American Medical Association House of Delegates, by a very narrow majority, voted to get in the position it was in the first place, and the overwhelming majority of physicians that I have met in the last 7 years support the position taken by the House in December in San Francisco.

I am Joseph Boyle, and I am a physician in Los Angeles.

I am vice-chairman of the Board of Trustees of the American Medical Association.

With me is Ross Rubin, who is with the American Medical Association, department of Federal legislation.

The association at its meeting in December adopted an action calling for an end of Federally-directed peer review programs.

The administration's plan to phase out the PSRO program and to simultaneously eliminate the federally mandated utilization review would accomplish this goal.

Although supporting the program for the past 9 years, when the AMA House of Delegates called for the repeal of federally mandated peer review programs, it was reflecting a growing unrest among the majority of physicians over the Federal direction and implementation of the PSRO program.

In supporting termination of the PSRO program, I want to emphasize that the AMA remains an advocate of peer review as a mechanism to assure high quality medical care.

However, it is our view that in attempting to federalize peer review the Government has misdirected the principal objectives of peer review itself, that is, to assure high quality care, and has inappropriately focused the program principally to contain costs.

Based upon recently released reports by the Congressional Budget Office, the Health Care Financing Administration, and the GAO, the ability of the Government to use the PSRO program as a cost savings mechanism is highly questionable.

The AMA recognizes the responsibility of the profession to work to assure quality care for patients undergoing medical treatment in this country. I want to assure you that in the absence of Government direction and interference, the profession will vigorously renew and strengthen the private sector peer review activities.

It must be remembered that when PSRO was enacted it merely capitalized upon the ongoing peer review existing at that time.

We at AMA intend that peer review activities—of which there are many—be encouraged to take up the slack of review activities if Government programs are terminated.

In addition, the AMA has historically supported, and continues to support, the voluntary accreditation of hospitals by the Joint Commission whose standards for accreditation call upon hospitals to have, in place, an effective utilization review program.

At this point, Mr. Chairman, I would like to briefly trace the history of AMA's involvement with PSRO and identify some of the causes for disenchantment of physicians with this program.

When the PSRO was enacted in 1972, it was over the objection of the AMA. In testifying before the Senate Finance Committee on PSRO provisions that later became enacted as Public Law 92-603, the AMA pointed out that:

> Expansion of peer review activity has been taking place throughout the country, independent of any special peer review legislation.
>
> Ongoing peer review and utilization programs of medical societies, foundations, carriers, and health care institutions were then operating, and we can expect new innovative programs to be established.
>
> We recommended that PSRO not be adopted and that the Secretary continue to conduct experiments with various forms of review, including those with PSRO features.

Nonetheless, PSRO was enacted. And we made a conscious decision to work with the Federal Government to try and make the program viable.

Since enactment, the AMA has been involved in major efforts to better the PSRO program. Some of these activities include the development of guidelines for the formation of PSRO data policy, a publication suggesting practical and legal guidelines for members of boards of directors of PSRO, and model memoranda of agreement between health system agencies and PSRO's.

In addition, the AMA has developed two sets of sample criteria to assist in the review process, one for short-stay, and one for surgical procedures.

These documents do not and were not intended to constitute standards of care. They were designed as tools that could be used by a local PSRO in developing individual review criteria.

These projects represented appropriate utilization of the private sector to aid PSRO. However, the revised short-stay criteria sets—completed by ARPS—and the newly developed surgical criteria sets have been held by HCFA for over a year. This lengthy delay has denied local PSRO's the benefit of this professional input. It is this type of Government activity which has partially led to the growing dissatisfaction with the program.

A situation which is exemplifying physician difficulty with the PSRO is the long-standing struggle between the Texas Medical Association and the Federal Government over the designation of a statewide PSRO for the State of Texas.

HHS divided the State into nine areas over the objection of the Texas Institute for Medical Assessment. This had been organized by the Texas Medical Association.

To overturn this, TMA successfully brought legal action. It was determined, in part, that the designation of Texas into nine PSRO areas was "unlawful and unvalid." The final result in this instance between the Federal Government and Texas to impose multiple PSROs in the State and TIMA's efforts to see the creation of a single statewide PSRO delayed the implementation of the PSRO in

Texas entirely until September of 1980. The medical community in that State now opposes PSRO altogether.

The AMA urged the 96th Congress to pass legislation that would help guarantee the confidentiality of PSRO records by exempting them from the Freedom of Information Act. Congress delayed a decision on this issue by passing a limited exemption that would allow judicial review. This lack of final resolution and the fact that PSRO records might be found to be subject to FOIA request has only served to heighten the uncertainty that many physicians feel upon becoming involved with the PSRO process. There is no question that without adequate confidentiality safeguards, both the physician/patient relationship and the peer review process will suffer. This issue has been one of the more significant factors that has disillusioned physicians with this program.

The AMA is also gravely concerned over another direction that PSRO is taking. Previously, we supported a program which had as its principal goal quality assurance. However, it now becomes clear that this is primarily a mechanism for rationing care by placing restraints on costs.

Efforts have also been made in recent years to greatly expand PSRO to include review of all services furnished in ambulatory settings, including the physicians' offices. This authority, passed by the 95th Congress, was then repealed by the 96th Congress because of a recognition of the impossibility of this task. This vacillation also has been seen with issues of inadequate financing, use of physician identifiers, and control of PSRO data, to heighten physician concerns.

In conclusion, Mr. Chairman, I would like to point out that the change in the AMA's position last December was a natural eventual result based upon growing dissatisfaction that has developed from fruitless and often frustrating efforts to work with this program.

We again emphasize that we are committed to peer review, and, in fact, the resolution adopted by our House of Delegates emphasizes that commitment.

Senator DURENBERGER. Thank you for your statement. I have just a question to make sure I understand your position.

The administration is recommending gradual elimination of funding for PSRO's. As part of that they are recommending that the so-called effective PSRO's continue to be funded for some period of time and the ineffective ones not be funded.

Do you think that it is possible to make those kinds of judgments?

Dr. BOYLE. Mr. Chairman, earlier today I listened to some discussion in which it was said that they do not know how to tell the effective from the ineffective. So how one is going to go on funding the effective ones, I do not know. What criteria would be used to establish that fact would be difficult for me to determine.

I believe that if what they are intending to do is to allow those physician organizations which are working conscientiously in an organized fashion to try and improve quality care, we would certainly support that. But as far as a continuation of a Federally mandated program in some areas, our House of Delegates would oppose that.

Senator DURENBERGER. How would the AMA answer the question that I think both Senator Baucus and I raised in our opening statements that we have somewhere between a $65 and $80 billion a year obligation to the people in this country that are providing the funds to subsidize access to health care for the aged and others who need subsidy when you recommend to us that we rely on basically a voluntarily peer review process to restrain the growth in those expenses at the same time when we are aiming at quality of care?

Dr. BOYLE. Senator, first of all, I believe that if what you are comparing is the structure that currently exists and what would be present if it were wiped out, it is not really a realistic comparison, because if the PSRO program was really an effective program we would not be here discussing it today, there would be no question about it in anybody's minds. It would be well known that this was restraining costs.

Our association, as I indicated to you earlier, is committed, not just to attempting to restrain costs in the federally financed programs and State financed programs, but in all areas of providing health care.

I believe that over the past 15 years, since medicare and medicaid became a reality, that there has been a growing sense of responsibility on the part, not only of the AMA but all of the components in our federation. Each State medical association and the major metropolitan, county medical societies as well, are all committed to this end.

There are so many programs going on out there right now in hospitals and in county societies and State medical associations directed toward trying to increase physician responsibility, hospital involvement, and hospital responsibility in restraining costs at all levels. That activity will continue.

Second, as I think was indicated by Dr. Smits, and I would certainly agree, it is bad medical care to keep people in hospitals that do not belong there. And we are committed to quality medical care through the Joint Commission and other survey processes. We will continue to policy.

Senator DURENBERGER. Well, I think our concern here is the old baby in the bath water approach. I mean, to the administration's recommendations.

You don't tell us that peer review is bad. You tell us that the way peer review has been practiced in the form of PSRO's results in lengthy delay, excess Government activity, imposition of a Federal process on a State like Texas, concern about confidentiality of PSRO records, and the possible extension of PSRO into the physician's office, none of which cannot be changed in the process of modifying PSRO activity.

I guess I read your statement as being more a condemnation of the way the PSRO process is regulated by HHS or not regulated or not properly funded than a condemnation of the system itself.

You probably do not need to comment on this.

Dr. BOYLE. Well, no matter how the bureaucracy does it, it is not going to work well. We had peer review long before the Federal Government discovered there was such a subject.

Senator DURENBERGER. Thank you.

Senator BAUCUS. That would be my question. That struck me the same way. This is, in reading your statement as you read it, it sounded like you are suggesting that we be able to pop up and pass a few amendments rather than that we junk it entirely.

Would you amplify a little more on that, please?

You do advocate junking the whole system, do you not?

Dr. BOYLE. That is correct, sir.

Senator BAUCUS. That is, you do not think the system could be fixed upon by amendments that address the specific points that you raised in your statement?

Dr. BOYLE. It is inherent in a federally mandated program such as this for review that there is going to be a process developed that in the end will be self-defeating.

I do not know how you can amend this into a form that would be helpful other than to say if somebody has a successful PSRO program or a successful review program that requires financing, and they were to come to the Federal Government and say here, we have this program which is going to accomplish whatever it is, and they contract to do so without imposing a mandate that the Federal PSRO program does, then that would be fine.

But at the moment, prior to the development of this program and at this very moment, there are many, many review programs that are going on without Federal financing and without any Federal law to give them any teeth.

Senator BAUCUS. I believe you when you say that physicians are dedicated to quality review. But obviously if Congress decides to repeal the PSRO system, we are doing it on the assumption that there are quality review systems in place.

Would you identify to me, in you judgment, the single most effective peer review system that you are aware of other than PSRO?

Dr. BOYLE. A peer review program?

Senator BAUCUS. Yes.

Dr. BOYLE. Certainly. I can give you examples of several if you would like in hospitals.

Senator BAUCUS. Yes.

Dr. BOYLE. We have had tissue review committees or surgery review committees for decades, for eons.

Senator BAUCUS. Which hospitals and which communities? I would like to know the most effective one that you can identify right now.

Dr. BOYLE. I can identify the Hospital of the Good Samaratin, in Los Angeles, where I practice. I can give you another program in that hospital: The infections control program in that hospital which was begun long before anybody decided this was something that had to be in the Joint Commission's standards.

Senator BAUCUS. Can you identify some in hospitals other than where you practice, other hospitals in the country?

Dr. BOYLE. I am not familiar with what goes on inside each of those hospitals, Senator. I can only tell you what is going on in my hospital.

Senator BAUCUS. Because we have to share ourselves, I would think that there are good quality peer review systems in place if not the Federal PSRO system we are talking about across the

country. I mean, you say that you have a good one at your own hospital. But I think we would have to know of others, of other hospitals.

Dr. BOYLE. I would say that you can almost take the list of members of the American Hospital Association and start at the top and go down to the bottom, and you will find that in those hospitals, with few exceptions, there are effective peer review programs.

Mr. RUBIN. Senator, I think you will also find that the PSRO program, by its very existence, preempted an awful lot of private activity over the last 8 years because people were directing their activity to the PSRO.

It was there. It had to be worked with. AMA chose to work with it.

Senator BAUCUS. I understand that. And that raises the next question, which is if you could identify what AMA or other physicians intend to set up in the event that PSRO's are repealed. If you could more precisely tell us what you are going to set up in its place. Then you are asking us to buy something, or a product that we do not know anything about.

Dr. BOYLE. We have not addressed that exact question, Senator.

Senator BAUCUS. I think it would be helpful, frankly, if you could sometime, because otherwise it is difficult for us to proceed.

Do you think that AMA will be in a position to work with precisely established statements that are set up?

Dr. BOYLE. I doubt seriously that we would attempt to develop some Federal program to replace another Federal program.

Senator BAUCUS. Well not Federal. I am talking about private programs, a private program.

Dr. BOYLE. I know, a private Federal program

Senator BAUCUS. I am talking about private/private. [Laughter.]

Dr. BOYLE. I think that that—as we say, we have not addressed that question, Senator.

Senator BAUCUS. All right. Thank you.

Senator DURENBEGER. Senator Dole?

Senator DOLE. I have no questions.

You indicated the AMA would have a number of suggestions on how we can save money in this $80 billion medicare/medicaid budget.

Dr. BOYLE. I did not make that statement, Senator.

Senator DOLE. Would you make that statement?

Dr. BOYLE. We will have suggestions as to how—we have not been asked the question, but I just hope we will address it.

Senator DOLE. Do you know where we can save some money?

Dr. BOYLE. Our association had not been asked the question. We will be glad to address it if you like.

Senator DOLE. As I understand, they oppose the medicaid caps as unfair.

Dr. BOYLE. I don't know that we have adopted a position on medicaid caps, Senator.

Senator DOLE. Maybe it is only a rumor. [Laughter.]

Dr. BOYLE. The Board of Trustees certainly has not considered that question either.

Senator DOLE. I think physicians ought to be able to tell us how they can save some money from some of these programs without doing violence to the program.

Dr. BOYLE. From the standpoint of medicaid, I can certainly tell you at least one proposal that has been made by the administration that I am aware of, is to turn much of this back to State administration, because I am absolutely certain from my involvement as the president of a State medical association this past year that the replication of administrative structure in the State and the Federal Gvernment has to cost an enormous amount of money. And in our State we estimate that it is 30 percent of the medicaid budget that is spent in adminstration in our State.

Now they tell us it is 2 percent, but we know that is baloney from our evaluation of that program. At least half of that is spent in trying to meet the requirements of the Federal agency. Now that is a lot of money.

Senator DOLE. That is what we propose to do, in part. Any other suggestion for medicare? That is fairly expensive, too. I know it is not the subject of this hearing, but I would hope at the appropriate time AMA would have a big list.

Dr. BOYLE. Yes, sir.

Senator DURENBERGER. Thank you very much, Dr. Boyle.

Dr. BOYLE. Thank you.

[The prepared statement of Dr. Boyle follows:]

SUMMARY OF THE AMERICAN MEDICAL ASSOCIATION'S STATEMENT

AMA policy, adopted in December 1980, calls for elimination of all government directed peer reveiw programs. The Administration's planned phase-out of PSRO and elimination of UR requirements would accomplish this.

Since the time of enactment of PSRO, the AMA has supported the program and has been involved in substantial efforts to better the program.

AMA's decision to call for repeal of PSRO was reached because of growing unrest among physicians over federal direction of the PSRO program as primarily a cost control effort.

Several federal actions contributed to growing disenchantment with the program, including: Conflict over PSRO designation in Texas; problem in guaranteeing confidentiality of PSRO records; new emphasis on PSRO's as a cost containment device; and efforts to expand PSRO review into ambulatory settings, including physican's offices.

AMA is still a staunch advocate of professional peer review as a mechanism to assure high quality medical care and will continue activities to foster professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration and rendered in an appropriate setting.

STATEMENT OF JOSEPH F. BOYLE, M.D.

Mr. Chairman and Members of the Committee, my name is Joseph F. Boyle, M.D., and I am a physician in the practice of Internal Medicine in Los Angeles, California. I am the Vice-Chairman of the Board of Trustees of the American Medical Association. The American Medical Association is pleased to have this opportunity to testify before this Committee today concerning the future of the PSRO program.

In the President's March 10 budget message to Congress, the Administration presented a plan to phase out the PSRO program over the 1981-1983 period. In conjunction with this planned phase-out, the budget statement also indicated that legislation will be proposed to seek the elimination of utilization review committees in providers not covered by PSRO review. Mr. Chairman, the American Medical Association, at its meeting in December 1980, adopted an action calling for the elimination of all Government directed peer review programs. The Administration's plan to phase-out the PSRO program and to simultaneously eliminate federally mandated utilization review would accomplish this goal.

Mr. Chairman, I would like to point out how the AMA has reached the decision calling for the repeal of the PSRO program after having been in support of the

program for the past nine years. When the AMA's House of Delegates called for the repeal of federally mandated peer review programs at its December 1980 meeting, it was reflecting a growing unrest among physicians over the Federal direction and implementation of the PSRO program.

In supporting termination of the PSRO program, I want to emphasize that the AMA remains a staunch advocate of peer review as a mechanism to assure high quality medical care. However, it is our view that in attempting to federalize peer review the Government has misdirected the professional objectives of peer review, i.e., to assure high quality care, and has inappropriately focused the PSRO program principally to contain costs. Based upon recently released reports by the Congressional Budget Office, the Health Care Financing Administration, and the General Accounting Office, the ability of the Government to use the PSRO program as a cost-savings mechanism is highly questionable.

The American Medical Association recognizes the responsibility of the profession to work to assure quality care for patients undergoing medical treatment in this country. I want to assure you that in the absence of Government direction and interference the profession will vigorously renew and strengthen private sector peer review activities. It must be remembered that when PSRO was enacted it merely capitalized upon then ongoing peer review. We at AMA intend that peer review activities—of which there are many—be encouraged to take up the slack in review activities if Government programs are terminated. In addition, the AMA has historically supported, and continues to support, the voluntary accreditation of hospitals by the Joint Commission on Accreditation of Hospitals whose standards for accreditation call upon hospitals to have in place an effective utilization review program.

At this point, Mr. Chairman, I would like to briefly trace the history of the AMA's involvement with the PSRO program and identify some of the causes for the disenchantment of physicians with the program.

When the PSRO program was enacted into law in 1972, it was over the objection of the AMA. In testifying before the Senate Finance Committee on the PSRO provision that later became enacted into P.L. 92-603, the AMA pointed out that "expansion of peer review activity has been taking place throughout the country, independent of any special peer review legislation. Many ongoing peer review and utilization programs of medical societies, foundations, carriers, and health care institutions are now operating, and we can expect new innovative programs to be established. . . . We strongly recommend that the PSRO amendment not be adopted, and that . . . the Secretary conduct experiments with various forms of peer review, including programs with PSRO features." Nevertheless, the PSRO provision was enacted into law and the AMA made a conscious decision to work with the Federal Government to try to make the program viable.

Since enactment of the PSRO program, the AMA has been involved in major efforts to better the PSRO program. Some of the AMA activities include the development of guidelines for the formation of PSRO data policy, a publication suggesting practical and legal guidelines for members of boards of directors of PSROs, and a model memorandum of agreement between health system agencies and PSROs. In addition to such activities, the AMA has developed through contracts with the Department of Health and Human Services two sets of sample criteria to assist local PSROs in their review process: one for short-stay hospital review and the other for surgical procedures. These documents do not and were not intended to constitute standards of care. They were designed as tools that could be used by a local PSRO in formulating individual review criteria. These projects represented an appropriate utilization of the private sector to aid PSROs in their review process. However, the revised short-stay criteria sets and the newly developed surgical criteria sets have been held by the Health Care Financing Administration for over a year. This lengthy delay has denied local PSROs the benefit of this professional input. Mr. Chairman, it is this type of Government activity which has partially led to the growing undercurrent of dissatisfaction with the PSRO program.

A situation which has caused significant physician dissatisfaction with the PSRO program is the long struggle between the Texas Medical Association and the Federal Government over the designation of a statewide PSRO for the State of Texas. In this particular situation, HHS divided the State of Texas into nine PSRO areas over the strong objections of the Texas Institute for Medical Assessment (TIMA), an organization endorsed by the Texas Medical Association (TMA) as the designated PSRO agency. To overturn this action, TMA successfully brought a legal action against HEW, and the United States Court of Appeals for the Western District of Texas determined that the designation of Texas into nine PSRO areas was "unlawful and invalid" (*Texas Medical Association* v. *Matthews*, 408 F. Supp. 303 (1976)).

The final result of the struggle in Texas between the Federal Government's efforts to impose multiple PSROs in the State and the Texas Medical Association's and TIMA's efforts to see the creation of a single statewide PSRO has been the absence of PSRO review for the entire State of Texas until September 1980. The medical community in the State of Texas, which was willing to work with the Government in the creation of a PSRO for the State in 1973, now opposes the national PSRO law. Furthermore, it is indeed ironic that after 8 years of unyielding resistance to the AMA's request that options be allowed for statewide designations, the Federal agencies are now proposing the designation of consolidated areas.

The AMA urged the 96th Congress to pass legislation that would help to guarantee the confidentiality of PSRO records by exempting them from Freedom of Information Act (FOIA) requests. However, Congress delayed a decision on this issue by passing a limited exemption that would allow the judicial system time to resolve the question. This lack of final resolution and the fact that PSRO records might be found to be subject to a FOIA request has only served to heighten the uncertainty that many physicians feel upon becoming involved with the PSRO review process. There is no question that without adequate confidentiality safeguards, both the physician/patient relationship and the peer review process will suffer. This issue has been one of the more significant factors that has disillusioned physicians with the PSRO program.

The AMA is also gravely concerned over another direction that the PSRO program is taking. Previously we supported a program which has as a principal goal the assurance of high quality medical care. However, it is clear that this purpose is not viewed as the primary goal for PSROs by HHS and that the PSRO program is simply being used as a mechanism to place restraints on the costs of health care; even in this mission it is unclear whether PSROs are succeeding. Recent reports from the Congressional Budget Office, the Health Care Financing Administration, and the General Accounting Office only attempt to measure how much money PSROs are or are not saving; not how or whether care is improved. It is this single-minded purpose of federal agencies that has convinced us the direction of the PSRO program is so far removed from quality assurance that it no longer reflects the program that we have supported.

Efforts were also made in recent years to greatly expand the PSRO program to include review of all services furnished in ambulatory settings, including physicians' offices. This authority, passed by the 95th Congress, was repealed by the 96th Congress because of recognition of the impossible scope of the task. This vacillation, however, which has also been seen in such issues as inadequate funding, use of physician identifiers, and control of PSRO data has only served to heighten physician concern.

An additional event that moved the AMA to its position of opposition to the PSRO program was the passage of the Reconciliation Bill of last year, P.L. 96-499. This bill diluted the physician role in the PSRO program. In addition, it authorized PSRO review of surgical procedures that are performed in the physician's office. This extension of PSRO authority is, in our opinion, far beyond the original intent of the bill and it would not work to assure quality of procedures performed in a physician's office. Indeed, this provision could have a counter-productive effect of raising the cost of medical care as physicians opt to care for patients in more expensive practice settings rather than open their offices to a PSRO. As Congress has yet to finally resolve whether or not PSRO records will be subject to a FOIA request, this last point remains a very real concern.

In concluding, Mr. Chairman, I would like to point to the AMA's change in position on the PSRO program last December as a natural, eventual result based upon the growing dissatisfaction that developed from the often fruitless and frustrating efforts to work with the federal bureaucracy and improve the PSRO program. This was an action that was taken after long-term suport of this program. However, we had to recognize the significant problems of the PSRO program, and therefore we recommend this Committee work to bring about termination of the program. Again I emphasize strongly this should not be considered a withdrawal of our support for professional peer review of medical service to ensure quality care. What the AMA is rejecting is a federally directed review program where the federal direction is no longer interested in patient care or quality service, but has become devoted to the single-minded purpose of restricting health expenditures.

Thank you again for this opportunity to present our views on the PSRO program. At this time, I would be pleased to respond to your questions.

Senator DURENBERGER. We will now undertake to do what may look like the impossible, but is designed not to be impossible, and that is a panel of eight.

Dr. Robert J. Becker, president of the American Association of Professioal Standards Review Organizations, from Joilet, Ill.; Stanley I. Fishman, M.D., Kings County Health Care Review Organization, New York; Duane Heintz, chairman of the board, Mid-West Business Group on Health; manager, health care services, John Deere & Co., in Illinois; Dr. Robert Morton, Colonial Virginia Foundation for Medical Care, in Tidewater; Dr. Richard Pierson, Jr., chairman of the board, New York County Health Services Review Organization, New York; Dr. John M. Wasserman, president, California PSRO, Torrance, Calif.; Dr. Joyce Lashof, Assistant Director, Health and Life Sciences Division, Office of Techology Assessment, Washington, D.C., accompanied by Dr. Bryan R. Luce; and James B. Cardwell, senior vice president for Blue Cross and Blue Shield Associations, Chicago, Ill.

And it is my understanding that——

Dr. LASHOF. These are separate.

Senator DURENBERGER. These are separate? Oh, well, this is not impossible at all. It is only the first six people, Dr. Becker through Dr. Wasserman.

Dr. WASSERMAN. Dr. Wasserman is separate, too.

Senator DURENBERGER. All right.

And I understand that each of you have submitted your own statement on the subject, and that Dr. Becker will be making a presentation on behalf of the panel and then you will all then respond to whatever questions we may have. Or I will be sure in a question to give all of you an opportunity to react if that is appropriate.

Dr. Becker?

STATEMENTS OF DR. ROBERT J. BECKER, PRESIDENT, AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, JOLIET, ILL.; DR. STANLEY I. FISHMAN, KINGS COUNTY HEALTH CARE REVIEW ORGANIZATION, NEW YORK, N.Y.; DR. ROBERT A. MORTON, COLONIAL VIRGINIA FOUNDATION FOR MEDICAL CARE, TIDEWATER, VA.; DR. RICHARD N. PIERSON, JR., CHAIRMAN OF THE BOARD, NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION, NEW YORK, N.Y.; AND DR. JOHN M. WASSERMAN, PRESIDENT, CALIFORNIA PSRO AREA 23, TORRANCE, CALIF.

Dr. BECKER. Thank you, Mr. Chairman, and Mr. Dole.

My name is Robert J. Becker. I am a practicing physician from Joliet, Ill., and I am currently president of the American Association of PSRO's. Our association represents 187 PSRO's with over 160,000 physician members.

I am pleased to present the thoughts of our organization.

I would also like to state that Duane Heintz of John Deere & Co. is unable to be here and I request that his testimony be made part of the record.

As has been stated in the past, several times, the current administation is proposing that funding for PSRO be phased out over the next 2 years and then eliminated.

Simultaneously, the administration is proposing repeal of the current medicare requirement that hospitals participating in medicare must have a utilization review committee.

The administration seems to have based its recommendations on two premises

First, that the CBO report on the program indicates that the PSRO program is not cost effective.

Second, it is assumed that by fiscal year 1984 the administration will have recommended a procompetitive type health system, that Congress will have enacted the necessary legislation, and that the program will be fully operational, and then PSRO and utilization review of government-funded patients will no longer be needed.

I would like to discuss each of these premises briefly, first, the CBO report.

We believe that that report has serious flaws, as has also previously been stated. The flaws have been pointed out by two other agencies of the Congress, the GAO and the Office of Technology Assessment. We ask that the attached excerpts from their comments be made part of the record.

[The excerpts follow:]

COMMENT BY THE GAO ON THE CBO EVALUATION OF THE PSRO PROGRAM

"Deciding which benefit-to-cost ratio appropriately measures PSRO program effectiveness depends on whether one views the PSRO program as trying to control federal expenditures for hospital care or total expenditures for hospital care."

"Neither the HHS nor CBO benefit-to-cost ratios consider savings that result from PSRO's review of Medicaid patients." [1]

COMMENT BY THE OFFICE OF TECHNOLOGY ASSESSMENT ON THE CONGRESSIONAL BUDGET OFFICE EVALUATION OF THE PSRO PROGRAM

"One problematic issue is the opposite conclusions reached by CBO and DHHS after analyzing the same data, i.e., utilization savings 30 percent less than review costs versus savings 10 percent greater than review costs. The CBO report lists a number of methodological problems that could shift the conclusion of the cost effectiveness of the PSRO program either to a net loss or to a net savings position, and the persuasiveness of either conclusion might well rest in the eye of the beholder." [2]

EXAMPLES OF PSRO QUALITY OF CARE ACTIVITIES

The New Hampshire Foundation for Medical Care suspected that patients with heart related problems were inappropriately being diagnosed as myocardial infarctions. They developed criteria for appropriate diagnosis and examined a sample of patients who had been discharged as MI patients. From the results of this study, they found 810 patients in one year in 27 hospitals who had been inaccurately diagnosed as having MIs.

The PSRO conducted an education program for physicians on the use of enzymes and isoenzymes in the diagnosis of myocardial infarctions. In addition, the PSRO distributed medical literature on how to diagnose an MI.

The PSRO later monitored, on-site, every record of every patient who was discharged as an MI. The fingings—diagnosing MIs is now being performed at close to 100 percent accuracy.

The Essex Physicians Review Organization (EPRO) in South Orange, New Jersey, examined data on average length of stay for their area and for each hospital in their area on several selected diagnoses and procedures. They found some hospitals with an excessive average length of stay for cataract with lens extraction. The PSRO staff and physicians began to monitor and communicate with these hospitals in order to determine why patients were staying longer.

The PSRO found that one hospital was performing the majority of bilateral cataract (removal of lens in both eyes) being performed in the county and as keeping their patients in the hospital for six to eight days between procedures.

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[1] Letter from Gregory J. Ahart, Director of the Human Resources Division of G.A.O. to the Honorable George M. O'Brien, June 12, 1980.

[2] *The Implications of Cost-Effectiveness Analysis of Medical Technology* Office of Technology Assessment, p. 66, August 1980.

Intensified review was implemented for these cataract patients and a monthly log was sent to the PSRO in order that more timely tracking could be performed.

In this PSRO area, average length of stay for cataracts has been dropping steadily since PSRO intervention from 5.3 days in 1977 to 4.08 days in 1979. For the one hospital mentioned above that was performing bilateral cataract surgery, the average length of stay has been reduced from 6.8 days in 1977 to 5.8 days in 1978 (a reduction of 13.2 percent) and to 4.8 days in 1979 (a reduction of 18.6 percent).

The Rhode Island PSRO, in their review of patients in skilled nursing facilities, found that patients who had been admitted to five of the SNFs for rehabilitative services were not receiving necessary skilled physicial therapy. The PSRO worked with the Physical Therapy Association to develop standard for documentation and provision of services. These standards were then communicated to all SNFs.

A follow-up examination of the results of these efforts showed more timely initiation of skilled physical therapy services. The five SNFs identified as having the most problems in this area have arranged for back-up physical therapy services during vacations and illnesses. In addition, registered physical therapists now supervise PT assistants and evaluate skilled patients at least weekly.

Admission and utilization data were compiled, by physician, to examine patterns of practice respecting the diagnosis, treatment and medication of patients with cardiac, pulmonary and renal failures by the Beverly Hills PSRO. Analysis of data accumulated for each physician and hospital affecting 350 patients was used to identify the problem. To verify that a problem did exist, the PSRO checked on the patients of these physicians while they were in the hopsital and found that not only were the patients being inaccurately diagnosed as cardiac, pulmonary or renal failure patients, but they were also being inappropriately treated and overmedicated even if the physician's diagnoses had been correct.

PSRO physicians held a conference with each of these physicians to explain the problem, to provide information on how to accurately diagnose and treat these types of cases and to suggest that their patterns of practice should be changed. This approach did not work, however. The physicians refused to change their practice.

Next, the PSRO placed both physicians on pre-admission certification and went back and retrospectively denied payment for the inappropriately diagnosed and treated patients. In addition, the PSRO reported on this problem to the Office of Program Integrity, the state licensing board, and the State Department of Health.

The PSRO ultimately achieved a reduction of 50 percent in the overall number of admissions for cardiac, pulmonary, and renal failures by eliminating these inappropriately diagnosed cases.

Dr. BECKER. Notwithstanding the deficiencies of the CBO report, it has been stated several times this morning that the PSRO program is saving Federal dollars in excess of its costs.

During the August 25, 1980, House Ways and Means Subcommittee hearings on the PSRO's program, the CBO stated:

> Specifically, we estimate that the gross savings to the Government exceed relevant program costs by about $17 million.

Since the relevant program costs were $105 million, this means that the CBO credits PSRO's with saving $122 million for the Federal Government.

This figure does not include any savings in the medicaid program.

The controversy over the PSRO cost effectiveness comes about in a large part because the CBO report generalizes its findings for society as a whole, and concludes that the program costs more than it saves.

There are two points we would like to make in response to this conclusion. First, PSRO's are not authorized by law to review private patients. Second, CBO's assertion that costs are shifted to the private sector to the degree estimated in their report is not supported by hard data.

Mr. Chairman, we recently explored with a reputable actuarial firm the possibility of doing an independent analysis of the CBO report. It may be instructive to give this committee the concluding

paragraph of the letter of reply from Milliman & Robertson, Inc., a nationally recognized actuarial consultant. I quote:

> If we were to advise the appropriate committees of the Congress regarding a basis for making decision as to the future of the PSRO or a successor program, we would have to recommend that they solicit the qualitative judgments of expert professionals in the health care delivery and financing fields, rather than rely on numerical results from the sort of research underlying the HCFA or CBO studies.

Our association has collected information on its own on the impact of PSRO activities and has made summaries of this information available to every member of this subcommittee. A brief excerpt from the material is attached to my testimony.

On the question of increased competition, until such a system is in place, we believe it would be shortsighted to remove the only effective review mechanism now working to control utilization.

Additional evidence of the effectiveness of PSRO's can be found in the fact that private industry increasingly is arranging for PSRO's to review private patients.

Approximately 50 PSRO's have entered into contracts with private industry to review the health care of their employees and their beneficiaries.

Private industry is paying with its own funds for this review. And the interest in private review is growing at a rapid rate.

Now, as far as poor performing PSRO's, we have had a strong position on this subject for years. That position is, poor PSRO's should be detected, an opportunity to improve should be given, if they don't they should be eliminated, and those funds allocated to PSRO's that are cost effective.

Mr. Chairman, we urge the Congress to restore fullfunding of the program, to insist that HHS do an effective job of defunding those PSRO's with the poorest performance and move effective PSRO's into the full range of review activities set forth in the statute.

We stand ready to cooperate with the Congress and the administration in meeting these objectives.

Mr. Chairman, I now speak only for myself. The house of delegates of AAPSRO will not take this or other policy positions until tomorrow.

If, despite our best efforts the Congress decides to defund the program, you may not wish to do it in the way the administration requests.

First, we have little or no confidence that HHS will be able to decide on its own which PSRO's should be defunded.

Second, the best people in the PSRO's are likely to leave immediately.

Third, hospitals, States, physicians, and others are unlikely to continue cooperating with a program which is scheduled for demise.

With these and other factors operating, a protracted winding down of the program, as proposed by the administration, may be a guaranteed disaster.

I would urge the physicians in my own PSRO, despite our own proven record of performance, to drop the program immediately and concentrate on our private review activities. In the final analysis, however, this decision will be made by each PSRO individually.

Mr. Chairman, we have tried to make the best case we can for the PSRO program because we believe so deeply in its accomplish-

ments and its potential. We have come to understand what Washington people meant when they told us, wistfully, I thought, that it is too bad that we do not have a natural constituency.

The program by its very nature does not earn many friends. We have earned the support of many in the private sector because we can show that we save them money. We have saved money on the Government's side, but that seems not to be sufficient.

Contrarily, the program has earned enemies because it has done its job well. We expected this development. After all, we are the ones who say No. We say No to the physician who wants to put the patient in the hospital who does not belong there. We say No to the hospital administrator who wants to keep his beds filled.

We say No to the family who wants to keep the family member in the hospital long after medical care is necessary.

We now say No to the administration, the Congress, about defunding PSRO's and discontinuing utilization review since PSRO's are the only organized effort at monitoring costs and quality of care.

We must look for our main support from Government among those who are concerned about the costs of Government programs and the quality of care provided to patients for whom the Government has assumed financial responsibility.

Gentlemen, from this perspective, the Government is this Congress and the administration. We ask for your support.

I will now ask other members of our panel to present examples of what PSRO's are doing. And we will then be ready for questions following that.

Dr. MORTON. Mr. Chairman, I am Robert A. Morton, M.D., a practicing physician from Norfolk, Va., and medical director of the PSRO in the Tidewater area.

I have submitted a written statement. I have few other observations to make.

I think enough has been said about the CBO report, and I endorse Mr. Constantine's opinion of that.

Of more importance to me and to hospitalized patients is the beneficial effect on the quality of care the patients receive. This is the very reason that I and virtually all of the physicians involved in PSRO activities have been such staunch supporters.

I find it quite impossible to display quality improvement by graphs or charts or in numerical terms. Such incidents of quality improvement frequently have to be anecdotal.

If quality does improve, there must be an implication that it was not as good as it should have been to start with. With confidentiality regulations and physicians' inherent reluctance to point out that if things are better they must not have been good in the past, it becomes very difficult to conclusively document improvement in the quality of medical care to the public, as well as to the medical profession.

Quality, like art or beauty, is most often in the eye of the beholder. Yet when the 100-plus physicians who make up the working committees and the board of directors of my PSRO agree that not only has PSRO review not interfered with a physician's ability to practice high quality medicine, it has also enhanced the quality

of care, then I think it is reasonable to conclude that knowledgeable professionals have reached a consensus which is valid.

There are two of many instances I would just briefly relate.

A physician who recognized that his patient was having internal hemorrhaging failed to manage that patient in an appropriate fashion resulting in the death of that patient, PSRO reviewers found other instances of inattention to patient's problems by this physician.

Joint action by his hospital medical staff and the PSRO has resulted in marked improvement in this physician's professional activities and his patients are now receiving the type of care they deserve.

In a study on hysterectomies performed in our PSRO area, four hospitals were singled out as having length of stay problems, especially in the preoperative phase of the hospitalizaton.

Special review of patients undergoing hysterectomy was instituted in these hospitals. Length-of-stay figures improved and approached or reached the norm. But an unexpected and dramatic result of this special review was a reduction in the actual number of hysterectomies being performed.

Prior to the institution of special review, these four hospitals performed over 150 hysterectomies in 1978. Two years later, by applying physician developed criteria justifying the need for a hysterectomy, only 64 such procedures were done. Thus, patient care benefited in both a quantitative and a qualitative sense.

As regard to the American Medical Association's decision, I will quote that decision:

> The current Association policy shall be to continue professionaly directed efforts to ensure that care provided to patients is of high quality, appropriate duration and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all Government directed peer review programs, including PSRO.

I would now like to close my statement by quoting a most respected physician, Dr. Kinloch Nelson, who, having retired as the dean of the Medical College of Virginia, has now assumed the chairmanship of the Commission on Continuing Education of the Medical Society of Virginia. This quote is from a letter he recently wrote to the governing council of that society.

> If PSRO is eliminated, what are the alternatives? What are the professionally directed efforts mentioned in the AMA action?

Senator DURENBERGER. Is that the conclusion?

Dr. MORTON. I think I will end it right there.

Senator DURENBERGER. Thank you very much. And I would give the same advice to the rest of the panel, that is to say you are going to work us out of time for asking questions and may not serve the cause.

Senator DURENBERGER. Are you going to make a brief statement, sir?

Dr. FISHMAN. Yes, sir. I hope so.

Senator DURENBERGER. Thank you. All right, sir.

Dr. FISHMAN. Mr. Chairman, these remarks are an extension of the written testimony submitted.

I am in the private practice of internal medicine performing primary care for patients, and I am the chairman of the PSRO

Committee of the Medical Society of the State of New York, comprising some 27,000 physicians.

That society has reaffirmed its strong support for the PSRO program. It is therefore fair to say that I am personally in the mainstream of primary patient care and that I also represent a large number of my colleagues.

As prudent concerned taxpayers, we support the need to hold down burgeoning Government expense. Moreover, we recognize PSRO as the best method of containing medical costs without sacrificing decent care.

We believe those PSRO's which have not produced a dollar saving over the costs have still prevented big increases in Federal costs, while some PSRO's show an actual $12 saving for every dollar expended in medicare alone

No one doubts that the presence of police prevents crime from running rampant.

There used to be a system in which troubleshooting teams of nurses, physicians, executive directors, and data managers from successful PSRO's went to other less successful PSRO's and advised them on how to improve their PSRO's. That was an early victim of budget cutting some years ago. And similar ill-advised budget cutting procedures have resulted in elimination of important programs since then, and have in fact also reduced the number of case reviews that any PSRO could perform.

Given that artificial handicap, it is not really surprising that the whole program could not perform as well as some people demanded.

It has been suggested that local governments or even insurance intermediaries could fill the void if PSRO's were eliminated.

In New York, the former adversary position between the State and the PSRO has been replaced by a successful cooperative effort.

You have probably seen the letters from top State officials urging continuation of the program, and the Governor's budget highlighted an anticipated savings of $5.2 million for medicaid by PSRO activities.

The critics also speculate that where successful PSRO's do effect savings, somehow this cost is transferred to non-Federal patients. Actually, the cost of merely maintaining a bed empty is a fraction of what it cost to maintain the bed and care for the patient if it is occupied.

There is, of course, a more effective method of cutting costs than PSRO reviews. Where benefits have been eliminated or artificial limits have been placed on hospital stays, these harsh methods have indeed produced savings for the particular program or locality. But, of course, serious illnesses have no respect for a budget's arbitrary cutoff point, and sick patients remain beyond that point, and here the cost must be shouldered by someone else, the general public.

Such approaches, previously tried, have thankfully given way to more humane methods.

All of us become patients sooner or later, and on behalf of all of those patients, ourselves included, we urge you to provide the means of improving the PSRO program where it needs improvement and furthering it where it is already successful.

The quality of care we improve may be our own.

Thank you.

Senator DURENBERGER. Thank you very much.

Dr. BECKER. Mr. Chairman, we are now ready to answer questions for our three.

Senator DURENBERGER. All right. Very good.

And I think that was an appropriate statement, that last sentence, for the purpose of this hearing.

Mr. Ahart pointed out 5, and I imagine there were more, but 5 main impediments to implementation over the last 5 years.

One is fragmented authority and program responsibility within HHS; the second, less than anticipated funding. That issue has been addressed here in the panel. Third, delays in issuing regulations and program guidance; fourth, lack of aggressive administration of contracts with PSRO's; and, fifth, perhaps the most important—and I am quoting—lack of physician support for the program in many areas of the country.

Now, Dr. Becker, in your testimony I believe I heard you say that what we ought to do is allocate money from ineffective PSRO's to effective PSRO's.

I am not clear that you meant to say that, but in case you did, that was followed by another statement which you said the Department of Health and Human Services cannot determine which are effective.

I guess I would like to know from the members of this panel whether you agree with the theory that we ought to keep the effective ones going and take the money away from the ineffective ones and give it to the effective ones, or whether you believe there are lessons to be learned from the effective PSRO's that might cause us, through HHS or some other form, to bring the value of the good PSRO's to those parts of the country that are not served by efficient PSRO's.

I would ask you to comment briefly on that.

Dr. BECKER. That was a several-faceted question. Now, first of all, we have recognized the problem of identifying ineffective PSRO's. Because of the delay in HHS in pursuing this, the executive directors of AAPSRO have developed a protocol which has been submitted to the National PSRO Council and to HSQB which addresses a mechanism for evaluating ineffective PSRO's.

Yes, we do suggest—we have suggested—this has been a policy for several years—that ineffective PSRO's be identified; that they be provided technical assistance, if necessary; that with technical assistance if they are unable to perform, for whatever reason, that they be defunded and those funds be allocated to PSRO's that are effective.

Senator DURENBERGER. Let me stop you at that point and ask you again, discharging our responsibility as policymakers here to the $65 to $80 billion we are spending every year in medicare/medicaid and child and maternal health care, what do we do in those areas where PSRO's have failed, besides taking their money away from them and putting it into the effective areas? Do we just sort of ignore those areas and say we don't care much about either the cost or the quality of the health care being delivered to subsidize patients who are part of this system?

Dr. BECKER. We would suggest there be one of two mechanisms. Either, one, mandate that those areas be reviewed by geographically adjacent PSRO's, or two, implement utilization review with good cost accounting to see the difference in both cost effectiveness of utilization review, as compared to PSRO review, as well as a review of the medical services provided within the two areas and compare them logically with good data.

Senator DURENBERGER. Are there incentives that we could somehow build into the system to the private marketplace? I guess the gentleman from John Deere is not here today. But are there incentives that could be built into this system that would cause the private marketplace to respond to ineffectual PSRO's with a better looking PSRO into which we could buy and into which others could buy also?

Dr. BECKER. I am not sure what private incentives there are, other than the fact that private industry has expressed a significantly increasing interest in PSRO review because of the fact that in those instances where private review is done it has been cost effective. Mr. Heintz of Deere & Co. has said that there has been a 20-percent decrease in the anticipated inflationary rate of health care cost during the period of review.

The same experience has occurred in the Caterpillar Co. Other industry groups have expressed interest in pursuing the private review sector for PSRO review.

Senator DURENBERGER. Obviously one of the incentives is junking some of the—Dr. Boyle may or may not have been correct in his 30 percent estimate in California, but maybe junking some of the regulations and the paperwork that goes with some of this system might be an incentive to effective PSRO's as well.

Thank you for your comments.

Senator Dole?

Senator DOLE. I just had one question. With reference to New York, you are saying that the Governor has put into his budget how much because of savings?

Dr. FISHMAN. $5.2 million. This is the Governor's estimated saving. Not the estimated cost, the estimated saving of $5.2 million as a result of projected PSRO activity in medicaid for the coming year. That is quite an endorsement, I think.

Senator DOLE. New York gets about $3 billion. That would be less than two-tenths of 1 percent. That is coffee money.

Dr. FISHMAN. I guess you should not mention coffee these days. [Laughter.]

Senator DOLE. It is not a lot of money if you look at the total amount.

Dr. FISHMAN. I think that is quite an admission from what was formerly an adversary, Senator, where they were very anxious to take over review from the PSRO, and, in fact, were one of the agencies that fought with the PSRO for so many years.

As has been mentioned before, a great deal of the activity of PSRO's in the past has simply been defending themselves rather than getting down to the job they were supposed to do.

Senator DOLE. I would just state, as I indicated before, this committee will have the responsibility to come up with substantial savings if we are going to get a handle on the budget. If every

program escapes because of some reason or another, then we are right back where we were. And if you like 17 percent interest, and 12 percent inflation, 8 percent unemployment, and all the regulations you have, then we should not do anything. But that is not the way most of us view it. I am certain you do not view it that way now.

If this is such a big money saver then maybe you ought to find us another $150 million somewhere from medicare and medicaid. If you are going to just say take us out, you should be willing to say put somebody else in the pot.

Dr. WASSERMAN. The red graph is before the implementation of binding review; the blue graph is after.

Senator DOLE. Everybody with a program can tell us how much we have saved. Nutrition programs I think save money in future years because, whether it is the WIC program or food stamps, school lunch, better nutrition. So we can all say well, we are really saving money because we are going to reduce hospital costs. That isn't going to cut it any more. We have got to find some real savings. We are still talking about a deficit in 1982 of $45 billion. We are not talking about in some cases of doing much for the cutting of throats.

It is a difficult proposition you have, and I am not certain we can resolve it as far as PSRO's are concerned.

I hope so. That is our problem.

Dr. WASSERMAN. Well, I have such a recommendation of how to save money.

Senator DOLE. Oh, you are the next witness. Good.

Senator DURENBERGER. Thank you.

Dr. WASSERMAN. I was just reminded that perhaps my remarks relative to the lights earlier might have discouraged your speaking up here. And you have come all the way from California. And I would be pleased to have you make some comments.

Dr. WASSERMAN. I am going to depart from my written text and comment on two or three things.

I agree entirely with Senator Dole's remarks and it is my purpose to testify as to how we can save the taxpayers money. I come from the same area of the country as Joe Boyle. He and I belong to the same medical society.

He commented about the Good Samaritan Hospital, which is an excellent hospital that has an excellent review program. I might tell you that that review program was initiated by Dr. Ray Killeen, the past president of the PSRO area 24 in California.

So that may have contributed somewhat to it.

I would also like to tell you that I was president of my medical society. I have never reached the exalted position of being President of CMA, but I was on the peer review commission there. I was chairman of the hospital care evaluation committee, and it was interesting that we did have the best of intentions. We did not have much process and we did not have any teeth. And that is the unfortunate part of organized medicine's performance. I am still a part of organized medicine. I am still one of Joe Boyle's constituents. I have been a member of the AMA for 25 years. And there are many members of AMA who do not indeed concur with the house of delegates and I am one of them. But so much for that.

They used to say that the mark of the golden years were preoccupation with bowels, bladder and teeth. That has changed somewhat. It is now inflation, bowels, bladder, teeth, medicare, and social security.

I, in about 8 days, will be one of those beneficiaries of medicare, so that I have even a greater vested interest in this program as well as being a taxpayer who is concerned about inflation and all the other things.

I think that if you are looking to really save money you can do it. You can do it by some legislative change and some change in the regulations.

Some of the things that have really bugged the PSRO people is that we perform PSRO program requirements and they may end up as a paper process.

For example, up until 2 or 3 years ago when we denied a stay that was unnecessary, it was paid for anyway, and it is still being paid for because it is being paid under presumption of waiver.

It seems that when something gets into HHS, formerly HEW, it is hard to get it out. This presumption of waiver was predicated on a retrospective review system. But how do you take your retrospective review benefit and apply it to a concurrent review system?

For the past year we have been harassing people. I testified before Oversight Investigation on the House side. And we seem to be unable to move HHS to save the money, Senator Dole, that you would like to save. And that is the waiver of liability.

In the matter of grace days, when the person is paying their own hospital bill, and you say your stay is over because you do not need anymore care, they leave when they are paying their own bill. Why shouldn't they leave if the taxpayers are paying the bill?

I can give you a litany of things that the PSRO's have been trying to influence the Federal Government to do to make this thing cost effective within the PSRO program itself.

Ancillary services now account for approximately 56 percent of the daily cost of acute hospital care in the title XVIII program in California.

The volume overwhelms the system. If you have a fairly long stay, you may have 400 items. There is no way in the world that anybody is going to fund a PSRO or another agency to be able to look at these volumes of bills.

We have come to the conclusion that the only way that you can handle this is to take a statistically valid sample and apply it to the universe.

We recommended this at least a year or two ago. We would like to recommend for your consideration.

I will not take the time of this committee to go into some of the details of other suggestions which we have submitted. We think they are important. We think in the context of the cost of the PSRO program that is a piddling amount in comparison to the amount of money that the PSRO could save, and, in fact, does save. And it could save even more with some regulation changes and some minor legislative changes.

Senator DURENBERGER. Thank you very much. Any questions?

Senator DOLE. Thank you. I think that is very helpful.

Senator DURENBERGER. Our thanks to the whole panel.

Dr. PIERSON. I am Dr. Pierson. Could I take just a moment? I am going to depart entirely from my text because you show excellent evidence that you can read, and it is contained there.

And I would like to do something also somewhat counter-cultural. Like Dr. Boyle, I am a member of the house of delegates of the American Medical Association, and I cannot tell you in how strong disagreement I find myself with the presentation which he has made, how one-sided and unrespective of many of the points of view which have been expressed in that house.

And I guess that I will give you evidence that organized medicine does not speak with a single voice.

He presented two things. One is looking backward and that is the historical presentation. And that was entirely accurate and it was well done. And the other part was looking forward, and that was not brillant in my view.

I would like to make just two points. The first is that it has been established, in my view and I think in the view of most of the representatives who spoke here today, that PSRO has been effective where physicians have taken an active role in its process.

It has also been established, in my view—and I will call this to your attention—that JCAH, the joint commission for accreditation of hospitals, has no operational method for a fine tune control of audit. They have an all or none control. They can either accredit your hospital or not accredit it, or they can come back a year sooner than they otherwise might have.

Their ability over the many years that they existed prior to PSRO to have an effect on audit has been absent, in my view.

As an amateur engineer—and I think systems require us to be engineers—we insisted there be some kind of a feedback loop in a system. Perhaps it is more fashionable in the medical circle to call it a linkage between performance and payment.

I would make one conclusion from my comparison between PSRO and the JCAH audit process to say that without fiscal penalty, audit is eerie and femoral. I believe that history can be easily and carefully read to bear that out. And I will not give further documentation because of our shortage of time.

I think the point is central and principal. When we have the ability to withhold payment, we gain the ear of the hospital administrator and of the attending physician.

The second point that I would make is I think you have a right to hear some comments from physicians because you have asked us to come here, and we are physicians, and these cannot help but be anecdotal. But my comment is not particularly anecdotal, although it is an argument by analogy.

PSRO offers the opportunity, as Dr. Helen Smits suggested, to do very specific case-by-case analysis of cases who were staying in too long, whose quality of care was questioned. And it is perfectly clear to you, gentlemen, that a physician, in looking at you, when you have a chest pain or a toe pain, is going to make a specific diagnosis to a specific complaint and is not going to present you a 100-page-long questionnaire, or should not present you that questionnaire to try to do the thing by broadcast or by bureaucratic method.

By analogy, there are many cures for cancer, and cancer can indeed be cured. But they all depend on an absolutely specific diagnosis for a specific cancer.

To give hemotherapy for breat cancer is not effective; to give radiation for Hodgson's disease is entirely effective or almost entirely effective.

These analogies suggest that if we know the disease, if we know the problem that exist in a given PSRO, if we can make a diagnosis of what it is either on a case-by-case basis, which is the PSRO system rather than filling out forms that cover all cases, this to me is Senator Wallace Bennett's magical insight into the PSRO process or what could be the PSRO process, which is that it should look at individual cases and make a decision whereas 50 days might be appropriate for one medicare patient and 3 days might be inappropriately long for another medicare patient. And that we do have to look at them case by case.

And where else can you find the staff to do that other than amongst the physicians of the community?

My final point refers to the possibility of looking at outpatients as well as hospitals. And I give it only because—and Senator Dole would be unhappy with the suggestion that this should be considered—to consider taking a look at outpatient medicine, it means increasing eventually the cost of the whole system.

And yet I would suggest to you, as Dr. Smits said and as Jay Constantine did more brillantly than I can, that until we are looking at the whole system, the possibility that we are shifting the activity from one place to another is very large.

And I would urge upon you the logic of sticking with the physicians who have been dedicated to the principles of PSRO, as indeed Wallace Bennett was, because I think he had some pretty good ideas.

Senator DURENBERGER. Thank you. Thank you, all of you. We appreciate your testimony. The next witness is Dr. Joyce Lashof, the assistant director of health and life sciences division of the Office of Technology Assessment. Thank you for your patience, Doctor.

STATEMENT OF DR. JOYCE LASHOF, ASSISTANT DIRECTOR, HEALTH AND LIFE SCIENCES DIVISION, OFFICE OF TECHNOLOGY ASSESSMENT, WASHINGTON, D.C.

Dr. LASHOF. Thank you, Mr. Chairman.

Let me briefly say that as a representative of the Office of Technology Assessment, I am here neither to speak for nor against the PSRO's. We are an impartial, analytical arm and we can only report in those areas in which we personally have done studies. So I am going to address myself to a very limited area.

We currently, at the Office, are doing a major study, looking at strategies for medical technology assessment.

As part of that study, we have been looking at the role the PSRO program could play as an instrument for two things. And I will briefly summarize my testimony, and ask that the complete testimony be placed in the record.

Our project really wants to examine the potential role of PSRO's for two fundamental activities related to technology assessment.

One is the dissemination of information to practicing physicians, and, the second is to collect technology assessment information either to evaluate at a local level or to funnel it elsewhere for assessment.

. To investigate these topics, we contracted with the Rand Corp., specifically with Drs. Brook and Kathleen Lohr, who are among the nation't most knowledgeable researchers in the field of quality of care and in the PSRO effort.

They have reviewed for us a selective body of literature on the whole problem of information dissemination. They then prepared a paper presenting hypotheses related to PSRO's being actively involved with information dissemination to the physician community and to PSRO's collecting data and conducting technology assessments.

This paper then served as the principal discussion point at two meetings which a small group of highly selective PSRO medical directors and executive officers attended.

Those meetings were held in January of this year, one in Washington and the other in Los Angeles.

We will have a final report from the Rand study available within the next few weeks and we will make that available to you and the staff.

But let me just summarize the findings at this stage of the game.

The problem of information overload in medicine is now well known. New technologies evolve, some established ones are discarded. Odds are high that practicing physicians will see many changes made to the body of medical knowledge during their medical careers.

For this reason, the medical profession considers continuing education to be an integral part of medical practice.

But one important dimension in this problem of information overload concerns a physician's ability to assimulate the particular type of medical literature that deals with safety, efficacy, and cost effectiveness of medical technologies both old and new.

Current research indicates that both broad channels of communication and individual personal contacts serve as the best conduits for information about medical technology.

The most effective influence on physicians' use of a new medical technology are face-to-face contacts with other physicians.

Evidence further suggests that new practices are adopted in medicine more rapidly than old practices are discarded.

In previous reports, the OTA has noted numerous examples of technologies, such as CT scanning, that have been adopted before there was complete knowledge of efficacy.

Similarly, procedures persisted in the face of discrediting data, such as the use of diethylstilbestrol for preventing miscarriages, and the implications and results of that are known to you.

As the Rand researchers examined PSRO's in terms of their structure and organizational uniqueness in disseminating technology assessment information, and in affecting change in medical practice, they note the following. Most important is that PSRO's can target assessment information to physicians who would be likely to benefit most from it, and they can choose their intervention strategy accordingly.

Identifying problems in the use of technologies, setting criteria for appropriate use, implementing educational interventions, and, if necessary, invoking sanctions against poor providers must all be tailored to specific settings and to the specific providers.

Diffuse or impersonal methods of communications are likely not to prove as fruitful in changing medical practice as are targeted, personal, face-to-face encounters that are consistent with the needs and characteristics of different physicians.

Finally, PSRO's can be expected to reach the great majority of practicing physicians in their areas directly or through hospital staffs. Many PSRO's routinely communicate with all physicians in their areas, members or not.

Finally, we also looked at the question of whether the PSRO's could serve a role in collecting data, and we did find that PSRO's would, if adequately funded, willingly take on technology assessments.

Some 60 or more PSRO's have within the past 2 to 3 years initiated one or more special initiative projects, often ones directly related to technology assessment topics. Four have collaborated in two different cross-country studies and some seven are currently engaged in a randomized, controlled experiment on the use of pelvimetry.

In summary then, our study would seem to indicate that the PSRO's could play a significant role in a national strategy for medical technology assessment in terms of informing the medical community regarding technological developments, encouraging and/or enforcing positive change in medical practice, and in conducting technology assessments.

Thank you.

Senator DURENBERGER. Thank you very much. There is substantially more to your statement than you were able to provide in this short period of time. And I want to express my appreciation to you for the effort of putting the complete statement together and relating the PSRO's to medical technology.

I do want to say I found it interesting that you left off in your presentation, one of the lines you left out was "Yet, physicians are often left to their own devices."

But I thank you very much. And after I have had an opportunity to go through the statement in greater detail, I have several questions that I would like to send to you and ask you to respond for the record so that we can get more specificity I think than is even contained in this very good statement. Thank you very much.

Dr. LASHOF. I would be happy. Thank you very much.

Senator DURENBERGER. Out next witness is Mr. James B. Cardwell, who was earlier introduced as the senior vice president, Blue Cross & Blue Shield Associations, of Chicago, Ill. Thank you for your patience.

STATEMENT OF JAMES B. CARDWELL, SENIOR VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATIONS, CHICAGO, ILL.

Mr. CARDWELL. Thank you, Mr. Chairman.

I am mindful of your time and the fact that we are approaching the lunch hour, and I will make my remarks brief.

I wanted to introduce Mr. Neil Hollander, who is a vice president of the associations, and whose specialty is cost containment and provider relations. I thought perhaps he could help answer any questions that you might have.

In general, Mr. Chairman, we have a very deep and abiding interest in the basic subject before this committee. In some ways, our interest in it is analogous to the interest of the Federal Government.

We are a very large insurer of a very large segment of the American public in the area of health care and health care coverage.

It is fundamental to our interest and the interest of our providers that the American system of health care delivery have an effective utilization review system.

And just like the Government, we are concerned about both the quality and the cost of the care that we pay for. And so we are sympathetic to the Government's objectives and interests and we certainly share them.

We have another interest. We are also a very large prime contractor to the Federal Government in the administration of medicare at the intermediary level. Approximately 60 of our plans carry that function. And among that number there are a large number that have linkages to PSRO.

I might note that there are some that function in areas not served by PSRO's and they function quite successfully from everything that we can see.

To get to the point, taken on balance and recognizing both our own role and our interest and/or experience, in the long term it is our judgment that the administration is probably right in recommending a phase out of the PSRO program.

We doubt that it can prove in the long term to be the most cost-effective way of providing utilization review. In saying this though we do want to recognize that the PSRO concept has made a significant contribution to utilization review and will continue to do so I think for as long as it exists.

We would remind the committee that 11 years has passed since the PSRO concept was conceptualized. There can be little question that there was a justification for the concept. The performance of neither the providers nor the Government's intermediary contractors by that time had jelled or taken hold insofar as medicare is concerned, and there were a great many gaps.

I think that probably it is fair to say that the emergence of the PSRO program itself perhaps slowed the natural evolution of utilization review at those two levels, but, nonetheless, I think it has evolved significantly since that time.

We think, looking at the private side of our business, the record shows quite clearly that utilization has been steadily declining for those patients whom we carry year in and year out, and so have the costs of administering our own utilization review.

Now while we think that it is probably a correct assumption under the pressures of the Federal budget to weigh the PSRO program against the demands of the budget, and that the conclusion that there is probably another way to do it is the correct one, we are not at all comfortable with what the administration is

talking about when it says that it would repeal those provisions of the Social Security Act, those medicare provisions, that require utilization review on behalf of medicare.

In short, we think there must be some utilization review arrangement left in place. We essentially see it as having three parts, and we see it as being a system of checks and balances.

The first part would be the Government itself setting the overall goals and expectations for utilization review on behalf of medicare and medicaid and other Federal-health-financed program.

The second part would rely on the provider community itself to establish given activities commensurate with those standards of the Government.

And the third part would be the intermediary.

We think such a system could be evolved, and that the framework for that is in place and it is essentially strong.

With that, I would try to answer any questions that you may have.

Senator DURENBERGER. Thank you very much.

Let met ask you a question about utilization reduction. I probably should have asked it somewhat earlier, but I will pick on you.

Is there any way to determine how much of the reduction in utilization might be attributable to PSRO activities and how much is attributable to insuror pressure, lawyer pressure, public pressure, where information is public knowledge, publicized, the competition where it exists, or to other things that are going on in the system?

Mr. CARDWELL. I do not think we could measure that with any precision. I think the best anybody could do for you would be to make a guess.

We can isolate our data in terms of medicare patients covered by our intermediaries, our plans and service intermediaries, and we can isolate that experience from our private coverage. But we cannot deny that even the private coverage decline may have been as a result, in part at least, from PSRO presence. But I do not think we can measure that.

Senator DURENBERGER. I am not asking you to be precise, and I am not going to hold your feet to the fire if it is designed to say that there are other things out there working in addition to PSRO's, even where you have good PSRO's working, that undoubtedly impact in some way on utilization, and to have you respond to that.

Mr. HOLLANDER. Well I think, Senator, to add what Mr. Cardwell said, the hallmark of the Blue Cross private-utilization-review programs has been the flexibility to deal with problems in different ways throughout the country. That is the strength of Blue Cross.

And so our utilization programs vary dramatically. And we think our results on our private side business reflect those kinds of changes in flexible approaches that the PSRO program has not experienced.

Senator DURENBERGER. On the subject of information as an asset in the whole business of cost and utilization, someone earlier in the morning had testified to the problems relative to the confidentiality of records.

Let me ask you whether you think without a mandate for a review in medicare and medicaid law, whether you think hospitals will comply with requests to release records and other necessary information?

Mr. CARDWELL. I do not think we can speak for the hospitals. I would rather have them speak for themselves. But I think our general feeling is that the mechanics of an effective system could be evolved within the private sector. But at the same time we believe the Government has to look out for its own interest. And in doing that, we think the statute itself, if not regulation, has to set at least the basic framework for medicare's interest.

I do not think they have to mandate the methodology, the processes or the procedures, but they should make very clear what their expectations are.

I think one of the earlier witnesses emphasized that being able to control the payment against care is in itself an important device. And the Government should preserve that control on its own behalf.

Now it can employ agents for that purpose. It happens to already employ a very large number of such agents, the fiscal intermediaries.

Senator DURENBERGER. Do you have any additional comment, Mr. Hollander?

Mr. HOLLANDER. Well there is only one thing I would add to that, and that is that the JCAH standards and the medicare standards are really quite close in this regard. They both require that utilization review records be kept and submitted to the appropriate hospital authorities.

The issue would be in effectively implementing JCAH standards in the private sector.

Senator DURENBERGER. I have other questions that I will send to you and ask you to respond to for the record.

Mr. CARDWELL. Would you allow me just one last remark?

Senator DURENBERGER. Certainly.

Mr. CARDWELL. Very much like Jay Constantine, I was in Washington when much of this started. And I have developed from that experience and from that time that has passed, a feeling that it would be wise for us to take stock of how we carry out these kinds of activities.

I think we have allowed too much superstructure to develop, and I personally see as a primary failing of the PSRO program its being it is a superstructure. Rather than trying to develop and build on the structure that was already there, we set up a new federally dependent layer.

While giving that layer strong credit for its accomplishments, I still have questions about its validity in the long term.

I also think that a lot of those decisions were borne out of a basic distrust of those out there in the system who carry on the daily work of the system. And I would hope that we could move back away from that in the process of evaluating these kinds of questions.

Thank you.

Senator DURENBERGER. That is why I in a previous comment and when I was talking about incentives for effective review, I talked

about getting rid of some of the things that imply lack of trust in exchange for letting people be a little more innovative and a little more personal in the way they address these problems.

And I thank you for your testimony.

Mr. CARDWELL. Thank you very much.

[The prepared statements of the preceding panel follows:]

SUMMARY OF MAJOR POINTS IN TESTIMONY OF ROBERT J. BECKER, M.D., PRESIDENT, AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The CBO report, as a basis for making decisions on the PSRO program, is seriously flawed according to other experts, public and private. But, CBO report says PSRO's do save federal dollars.

The pro-competition health care model is not in place: PSRO's should be kept until then.

Private industry supports PSRO, many firms use them because they save money.

If the Congress should decide to wind down the program, it should do so immediately and not dribble it out over a two year period.

AAPSRO has a strong position on removing ineffective PSRO's and has developed the criteria to evaluate them.

If the Congress decides to defund the program, it is likely that PSRO's will disband immediately.

AAPSRO urges the Congress:

(1) To fund PSRO's adequately,

(2) See that ineffective PSRO's are defunded, and

(3) See to it that effective PSRO's are moved into the full range of review activities set out in the law in order realize the full potential of the program.

STATEMENT OF ROBERT J. BECKER, M.D.

Mr. Chairman, my name is Robert J. Becker. I am a practicing physician from Joliet, Illinois, and currently president of the Amerian Association of Professional Standards Review Organizations. Our Association represents 187 PSRO's with over 160,000 physician members.

With me today is Dr. Stanley Fishman, Dr. Robert Morton, and Mr. Duane Heintz who will assist in our presentation.

The current Administration is proposing that funding for the PSRO program be phased out over the next two years and then eliminated. Simultaneously, the Administration is proposing repeal of the current medicare requirement that hospitals participating in medicare must have a utilization review committee, saving an estimated $66 million which would otherwise be paid to hospitals for these activities.

The Administration seems to have based its recommendations on two premises. First, that the Congressional Budget Office report on the program indicates that the PSRO program is not cost effective. Second, it is assumed that by fiscal year 1984 the Administration will have recommended a pro-competitive type health system, that Congress will have enacted the necessary legislation, and that the program will be fully operational; therefore, PSRO review of government patients will no longer be needed.

I would like to discuss each of these premises briefly. First, the CBO report. We believe that this report has serious flaws. We do not believe it is phoney, rather its methods and assumptions are open to genuine dispute. The flaws have been pointed out by two other agencies of the Congress, the General Accounting Office and the Office of Technology Assessment and we ask that the attached excerpts from their comments be made part of the record.

Notwithstanding the deficiencies of the CBO report, you should know that it concludes that the PSRO program is saving federal dollars in excess of its costs. During the August 25, 1980 Ways and Means Health Subcommittee hearings on the PSRO program, the CBO stated, "Specifically, we estimate that gross savings to the government exceed relevant program costs by about $17 million." Since the relevant program costs were $105 million this means the CB credits PSRO's with saving $122 million for the Federal government.

This figure does not include any savings in the Medicaid program. Since no information on the effects of PSRO on Medicaid costs was available, it was assumed, without any supporting rationale, that any savings in Medicaid had to be less than for Medicare.

In addition, no attempt was made to estimate program savings achieved through PSRO review of long-term care, ambulatory care or ancillary services despite the fact that the costs of these reviews were included in the calculations to determine "relevant" program costs. Nor was there any attempt to evaluate the activities of PSRO's in improving the quality of care, such as the thousands of medical care evaluation studies.

The controversy over PSRO cost-effectiveness comes about in large part because the CBO report generalizes its findings for society as a whole, and concludes that the program costs more than it saves. This conclusion, says the CBO, is valid because the federally saved costs are shifted to the private sector in the form of higher charges and higher utilization of hospital services in the private sector. There are two points we would like to make in response to this conclusion. First, PSRO's are not mandated by law to review private patients. Our authority, by law, extends only to those whose care is paid for by the federal government. Second, CBO's assertion that costs are shifted to the private sector to the degree estimated in their report is not supported by any empirical data—just assertions with which we take strong exception.

Mr. Chairman, we recently explored with a reputable actuarial firm the possibility of doing an independent analysis of the CBO report. It may be instructive to give you the concluding paragraph of their letter of reply from Milliman & Robertson, Inc.—nationally recognized actuarial consultants:

"Because of our lack of confidence in the technique used and our inability at this time to recommend a quantitive technique which is appropriate, we believe that an actuarial analysis of the CBO study's assumptions and conclusions would not be productive. If we were to advise the appropriate committees of the Congress regarding a basis for making a decision as to the future of the PSRO or a successor program, we would have to recommend that this solicit the qualitative judgments of expert professionals in the health care delivery and financing fields, rather than relying on numerical results from the sort of research underlying the HCFA or CBO studies."

Our Association has collected information on its own on the impact of PSRO activities and has made summaries of this information available to every member of the subcommittee. We believe that this information should be more useful to you than the CBO or HCFA report for the reasons stated by Milliman and Robertson. A brief excerpt from the material is attached to my testimony.

On the question of increased competition, I wrote to Mr. David Stockman earlier this year to the effect that physicians may find much to support in the concept—substituting market forces for government regulation. But until such a system is in place, it would be short-sighted to remove the only effective review mechanism now working to control utilization and assure the quality of services provided to government-sponsored patients.

Additional evidence of the effectiveness of PSRO's can be found in the fact that private industry increasingly is arranging for PSRO's to review private patients—in some cases over the objections of insuring organizations and of hospitals. Approximately 50 PSRO's have entered into contracts with private industry to review the health care of their employees. Private industry is paying, with its own funds for this review, and the interest in private review is growing at a rapid pace. Incidentally, to the extent that the CBO may be correct that costs are shifted from the Federal sector to the private sector when only Federal patients are reviewed, then Federal costs will increase. Under the CBO theory, when private review empties a hospital bed, a Federal patient will immediately be placed in it. Without *any* Federal review activities it might very well happen.

The Administration also proposes a slow wind down of the program over the next two years—defunding the poorer performing PSRO's first and letting the better performing ones expire over a longer period of time. I would like to speak first to the point on poorer performing PSRO's.

This organization has had a strong position on this subject for a number of years. I would like to read it to you—it is short and to the point.

"Whenever a Professional Standards Review Organization has been found to have difficulty in carrying out its functions in a satisfactory manner, the organization should be offered technical and other assistance adequate and appropriate to meet identified problem areas and should be given a reasonable period of time within which to improve its performance. However, whenever such a Professional Standards Review Organization cannot substantially improve its performance, it should be terminated from the program, and funds which it would otherwise receive should be made available to PSRO's which have shown that they can use increased funding in a cost effective manner."

Actually, we believe that the Department has not been active enough in pursuing this problem. It has appeared to our members that there are at least as many opinions on how to evaluate a PSRO as there are HHS regional offices. We moved into that vacuum by having our best people sit down and agree on a set of criteria with which to judge PSRO performance. These criteria are attached to our statement—I ask that they be made part of the hearing record.

Mr. Chairman, the members of the Subcommittee may not be aware that the program has already been starved for funds to the point that many PSRO's cannot conduct or even monitor review activities in all the hospitals in their areas. Review activities in the area of long-term care facilities, ambulatory care and ancillary services have had to be curtailed and would be done away with immediately under the proposed budget.

At this point, while we know that most physicians support the program, growing numbers are increasingly disillusioned with the government's handling of the program at all levels.

It is difficult indeed for me to respond to the physician who says "Look, the Government does not want a utilization and quality review mechanism—it doesn't even want the individual hospital to worry about it. Why should we worry about the costs of these programs if they don't?" The Congress will soon answer his question.

Mr. Chairman, we urge the Congress to respond to the question by restoring full funding to the program, by insisting that HHS do an effective job of defunding those PSRO's with the poorest performance and by moving effective PSRO's into the full range of review activities set forth in the statute. In my judgment, only in this way will the full potential of the program be realized.

We stand ready to cooperate with the Congress and the Administration in meeting these objectives.

Mr. Chairman, a word about quality. When this program was signed into law by the previous Republican Administration, many physicians were, to put it in most positive fashion, very skeptical of working so closely with the Federal government on matters which involve so intimately the treatment of their aged and poor patients. The program was accepted by many physicians on the basis that here was an opportunity to improve the quality of medical care whether the results saved money or not. Physicians have not lost sight of this objective even though we seem to be judged on cost-effectiveness alone. While most improvements in quality also result in savings, we believe that a quality control mechanism, costing less than ⅓ of 1 percent of total program expenditures is a worthwhile investment in its own right.

Mr. Chairman, if, despite our best efforts, the Congress decides to defund the program, we urge you not to do it in the way the Administration requests. We would request that you close down the whole program immediately and completely. To continue to spend money on a program which is scheduled to die would be wasteful.

First, we have little or no confidence that HHS will be able to decide on its own which PSRO's should be defunded and which should be scheduled for execution a few months later. Second, the best people in the PSRO's will leave immediately for other jobs when they know the ax can fall at any time. Third, I would expect that some PSROs might go the political route in an attempt to save themselves for a little while longer. As you can see, sir, political connections are not among our evaluation criteria. Fourth, hospitals, States, physicians and others are hardly likely to continue cooperation with a program which is scheduled for demise no matter how good the initial survivors have been up to now. With these and other factors operating, a protracted winding down of the program, as proposed by the Administration, will be a guaranteed disaster.

For myself, I would urge the physicians in my PSRO, despite our proven record of performance, to drop the program immediately and concentrate on our private review activities. It is not unlikely, in my judgment, that the governing bodies of our association will take this same position later—recommending to our physician members that all PSRO's disband within days after a Congressional decision to accept the Administration's recommendations. We simply will not want to be part of a program which has been sentenced to death and whose performance during its death throes will be mediocre at best.

Mr. Chairman, we have tried to make the best case we can for the PSRO program because we believe so deeply in the accomplishments and in its potential. But we have come to understand what Washington people meant when they told us, wistfully I thought, that it is too bad we do not have a natural constituency. The program by its very nature does not earn many friends. We have earned the support of many in the private sector because we can show them we save money. We have saved money on the Government side but that appears not to be sufficient. The program

has earned enemies because it has done its job well; and we have been made very much aware that these enemies talk to their elected representatives. We expected this development, of course. After all we are the ones who say "no." We say no to the physician who wants to put a patient in a hospital who does not belong there. We say no to the hospital administrator who wants to keep his beds filled. We say no to the family who wants to keep a family member in the hospital long after such care is necessary. We must look for our support from Government among those who are concerned about the costs of these programs and the quality of care provided to patients for whom the Government has assumed responsibility.

Gentlemen, from our perspective the Government is this Congress and the Administration. We ask for your support.

I will now ask other members of our panel, to present examples of what PSRO's are doing. We will then be ready for any questions you may have.

SUMMARY OF TESTIMONY PRESENTED BY DUANE H. HEINTZ

Deere and Company has contracted with PSROs to review services provided to the company's insured.

PSRO helps Deere and Company assure the principal objective of the Company: that health care costs be constrained only in a manner that does not sacrifice the quality of care provided our employees, retirees and their dependents.

Results are encouraging:

In the Western Illinois area the Deere inpatient days per 1,000 population declined 30.2 percent, the average length of stay declined by nearly one full day; and the admissions per 1,000 insureds declined 17.3 percent.

In Iowa the inpatient days per 1,000 population declined by 18.7 percent; admissions per 1,000 insureds declined by 10.6 percent; and the average length of acute stay declined by one-half day.

These respective declines have generated a net return of at least 10 times our monetary investment in private review.

It should not be assumed that the conduct of review for services provided Medicaid and Medicare beneficiaries will alone resolve excessive inpatient hospital utilization for entire communities.

PSROs and private review are one effort that should continue to be pursued vigorously by all.

STATEMENT OF DUANE H. HEINTZ

I am Duane H. Heintz, Manager of Health Care Service for Deere & Company and Chairman of the Board of the Midwest Business Group on Health.

As a company which self-insures and self-administers a negotiated health care benefit plan for approximately 200,000 persons, we are vitally concerned with the future of the American health care system. The substantial committment we've made to health care innovation has been precipitated by two principal factors. First, our concern as a corporate community citizen in assuring the future viability of the private sector health care industy. Secondly, our increasing concern over the rapid escalation in health care benefit costs and their sizable impact on our costs of doing business.

In 1979 we expended over $74 million for health care services. During the period 1975 through 1977 these costs were escalating at a compound growth rate of 18.6 percent per annum. The excalation in 1977 alone was 27.8 percent over our U.S.-wide health expenditures in 1976. The impact of these costs on our production costs—11 percent of total direct labor costs in 1977—prompted the creation of a corporate health care department. Several major health program efforts were initiated during 1978-79. As a result, significant positive results have been realized by the Company. The compound growth rate has been reduced 20.4 percent (18.6 percent 1795-77 vs. 14.8 percent 1975-79).

The reasons for this apparent success during the past two years are manyfold. However, the single most significant endeavor undertaken has been the implementation of private utilization review under the auspices of two foundations for medical care—PSRO's. We have contracted with the Iowa Foundation for Medical Care for review of services provided 92,000 of our Iowa insured since January 1978; and, with the Mid-State Foundation for Medical Care since July 1977 covering an additional 38,000 persons in Western Illinois. Review is conducted in hospitals with an aggregate of over 7,000 beds. In reviewing the care delivered these 130,000 Deere & Company insureds, these two PSRO's have served as a critical forum for addressing the principal historical contributor to an escalating health care costs for the company—inappropriate utilization of inpatient acute care beds and services.

It has been paramount in our philosophy that health care costs be constrained only in a manner that does not sacrifice the quality of care provided our employees, retirees, and their dependents. The PSRO, organized and largely administered at the local level by organized medicine, helps assure this principal objective of the Company.

As may be inferred from recent authoritative reports published by both the Congressional Budget Office and the Department of Health and Human Services, the calculation of absolute cost savings to the "community" of utilization review efforts is at best an ambiguous undertaking. Any effort to cost justify a review program without holding constant hospital "price" considerations is fallacious. The objectives of the PSRO and private review effort are principally focused on monitoring quality of care and assuring that services are delivered in the most appropriate setting—whether that be inpatient, outpatient, or ambulatory. The review program should be held accountable only for achieving reduction in inpatient acute care service "volume," not the impact "volume" reductions have on the escalation of "price" levels charged by hospitals. As a private enterprise, we are, of course, concerned that successful inpatient volume reductions may simply cause a corollary per unit price increase. The net impact might be no change in the Company's aggregate expenditure for health care costs. However, hospital cost/price considerations fall outside the purview of our expectations of private review. Private industry as well as the Government should manage the price per unit or aggregate cost issue with the health care industry as a separate, albeit interrelated, issue to utilization review.

As a mandated federal program, the PSRO concept of utilization review has, in fact, provided Deere & Company with a solid base an organized local forum within the health care industry to address "volume" inpatient acute care utilization concerns. Upon this base, the review program concept has been modified to accommodate:

1. Management-labor contract restrictions and differing benefit plan designs;
2. Geographically unique health care provider issues;
3. Data acquisition and analysis to delineate specific excess usage areas by provider or specialty; and
4. Prioritization and implementation of cooperative health care service innovations among providers, business, and labor.

Key in the private review program's success at Deere & Company has been this flexibility to endeavor at the local level to modify historical practice patterns of physicians, administrative procedures of hospitals, and to address benefit plan design without sacrificing quality of care or placing our employees in a position of greater financial jeopardy. Change in the health care system cannot be legislated or dictated without sacrificing one of these principles.

MID-STATE FOUNDATION FOR MEDICAL CARE DEERE & CO., EXPERIENCE, JULY 1976–DECEMBER 1979

[Persons under age 65 only]

Indicator (in-area only)	Base year July 1, 1976–June 30, 1977	Jan. 1–Dec. 31, 1978	Percent change	Jan. 1–Dec. 31, 1979 [1]	Percent change 1978 vs. 1979	Percent change base vs. 1979
Population/insureds	33,735	35,493	6.1	38,287	7.0	13.5
Admissions	6,049	5,974	(1.2)	5,677	(5.0)	(6.2)
Admissions/1,000 population	179	167	(6.7)	148	(11.4)	(17.3)
Days	38,447	34,367	(10.6)	30,472	(11.3)	(20.7)
Days/1,000 population	1,140	960	(15.8)	796	(17.1)	(30.2)
Average length of stay	6.36	5.75	(9.6)	5.37	(6.6)	(15.6)

[1] Total utilization (in- and out-area) for calendar 1979 was 174 admissions and 980 days per 1,000 insureds vs. base year of 207 admissions and 1,357 days per 1,000 insureds.

IOWA FOUNDATION FOR MEDICAL CARE DEERE & CO., EXPERIENCE, JANUARY 1, 1977–DECEMBER 31, 1979

[Persons under age 65 only]

Indicator (In-area only)	Base year Jan. 1, 1977–Dec. 31, 1977	Jan. 1, 1978–Dec. 31, 1978	Percent change	Jan. 1, 1979–Dec. 31, 1979 [1]	Percent change 1978 vs. 1979	Percent change base vs. 1979
Population/insureds	78,664	82,348	4.7	92,478	12.3	17.6
Admissions	15,665	15,410	(1.6)	16,426	6.6	4.9
Admissions/1,000 population	199	187	(6.0)	178	(4.8)	(10.6)
Days	89,421	85,255	(4.7)	85,476	.26	(4.4)
Days/1,000 population	1,137	1,035	(9.0)	924	(10.7)	(18.7)
Average length of stay	5.71	5.53	(3.2)	5.20	(6.0)	(8.9)

[1] Total Iowa utilization (in- and out-area) for calendar 1979 was 211 admissions and 1,152 days per 1,000 insureds vs. base year of 226 admissions and 1,343 days per 1,000 insureds.

[From the MBGH Bulletin]

DEERE & COMPANY'S REVIEW PROGRAM: A MODEL OF SUCCESS

While many companies have experimented with various cost-containment measures, often with only incremental success, creative application of private utilization review of hospital stays has saved Deere & Company more than $2.5 million in health benefit costs in barely two years, according to Duane Heintz, Health Services Manager for Deere.

The Iowa Foundation for Medical Care conducts review for 80,000 Deere insureds in Iowa, as well as for the Iowa Blue Cross and employees of Bankers Life. In Illinois, mostly in the Rock Island-Moline area, review is conducted for 35,000 insureds by the Mid-State Foundation for Medical Care.

According to Heintz, the two review programs have led to dramatic decreases in Deere's hospitalization rates. The total yearly hospital days per thousand insureds have declined 13.2 percent in both States, comparing the year ending June 1979 with years previous to review initiation—July 1977 in Illinois and January 1978 in Iowa.

But aside from more obvious changes in this and other utilization rates, review has given a direction to Deere's overall efforts to manage and control its benefit program. Utilization review reports provided by the Foundations, combined with claim reports from Deere's captive insurance company, have helped to identify and characterize patterns of benefit use. Heintz' office can then focus efforts on problem areas to solve particularly difficult problems in quality and cost that had not been previously recognized.

For example, Heintz suspected that he was paying more than he should for inpatient procedures which, according to a roster of ambulatory care made available by the Foundation, could be performed equally well in an outpatient setting. Confirming his hunch in the area of inpatient oral surgery was especially significant, since Deere covers the oral surgical work with its outpatient benefit package.

Pointing to high oral surgery costs, Deere approached the Foundation. Plans were drawn to require prior certification for oral surgery done as an inpatient, while a "package pricing" arrangement was worked out with an area hospital. The hospital agreed to accept a prearranged, set fee for common oral surgery procedures performed in its new outpatient wing.

Prepayment of this outpatient charge, which is less than the comparable inpatient charge, saves time and money over itemized billing, and with annual reconciliation, the hospital saves paper work and Deere reduces its cost and encourages providers to favor outpatient work over expensive inpatient care when either is possible. Initial indications are that the number of inpatient and surgical admissions have declined by approximately 75 percent.

Deere's data also pointed to high costs for inpatient psychiatric care, particularly in a single factory area where costs were double those in any other area. Talks are underway with local psychiatrists and hospital representatives to develop a pilot intermediate-level hospital treatment program.

Such a program would allow a patient to leave the hospital for part of the day and return for continued treatment the rest of the day. To be billed as a hospital expense, the pilot program will save money, Deere feels, but more importantly, area doctors are convinced that the plan will lead to better care and treatment.

Utilization and claims data have also led to preliminary identification of three or four more areas in which Deere can possibly reduce costs by facilitating a shift of inpatient care to covered outpatient treatment. Agreements might also be made with providers to somehow modify inpatient or outpatient care in a way that would reduce costs and make for higher quality, once Deere identifies special problems.

In addition, Deere is investigating ways in which the benefit plan might be more substantially changed, to perhaps include expanded outpatient therapy, diagnosis, and surgery. But such extension of benefits must undergo rigorous cost-benefit scrutiny to prove its worth. Besides, Heintz and his staff have shown that with careful analysis of data from utilization review programs, relatively small modifications of existing benefits can result in better care for employees and substantial savings.

UTILIZATION REVIEW PROJECT UNDERWAY

Business organizations of all sizes have long been concerned about having high quality health care available for employees. Business has supported the development and expansion of clinics and hospitals and the training of physicians and nurses with money, time and community leadership. Business people feel comfortable and familiar with programs needed to expand the health care system. But now, in many areas, the health care system has grown faster than the need for services, and business people are searching for ways to control medical costs.

The companies that have had the most significant results in controlling health care costs have done so by managing the use of hospital services. Hospital care is the most expensive component of the health care dollar. Using less of this service can slow the increase of total costs to the employee health plan.

Managing utilization of hospital care has been accomplished in two main ways: private utilization review programs and Health Maintenance Organizations (HMO's). HMO's use fewer hospital days per 1,000 employees and dependents per year than other insurance programs. However, the age profile and prior health care patterns of HMO enrollees may actuarially account for some of the difference. We will deal with the issue of Health Maintenance Organizations in a future issue of the MBGH Bulletin.

Private utilization review programs use doctors and nurses like auditors. They study the care received by covered patients in the hospital and communicate to the attending physician how his or her pattern of practice compares with agreed upon standards for use of hospital care. These standards cover the factors that determine the need to admit a person to a hospital, the use of tests and x-rays, the general level of care received in a hospital, and the length of stay for specific diagnoses.

A utilization review program can be linked to the health benefit claims administration process if benefits for unnecessary or inappropriate services are excluded from the benefit plan's coverage. Linking review to benefits can be advantageous for physicians as well as employers, since doctors have an additional tool at their disposal for manging their patient's hospital stays. The doctor's suggestion that hospitalization is no longer necessary can carry the weight of financial responsiblity for the patient who wants to remain in the hospital longer then the doctor recommends.

In several midwest areas, review projects are already operating successfully, and in other areas, talks leading to review implementation are off to a good start.

Akron review project

On March 18, a meeting was held in Akron, Ohio by the Region Six Professional Standards Review Organization to explore the interests of local business and insurance people in private review programs. The following day, a new Board of Directors was elected in that organization. The new board is reviewing the recommendations from the meeting along with past resolutions to decide on an approach to private review. Once the board has decided on its approach, working with the hospitals and their medical staffs will be the next step to establishing a program for that area.

CHICAGO UTILIZATION REVIEW

Plans for private review programs in the Chicago area are taking shape with the Chicago Foundation for Medical Care and the Crescent Counties Foundation for Medical Care, the two review organizations that operate in the Chicago area. Details of proposed programs from both these organizations should be available within the next three months.

Within the next several weeks we will have a background paper entitled "Containing Health Benefit Costs: A Business Guide To Utilization Review" available for

distribution. This paper researches the functioning and application of utilization review programs in connection with employee health benefit programs, and leads business to examine their employees' health experience to estimate what effect review might have.

Other plans for coordinating utilization review for business include providing technical assistance in data analysis and interpretation, a guide to participation agreements between business and review organizations, and a network of benefit administrators willing to discuss their experience with review and its applicability to other companies' health plans.

ABOUT THE MBGH

The Midwest Business Group on Health was established by several corporations in the midwest to help businesses improve the quality and cost-effectiveness of health services for employees. Member companies work together on health action projects at the community level throughout the region.

During the first ten weeks of operation all of our staff positions have been filled or offered. James Mortimer, who was Manager of Indirect Compensation at Continental Bank, is employed as President. Steven Borzak, who recently graduated from Oberlin College, is Staff Associate and MBGH Bulletin Editor, and Arline Sussman, who has been with FMC Corporation, is Administrative Assistant.

We presented the scope and objectives of our trustee education project, part of the action plan, to the Business Roundtable Task Force on National Health in New York in March. We are seeking their endorsement of this project to help make it viable for the use of officers and managers who are also hospital trustees, HMO board members, Health Systems Agency board members or Blue Cross trustees. Copies of this information is available now for anyone who would like to request it.

We are continuing to identify the sources of Developmental Funds we need to finance our first year of operation. We welcome any assistance that is not tied to health care industry interests.

UTILIZATION STATISTICS FOR THE MIDWEST AREA, ARRANGED BY STANDARD METROPOLITAN STATISTICAL AREA (SMSA), 1978

Hospital beds per 1,000	Hospital admissions per 1,000	Hospital outpatient visits per 1,000	Hospital inpatient days per 1,000	Hospital occupancy (percent)	Average hospital stay (days)	Total hospital expenses per inpatient day (dollars)	Total hospital expenses per capita (dollars)
4.44	157	919	1,192	73.6	7.6	222	265
4.94	170	1,040	1,353	75.1	7.9	239	324
4.82	168	1,106	1,392	79.2	8.3	268	372
4.51	167	1,078	1,159	70 3	6.9	230	267
4.46	159	951	1,228	75.5	7.7	196	241
4.77	155	1,055	1,355	78.0	8.8	249	338
5.76	189	810	1,412	67.2	7.5	171	242
4.84	169	935	1,165	64.0	7.2	213	248
6.75	231	973	1,922	77 9	8.3	210	409
7.13	267	1,231	1,457	70.6	6.9	155	286
4.36	154	1,070	1,215	76.4	7.9	250	304
4.23	149	1,181	1,239	80.8	8.3	278	345
5.94	170	673	1,521	70.1	8.9	178	271
5.42	170	850	1,406	71.1	8.2	240	337
5.61	184	801	1,519	74.3	8.3	193	293
5.27	191	1,011	1,465	76.1	7.7	237	346
6.10	190	976	1,745	78.7	9.6	199	347
4.65	165	938	1,329	78.1	8.0	212	282
4.95	159	1,027	1,384	81.6	8.8	199	276
4.42	160	858	1,351	84.0	8.6	235	317
5.23	171	1,071	1,547	81.0	9.0	240	371
4.66	158	876	1,347	79.5	8.5	204	274
4.58	176	1,089	1,364	82.8	8.0	261	356
4.98	157	835	1,256	69.1	8.0	201	253
4.65	153	1,169	1,236	72.8	8.1	285	353

SUMMARY OF TESTIMONY PRESENTED BY ROBERT A. MORTON, M.D.

PSRO review of patients with a diagnosis of schizophrenia undertaken at request of the National Institute of Mental Health, resulted, within one year, in a 22 percent decrease in the average length of stay.

PSRO review of all patients in psychiatric facilities at the request of the Department of Defense resulted, within one year, in a 34 percent reduction in the average length of stay and a 33 percent drop in admission rate.

STATEMENT OF ROBERT A. MORTON, M.D.

Mr. Chairman, my name is Robert A. Morton, and I am a practicing phsycian in the Tidewater area of Virginia and medical director of the Colonial Virginia Foundation for Medical Care. Our PSRO was originally organized in 1975 and is the PSRO for Area V, the easternmost or Tidewater portion of Virginia. Funding for review activities became available in 1977, and we are now in our fourth year of activity of assuring the necessity and appropriateness of medical care rendered to federal health care beneficiaries. There are many, many accomplishments and a few trials and tribulations I would like to share with you. We have identified many areas which we feel will benefit from continued study, analysis and corrective action programs, but because of time constraints, there are only two topics I wish to discuss briefly. One of these is our success in bringing about beneficial changes in the delivery of care to psychiatric patients. And the other is the benefit of the PSRO Program to the private sector of health care that has occurred in our PSRO area.

In 1978, the Colonial Virginia Foundation undertook a project for the National Institute of Mental Health to conduct utilization review and a retrospective analysis of care rendered to patients with a diagnosis of schizophrenia who were funded under the Department of Defense Champus Program and who were hospitalized in psychiatric facilities in our area. For this single diagnostic group of patients, we developed a program that not only addressed length of stay but also applied criteria relative to the quality of care being rendered. In this one-year project, those patients subject to review showed a 22 percent decrease in average length of stay and, furthermore, 17 percent of the discharges occurred just after the attending physician was contacted by a reviewer relative to the necessity for continued hospitalization. In addition, compliance with the quality of care criteria was much greater in those patients subjected to concurrent review than in similar patients who were not under review as measured by a retrospective analysis.

As a result of the success of this project, the Department of Defense contracted with the Colonial Virginia Foundation to review all patients in psychiatric facilities regardless of diagnosis in March, 1979. By February, 1980 the average length of stay of Champus patients with a psychiatric diagnosis had decreased from 52 to 34 days—or a 34 percent reduction.

In addition, the admission rate dropped to one-third of its previous level. These factors led to a saving of more than 17,000 days of care from 1978 to 1979. The Department of Defense paid $25,000 for this one-year contract. At the same time, the Department of Health, Education and Welfare authorized the Colonial Virginia Foundation to begin review of psychiatric patients funded by Medicare and Medicaid, and a uniform psychiatric review program is applied to Champus, Medicare and Medicaid patients. The change in average length of stay is less dramatic in the Medicare/Medicaid group, perhaps because some utilization review whad been in effect previously, but, nonetheless, the average length of stay has dropped by 8.4 percent since the institution of this program.

There are two signficant reasons for this dramatic impact. The first is that effective peer review is being conducted by the psychiatric community. Over one-third of all practicing psychiatrists in our area are actively engaged in the PSRO Review Program. The second reason is that the application of clincially valid quality of care criteria and length of stay norms were developed locally by the psychiatric community.

The quality of care screening criteria are applied soon after admission and set such standards as a physician written treatment plan which outlines the goals to be achieved and the treatment to be used; adequate documentation of the patients presenting problems and use of excessive or multiple drugs; the application of appropriate ancillary testing which is dependent upon the specific diagnosis and treatment modality; and the institution of investigations into situations where there are discrepancies or contradictions between observations of attending physicians and of nursing or paramedical staffs.

Peer reviewers in this program can, and do, suggest changes in treatment plan when current management appears less than effective or less than ideal. They can, and do, deny payment if the patient is not receiving appropriate quality of care.

Length of stay screens are applied every seven days, at a minimum, and patients staying longer than 60 days in an institution must be individually certified by the PSRO Psychiatric Review Committee.

The Department of Defense has renewed its contract with Colonial Virginia Foundation and expanded it to include all patients with the primary diagnosis of a psychiatric disorder regardless of the type of institution in which the care is rendered and regardless of specialty of the attending physician.

We have discovered a wide discrepancy among facilities in length of stay figures for children and adolescents with psychiatric diagnoses. It appears that some hospitals can handle young people with emotional disorders more efficiently than others. This phenomenon will be addressed by an in-depth study in the coming year.

The other inpact of PSRO activity I would like to mention is the benefit to the so-called private sector of health care. You are no doubt aware that one criticism of the PSRO Program is that any cost savings are merely passed on to the private sector. Though I do not agree with this argument, for evaluating the effects in federal patients, it is instructive to look at the benefits to the private sector as well. The Colonial Virginia Foundation has identified practitioners with patterns of care which indicate serious problems with both utilization and quality of care. These are instances of loss of hospital privileges, redefinition of privileges and requests for the individual physicians to seek additional training. These actions have not been taken by the PSRO itself but by the hospital medical staffs as a result of PSRO supplied information. In addition, within the past six months, the Colonial Virginia Foundation has begun its own investigation of seven physicians who are suspected of failing to fulfill the obligations specified in the PSRO law. One has already self-corrected, four are currently in a phase of education relative to their specific problems and what the PSRO expectations are, and investigation is just beginning in two other cases.

Obviously, these activities benefit all patients regardless of payment source, but the benefit is probably immeasurable.

Another instance of private sector benefit is the fact that Blue Cross of Virginia has recognized the merit of effective concurrent review. Blue Cross would not contract with the Colonial Virginia Foundation for review but did establish a program of allowing hospital review committees the authority to make binding payment decisions if the committee used effective review methods. The method used, of course, is the PSRO review system, which was developed by local physicians with federal financing. Newpaper articles have touted the success of the Blue Cross review plan, indicating the significant savings to Blue Cross subscribers. Thus, there is a direct monetary benefit accruing to the private sector as a result of the PSRO program without any private financial investment in the original and on-going development of the review system. The program developed with public funds for Medicare and Medicaid patients is available to, and is definitely being used by, other sectors of the general public.

Summary of Testimony Presented by Stanley I. Fishman, M.D.

Over 60 percent of the practicing physicians in New York State are members of PSRO.

Many examples of impact can be seen in each PSRO, including:

The PSRO of Central New York found that, on completion of intervention to correct problems, there was an 83 percent improvement rate in the 96 re-studies conducted.

The Adirondack PSRO has improved the credentialing practices of one of its hospitals.

Nassau Physicians Review Organization achieved a 28 percent reduction in preoperative length of stay.

PSROs in New York State were the first in the Nation to establish a common data set to link various health agency data collection requirements into a single uniform data collection instrument, thereby eliminating duplication and reducing costs of data collection.

Statement of Stanley I. Fishman, M.D.

Mr. Chairman, I am Stanley I. Fishman, a practicing physician in the County of Kings, Brooklyn, New York. I am here today on behalf of the New York Statewide Professional Standards Review Council, Inc. representing the PSROs of New York State. I am a member of the Executive Committee of the Statewide Council and Past President of the Kings County Health Care Review Organization, the Brooklyn PSRO. I am also chairman of the Council of the Hospital Medical Staffs for Brook-

lyn of the Kings County Medical Society and chairman of the PSRO Coordinating Committee of the Medical Society of the State of New York.

My primary reason for participating on the AAPSRO panel is to underscore the strong involvement and deep commitment of New York State physicians in the PSRO program. Over 60 percent of the practicing physicians in New York State are members of the PSRO. Many of these are active in board, committee and hospital utilization review activities. Physicians around the State are working on improving the practices of their peers. They are seeking to assure that patients receive high quality care within a cost effective health care system. They are calling their colleagues to task for inappropriate utilization review practices and are questioning the time patients remain in the hospital. They are reviewing their colleagues' medical records to determine that high standards of medical practice are maintained. They are, in various and intensive ways, changing the structure, pattern and utilization of the health care delivery system in New York State. I think the following examples will give the Committee a concrete idea of how physicians are working in the PSRO program to assure that Federal monies are spent in an appropriate manner and to give patients in the Medicare and Medicaid program quality care which is humanely and effectively delivered.

For example, PSROs in New York State are calling upon hospitals to correct poor utilization practices. In two PSROs, the New York County Health Services Review Organization and the Kings County Health Care Review Organization, over eleven hospitals in both areas have been required to submit corrective action plans. In the Kings County PSRO, within 45 days of the PSRO notice five hospitals effected a significant change in their previous patterns of inappropriate utilization review practices.

Physicians whose practice deviates from acceptable professional standards are required to undergo educational programs. Those physicians who continue to show deviant patterns of practice are subject to a PSRO sanction report which may recommend to the Secretary of the Department of Health and Human Services practitioner exclusion from the Medicare/Medicaid programs.

The PSRO medical audit, otherwise known as the Medical Care Evaluation Study, has become a key mechanism to validate whether surgical procedures are justified and are used to profile physician behavior in the community. PSRO physicians go into the local hospital and perform an intensive review of a sample of medical records to determine how hospitals and physicians carry out health care delivery.

Through the intensive review, or medical audit, the PSROs have found and are taking action in the following areas:

1. A significant delay in obtaining EKG consults for five hospitals, or a 40 percent deficiency rate, was found in the Area 9 PSRO of New York State. The PSRO monitoring and corrective action has reduced the problem to 28 percent, and continued action will further reduce this serious quality of care problem.

2. A high incidence of cross matching of blood with a low utilization of the blood was found by the Professional Standards Review Organization, District VI, in an areawide study. The PSRO established criteria for cross matching by procedure and for procedures for typing and screening blood instead of cross matching. There has been a dramatic improvement in blood utilization and blood supply in the area.

The PSRO of Rockland, Inc., through data collected on all Federal patients, has developed a sophisticated physician profile mechanism which allows the PSRO to compare physicians in accordance with specific performance indicators for given diagnostic related groups.

In a medical audit on carotid endarterectomy, the New York State Area 8 PSRO found improper physician practices in performing the procedure. In one case, a physician lost the privilege to perform the procedure in the hospital of audit. The same PSRO identified that patients were misdiagnosed with bleeding peptic ulcers. They established criteria to identify the diagnosis properly, and the problem has been reduced considerably.

3. A medical audit in the PSRO of Queens County, Inc., indicated that congestive heart failure patients were poorly managed. No daily weights or intake or output were recorded. The PSRO established criteria for the management of these patients and doctors and staff in the hospitals monitored whether the criteria were being met.

4. Errors in medication administration in a local hospital were found by the Genesee Region PSRO, Inc. In consultation with hospital and medical staff, the PSRO worked to develop new procedures to revise nursing, pharmacy and medical staff protocols to prevent the double administration of medication. This PSRO also worked with an independent agency, The Rockburn Institute, to evalute the PSRO re-audit showed a 27 percent improvement rate.

The medical re-audit, or re-study, of the previously identified problem is a tool used by the PSRO's to document that improvement has taken place and the PSRO corrective action plan has been implemented. In the PSRO if Central New York, Inc., as of the end of 1979, the PSRO has carried out 321 medical audits which had identified 304 areas which needed improvement. In performing 96 re-studies of these problems, the PSRO found there was an 83 percent improvement rate, or deficiencies were corrected in four out of five re-audits.

In addition to these improvements in medical care delivery, the PSROs have also taken steps to help restructure the health care delivery system. The Adirondack PSRO changed the credentialing practices of one hospital by mandating that only board certified physicians obtain obstetrical privileges. Further, a group of surgeons, in one acute care hospital in this region were placed on pre-admission certification due to problems found in their admitting practices.

The Five-County Organization for Medical Care and Professional Standards Review, Inc., in Utica, New York, instituted an educational program in conjunction with the Central New York Acadmey of Medicine on the appropriate use of blood components. Deficiencies have been identified by the PSRO with respect to the necessity of blood transfusions and inappropriate component usuage. The educational program which was carried out on an areawide basis proved constructive. The PSRO will perform a re-study of the problem to assure that the improvements have been implemented.

The Nassau Physicians Review Organization concentrated on pre-operative length of stay and reports a drop of 28 percent or 1.53 days in pre-operative length of stay. This has amounted to a reduction of 29,000 pre-operative days.

The Kings County Health Care Review Organization has developed a unique program of continuing medical education with the Downstate School of Medicine of the State University of New York. PSRO physicians and administrative staff lecture on a regular basis to medical students on principles of utilization review and quality assurance. This PSRO initiated program is part of the regular medical curriculum.

The Richmond County, New York PSRO, Inc., formed individual task forces in area hospitals headed by the chief of the service to establish stringent standards for the practice of the discipline. These standards addressed areas such as the need for complete blood counts, the number of psychiatric consultations needed for alcoholism patients and the necessity for liver scans.

The Suffolk Physicians Review Organization reports a sigificant reduction in the number of routine tests performed on admissions in its area hospitals.

The Bronx PSRO, Inc., prohibited one hospital from admitting psychiatric patient as the hospital was not certified for such admissions, nor had the program or staff to carry out adequate patient care. In addition, a medical care audit found pneumonia patients being discharged without arterial blood gas tests to determine pulmonary status. The hospital initiated an action plan; a PSRO re-audit found an 80 percent compliance rate.

The PSRO of Eastern New York, Inc., is working with two upstate PSROs, Adirondack PSRO, Inc., and the Professional Standards Review Organization, District VI, in a number of areas to improve efficiency and reduce duplication. The PSRO of Eastern New York is cooperating with the Office of Health Systems Management, New York State Department of Health, (OHSM) to validate the patient assessment tool used by the state to determine a patient's need for long-term care. The Adirondack PSRO is pilot-testing the OHSM protocols developed to evaluate the quality of medical care in long-term care facilities. The District VI PSRO is working with community services organizations to provide a link between discharge planning and patient placement in long-term care facilities. Each of these separate undertakings will be shared by the three PSROs and, eventually, can be replicated in other areas of the state.

It is probably well known by now that for the past three years the PSROs have worked closely with the state regulatory agencies, especially the OHSM, on a series of cooperative activities. Memoranda of Understanding for binding Medicaid review in acute care and long-term care facilities have been worked out; PSRO/State Task Forces on resolving the patient backlog problem in New York State hospitals have been established and will make recommendations within the next several months to reduce the patient backlog problem. Through their statewide council, the PSROs are also working on statewide criteria for alcoholism and drug related admissions to acute care hospitals as these admissions represent the major source of hospital utilization in some PSRO areas.

Finally, the PSROs in New York State were the first in the nation to establish a common data set which will link up with the Statewide Planning and Research Cooperative System (SPARCS) to provide hospitals with a uniform data collection instrument for New York State. Such a mechanism reduces costs and duplication of

data collection activities. This agreement is indicative of the developing partnership between State authorities and the PSRO program in data collection and dissemination.

In these and in other ways, physicians in New York State have significantly demonstrated their commitment to the PSRO program. We believe the key to the PSRO program is the physicians. It is the physicians who best understand the medical care delivery process, who manage the patients' care in the hospital and, ultimately, who will carry out the changes needed in the review process in New York State and the nation. It is essential that our Congressional representatives understand and support the vital activities now carried out by the Professional Standards Review Organizations. The PSRO physicians are changing the practice of medicine, where needed, and are improving the quality of health care for Medicare and Medicaid patients.

STATEMENT OF JOHN M. WASSERMAN, PRESIDENT, BOARD OF DIRECTORS, PSRO AREA 23

Mr. Chairman, Members of the Committee, thank you for the invitation to appear before you.

The Title XVIII and XIX entitlement programs as currently administered are wasteful and extravagant.

Minimal statutory change with some reasonable regulations could reduce the drain on the trust funds and provide Professional Standards Review Organizations, or whatever agency Congress determines is appropriate, some tools to do the job.

Acute hospital costs are the highest single cost factors in Title XVIII and XIX and collectively are accelerating at a rate that the national and each state administration have found unbearable.

It must be a good business since the expansion of the proprietary hospital chain has been explosive in the past five (5) years.

Permit me to outline the defects which make the trust funds appropriation resemble a sieve.

1. PRESUMPTION OF WAIVER—ATTACHMENT 1

The intent of Congress appears to "hold harmless" patients, physicians and hospitals for determining non-covered Title XVIII services because they "could not have known" that a service was inappropriate for inpatient care; e.g.,

Example I: A diagnostic admission for tests which could have been performed as an outpatient.

Example II: A three (3) day inappropriate delay in a laboratory report resulting in unnecessary stay.

Example III: An inpatient surgery that could and should have been performed as an outpatient.

Example IV: A patient admitted inappropriately for minor illness.

Example V: A patient retained in hospital for convenience or other non-medical reasons.

Current regulations now mandate payment by the taxpayer for all the above unless the institution has experienced a 2.5 percent denial rate in days in the previous ninety (90) days which is inappropriate in a concurrent review process.

We have repeatedly drawn this to the attention of Health Care Financing Administration and testified before Oversight and Investigation Subcommittee of the Committee on Interstate and Foreign Commerce of the House of Representatives with the recommendation that "once is enough".

One (1) abuse should produce a "Due Process" notice with subsequent denials becoming actual reimbursement denials rather than a toothless process. Taxpayers should not pay for unnecessary care.

2. GRACE DAYS

Current regulations permit every Title XVIII patient one (1) additional hospital day to be paid by Medicare after medical necessity has been terminated.

This might be justified on rate occasions but this blanket entitlement is unnecessary and wasteful. Patients paying for their own care do not use an extra day to depart from the hospital nor do Title XIX patients.

3. ANCILLARY SERVICES—ATTACHMENT 2

Ancillary services (services other than room charge) account for over fifty percent (50%) of Title XVIII AND XIX acute hospital bills. Currently Title XIX in Califor-

nia has determined this to be fifty-six percent (56%), an increase from forty-three percent (43%) in three (3) years.

The hospital's detailed ledger is made up of dozens of items and in long stays, hundreds of items. The volume overwhelms the monitoring system.

Fiscal Intermediaries receive an abbreviated bill made up of nine (9) or ten (10) groups with no detail. No private business could remain solvent if it were to use the same non-questioning payment system.

Our nurse analysts in routine monitoring of x-ray, laboratory services, physiotherapy and other ancillary services are finding up to fifty thousand dollars ($50,000) of inappropriate ancillary services per analyst per month confirmed by Physican Advisors.

It is however, labor intensive and with our budget it is difficult to find the two thousand five hundred dollars ($2,500) per month per analyst to save the forth thousand dollars ($40,000) to fifth thousand dollars ($50,000).

The detailed volume of individual bills are of such a magnitude, that we have concluded the solution to be a statistically valid sample applied to the universe of charges, institution by institution.

The potential savings in this area are in the hundreds of millions.

4. BED OCCUPANCY

Since Title XVIII and XIX hospital reimbursement is based on demonstrated cost, percentage of bed occupancy becomes an important factor in determining unit cost.

In overbedded urban areas, costs relating to hospitals with occupancy of less than sixty percent (60%) (annually computed) should not be taken into consideration in determining reimbursement per unit cost.

5. ADMINISTRATIVE LAW JUDGES

The activities of the Administration Law Judge are an appropriate urgent area of inquiry by Congress.

Frequently decisions are not based on Law or Medical Necessity and negate apparent congressional intent.

This is a perception of many Fiscal Intermediaries, Professional Standards Review Organizations and Statewide Councils.

6. SANCTION PROCESS

The regulations authorizing the exclusion of physicians from Title XVIII and XIX programs are grossly defective.

The average time from discovery of grossly inappropriate activity of a physician by a Professional Standards Review Organization to action by Health and Human Services has been over one (1) year. The end product of the sanction is frequently ineffective.

Current regulations mandate that after a Due Process determination exclusion of a practioner for "violation of obligation" a notice of exclusion is published in a local newspaper.

Each patient thereafter is notified by Health Care Financing Administration after receiving a bill for services that he or she has fifteen (15) days of covered service by the involved physician.

The net result effect for a surgeon is no effect. He finishes off with this patient and moves on to the next.

7. FISCAL INTERMEDIARY

We observe a wide variation in the performance of Title XVIII Fiscal Intermediaries.

One (1) or two (2) are excellent. The remainder offer no obstruction to raids on the treasury.

The monitoring of the Fiscal Intermediaries is totally a process monitoring with little effect on quality of the product.

We have been advised by our most effective Fiscal Intermediary, that in those geographic areas where there is no Professional Standards Review Organization the evaluation of the Fiscal Intermediary is based purely on paper flow, not on medical necessity or patient risk.

8. PROFESSIONAL STANDARDS REVIEW ORGANIZATION PERFORMANCE—ATTACHMENT 3

The sad fact is that there are some ineffective Professional Standards Review Organizations, not all, but some.

Some have only recently been funded and are immature.

Some have no commitment and/or process.

Paradoxically private industry is finding selected Professional Standards Review Organizations cost effective on an individual basis. Mass evaluations have been less than laudatory, alleging that Professional Standards Review Organization activity transfers costs to private industry.

This has not been the experience of private companies which have contracted with achieving Professional Standards Review Organizations.

Our Blue Cross experience suggests a cost effective ratio of between 10:1 and 40:1.

Preadmission certification on a selective basis adds to the effectiveness of the proven Professional Standards Review Organization performers.

It would seem reasonable to perpetuate the exemplary performers with the hope that the ingredients which have produced achievement may be employed to modify future systems to protect taxpayer and patient.

Health and Human Services should be given the statutory authority which it now lacks to terminate ineffective Professional Standards Review Organizations expeditiously.

Finally, Health and Human Services should have some Health Professionals in policy and planning, who have field experience, which now appears lacking.

[Attachment I]

MEDICARE WAIVER OF LIABILITY

Waiver of liability is Section 213 of Public Law 92-603 (effective October 31, 1972) which protects the Beneficiary in the denial of a claim when he did not know or have reason to know:

1. services were not reasonable or necessary;
2. custodial care was involved.

Previous to waiver of liability, when a Medicare claim was denied, liability for payment fell upon the patient, often causing financial hardship.

Now Medicare law reflects the following for a hospital on waiver:

1. If a Beneficiary knows services are not covered, the Beneficiary is liable.
2. If a Provider knows or should have known services are not covered, the Provider is liable.
3. If neither the Provider nor the Beneficiary knew services were not medically necessary or not a covered level of care, the Medicare program is liable.

"The following are examples of PSRO disapproved claims that would justify a finding by the intermediary that the PSRO jurisdiction hospital knew or should have known that the services it rendered were not covered under Medicare because they were not medically necessary or constituted custodial care:

1. A service is excluded from coverage by a national coverage policy (the hospital has ben given written notice).
2. A hospital has been notified that a certain service was not medically necessary under certain circumstances, but the hospital subsequently provided a similar or identical service under similar circumstances.
3. The hospital's medical records contain an attending physician's written discharge in accordance with the order.
4. The hospital's medical records show the patient required and was furnished only custodial services."

MEDICARE HOSPITAL MANUAL—SECTION 292.3

Section 292.2 of the Hospital Manual goes on to state "A provider will be held liable for non-covered services if it is determined that the provider:

1. had actual knowledge of the non-coverage of services in a particular case, or
2. could reasonably have been expected to have such knowledge.

When a provider has been found to make all reasonable efforts to assure its Medicare coverage decisions are correct and has demonstrated the ability to make accurate Medicare coverage decisions, it may be presumed that the provider did not have knowledge of non-coverage." (emphases added)

Analyses of PSRO Area 23 denial data by volume and types of denials has led to the following:

1. Total removal of waiver from six (6) hospitals.
2. Removal of waiver for the hospital admissions of two physicians.

One off-waiver hospital became delegated but remained off-waiver due to administrative problems with surgical delay and retrospective identification of patients.

Program payments are no longer made for non-covered services in the above-mentioned cases.

Attached there are deidentified copies of three (3) letters (I, II, III) which shall serve as examples of notifications previously sent by PSRO Area 23. It is clear that the liability of a Provider was never intended to be waived when that Provider has received prior notice that certain practices or treatments are non-covered under Medicare regulations. Also attached (IV, V-A,B) are copies of a letter requesting information regarding PSRO removal of waiver instructions to the Fiscal Intermediary, and a letter to a hospital regarding medically unnecessary delays in surgery.

An application of the 2.5 percent rate of disagreement, which was solely intended to be used by the Fiscal Intermediary doing retrospective reviews under the UR regulations, to the PSRO program is clearly erroneous. Retrospective review of any well-functioning concurrent review program should never find such a rate of disagreement, even in those institutions which have little or no commitment to quality care and utilization review.

MARCH 15, 1978.

——— ———, M.D.,
Utilization Review Chairman,
Community Hospital.

DEAR DR. ———: The presumption of waiver status which your hospital has enjoyed under PSRO binding review guarantees Medicare coverage for those days prior to notice of non-certification. However, if the PSRO becomes aware of specific types of care rendered to in-patients which do not require an in-patient setting, we are required to bring them to your attention.

We would, therefore, like to draw your attention to the following two cases:
1. Case ———.
2. Case ———.

These cases are specific examples of diagnostic studies which could have been performed on an out-patient basis.

This letter will serve as formal notification that the waiver of liability provision will not apply to cases of this type in the future. The Fiscal Intermediary for Community Hospital Blue Cross of Southern California, will no longer apply the waiver procedure to non-certified days involving the aforementioned types of diagnostic-in-patient studies.

We have no desire to impose hardship on your facility, patients or physicians. However, only medical necessity, as evidenced in the medical record, will be the basis for certification. Hospitalization based solely upon the convenience of any of the parties mentioned above may not be certified by Medicare regulation.

Sincerely,

JOHN M. WASSERMAN, M.D.
Medical Director.

JANUARY 26, 1978.

——— ——— M.D.,
Utilization Review Chairman.

DEAR DR. ———: The above patient was admitted to ——— Hospital January 23, 1978, for a scheduled bunionectomy January 26, 1978. She apparently had a cardiac work-up and this was the reason for admission three days prior to the scheduled surgery.

Medicare specifically excludes as a benefit admissions for diagnostic purposes which could have been performed on an out-patient basis. Since this patient seems to fit into this category, we will be unable to certify the medical necessity of the first two days of hospitalization and the appropriate notification letters have been sent.

Since ——— Hospital enjoys waiver status, the hospital and the patient will be protected financially under waiver unless we are overruled by an intermediary decision based on the regulations.

The waiver provision may only be employed to reimburse the hospital when the hospital, attending physician and the patient could not have known that the service referred to is a non-covered benefit.

We should, therefore, like to draw to your attention that this letter is a notification of the limit of Medicare benefits in this particular area and that, in the future, payments to the hospital may not be certified under waiver for similar admissions.

This does not mean to imply that pre-operative work-ups are prohibited when they are indicated on the basis of medical necessity for in-patient care.

Sincerely,

JOHN M. WASSERMAN, M.D.,
Medical Director.

MARCH 6, 1979.

——— ——— M.D.,
Chief of Staff,
——— *Hospital.*

DEAR DOCTOR ———: Hospitals which are reviewed by the PSRO are granted presumptive Waiver of Liability Status. Such favorable status shall continue to apply as long as the provider has been found to make all reasonable efforts to assure its Medicare coverage decisions are correct and has demonstrated the ability to make accurate Medicare coverage decisions.

If the aforementioned conditions continue to be met, it shall be presummed that the provider did not have knowledge of non-coverage.

Inordinately high numbers of review denials (summary attached) from ——— Hospital have placed PSRO Area 23 into the position of determining that this provider has not demonstrated a reasonable commitment to assuring that federally funded patients who are admitted or who continue to be hospitalized exhibit medical necessity for the hospitalization and are at the appropriate level of care.

PSRO Area 23, therefore, will recommend to the Fiscal Intermediary, Aetna Life and Casualty, that favorable Waiver of Liability Status be removed from ——— Hospital.

The Waiver of Liability status will be reviewed periodically, and significant improvement may lead to a resumption of favorable status.

Sincerely,

JOHN M. WASSERMAN, M.D.
Medicare Director.

JUNE 21, 1979.

ASSISTANT MANAGER—MEDICAL DEPT.

DEAR ———: PSRO Area 23 has requested removal of waiver for several hospitals in the area. We would like to confirm the effectiveness of this process by validating serveral payment certifications, 1453 billings and payments. We would appreciate copies of the certification and Medicare claim on the following patient(s) at your convenience.

Provider	Beneficiary	H.I. No.	Dates of stay
05-0212			Apr. 23-25, 1979.
05-0212			Apr. 16-17, 1979.
05-0376			Apr. 13-24, 1979.
05-0376			Apr. 20-26, 1979.

Sincerely,

VICKI M. NISHIOKA, R.N.B.S.,
Review Manager.

JUNE 20, 1979.

MEDICAL DIRECTOR

DEAR ———: We have previously discussed the problem of surgical delays at Hospital which have resulted in removal of waiver of liability for days denied under the Medicare program. The addition of Medi-Cal patients to the review system on May 1, 1979, has magnified the problem. In some cases, surgical delays may have an impact on quality of care. A potential for patient harm exists in any delay of non-elective procedures. The following cases are examples of possible quality problems arising out of these delays.

Admitted 5/30/79 with fracture dislocation of left humerus. Open reduction cancelled on 6/1/79 and 6/3/79 due to lack of operating room time. Surgery ultimately performed 6/5/79.

Open fracture and dislocation ring and little fingers with tendon avulsion left hand admitted 5/18/79. Surgical closure with split thickness graft on 5/23/79, after a false start to surgery on 5/22/79.

Admitted 5/24/79 for elective knee amputation. Surgery cancelled due to lack of equipment after induction of anesthesia. The patient was discharged 5/26/79 for readmission at a later date.

Admitted 5/22/79 for repair of Medial Meniscus Tear. Surgery cancelled 5/23/79 due to lack of operating room time.

Admitted 5/4/79 with foreign body in hand. Surgery cancelled due to schedule overload until 5/7/79.

Each of these cases resulting in a denial payment for one to six days due to these delays. In addition, some of these delays may have adversely affected the patients' medical condition.

While we recognize the unpredicability of patient flow, it would appear that the cost of appropriate allocation of resources by the would be matched by diminished certification denials, improved reimbursement and favorable impact on the quality of care.

Sincerely,

JOHN M. WASSERMAN, M.D.,
Medical Director.

[Attachment 2]

FEBRUARY 23, 1981.

DEAR DR. ———: The following information was developed as a result of ancillary review at your hospital during the month of January 29-February 20, 1981, for Medicare and Blue Cross admissions:

Total Cases Completed	41
No medical indication for Lab., X-ray, I.T., I.V. Solutions, EKG	$10,200.00
Tests deleted; no physician order	111.00
Tests deleted by Review Coordinator as Routine Orders, no Record, Overcharges and Duplication	1,901.50
Total dollars denied	12,212.50
Average denial per case	297.86

This information should be shared with your medical staff.

Sincerely,

JOHN M. WASSERMAN, M.D.,
Executive Medical Director.

FEBRUARY 5, 1981.

DEAR DR. ———: The following information was developed as a result of ancillary review at your hospital during the month of December 5, 1980 to January 16, 1981, for Medicare and Blue Cross admissions:

Total Cases Completed	53
No medical indication for Lab., X-ray, I.T., I.V. Solutions, EKG	$11,929.50
Tests deleted; no physician order	68.00
Tests deleted by Review Coordinator as Routine Orders	1,276.00
Total dollars denied	13,273.50
Average denial per case	250.44

This information should be shared with your medical staff.

Sincerely,

JOHN M. WASSERMAN, M.D.,
Executive Medical Director.

[Attachment III]

PRE-ADMISSION CERTIFICATION

Pre-Admission Certification has been selectively utilized for all elective Medicaid admissions and some Medicare admissions to all nondelegated hospitals. At the present time, 50 percent (19 out of 38) of the hospitals in Area 23 are nondelegated.

In addition, one (1) delegated hospital must obtain prior authorization for all Podiatry admissions, and eleven (11) physicians must obtain a certificate of medical necessity prior to admission for all federally funded patients regardless of hospital utilized.

2,574 Treatment Authorization Requests (TARs) were submitted during the year beginning July 1, 1979 and ending June 30, 1980. 2,176 (84.5 percent) were approved, 168 (6.5 percent) were denied and 231 (9 percent) were deferred. The costs of processing these TARs were approximately $20,100.

One of our intermediaries, Blue Cross of Southern California, supplied fiscal information based upon the actual procedures which were denied and deferred.

If we consider only those cases which were denied, the savings to the program has been conservatively estimated at $335,000. And if only one-third of those deferred are either eventually denied or are never resubmitted, the additional savings would be $153,500.

These total cost savings of $488,500 are but a reflection of the 245 patients who have been spared unnecessary surgery.

Fifty-four (54) additional cases were mandated to be seen in consultation by a consultant chosen by the PSRO. Of these, nineteen (19) were approved and eight (8) were denied. The remaining twenty-seven (27) were never seen by the consultant.

The total cost authorized for these consultants by the PSRO was $1,330. The denied cases, aside from protecting the patients from unnecessary surgery, saved the program $26,300. When combined with the cases which were never seen, the total savings is approximately $116,500.

The total cost avoidance impact due to pre-admission certification and mandatory consultation requirements during the twelve (12) month time frame is $605,000.

MARCH 30, 1978.

——— ———, ADMINISTRATOR
——— *Hospital,*
———, *California,*

DEAR ———: There are a few changes in the Pre-Admission Certification procedure in use by PSRO Area 23. PSRO Area 23 will certify admissions for physicians who have been placed on Pre-Admission Certification when:

(1) Elective admissions have been approved by the PSRO Prior to the admission and contingent upon the in-house consultant's detailed confirmation of the necessity for admission and approval of the plan of treatment outlined by the attending physician, by the PSRO.

(2) Emergency admissions have been approved retrospectively by the in-house consultant detailing his reasons for concurrence with the emergency admission and the attending physician's plan of treatment.

(3) In the case of elective surgery, detailed consultation is performed prior to the admission and the consultant concurs with the indications for surgery, and this information is transmitted to and approved by the PSRO Area 23 Physician Advisor.

The requirement for a consultation prior to admission for elective surgery is a change in the procedure previously established. The written or typed consultation reports should be sent to ———, at the PSRO office.

Elective medical admissions and emergency admissions still require consultation after admission. However, this consultation will be acceptable if performed within 24 hours after admission rather than 12 hours as previously required.

Sincerely,

JOHN M. WASSERMAN, M.D.,
Medical Director.

Re pre-admission certification coordinator procedures.
To: PSRO review coordinators.
From: Lura Vali, R.N.
Date: February 13, 1978.

Beginning February 15, 1978, all non-emergency Medicare patients admitted by ——— will require pre-admission certification by a PSRO physician. The probable hospitals involved will be ——— and ———. In addition, consultation from an approved list of physicians will be required for all of ——— Medicare patients within 12 hours of admission. The attached outline explains the basic procedures to be followed. Specific procedures for PSRO Coordinators are outlined in this memo.

I. EMERGENCY ADMISSIONS

A. The Coordinator must first verify the emergency nature of the admission.
1. If the attached criteria defining an emergency are not met, refer the case to a Physician Advisor for non-certification.
2. If a negative decision is reached, initiate normal denial letters, certify zero days and stamp OFF WAIVER on the payment certification.
3. Document on the Coordinator Worksheet that the emergency nature of the admission was not certified.

B. If the emergency criteria are documented, the Coordinator will verify that a consultant has seen the patient within 24 hours of admission.
1. A dictated or written consultation note in the chart should be present.
2. If 24 hours from time of admission have not yet passed, the Coordinator may have to return to the chart later in the day.
3. The consultant's note must be present and confirm the need for admission; if not, refer the case to a Physician Advisor.
4. If a negative decision is reached, initiate normal denial letters, certify zero days and stamp OFF WAIVER on the payment certificate.
5. Document on the Coordinator Worksheet the absence of a consultation or the contents of the consultation which caused referral to the P.A.

II. ELECTIVE ADMISSIONS

A. Pre-admission certification msut be obtained by phone by ——— from the PSRO physician on duty. (Form attached.)
1. A copy of this certification will be mailed to ——— and to the PSRO Coordinator.
2. The Coordinator will attach her copy of the certification to her Worksheet.
3. If the hospital, Coordinator or physician needs to verify that pre-admission certification has been obtained, ——— at the PSRO (377-8731) will retain a file copy.
4. Any case without pre-admission certification will be treated as an emergency admission and the emergency procedures followed.
5. If pre-admission crtification has been obtained, the stay will be certified at least through the day of admission review by the Coordinator, unless the consultation requirement is not met.
6. The assistant managers will be notified by the Coordinator, if the medical record does not confirm the symptoms or plan of treatment indicated on the pre-admission certification form ———.

B. If pre-admission certification has been obtained, the Coordinator will verify that a consultant has seen the patient within 24 hours of admission.
1. Follow the procedures for consultations on emergency admissions.
2. A pre-admission certification is void if the required consultation is not also obtained and the admission will not be certified.
3. If pre-admission certification has been obtained and a timely consultation is present, certification will be granted at least through the day of admission review by the Coordinator.
4. Continued stay may be questioned on any case by the Coordinator following usual PSRO procedures.

FEBRUARY 13, 1978.

Attached is the PSRO area 23 procedure for pre-admission certification. This procedure will apply to one physician, ——— for Medicare admission beginning February 15, 1978. The hospitals involved will be ———.

If pre-admission certification has not been granted by the PSRO, the Review Coordinator will stamp OFF WAIVER on the payment certification and certify zero

days. The SSA-1453 should not indicate any covered days. If covered days are billed, they should not be paid under waiver.

In the cases of non-payment for a program exclusion, the Review Coordinator will stamp Program Exclusion on the payment certification and indicate on the certification either (a) dates excluded for payment or (b) service excluded for payment. Please call if we have done anything too confusing here.

Sincerely,

VICKI NISHIOKA, R.N.,
Assistant Manager, Delegated Review and Training.

PRE-ADMISSION CERTIFICATION

I. EMERGENCY ADMISSIONS

A. Definition.
1. A potentially life threatening situation.
2. Progressive disability might occur without immediate admission.
3. Severe pain which has not responded to out-patient methods of therapy.
B. Consultation.
1. Shall be performed within 24 hours of admission.
2. Will utilize a physician on a PSRO approved roster.
3. Must confirm the need for admission with objective findings.
C. Certification of medical necessity.
1. Will not be granted if a consultation note is not present within 12 hours.
2. Will not be granted if the emergency nature of the admission is not documented in the medical record.
3. Waiver will not apply to non-certified days; a stamp on the payment certification form will instruct the Fiscal Intermediary in the correct payment.

II. ELECTIVE ADMISSION

A. Pre-Admission Certification.
1. Will be required on all non-emergency admissions.
2. Will be valid for seven days from date of issuance.
B. Procedure.
1. Admitting physician will contact the PSRO office by phone between 1:00 and 3:00 p.m.
2. A PSRO physician will discuss the admission with the attending physician.
3. The PSRO physician will complete a pre-admission certification form indicating the decision reached.
4. The attending physician will receive a copy of the approval of admission by mail to confirm the telephonic approval.
5. The hospital may obtain a copy of this approval from the attending physician or a phone confirmation of the approval from the PSRO.
C. Consultation.
1. Electively admitted patients will require a consultation note within 24 hours of admission.
2. This consultation must confirm the factors which led to prior approval of the admission.
3. Will utilize a physician on a PSRO approved roster.
D. Certification of medical necessity.
1. The pre-admission certification will guarantee payment to the hospital.
2. If acute care is not longer required at some point later in the stay, the usual denial letters will be distributed.
3. Non-emergency patients admitted without pre-admission approval will not be certified.
4. Waiver will not apply to non-certified days and a stamp on the payment certification form will instruct the Fiscal Intermediary in the correct payment.

STATEMENT OF RICHARD N. PIERSON, JR., M.D.

Mr. Chairman and Members of the Subcommittee, my name is Richard N. Pierson, Jr. I am Director of the Division of Nuclear Medicine at St. Luke's Hospital Center in New York City, and Professor of Clinical medicine at Columbia University College of Physicians and Surgeons. I have been practicing medicine for 24 years, and have been certified by the National Board of Medical Examiners, the American Board of Internal Medicine, and the American Board of Nuclear Medicine. I have published 35 research papers in the professional literature over the past two dec-

ades, and have been active in such professional organizations as the New York County Medical Society, of which I am a past President, the New York Academy of Sciences, the American Heart Association, and the American Physiological Society.

I am one of the founders of New York County Health Services Review Organization (NYCHSRO), a PSRO located in New York City in the Borough of Manhattan (New York County). In addition to having served on the first permanent elected Board of Directors and its Executive Committee, I have been Chairman of the Board of Directors since June 18, 1979. In addition, I was the first Chairman of the NYCHSRO Continuing Medical Education (CME) Committee, a position I held until August 2, 1979.

I am here today to provide an update on some of the significant achievements of the New York County PSRO, and, most importantly, I am here to share with you, Mr. Chairman, and with the members of this Committee, what I believe to be convincing evidence that the PSRO program is the most appropriate and effective means of positively affecting the quality and quantity of medical care paid for by the Federal government.

ABOUT NYCHSRO

New York County Health Services Review Organization (NYCHSRO), which is the PSRO for New York State Area XI, is located in New York City in the Borough of Manhattan (New York County). Manhattan, a 22.6-square-mile island, is densely populated with approximately 1,454,600 people (or about 75,000 per square mile). Of the area population, 14.6 percent are Medicare enrollees, and 9.8 percent are Medicaid eligibles.

Manhattan has four medical schools, more than twenty teaching hospitals, and from 10,000–12,000 practicing physicians, one-fourth of all the physicians registered in New York State. Its twenty-eight hospitals account for over 15,000 acute care beds and an estimated 425,000 annual discharges, of which 240,000 are paid for under the Medicare, Medicaid and the Maternal and Child Health Programs. Nearly 50 percent of those who seek their inpatient acute care services in New York County annually are residents of other areas of New York State or the Nation. While there is a high number of acute care beds in the area (about 10 beds per 1,000 population) Manhattan has many specialty facilities and serves as a national and international referral center.

NYCHSRO's organizational structure currently provides for a 27-member governing body. This allows for broad representation from among the specialty societies, local hospitals, practicing physicians, organized medicine, and the public health sector. As of July 1979, there were an estimated 6,000 doctors of medicine and osteopathy (approximately 50 percent of those eligible to join) who have demonstrated their support for the PSRO program by becoming members.

In July of 1975, the New York County Health Services Review Organization (NYCHSRO) was designated as a conditional PSRO by the Secretary of DHEW. By March of 1976, NYCHSRO initiated the phase-in of hospital PSRO review activities and, by the end of 1977, 50 percent of all Federal inpatients were under NYCHSRO's review system. By the end of 1978, approximately 80 percent of the Federal inpatient population was subject to PSRO certification for admission to and/or continued stay in Manhattan's acute care hospitals.

NYCHSRO's deliberate phase-in of hospitals reflected its early findings that many hospitals were either unwilling or unable to perform delegated PSRO review functions. Accordingly, NYCHSRO developed its own capability by the hiring and training of over 100 professional staff and a cadre of approximately 116 physicians to perform direct review in twelve (12) of the twenty-eight (28) hospitals within NYCHSRO's jurisdictional boundaries. In the other 16 hospitals (57 percent), quality control was delegated to the hospital, the preferred method in keeping with the original view of Senator Wallace Bennett who first conceptualized this method of peer review.

QUALITY AND UTILIZATION PROBLEMS

While New York enjoys a national, and in many cases, an international reputation for major achievements in the medical sciences, it also has the longest lengths of stay in the Nation. According to comparative data from HHS (formerly HEW) the LOS for Medicare patients was 20 percent above the national average in New York County hospitals. Similar problems were noted for Medicaid patients and the LOS for all Federal beneficiaries was significantly higher than those of the northeastern region.

Not only were the total lengths of stay longer than those for the Nation and the region, but so were the pre-operative stays for elective surgical procedures. In

addition, New York County showed an unusually high rate of Medicare days of care per 1,000 aged enrollees compared to other areas of the country. In addition, scandalous medical practices have also been documented, including, among others, serious quality and overutilization problems in ghetto-area shared health facilities (the so-called "Medicaid mills").

IMPACT ON UTILIZATION

NYCHSRO has had the privilege of reporting at previous congressional hearings on its achievements in assuring that Federal health care dollars are being spent for necessary and appropriate medical care of acceptable quality. The recently released 1979 Medicare data continues to testify to the effectiveness of physician peer review. The decline of over 8.2 percent in Manhattan's rate of hospital patient days per 1,000 Medicare eligibles with a corresponding 6.3 percent reduction in the average length of stay, (see Tables 1 and 2), translated into at least 50,000 less patient days billed to the Medicare program, according to data maintained by the Medicare fiscal intermediaries. Similarly, in 1979, NYCHSRO had denied payment for over 16,000 unnecessary Medicaid hospitals days. Assuming a 60 percent hospital ratio, this suggests savings to the Medicare and Medicaid programs of over $8 million in 1979 alone.

This is the fourth consecutive year of decline in Manhattan's Medicare hospital utilization which commenced with the activation of the PSRO. Prior to PSRO review, Medicare patient days had been spiraling upward.

Preliminary analysis of NYCHSRO's 1980 data shows that an additional 30,000 Medicare and 21,000 Medicaid patient days (for a total of 51,000 unnecessary patient days) were also denied payment.

IMPACT ON QUALITY

NYCHSRO has also established an outstanding track record in identifying quality of care problems in both the outpatient and inpatient settings. In fact, NYCHSRO's actions have resulted in the closing of one hospital and the upgrading of care in four (4) others, as well as the recommendation that three (3) practitioners be disqualified from the Medicare and Medicaid programs.

Presently, review emphasis has been shifted to identifying individual aberrant practitioners. To date, fourteen primary care physicians (internists, family practitioners and pediatricians) and sixteen specialty practitioners (allergists, dermatologists, psychiatrists, urologists, podiatrists and dentists) practicing in shared health facilities, better known as Medicaid mills, have been identified as having questionable practices. Seven peer review hearings have been held thus far. Among the findings were:

Case I (Physician—Facility No. 103)

1. Indiscriminate use of procaine penicillin intramuscular (e.g., for shoulder pain, obesity, etc.)
2. Prescribing Diethylstilliesteral (DES) for a woman with amenorrhea.
3. Inappropriate use of tranquilizers and anti-psychotic medications.
4. Inordinate number of physician-initiated visits to the facility (e.g., 72 visits in one year for chronic cough) with no history, x-ray or sputum analysis ever recorded).
5. Submitting disability forms indicating patient was being treated for essential hypertension when in fact all the recorded blood pressures except for the initial one were normal.
6. Doctoring of medical records.

NYCHSRO's recommendations of disqualification from the Medicaid/Medicare programs was upheld by the New York Statewide PSR Council and subsequently forwarded to the Secretary of the Department of Health and Human Services.

Case II (Facility No. 104—2 practitioners: Internist and Pediatrician)

1. Excessive chest x-rays with inappropriate interpretations and poor quality films.
2. Inappropriate and excessive prescribing of Vitamin B12 injections (e.g., 27 year old female with 3 normal CBCs was given 17 injections of liver and Vitamin B12 over a period of 14 months).

PSRO action included placing restrictions on diagnostic and therapeutic services (e.g., no x-rays permitted to be taken on premises and the requirement that a hemotologist be consulted if Vitamin B12 is indicated). These physicians must also take Continuing Medical Education (CME) course. Finally, the PSRO has recommended to the State that it calculate appropriate restitution for unnecessary services.

Case III (Facility No. 103—Dentist)

1. Dentist readily admits having a different mode of practice for her Medicaid patients as compared to her private patients.
2. Widespread instances where radiographs did not indicate need for specific services.
3. Frequent, duplicate series of x-rays taken and billed because the initial series were inadequately performed thereby subjecting the patient to unnecessary radiation.
4. Number of radiographs billed often did not correlate with the number attached to the record.

NYCHSRO's recommendations included disqualification from the Medicaid/Medicare program and appropriate restitution.

In addition, significant quality of care problems were found in the performance of inpatient abortions by one physician. After performing in-depth chart reviews, NYCHSRO's Subcommittee on Gynecology judged that the care provided seriously deviated from acceptable medical practice. Among the cited problems were:

1. Absence of specific documentation: (a) relating to pre-existing medical problems; (b) identifying abnormal laboratory findings; (c) recording any complications which occur during the patient's hospitalization; and (d) regarding plan of care and treatment for the above.
2. No cross-match on patients with a hemoglobin below 10 grams.
3. No sickle cell preparation on most anemic black patients.
4. No electrophoresis on black patients with a positive sickle cell preparation to determine whether the patient has sickle cell disease or sickle cell traits.
5. No repeat CBC on most anemic patients after abortion, and on patients who have greater than average blood loss.
6. No cross-match on patients with previous Caesarean sections.
7. No sonogram report on most charts of patients 20 weeks gestation and over.
8. No Papanicolaou smears on any of the cases.

This physician is cooperating fully in a major effort to correct these deficiencies.

Similarly, through an areawide Medical Care Evaluation study on Cataract Extraction, one hospital was found to be performing an inordinate percent of bilateral extractions (61 percent) with an average length of stay of 31.1 days. Fifty-seven percent (57 percent) of these cases were found to have complications. Data analysis indicated that one physician was responsible for performing all the bilateral extractions in this hospital.

Based on an in-depth study of NYCHSRO's Ophthalmology Peer Review Team, this physician was subsequently subjected to continuous close scrutiny including pre-admission review except for ophthalmic plastic surgical procedures which will require a second confirmatory surgical opinion.

Preliminary analysis of the physician's subsequent behavior indicates that this physician has stopped performing bilateral cataract extractions.

All of these achievements in utilization review and quality assurance have been made notwithstanding inadequate funding. Between 1978 and 1980, the PSRO program funding incurred a 15 percent decline in real dollar terms which then had to be spread among growing numbers of new PSROs being implemented.

PSRO PROGRAM COST-EFFECTIVENESS

Despite the PSRO program's admitted imperfections, including uneven performance levels between individual PSROs, the Congressional Budget Office (CBO) has estimated that PSRO review of Medicare alone has saved the Federal Government 20 percent more than the cost of running the program. By most standards, that is still considered a healthy return on investment even in our inflationary times. Although the CBO professes uncertainty as to whether PSRO review has had similar salutary effects on Medicaid hospital use, it is crystal clear in Manhattan when one considers that during 1979 and 1980 the PSRO spared the Medicaid program from paying for at least 37,000 unnecessary days of hospitalization.

A close examination of the arguments made by the PSRO program's critics reveal a series of conclusions based upon unsupportable assumptions, irrelevant considerations and questionable reasoning.

For example, the CBO suggests that even if PSROs have had the same positive impact on Medicaid utilization as they have had on Medicare, it would only mean that the overall savings to the Federal Government would drop from 20 percent to 10 percent! The apparent underlying premise is that Medicaid savings which accrue to State and local governments are not worthy of recognition. The taxpayers benefit cumulatively from the savings enjoyed by all levels of government. Clearly, any serious and objective evaluation of the PSRO program must include such State and local savings.

We are also told that, in any case, the PSRO savings of Government expenditures are illusory since the PSRO program transfers costs to private patients. Therefore, in the words of the CBO, the PSRO program "costs society as a whole more than it saves." The fact that non-Government health care costs were irrelevant to the legislative purpose of the PSRO program is as easily ignored as the fact that PSRO statutory review authority has been limited to Medicare, Medicaid and Title V patients. This expression of concern for the theoretical costs being shifted to other payors, who have not been wise enough to contract with PSROs, is especially unconvincing coming from those espousing the virtues of competitive free market forces. The true free market response to this criticism is that these shifting cost pressures will stimulate efforts by other payors to also attack their own utilization problems. In fact, there is evidence of a small but growing interest in PSRO activities being exhibited by the private sector. In addition, there is reason to believe that private pay patients also benefit from the PSRO program. When the PSRO identifies and remedies a deficiency in the quality of medical care provided by a hospital or physician, the benefit accrues to all patients treated by them regardless of who pays for the medical services.

Even the CBO had to concede that other review systems including the Medicare utilization review regulations have not proved as cost-effective as the PSRO program. The Medicare utilization review regulations, I should point out, would automatically be reinstituted if PSRO review were simply ended. The option of eliminating all review, including repeal of the Medicare utilization review regulations, raises the risk of a precipitous increase in utilization with the concomitant significant increases in Federal health care costs.

FRAUD AND ABUSE

The Reagan Administration proposed phase-out of the PSRO program is also inconsistent with its proposed concern regarding the serious problem of fraud, abuse and waste within Government programs.

For example, NYCHSRO, along with four other PSROs, cooperated with the DHHS Office of Program Integrity (OPI) by providing peer review support for a special systematic fraud and abuse study in the area of private practitioner inpatient fee-for-service psychiatric care.

NYCHSRO reviewed 155 hospital medical records of 14 physicians who billed Medicare for services provided to patients admitted to New York County hospitals. The PSRO's responsibility was to perform validation review of medical services provided to Medicare beneficiaries receiving psychiatric inpatient services. This entailed a screening of the entire medical record and the physicians' bills for each case in order to substantiate a correlation in the following areas:

1. The intensity, depth and frequency of psychotherapy sessions provided (i.e., was the documentation in the medical records reflective of a 15, 30 or 45 minute psychotherapy session as billed?).
2. The number of electroconvulsive therapies given.
3. The number of physician visits made to the patient.

Based upon a close review of these records, NYCHSRO's physician advisors and review coordinators were unable to substantiate part or all of the claims made in 135 of the 155 cases. As a result of NYCHSRO's peer review findings, the Federal Government has recouped over $200,000 in overpayments. NYCHSRO's costs relating to this study was less than $20,000 which come to a 10 to 1 cost-benefit ratio.

OPI itself has concluded that "the cooperation of five (5) PSROs in New York State in providing peer review for the study was unprecedented. The PSRO presence and professional judgments gave the study a stature and credibility it might otherwise have lacked."

FREE MARKET V. SELF-REGULATION

When asked how, in the absence of PSROs, the Federal Government will assure that the medical care for which it pays is necessary appropriate, and meets professionally recognized quality standards, the Administration refers to some undefined competitive market model which will evolve over the coming years. The health care delivery system is one in which the provider (i.e., physician) and not the consumer (i.e., patient) decides on the need for and provision of medical care. Furthermore, the consumer is not in a position to judge the quality let alone the correct quantity of the services being provided.

Physician peer review is the only viable long term answer to the problem of quality assurance and utilization review. The PSRO program represents the least cumbersome and minimalist form of regulation because it is self-regulating. Certain-

ly this approach is consistent with the social philosophy of the Reagan Administration.

Even more importantly, the PSRO program is in a position to take advantage of the participation of the elected leadership structure of organized medicine. Medicine is too complicated to be wisely controlled without the input of physicians who are wise in the details of the practice of medicine. Perhaps the most important achievement of the PSRO Movement, in the view of many physicians, is this linkage between those who practice medicine and those who judge its quality.

CONCLUSION

Over the past five years, the PSRO program has provided Manhattan physicians with the resources and authority to address, through peer review, the efficiency and quality with which medical care is provided to the elderly and needy (i.e., Medicare and Medicaid populations). These have not been easy tasks, and they certainly have not been popular for the PSRO physician reviewers or in the relationship between physicians and hospital administrators. Yet, the persistent efforts of many physicians who have actively participated in NYCHSRO's utilization review and quality assurance programs, and the continued support of its nearly 6,000 members, have resulted in solid achievements in remedying deficiencies in the qualitative practices of individual hospitals and physicians as well as in reducing patterns of costly overutilization and inefficiency.

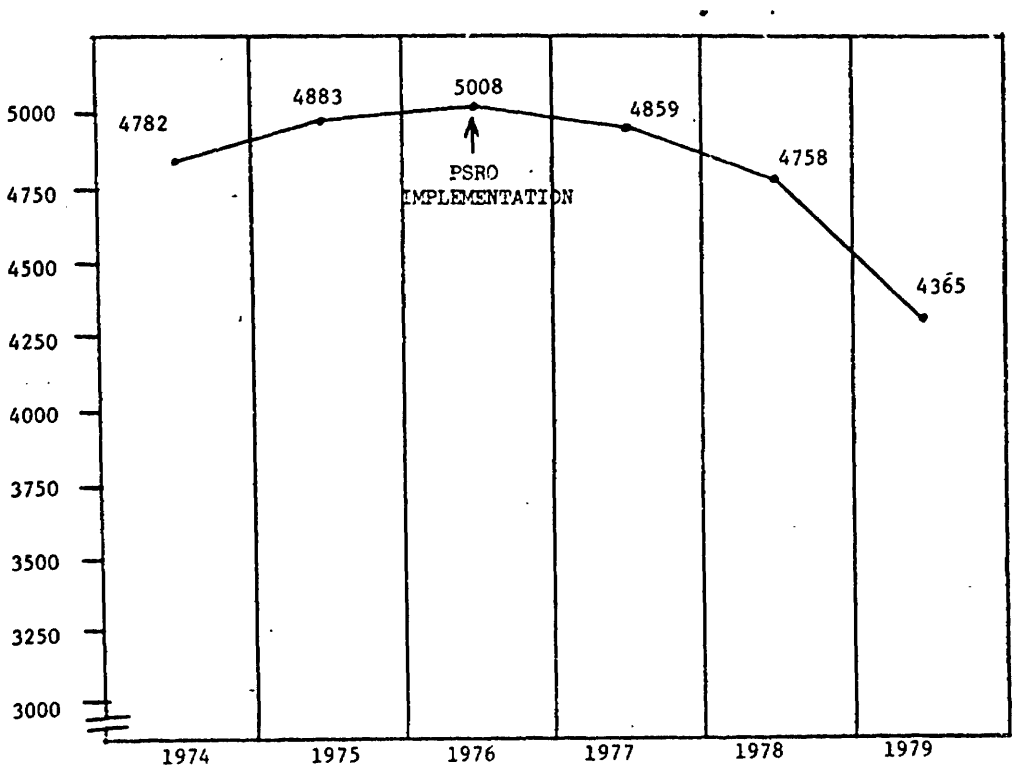
NYCHSRO's performance has earned it a national reputation for excellence. This recognition has resulted, in part, from our willingness to press our case when necessary; we have helped to close ineffective institutions, and we have provided the data to remove some physicians from practice. These accomplishments were made despite initial skepticism expressed by State agencies and others that have all along believed themselves better suited for judging physicians' professional behavior but who have not been able to do so effectively.

Now, the PSRO program faced the greated challenge to its continued existence as the propsect grows for its being caught up in the fever of federal budget cutting. There is clear evidence that far more taxpayer dollars are being saved by effective PSROs (like NYCHSRO) than are being spent on them by the Federal government. There is also evidence that we have positively affected the quality care in New York.

The CBO reports that little is known about why some PSROs have performed effectively and others have not. It seems obvious to suggest that what is needed now is a thorough study to identify the ingredients that go into the making of a successful PSRO so that it can be applied throughout the nation. But the phase-out of the PSRO program would be a classic case of throwing the baby out with the bath water in a calculation that is penny-wise and pound-foolish. Finally, such a phase-out would be a breach of faith with those physicians who have given of themselves fully to make this unique partnership between the government and the medical profession work.

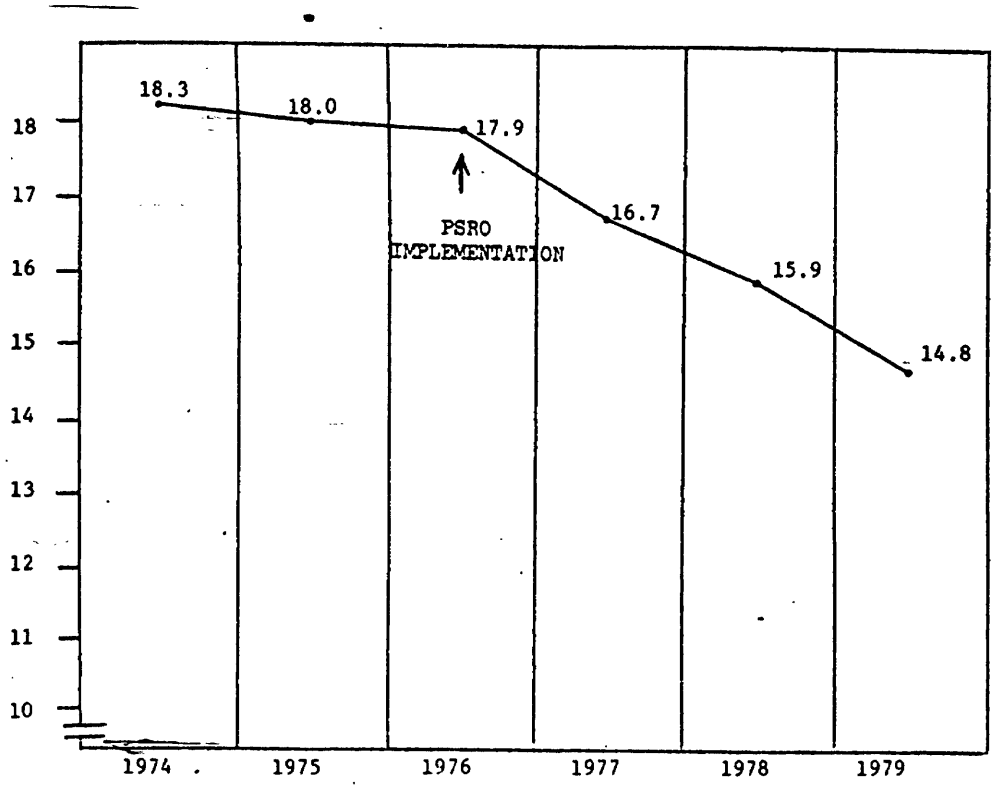
We concerned physicians have an alternative to offer President Reagan; what alternative to PSROs does President Reagan have to offer?

TABLE 1
DAYS-OF-CARE RATES
FOR MEDICARE BENEFICIARIES
AGE 65 AND OVER
1974-1979



SOURCES: Health Care Financing Administration

TABLE 2
AVERAGE LENGTH OF STAY
FOR MEDICARE BENEFICIARIES
AGE 65 AND OVER
1974-1979



SOURCE: Health Care Financing Administration

STATEMENT OF JOYCE C. LASHOF, M.D.

Mr. Chairman and Members of the Committee, I am Dr. Joyce C. Lashof, Assistant Director of the Office of Technolgy Assessment. Accompanying me is Dr. Bryan R. Luce, Project Director in the Health Program. We are pleased to appear before you to describe the PSRO program and its potential involvement in medical technology assessment activities. OTA's interest in such a relationship stems from a request by the House Committee on Energy and Commerce to examine alternative "Strategies for Medical Technology Assessment". The PSRO Study is but one component of a much larger OTA effort, due for completion next Fall.

Any strategy for technology assessment requires the ability to collect and analyze data, to perform and evaluate studies and to disseminate information. It seemed to OTA that PSROs may be especially relevant for some of these aspects of technology assessment for a number of reasons. They are broadly representative of practicing physicians in this area. They should be a good organizational vehicle by which to reach physicians of different political persuasions, personal and practice characteristics, and specialties. They gather data in a variety of formal ways about the applications of medical technologies, mainly in hospitals but also in ambulatory and nursing home settings. They have in place mechanisms for changing physician behaviors that rely on peer review, face-to-face contact, direct exchange of information, and sanctions and penalties when educational interactions are ineffective.

The PSRO program was established in 1972 in an amendment to the Social Security Act (PL 92-603). Institutionally, it was a descendent of private sector peer review efforts such as foundations for medical care which were concerned primarily with quality assurance and a first cousin of public sector organizations such as the Experimental Medical Care Review Organization (EMCRO) program. This program operated from 1971 to 1975, to determine if foundations or other physician groups organized on an areawide basis could decrease unnecessary use of services. Roughly halfway through the EMCRO program, the legislation establishing the PSRO program went into effect. Its creation had been prompted in part by the failure of the earlier hospital-based utilization review committees to control adequately the use of inpatient services reimbursed by Medicare.

PSROs are responsible for assuring that services provided and paid for by federal beneficiary programs are medically necessary and of a quality that meets locally determined professional standards, and that they are provided at the most economical level consistent with quality of care.

The PSRO statute itself and the legislative history make clear that the Congress intended that its main goals be to decrease the inappropriate or unnecessary use of services paid for by public programs (Medicare, Medicaid, and Maternal and Child Health). This goal of course has a significant quality-of-care dimension, but the underlying motivation for PSROs is widely perceived to be the alarming rise in the cost of medical care. The federal executive branch nonetheless put great emphasis on the quality-of-care aspect of the program, for several reasons: (1) to convince the medical profession to cooperate in an activity that essentially relies on voluntary support; (2) to creat as favorable an environment as possible for successful implementation of the program; (3) to reflect the prevailing attitude in the Department that quality and cost containment should have co-equal status in the program.

This created a situation in which those responsible for initiating and running the PSRO program tended to stress the quality-assurance aspects and yet often were held accountable primarily for cost containment. Congressional intent and subsequent oversight/evaluation (in the form of annual appropriations, if nothing else) led PSROs to emphasize cost containment even when quality assurance might have better reflected the primary motivation of PSROs' "natural constituency"—patients and physicans. Even to the present, official evaluations concentrate on the cost-containment and cost-effectiveness aspects of the PSRO mandate, and give little attention to evaluations of PSRO impacts on quality of care generally or on use of long term care, ambulatory care, and ancillary services.

Our project examines the potential role of PSROs for two fundamental activities related to technology assessment: (1) dissemination of information to practicing physicians, and (2) collecting technology assessment information either to evaluate at a local level or to funnel it elsewhere for assessment.

To investigate these topics, we contracted with Rand Corporation. The individuals who did the study, principally Drs. Robert Brook and Kathleen Lohr, are among the nation's most knowledgeable researchers in both the field of quality of care and in the PSRO effort. First, they reviewed a selective body of literature on information dissemination, with special reference to medicine in general and to factors that lead from general awareness of a subject to modification of clinical practice on the basis of information about the subject. Simultaneously, they undertook to obtain the most up-to-date information about the current status of the PSRO program. Then, they

prepared a paper presenting hypotheses related to PSRO's being actively involved with information dissemination to the physician community and to PSRO's collecting data and conducting technology assessments. This paper then served as the principal discussion point for two small, but highly selected groups of PSRO medical directors and executive officers. The meetings were held in January 1981; one was held here in Washington, the other was held in Los Angeles.

We expect to have a final draft of the Rand study within the next week or so, and we would be happy to make copies available to you, Mr. Chairman, as well as to other members of this committee and to staff. Our testimony this morning draws heavily on an earlier draft of that report.

The problem of information overload in medicine is well known. New technologies evolve; some established ones are discarded. Odds are high that practicing physicians will see many changes made to the body of medical knowledge during their medical careers. For this reason, the medical profession considers continuing education to be an integral part of medical practice.

Yet physicians are often left to their own devices for updating their knowledge. Studies have shown that important new medical facts may not be reaching their intended audience and the medical professional has itself been acutely aware of the constraints on physicians' capacities to stay informed of medical advances.

One important dimension of this problem of information overload concerns physicians' ability to assimilate a particular type of medical literature—that dealing with the safety, efficacy, and cost-effectiveness of medical technologies, old and new. Use of outmoded technology diminishes the quality of medical care. The use of new technologies is of concern partly because its diffusion into medical practice is believed by many to be an important factor in the spiraling costs of medical care.

Perhaps the most firmly established finding in research on dissemination and adoption of medical innovations is that physicians hear about new technologies from a variety of sources, but that only selected sources influence changes in practice. With pharmaceutical products, for example, both commercial and scientific/professional sources serve to make the physician aware of new drugs, but the latter play the predominant role in the actual decision to prescribe. Additionally, while the most important source of new knowledge about improvements in medical techniques is the professional literature, physicians cite professional colleagues more often as sources they turn to when actual adoption of new procedures is contemplated. This is not to suggest that scientific sources and professional colleagues are entirely adequate or complete for the purpose of translating research findings for medical practice. However, when actual changes in medical practice have been retrospectively analyzed, this generalization holds.

Concurrent with these findings, research indicates that both broad channels of communication (commercial and professional) and individual personal contacts (commercial and professional) serve as conduits for information about medical technologies, but face-to-face contacts are most effective in legitimizing the implementation of new techniques. Face-to-face contacts appear to be most effective for their greater immediacy, and because they involve the physician actively. These reasons may partially account for the long-running success of the drug detailman, a nonprofessional source, in influencing doctors' drug prescribing decisions. However, the most effective influence on physicians' use of new medical technology are face-to-face contacts with other physicians.

Although it might seem that the type of information itself is of critical importance in influencing physicians' practices, little research has focused on this variable, and its role is not well understood. One might speculate, for example, that awareness of or implementation of an innovation in medical practice might differ by whether the message calls for adoption of or rejection of a medical technology. Evidence suggests that new practices are adopted in medicine more rapidly than old practices are discarded. In previous reports, OTA has noted numerous examples of technologies (e.g. CT scanning) that have been adopted without complete knowledge of efficacy. Similarly, procedures persisted in the face of discrediting data, such as the use of diethylstilbestrol (DES) for preventing miscarriages.

Another factor that may influence a technology's acceptance might be the type of assessment communicated. For example, one type of assessment may have greater legitimacy to physicians than another. Randomized clinical trials, in principle, should prove to be highly persuasive to physicians, yet the literature abounds with examples of how published results of controlled clinical trials failed to have any significant impact on clinical practice. By contrast, a colleague's anecdotal case history may produce a lasting change.

A final message factor that may influence the adoption of suggested change in medical practice concerns the particular technology in question. For instance, evi-

dence does suggest that more complex procedures are adopted slowly, partly because of the difficulty of understanding and assessing them.

As the Rand researchers examined PSROs in terms of their structural and organizational uniqueness in disseminating technology assessment information and in affecting change in medical practice, they note the following. Perhaps most important is that PSRO's can target assessment information to physicians who would be likely to benefit most from it, and can choose their intervention strategy accordingly. Identifying problems in the use of technologies, setting criteria for appropriate use, implementing educational interventions, and, if necessary, invoking sanctions against poor providers must all be tailored to specific settings and providers. Diffuse or impersonal methods of communications are likely not to prove as fruitful in changing medical practice as are targeted, personal, face-to-face encounters that are consistent with the needs and characteristics of different physicians.

Review and synthesis of technology assessment information by local physicians can provide PSROs with a highly credible and powerful tool with which to assist physicians to improve their practices. PSRO's are in a position to argue to offending providers that their peers have developed guidelines for the use of a technology that are acceptable to the medical community. By implication, a physician not observing such guidelines would be viewed as practicing in a manner inconsistent with how the medical community believes the technology should best be used.

Finally, PSROs can be expected to reach the great majority of practicing physicians in their areas, directly or through hospital staffs. Many PSROs routinely communicate with all physicians in their areas, members or not. With the exception of doctors practicing in very unusual or individualized settings (e.g., industrial or corporate physicians), it is reasonable to expect the PSRO to be able to communicate with virtually all physicians within its area.

Although there is substantial evidence that PSROs can and do affect change in medical practice, there is controversy as to whether that change is significant. Unfortunately, the 8 years of the PSRO program have not produced the hoped-for reductions in hospital stays or costs of federal health programs such as Medicare, at least according to most official evaluations. However, since our study did not focus on these issues, we will leave it to others to discuss that evidence with you.

One important point to note in discussing the evaluations of PSRO is that they are, as a class, rather narrowly focused. Of all the activities that the national program undertakes, for instance, the evaluations have devoted their attention largely to the cost-effectiveness of admission and continued stay review activities for the Medicare population. This focus slights the effect of PSRO review on, for instance, ancillary services or the intensity of service that the Medicare population receives, and on the quality of care generally.

The existing reviews of the PSRO program also tend to ignore its effects on the Medicaid population. This is caused mainly by the relatively poor quality of data that has been available on Medicaid patients in the past. These problems are being slowly ameliorated, however.

One indication of at least the perception that PSROs are effective is what one could label the "private market test." PSROs across the country do utilization review for private firms on a contract basis. The number of PSROs engaged in this "private review" is growing dramatically. Close to one-quarter of all PSROs were engaged in such review as of 1980, and covered patients whose case was financed by private insurance companies, self-insured corporations, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), labor unions, and municipal governments. Anecdotal evidence suggests that the private sector often pays considerably more for such review (per review) than the current $8.70 per review target set for Medicare. The success of these PSROs (or separately incorporated analogues) in attracting private capital to do such review is an as-yet little appreciated fact and is at least indirect evidence that total benefits can outweigh total costs.

As we mentioned earlier in the testimony, the second major area of interest in this study was to explore the role which PSROs could play in technology assessment itself; that is, actually carrying out scientific investigations. The study indicated tht (a) PSROs, especially the more mature ones, are under certain circumstances a significant resource for technology assessment and that (b) their skills and capabilities should be exploited when national assessment activities are designed. These capacities include: familiarity with following standardized research protocols, collecting data in ways that fulfill rigorous specifications of reliability and validity; longstanding experience with medical record abstracting and audit procedures; long-term relationships with local physicians and facilities, including paraprofessional and administrative staffs; easy access to computer facilities; familiarity with analytic methods; and experience in reporting research results. Not all PSROs, even the

more sophisticated, are highly qualified along all these dimensions, of course, but neither is any other set of physician organizations or associations (such as medical schools or specialty societies).

The barriers to adequate data collection from noninstitutional settings are formidable. to overcome them, PSROs have one advantage not shared by most other governmental or professional agencies: the perception that they are oriented toward and concerned with the local practicing community. Hence, PSROs may be able to gain access to physician offices much more readily than, say, academic researchers or government officials. Numerous PSROs such as the statewide PSROs are quite large, and cannot be said to represent a cohesive "local" constituency. Even the statewide PSROs, however, share a perception that they would enjoy relatively better access to physician office records than would any other group able to undertake large data collection efforts in ambulatory care settings (including, especially, academic medical centers and government agencies).

One interesting observation drawn from this study is that physicians who are active in PSROs would, if adequately funded, willingly take on such technology assessments in part because they would find them an important and interesting challenge. This is particularly true of the more mature PSROs, which have in many cases already initiated various studies (generally as special initiatives or ancillary services review) that they believe qualify as technology assessment projects. Some PSROs, however, have been in operation for too short a time, and do not have the staff capabilities as yet. Others must concentrate on more pressing problems such as continued high hospital use or serious quality problems.

Nonetheless, the study indicates that perhaps between 40 and 60 PSROs today are in a position to contribute to various data collection or research activities related to technology assessment. For example, 60 or more PSROs have within the past two to three years initiated one or more special initiative projects, often ones directly relevant to technology assessment topics, 4 PSROs have collaborated in two different cross-country studies and some 7 PSROs are currently engaged in a randomized controlled experiment on use of pelvimetry. In short, perhaps 20 PSROs around the country could be regarded as an institutional nucleus with the capacity to carry out technology assessments meeting the most rigorous scientific specifications, and at least an equal number would be able to contribute to many types of studies mounted by other PSRO regional or central offices, or other health-related agencies.

Despite acknowledged problems about the routine data reporting done by all PSROs, it seems clear that data that are now collected by PSROs to select their topics for special study, or that could be specially collected by these more advanced PSROs, would serve one crucial purpose for national efforts in technology assessment--that of problem identification. Those PSROs wishing to participate in technology assessment efforts could provide an excellent mechanism by which to investigate whether problems even exist in the use of a given technology, or whether the problems that do exist appear to have any health or economic significance, before large-scale studies are begun. These PSROs could, in other words, serve as a screening mechanism for identifying "problem technologies" and for placing priorities on what to study.

In summary, this study seems to indicate that PSROs could play a significant role in a national strategy for medical technology assessment in terms of informing the medical community regarding technological developments, encouraging and/or enforcing positive change in medical practice and in conducting technology assessments. Currently, although the progam's effect on the quality of medical care has not been adequately assessed there has probably been a net positive gain. One concern that was noted in our study was that in an era of finite resources and increasing incentives to constrain spending, the PSRO program is the only national program currently available and in place which can monitor the quality of medical care provided.

Thank you for inviting us, Mr. Chairman. We would be happy to try to address any questions.

STATEMENT OF JAMES B. CARDWELL

Mr. Chairman and members of the committee, I am James B. Cardwell, a Senior Vice President of the Blue Cross and Blue Shield Associations, located in Chicago, Illinois. I am here today on behalf of the Associations and our member Plans to speak about Professional Standards Review Organizations in particular and utilization review in general.

It is our understanding that although the Committee has no specific bill before it at the moment, you are considering a proposal of the Administration to phase out

the professional standards review program and to rely on the private sector for utilization review on behalf of Medicare.

I would start, Mr. Chairman, by saying that the Blue Cross and Blue Shield Associations and their member Plans have a basic and a vital interest in not just the subject of PSROs and their future, but also in the entire subject of how to best achieve a balance and cost-effective approach to utilization review throughout the health care delivery and financing systems. We are interested in these important subjects both in our role as health insurers to a large segment of the American population and in our role as a Prime Contractor to the government in the administration of Part A of the Medicare program. We will speak to both in our testimony today.

We will address three questions that we believe to be germane to the committee's review of the Administration's proposals:

We will speak to the question of whether the federal government should continue to support PSROs as the primary utilization reveiw mechanism for Medicare.

Next, we will speak to the possible consequences of any decision to discontinue PSROs, particularly as the decision might affect the quality and cost of care.

Finally, we want to speak to the role of the Medicare intermediary in the event of a decision to phase out PSROs.

PROPOSALS TO PHASE OUT PSRO'S AND "DEREGULATE" UTILIZATION REVIEW

As a general proposition, we agree with the administration's decision to recommend a phase-out of the Federal support for PSROs. Although many explanations may eventually be offered for the failure of the PSRO concept to prove its cost-effectiveness on a broad scale, we believe that the most significant contributing factor has been the requirement that PSROs maintain their own superstructure—a superstructure that was added on top of the existing provider and third party payer UR systems. PSRO functions overlap those of both providers and intermediaries and this has added to the overall cost of UR for Medicare and other federally assisted health programs.

While we share the conclusion of the Administration and others that their retention is not justified in terms of their cost-effectiveness, we also believe it is important to recognize that significant advances have been made in utilization review during the last several years, of which PSROs have been a part. In some areas PSROs have helped control utilization. For this reason, their demise will leave a vacuum, a vacuum that must not be left unattended by either the government or the private sector.

Although we see the PSRO program as an important experiment in utilization review, we nonetheless, accept the findings of the General Accounting Office, the Congressional Budget Office and others. As we see them, these findings show that, all factors considered, the PSRO movement cannot sustain itself as a cost-effective approach to Medicare utilization review.

CHANGES IN UTILIZATION REVIEW FOR MEDICARE

We are uncertain as to just what the Administration has in mind when it speaks of deregulating utilization review, but it is our assumption that, in conjunction with the PSRO proposal, the Admistration is also proposing to repeal the present statutory requirement for utilization review as a condition of participation in the Medicare program. This seems to be a part of their plan to leave, as they put it, responsibility for utilization review with the private sector. We would like to say three things about this approach—

First, we support the idea of leaving the basic determination of the form and structure of utilization review in the hands of the private sector, even for Medicare.

While we do not believe it needs to be mandated by law, we support the continuation of utilization review at the provider level. It is vital to the effective control of all health care quality and cost, including the effective management and control of the quality and costs of Medicare. The latest standards for hospital accreditation require an effective utilization review program as a basis for accreditation of a given hospital. Thus, it would appear that it will continue, with or without PSROs. We do not see this as being inconsistent with the Administration's interest. Indeed, we believe it should be clearly in the best interest of the government and all other consumers of health care.

Our third point deals with who bears the cost of utilization review. We believe that the government must bear its fair share of such costs along with the private sector. On this point, it is our opinion that the net cost to the government for its share of utilization review will be lower without the PSRO superstructure. Further we believe the result will be as good or better. Our concern at the moment is that

we are uncertain as to the intent of the government when it comes to sharing in such costs.

We recognize the pressure to reduce the federal budget and eliminate excessive regulation and agree that the PSRO program should be appraised in the light of this pressure. However, we are concerned that in the process utilization controls at the provider level not be dropped from the Medicare program. Any proposal to eliminate utilization review as a condition for hospital participation in Medicare and at the same time phases out the PSRO program could result in the loss of utilization controls vital to the integrity of Medicare. If budget constraints were also to result in a lack of funds for review by intermediaries of claims previously certified by PSROs, the result could be that the medical necessity of services billed under Medicare would go essentially unmonitored. This is not in the best interest of either the total federal budget or the Medicare program

IMPACT ON UR IF PSRO'S ARE PHASED OUT

In examining the consequences of any decision to deactivate PSROs, we should remember that utilization review existed before PSROs. Today, it is a fundamental factor in the way hospitals do their jobs and it will continue to develop with or without a separate PSRO program. Before the PSRO program came into existence in 1972, utilization review methods and systems of considerable consequence had already emerged in several important forms on behalf of both Medicare and health care delivery in general. The point to be made is that there is a strong framework already in place within the delivery and financing systems on which to build improved post-PSRO utilization review capacities.

Our question today is whether an adquate future utilization review program will develop in the event a significant third party payer, the government, fails to support it. We in the Blue Cross and Blue Shield organization have a strong commitment to effective utilization review for Medicare and our private business alike. In fact, we hold the function to be so important that it stands as a condition of membership for all Blue Cross and Blue Shield Plans. Just as we see a growing capacity for a balanced and effective approach to UR at the provider level, so do we have confidence in the capacity of Medicare intermediaries—both Blue Cross Plans and commercial insurers—to fill any gaps left by PSROs.

Both the government and the private sector have a stake in improving utilization review capacities from the perspective of both costs and quality. Although it can be done effectively at less cost, it is our opinion that the government will need to offset to some degree the loss of the PSRO contribution to Medicare utilization review and that the private health care industy will have to do the same with respect to their coverage.

THE ROLE OF THE INTERMEDIARY

As a prime contractor for administration of Part A of Medicare, we are vitally interested in any post-PSRO arrangement for utilization review at both the provider and intermediary levels. First, emphasis must, in our opinion, be given to preserving and even strengthening claims review activities carried on by intermediaries. Even more important for the interests of Medicare is the need for the government to provide sufficient administrative funds to finance a balanced, cost-effective claims review program at the intermediary level.

The challenge, of course, is to keep constructive mechanisms for surveillance in place and in some cases to even enhance them while at the same time lowering the overall cost to the public. We believe this can be achieved.

There also must be some provision for oversight of the provider's decisions as they affect both the quality and cost of care. Insofar as Medicare is concerned this is a basic responsibility of the Medicare intermediary and should be recognized as such in any post-PSRO arrangement or structure for UR. This oversight is clearly in the government's interest as a prudent purchaser. Ultimate oversight on behalf of Medicare must, of course, be carried on by the Federal government. We believe this should be done, first, through the establishment by the government of goals and objectives for utilization review; second, through the development of supporting guidelines; and third, through evaluation and testing of both provider and intermediary performance against such guidelines. Both providers and intermediaries must be given reasonable flexibility and encouragement to innovate and produce improvements in the overall effort. The objective of the government, providers, and intermediaries should be to pursue maximum effectiveness at the least cost. In short, we urge focus by the Federal government on outcomes rather than the means to those outcomes.

Mr. Chairman, we have referred to the fact that deactivation of PSROs may leave voids in utilization controls in some areas. I would like to put that in perspective insofar as the intermediaries' role is concerned by pointing out that a number of Blue Cross Plans have carried on effective Medicare utilization activities in those communities where there are no PSROs or where PSROs have already been disbanded. These experiences, coupled with our extensive private business experience with utilization control give us confidence that Medicare interests can be served very cost-effectively by Medicare's own intermediaries. We shall be glad to furnish details of these experiences for the record if the committee is interested.

NEED FOR CLEAR-CUT AUTHORITY TO CONDUCT UR

If the Congress elects to discontinue the PSRO program, it should, in the process, examine the Medicare provisions of the Social Security Act to be certain that the statute provides a solid base for the concept of utilization review. The law should afford both the Secretary and Medicare contractors sufficient authority and leverage to carry out their basic responsibilities. On this point, as Congress considers PSROs, care must be taken not to discourage or inhibit the further development of utilization review. To do so will be detrimental not just to the cost of care but to the quality of care itself.

In summary, Mr. Chairman, we generally support a decision to phase out Professional Standards Review Organizations. This is not to say that we do not recognize the contributions that they have made. Any decision to discontinue the PSRO program should, as we suggest, be made in a way that assures sound utilization and medical review for Medicare at both the provider and intermediary levels. We believe it is in the best interest of both the public and the private sector to recognize the need for such control and to share in its development as well as its cost.

We see this as an excellent opportunity to test the effectiveness of a combined effort on the part of the public and private sector to share both responsibility and accountability for the quality and cost of medical care.

Thank you.

Senator DURENBERGER. Next we have a panel, if they are still here, consisting of Willis Goldbeck—and I see he is—the executive director, Washington Business Group on Health, and Jan Peter Ozga, director, Health Care, U.S. Chamber of Commerce.

Gentlemen, you may proceed in either the order of introduction or some other preconceived order, whichever you prefer.

STATEMENTS OF JAN PETER OZGA, DIRECTOR, HEALTH CARE, U.S. CHAMBER OF COMMERCE, WASHINGTON, D.C. AND WILLIS GOLDBECK, EXECUTIVE DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, D.C.

Mr. OZGA. Thank you, Mr. Chairman. My name is John Ozga, and I am the director for health care at the U.S. Chamber of Commerce.

On behalf of our 112,000 members I am pleased to have the opportunity to comment on PSRO's. Incidentally, these comments augment the written statement that we submitted earlier for the record.

The chamber has long supported all reasonable means, both private and public, to contain the rising cost of health care. Peer review and quality assurance mechanisms are some of the ways to achieve this objective.

For this reason we supported legislation to create PSRO's as a method of containing the runaway cost of medicare and medicaid.

We were disappointed to learn, therefore, that PSRO's in the aggregate may be spending more money than they are saving. We say in the aggregate because as many as 15 percent of existing PSRO's seem to be accomplishing their mission. And for this reason we have encouraged our business members to consider contracting with these review bodies and scrutinize employee claims.

To date about 25 organizations have contracted with about 50 PSRO's for this purpose.

We also say PSRO's may be spending more than they are saving because of the conflicting results of several evaluations of the program which you have heard today.

But the preponderance of evidence from independent assessments suggests that on the whole again PSRO performance has not much promise.

Therefore, the U.S. Chamber agrees with the administration's budget proposal——

Senator DURENBERGER. Jan, what was the tail end of that last sentence?

Mr. OZGA. I said that on the whole, the PSRO performance has not matched promise.

Senator DURENBERGER. Thank you.

Mr. OZGA. Therefore, the U.S. Chamber agrees with the administration's budget proposal to trim and eventually terminate the PSRO program as now constructed.

There are concerns that with the elimination of the PSRO program, medicare and medicaid costs, estimated to reach upwards of $80 billion a year by 1982, will preclude unreview cost but it could increase that estimate.

Ten years ago this may have become a reality. However, in today's cost-conscious climate, typified by the health industry's voluntary effort, voluntary rate review activities, the national chamber's health action program, and more informed consumers, we feel confident that an explosion of medicare and medicaid costs will not occur.

However, to further guard against such a short-fall increase, we recommend several actions.

First, continue to allow effective PSRO's to provide review services for Government patients on a contract basis. At the same time ask the Department of Health and Human Services to determine what makes these PSRO's more effective.

Second, as the PSRO program is phased out, compare the experience of areas with PSRO's to those without to see if their presence does make a difference. Even in our State, in Nebraska, may offer some clues since it does not now nor has it ever had a PSRO.

Third, consolidate the PSRO service areas so that the current and future effective review bodies can service a larger population without a decrease in quality.

In the present arrangement there appear to be more PSRO's than necessary. For example, Maryland with only 54 short-stay hospitals has 7 service areas.

This consolidation could result in about one PSRO for each State, perhaps more for larger States. This would be in line with returning more control of health programs to the States.

Fourth, another approach which is already allowed for in the PSRO program is to require State agencies with third party payers to conduct this review.

We recognize that in the past these entities were not successful as desired in performing this function. But as we have noted on change, the need for more scrutiny is accepted by all participants

in the health care system. The phaseout of the PSRO program will provide these participants the chance to practice what they preach.

Mr. Chairman, we understand you, like the administration, advocate the creation of a more competitive cost effective health care system. Such a system we think should have an inherent cost containment mechanism, including consumer choice built into it.

When this state of affairs is reached, the need for PSRO and similar organizations will diminish. However, in the meantime, business shares the concerns of other witnesses today that some type of peer review and a quality assurance process should continue, not only for medicare and medicaid patients but for private paying patients as well.

The PSRO program held great promise to contain rising health care cost, but in reality the evidence suggests that this promise has not been realized on the whole. Accordingly, we support the President's budget to phase out the PSRO program by fiscal year 1984.

In the meantime, we advocate that our recommendations be adopted so that this process is orderly and in the best interest of medicare and medicaid patients and the American taxpayer.

These recommendations will continue to hold providers accountable for their decision and will pave the way for a more competitive cost effective health care system that will be in the best interest of all Americans.

Senator DURENBERGER. Thank you.

Willis?

Mr. GOLDBECK. Thank you, Mr. Chairman. My name is Willis Goldbeck, and I am the director of the Washington Business Group on Health. I guess, as 200 real large firms paying the medical care benefits for about 55 million people, we are the dubious beneficiaries of the cost shifting that is being discussed on and off throughout most of the morning.

I would like to make my few comments try and fit into the context of what you have already heard.

One, we do not support the eradication of the PSRO program within the 2-year time frame that has been suggested. And I would further suggest that a 2-year phaseout that started on the fiscal year, part of which has already departed, is not in fact a phaseout, it is elimination.

Second, to Senator Dole's point, I think there are other places to look for savings today. You could probably suggest that making much of medicare and medicaid payment on a perspective basis would more than equal all the savings that are being suggested under both PSRO and planning program reductions, just as one for example.

But I think perhaps even more important is the fact that you cannot look only at this year.

If we really want to change the way things are financed in the United States, for this entire very complexed system, we are talking about a decade-long approach, and it is just as irresponsible to stop something precipitously as it is to have the Fed starting something precipitously.

Actually, you might even go so far as to say that opposing the cutting of the PSRO program and probably planning as well is supportive of the President's general directions.

If in fact we want to move to a competition system, and there are many of my constituency as well as your own who would certainly support that, then to do so we cannot afford to have a very large cost bubble in the meantime due to a void of control and regulation.

We are talking about cost management rather than cost containment.

This country is never going to afford all the care that people are going to request. The issue that was raised earlier by a previous witness that this might lead to rationing is a sham. We have had rationing and we will always have rationing. The question is how much we need, and perhaps most importantly, who is going to make the decisions.

As you have said, there is not a single theoretician who created the competition philosophy and is now trying to articulate it in practical language who suggests that it does not need at least a 10-year maturation process.

Therefore, if the Congress deems it appropriate to get rid of the PSRO program as part of the growth of competition, then the removal of PSROs should be timed accordingly to fit that growth.

To remove it before the Congress will even fully consider the competition process, much less for that maturation process to have taken place, seems to be ill-designed.

There are also many measures of cost effectiveness that are not even being considered.

You cannot logically blame a PSRO for failing to move somebody out of a hospital bed, once that patient has been identified as appropriate for removal, if there is not other place to put that patient. In fact, in many cases the law, let alone the conscence, would not allow that. Certainly our employers would not be in favor of it either.

The same is true with basic benefit design. If you turn the system back over to a more higher approach immediately, what do the economic incentives now suggest? They suggest that those who make the most conscious efforts at cost containment are those who are bound to be bankrupt the first. It is not an incentive that is particularly conducive to acting on a totally voluntarily basis.

The question of the role of JCAH is an interesting one. I also serve as a member of the Policy Advisory Committee to the Board of JCAH, and I have never heard JCAH volunteer to take over the PSRO system.

JCAH is a cooperative process. Over 25 percent of the Nation's hospitals are currently not cooperating in its existence. It is a voluntary process. It is one that will fail completely if its confidentiality is removed. It is one that I think serves this country extraordinarily well, and it would be most inappropriate to saddle JCAH with the responsibilities of becoming a substitute regulatory agency while competition may or may not grow from infancy to some more practical level of maturity.

There has also been the suggestion that local business coalitions should take the place of planning and PSRO. Whereas we certainly endorse their development and are working very hard at it. They are not enforcement agencies. They are not looking for antitrust arguments, and indeed they do not have the teeth that was spoken

of before to regulate patient care, nor should they be. Nor does the Voluntary Effort. The Voluntary Effort is vitally important and I think a commendable effort in which we participate as well.

However, it is clearly not something that is supposed to review patient care in individual hospitals around the country.

My closing comment will be simply to suggest four or five little steps that might warrant your consideration.

First, to reiterate, our position is to keep and improve the system rather than throwing it away.

Second, if we are going to talk about cost effectiveness, we have got to come up with a consensus as to what the measures are and they must respect the mix of cost measurement and quality of care responsibilities that PSRO's have.

Third, that the PSRO's be provided with incentives to include preadmission testing as part of their mandate because as it is, the first 1 to 3 days tend to fall through the system, and that is a tremendous cost inducer that ought to be well managed.

Fourth, schedule the PSRO phaseout, if indeed there is to be one, to match the competition phase in.

And, finally, if in fact you are to accept the budget cuts as proposed and the block grant proposal as it is proposed, then one might want to consider placing the PSRO program funds for a given set of years within the health services block grant. And let's watch and see what States pick up what kind of programs. In a sense, it is within the context of the demonstration suggestion that was made earlier today.

The block grant process is a mechanism by which one might not have to arbitrarily remove the entire system. Instead, the Federal effort should be to improve and shift it over to the kind of a system where the states would have the flexibility that would be consistent with what the President is talking about.

Thank you very much.

Senator DURENBERGER. Thank you.

Jan, do you want to add anything by way of reaction to those statements?

Mr. OZGA. Only that I think that any differences that may be perceived are more a matter of degree rather than of kind. As we said, we support the phaseout of the program in line with the President's budget, as indeed all of our statements are predicated on that support for an across the board cut.

As we have said, we think there is a mechanism by which PSRO's that are effective, and there indeed is the challenge that seems to be confronting all of us which ones are.

I might say that there is a mechanism to determine that. I think where the private system continues to pour money into those PSRO's, true, they are not going to lose money in that process. And I think there is an indication in of itself. But as that phaseout takes place, it is simply how these entities be contractors to the Government for that process. In the meantime, we have an interim approach that they can use, State and insurance mechanisms, to perform that function.

Mr. GOLDBECK. I would also think that it should be on the record that tissue committees and infection control committees do not

equate to utilization review processes for all of patient care in a hospital system.

Had the previous system been all well and good it is probably true that the Congress would not have been able to override the rather vigorous opposition to the creation of the PSRO system in the first place.

The economic problems facing the medical care system, which are clearly exemplified by the decision to have medicaid cut both by the States and by the Feds, and increases in medicare out of pocket expenses, does not suggest that this is an opportune time to remove one of the few slightly cost controlling vehicles that you have in your hands.

Senator DURENBERGER. Thank you both for your testimony. When the administration moves from the what position they are in to the how position, we will appreciate the reaction from both of your organizations. Thank you very much for your testimony.

[The prepared statements of Messrs. Ozga and Goldbeck follows:]

STATEMENT OF JAN PETER OZGA

Mr. Chairman: My name is Jan Peter Ozga. I am director of health care for the U.S. Chamber.

On behalf of the 112,000 members of the U.S. Chamber, please be advised that the Chamber supports the President's proposed cuts to, and the eventual elimination, of Professional Standards Review Organization (PSROs).

The Administration's proposed spending cuts are distributed equally throughout the federal budget, affecting virtually everyone in both the public and the private sectors. For the President's program to succeed, each of us must be willing to accept a share of the sacrifice. With respect to PSROs, the evidence suggests that this sacrifice will not be too great.

PSROs were created by Public Law 92-603 to assure that health care services (primarily in hospitals) provided to Medicare and Medicaid patients are delivered as effectively, efficiently and economically as possible. There are approximately 200 PSROs around the country. They are composed of physicians who utilize a number of techniques to monitor and evaluate care provided by other physicians. These include pre-admission testing, concurrent and utilization review, discharge planning, and medical care evaluations. Last year approximately $180 million was spent for this purpose.

Business supported the creation of PSROs to help control the runaway cost of Medicare and Medicaid. It still supports the concept of peer review and quality assurance as a sound business technique. However, most PSROs have failed to translate the concept into a successful reality.

Evaluations of the PSRO program, included those conducted by the Congressional Budget Office (CBO)[1] reveal that, with some notable exceptions, "PSRO review has reduced Medicare outlays but the Federal Government saves little more than the cost of the review itself." Moreover, it is disturbing to learn in the CBO report that PSRO review "reduces Medicare outlays in part by *transferring costs to private patients, whose charges will rise accordingly.* When the increased costs to private patients are taken into account, PSRO review saves society as a whole *substantially less* than it costs." (Emphasis added.)

Although the overall evaluation of PSROs suggests that they are spending more than they are saving, it must be noted that not all PSROs are in this category. Independent surveys of PSROs have determined that 10 to 15 percent of PSROs are accomplishing their mission. Unfortunately, this proportion of PSROs with a positive rating has not increased over the past several years. Even the PSRO program has recognized this situation and in recent years has implemented a "focused" approach to PSRO review, whereby PSRO would receive reduced funding forcing them to concentrate on seemingly abnormal cases (review by exception).

Our original support for PSROs was based on the need to control the cost of Medicare and Medicaid, especially when we noted that, soon after the implementation of these health programs, the rise in the cost of medical care surpassed the rise

[1] *The Impact of PSROs on Health-Care Costs: Update of CBO's 1979 Evaluation.* Congressional Budget Office Study. January 1971. pp. xi and xii.

in the overall cost of living. The need to control these costs remains since Medicare and Medicaid are spending over $50 billion a year on elderly, disabled, and poor people. As so-called "entitlement" programs, these costs will continue to rise even under the President's budget proposal: to date, Medicare is unaffected by these cuts under a "safety net" program; a funding cap, saving the federal government about $1 billion in Fiscal Year 1982, has been advocated for Medicaid.

Therefore, while PSROs are phased out in accordance with the Administration's proposed economic package, the U.S. Chamber recommends that the Department of Health and Human Services conduct an objective assessment of their PSROs to verify the 10-15 percent "good" programs and determine the reasons for their success. These well run, effective PSROs should continue to provide services to Medicare and Medicaid patients under contract, just as many of these PSROs are providing review functions for private organizations, including large employers who are concerned about the rising cost of health care for their employees. Foremost among these is John Deere, Caterpillar, and Honeywell while many others, including F. W. Woolworth, are seriously considering such agreements. Until such time as there are enough effective PSROs to cover all Medicare and Medicaid patients, state governments and third party payers should implement more stringent review practices.

Mr. Chairman, the Chamber supports all reasonable attempts, both public and private, to contain rising health costs, without resorting to price controls. Although PSROs held great promise to achieve this goal, overall performance has not matched this promise. Yet, we recognize some PSROs—perhaps as much as 15 percent—are realizing their objectives. These PSROs should be encouraged to provide review services to government patients and to private paying clients, just as any contractor would.

It is clear to us that as doctors and hospital voluntarily exercise their own discipline—which will be complemented by effective demand from employers and insurers, as well as federal and state officials—peer review will not be diminished. The pocketbook teaches discipline swiftly, and the business community is determined to contain rising health care costs through all effective means, including peer review.

For this reason, we support trimming and terminating the PSRO program in accordance with President Reagan's budget, confident that successful PSROs will survive in the marketplace, with the net result being reduced cost to American patients and taxpayers.

...

STATEMENT OF WILLIS B. GOLDBECK

My name is Willis B. Goldbeck, Executive Director of the Washington Business Group on Health. We are a membership organization of major employers which have a great concern for health policy, for responsible health care cost management, and for the integration of improvements in our health care system with the improvements that are so clearly necessary in our total economy.

As you can see from the enclosed membership list, our 200 companies are very large. The fact that together, they provide the health and medical benefits for some 55,000,000 employees, dependents and retirees is ample justification for their desire to support changes in the health care system and its regulations that stand a reasonable chance of reducing waste and otherwise unnecessary cost escalation.

After careful consideration, we have reached the conclusion that this cost management objective cannot best be achieved by the eradication of the PSRO program.

Let me hasten to note that our membership stands strongly behind the President, Administration and Congress in your collective efforts to reduce Federal spending and regulation.

However, having agreed upon the goal, we are faced with many choices of direction and an even broader array of program options that might be selected to help achieve our common goal.

Therefore, we hope that you will find our concerns and recommendations concerning the PSRO program to be constructive and within the overall concept of trying to work together for a balanced approach to a stronger economy and improved health care system.

Consideration of whether or how to cut the PSRO program must take place within the context of an appreciation for the complexity of the situation in which we find ourselves, the premise upon which the proposed cut is to be made, the usefulness of the program itself, and the alternatives.

THE CURRENT SITUATION

Without belaboring the statistics you know all too well about health care costs, a few points are worth noting:

1. This country will never be able to afford all the care people will demand. Therefore, resource allocation and increasingly ethically challenging rationing are unavoidable. Faced with this reality, making an investment in systems designed to reduce waste is sound fiscal policy.

2. Many of the forces driving health care costs up are exogenous to the health industry per se:

A. aging
B. increasing birth rate
C. tort law
D. violence, accidents and narcotics
E. unemployment, with its resulting increases in cardiovascular diseases, suicide and homicide
F. environmental hazards
G. communications technology
H. unhealthy lifestyles

In addition, such cost-push factors as decreased infant mortality and increased longevity are the result of the very best our health care system has achieved.

There are also factors such as the explosion of medical technology and excess numbers of physicians about which we do not seem willing to adopt restrictive measures.

Finally, there are a few factors which lend themselves to improvement by dirct intervention through the medical system itself. Of these, none have a potential return on investment that equals utilization review.

3. The PSRO system was created to help control costs and improve quality of care within the governmental medical care reimbursement system. The fact that both the States and the Federal government find it necessary to reduce Medicaid benefits and increase Medicare out-of-pocket expenditures suggests that this is not an opportune time to remove the utilizatinon review system. Reviewing the Medicaid Quality Control Reports and reading that HCFA's own data shows some 67 percent of all Medicaid eligibility errors are made by state agency staff does not contribute to building confidence that the system will function better without a federally coordinated review program.

4. The private sector, as examples later in this testimony will establish, has increasingly found that utilization review in general and the PSROs specifically are a valid, local, physican-controlled system for making progress in cost management by reducing unnecessary and inappropriate utilization, an act which by its very nature also enhances the quality of care. It seems incongruous to have the Federal government take the lead in this aspect of cost management, spend years urging private sector cooperative participation and just when facing the most severe resource limitations, decide to end the program while simultaneously urging the private sector to continue to work with those PSROs which it has found to be effective. Clearly, one result of this approach will be to have costs shifted onto non-reviewed Medicaid and Medicare patients in direct proportion to the degree that the PSROs become creatures of the private sector payers. Even if this were good for our members we would have to responsibly note that it does not appear to be good public policy. Cost management will only be effective on a true systems-wide basis if all the payers, public and private, work together.

THE PREMISE

In fact, the budget justifies the end of the PSRO program on two bases: first, the program has not been adequately cost-effective, and, second, there will be no need for the program since the Administration plans to have a "competition" national health system in place in two years.

On the first point, I think we would all agree that there is considerable uncertainty. Studies have pointed to the PSRO's failures and to their successes. Private sector experience has been similarly mixed and none of our remarks today should be construed to signal support for specific PSROs or for retention of those that are known to be counterproductive. On-the-other-hand, we feel the examples of success are sufficient, when combined with the severity of the problem as discussed above, to warrant retaining the system and making the federal effort concentrate on improving those units within the system that have not been successful rather than destroying those that have done well.

Your colleague, Congressman Gephardt, certainly not one to shy away from supporting radical system reform, spoke of the PSRO program in a speech to our

members: "I'm aware of what the PSRO program has done in St. Louis. They've been able to get rid of some quack doctors and quack hospitals. That's happened in other places. These are probably things that the industry should have done on its own a long time ago, but it took the PSRO program and the millions we've spent on it to get this done."

Indeed, the results have been supportive elsewhere:

Working with the PSRO in the Peoria area, Caterpiller's average length-of-stay in 1979 was down 10% from 1977; patient days-per-thousand were down 19% and their admission rate was down 10%. These reductions resulted in a cost-benefit return of $4.00 saved for each $1.00 Caterpiller expended on the PSRO program.

Reynolds Aluminum's work with the PSRO resulted in an overall reduction of over ½ day in the average length-of-stay in eight Richmond, Virginia hospitals. For Reynolds, this was equal to a $2.00 savings for each $1.00 invested in the PSRO.

A.O. Smith Corporation, working with the PSRO in Southeastern Wisconsin, have seen their hospital-days-per-thousand drop from 873.5 to 535 in less than two years.

It is the opinion of many of our members that the government cannot afford to ignore gains like these, even in the short-run, and fully appreciating the laudable longer-run goal of increasing the competitive environment by reducing federal regulation.

That leads to the second premise; that competition will be ready to replace existing regulations in two years. This is simply not a realistic time-frame. All the leading designers of the competition, or "market forces" plans agree that they will take at least ten years to mature. Given the demands on Congress, it would be the height of optimism to think that legislation as complex and controversial as that necessary to implement a competition-style reform of the health care system will have even passed Congress in the next two years. Our concern is for the interim. I fail to see how it will be to the advantage of the government, in its role as payer, to remove its few existing cost management systems rather than establishing a phase out schedule that respects the real time it will take to have a replacement system in operation. I might further note that, until the government is prepared to pay full costs for Medicare and Medicaid it will not be serious about supporting a competitive system.

THE PROGRAM

Employer support for PSROs can be succinctly stated:

1. gross over and inappropriate utilization exists, therefore some program involving both public and private payers is needed
2. the PSRO program is conducted at the local level, thus, while federal in its derivation it is in fact a local program
3. it is review conducted by local doctors and while we feel strongly that all parties should be party to health policy decisions, medical care review should be left to the medical professionals
4. the program has proven sufficienctly successful in enough places to warrant improvement rather than erradication
5. PSRO's have a quality improvement responsibility as well as their cost containment mandate. We believe this is much better for the patient and for the future of the health system that any program, public or private, that would have short-term cost reductions as its only purpose.

We are also concerned that the cost-effectiveness determination made by the Administration seems to have ignored certain realities that are beyond the control of the PSRO, and other criteria that, although harder to quantify, are none-the-less legitimate. For example:

1. The absence of alternative care settings can undermine the best PSRO. The review process can correctly identify the patient that should, for both cost and quality of care reasons, be relocated in a facility designed to give a lower level of care, but such facilities are rarely available.
2. PSRO effectiveness must be measured in relation to the negative incentives resulting from poor benefit design, a problem of great magnitude in the public as well as private sectors. As long as we pay the physician more to treat the patient in the acute care setting than we do to perform the same procedure safely in an ambulatory setting we cannot expect the review process to solve all our problems.
3. It should be understood that one result of a very effective PSRO and health planning program will be a gradual increase in hospital costs for those who really need the services. The only way this can be avoided is to have a simultaneous reduction in the capacity of the entire system, including the number of physicians, and a redirection of economic incentives so that reduced patient volume due to utilization review does not cause an increase intensity of care to be compensated for lost revenues.

4. It is much harder to measure improvements in accountability, in physician awareness, in quality of care, but these are legitimate elements of the PSRO process. One need only note the great human and financial cost resulting from nosocomial infection to recognize that statistically small improvements can produce large returns on investment.

CONCERNS AND RECOMMENDATIONS

Since 1974, expenditures for Medicaid have increased at an annual rate of approximately 15 percent, despite virtually no increase in the number of beneficiaries. With or without the proposed cap on Medicaid increases, the demand for these services, or participation in Medicare, or even "bad debt" that then gets reallocated to all those who do pay, will inevitably increase.

Current rate of health care cost increases and trends for the future do not support the removal of the PSRO system. Community hospital inpatient expenses rose 16.8 percent in 1980 and our members are reporting last quarter 1980 and first quarter 1981 increases in claims and insurance premiums in the 22-35 percent range.

One of the reasons our private sector employer members do not support the immediate removal of the PSRO or planning systems is because we are deeply concerned that the current cost trends, when combined with the inenitable hiatus between control removal and effective substitution of a competition system that it itself unproven, will result in rapidly increasing public demand for more, rather than less, federal controls.

We are also concerned with the recent statement by the Department of Health and Human Services at the health budget briefing a few days ago that the Joint Commission on Accreditation of Hospitals (JCAH) was a sufficient guarantor of utilization review that the PSRO system was no longer needed. In addition to my role with the WBGH, I also serve as a member of the Policy Advisory Committee to the Board of JCAH. I want to assure you that JCAH is not and has never claimed to be a replacement for PSRO. The two can, and increasingly do, work cooperatively. Further, the better the hospitals follow the JCAH standard for in-house utilization review the greater the chance that their review will be delegated by the PSRO. However, JCAH is a completely voluntary process and one in which more than 25 percent of the nation's hospitals have elected not to participate. The JCAH system is highly dependent upon its pledge of confidentiality; its data cannot be publicly used to compare hospitals; and, the tougher the JCAH makes its standards the more opposition it receives from the very hospitals and physicians it is seeking to have participate. JCAH is a fine and invaluable institution that is striving to improve. It would be grossly unfair to saddle it with unrealistic and undesired expectations. Neither the public nor private sectors will have been well served if the PSRO budget cuts results in JCAH being unwittingly turned into a substitute regulatory agency.

Rather than simply eliminating the PSRO system in two years, you may wish to consider the following suggestions:

1. establish publicly understood criteria for success that respect the mix of cost management and quality of care responsibilities which Congress gave to the PSROs.

2. provide economic incentives for the PSROs to establish pre-admission testing programs that will apply review standards to the first 1-3 days of care which now are generally outside the process.

3. change the schedule of PSRO phase-out to more accurate reflect the phase-in of the competition system. This means that Congress will not attempt to set the phase-out schedule prior to the time it reaches a decision on competition.

4. if Congress accepts the budget cuts as proposed, and the block grant proposal, than I recommend that you place the PSRO program funds that remain, and the program even when no specific funds are allocated, within the Health Service block thus allowing the states the real flexibility about which the budget speaks so strongly. The PSRO program has sufficient evidence of success to warrant allowing the states the option of retaining it within the federally funded system as long as they elect to use their block grant allocation to do so.

CONCLUSION

The nationwide sensitivity to the need for an economic re-ordering and the leadership shown by the Administration in its early days presents you, the Congress, with a great opportunity and challenging responsibility.

Together, we must seek balance:

Balance between competition and regulation; neither are sufficient in their own right and the mere shifting of regulation should not be expressed as the removal of regulation

Balance between the costs to be paid by the public and private sectors; cost shifting is an elixir the false value of which should clearly be recognized

Balance between our fine medical system and our struggling health system

Balance between the resources allocated to the prevention and treatment of mental and physical illness

Balance between the pressure for a quick fix to a system the problems of which cannot be quickly solved, and the need to exercise the real national leadership, that can only come from the Congress, to establish the next ten years as a "Health Decade." A time in which the nation moves collectively and responsibly to a health care system that is founded on more sound economic principles while respecting the very real needs of those who must use that system during its transition.

Finally, strict management and fiscal responsibility will only be sustained if its practitioners build a base of public support for the results, not the rhetoric, theory or methods. That support will not be forthcoming if new directions are not guided with a balancing hand of compassion.

When considering budget and program reductions, no matter how good the economic justification, consideration must also be given to where else in our society responsibility for that need is to be assumed.

Turning more to the private sector is highly desirable. That, too can be carried to an extreme. We need a serious assessment of what levels of government, as well as what parts of the private sector, should have responsibility for social services.

If these remarks seem distant from the immediate needs of an employer organization, let me assure you that they are carefully chosen to reflect our commitment that economically sound and compassionate health policy will be to the enduring advantage of all Americans and thus to all employers as well.

Thank you for this opportunity to present our views and I would be happy to respond to any questions.

Senator DURENBERGER. Our next witness is Dr. Jose L. Garcia Oller, who is the chairman, chief executive, Private Doctors of America, New Orleans, La. Doctor, thank you so much for your patience. I know you have been sitting up there in the front row taking all of this in for the last 3 hours and 15 minutes and we do appreciate your being here.

STATEMENT OF DR. JOSE L. GARCIA OLLER, CHAIRMAN, CHIEF EXECUTIVE, PRIVATE DOCTORS OF AMERICA, NEW ORLEANS, LA.

Dr. OLLER. I certainly appreciate being here. Our patience has now been tried for 11 years—we have been testifying here since September 1970 for the elimination of the hallucinations of PSRO's.

Mr. Chairman, I am a brain surgeon. I have been in practice as a specialist since 1950, as a physician since 1945, before medicare/medicaid, before the PSRO's.

I have with me Dr. Noble Correll, who is a practicing thoracic surgeon from Stuart, Fla., and president of Private Doctors of America.

When the Government assumed the burden which you now estimate at $65 to $80 billion plus or minus $15 billion, we decided we should organize and have a responsible association that would look to the problems of cost, quality, et cetera, et cetera, which we knew the Government would be asking of the private doctor when the Government was paying the bill for our patients. Not the doctor's bill, but the patient's bill, the hospital's bills.

The fundamental defect of the system and the huge escalation of cost is twofold. Number one, hospitals are guaranteed payment no matter what service they give; first dollar coverage essentially means that the patient does not have to pay the bill. He or she is not going to question that.

We suggest that there be a possibility of getting back to hospital billing patients and then the Government be an insurer of the patient and not of the hospital. Make it like medicare is now where a doctor does not have to accept a penny from the Government. It is up to his patient to be insured. The doctor can treat patients, and that patient does not have to pay the doctor. And that we call peer review, when the patient makes the decision to pay the doctor, and we would like to see that.

The second reason was regulation. If you look at the graph, the increasing cost of medicare hospitalization escalates from 1966 on, due to the care and feeding of the regulatory system. And that cost, as you know, has been estimated to be about a third of hospital cost by experts far more competent than we are in that area.

What we see are the typewriter jockeys, what we see is that the hospitals have computers, and alternate computers. We see the administrations of hospitals metastasizing and multiplying. The number of patient-care people is minute compared to the administration and all those who have to feed the paper for the Government. That is the malignancy. We have paper care, not medical care. And that is where the increased cost goes, to the typewriter jockeys.

The nurses do not take care of patients, they take care of paper because the hospital gets paid for paper.

Those are fundamental backgrounds.

We now want to address, Senator, your stated questions on PSRO. We have prepared for your committee a book called PSRO, $8 Billion Hoax, our review of 10 years of PSRO testimony before the Congress. And, Senator, we cannot cover that in the few minutes that we have before your committee.

We have tried to answer all of the questions that were posed by this committee in this book. I will not go into detail, but I would like to refer to these few points.

Number one, we support the administration's program for the phasing out of PSRO. We, like the AAPSRO, would like to have the funding stopped at the end of this fiscal year so that they can go back and have the programs with a private system, if, as they say they are, successful.

Senator Baucus asked whether the concept of PSRO cost control was proper. I would refer you to the testimony on page i and ii on our book. There is a summary of our previous testimony. It says that in 1970, when Congress faced the problem of a $216 billion overrun in medicare for the next 25 years, Senator Bennett offered PSRO "as the principal answer to controlling medicare and medicaid cost."

The hearings which were heard by Senator Bennett in this committee, PSRO's offered the following: The Sacramento Foundation PSRO prototype offered to save $1 billion a year; Colorado, they were spending $2.00 to save $8.50—about $1.28 billion a year nationwide.

New Mexico estimated they would save $750 million a year, and Georgia $1 billion nationally.

That is the documentary evidence before this same committee: that the PSRO's said they can save Congress $1 billion a year, Mr.

Chairman. Now they are saying that maybe they can just about pay their way. Maybe they can pay their way.

That testimony 1969-74 is the context in which I believe we should look at this program.

The second point that I would like to bring in these few minutes is our summary where we—on page S-3 and S-4—have summarized for you 24 Government audits.

Sacramento and San Joaquin and the others, offered to make savings. We are talking about in-place prototype PSRO review programs that had been reviewing for years by 1969-74, and they offered the Congress 27 percent savings in hospitals days of care. They said, we can do that; we have been doing it.

Now, 10 years later, we have before you, on pages 3 and 4, a summary of 24 studies which have shown the absolute failure of all of these offered savings.

When all of them were studied years later, we found out that none of them can be substantiated.

And as you probably recall, the General Accounting Office stated that the PSRO's—and I have this on page 24 of my testimony—that "the PSRO's are incapable of accurate estimates of savings and should not be allowed to make representations of savings to the people and to the U.S. Congress." This is the opinion of the General Accounting Office.

So we have then all of these years of study which are here for your review in which have shown the failure of presumably $8 billion of savings that we should have had once the PSRO programs went into effect.

We, of course, are told by the AAPSRO's that they need time to mature, that it took time to put them in place. As you know, ever since 1974, many, many of them are in place. As you know, the Massachusetts Bay State PSRO, was considered to be for 5 years one of the best in the country. Yet, a year ago, they were told by the Government that they would be continued only—and this is the model PSRO in the country—if they fired the chief executive director, the medical director, the president of the board, and the entire board, then perhaps the PSRO could be funded.

The second question that we addressed is the alternatives for PSRO, which Senator Baucus asked about.

Mr. Chairman, there are three alternatives. Number one, what happens if we eliminate PSRO?

I would like to remind you that if we stop PSRO today we would still have PSRO, Mr. Chairman. And the reason is—and we refer to our recommendations on page S-5, numbers 4 and 6—that the medicare bureaucracy has changed utilization review regulations in such a manner that we now have PSRO built into utilization review.

And I would seriously ask you to please go over those regulations that were progressively expanded in the last year to change utilization review into PSRO.

So if you repeal PSRO, we still have utilization review—and the PSRO is correct: We have the same expensive system because the bureaucrat changed it.

So we recommend to you that if we are going to have utilization review—President Reagan has recommended that we have none—

but if we are going to go back to the medicare/UR, we recommend that we go back to the UR under the regulations prior to 1974, before they were doctored into expensive PSRO regulations.

One simple example. Utilization review before 1974 cost $20,000 for an average hospital a year. The same PSRO review cost five times more, $100,000. And we have this documentation from hospitals and their records in our testimony.

Roughly five times the cost of old UR is the cost of the new PSRO or the new UR.

We have a statement here by Dr. McSherry from Cornell University, a big university hospital, that it cost them, with new utilization review of PSRO, $34,000 to find one patient who had overstayed in the hospital. And we submit that that is not the most cost effective way of doing it.

So we suggest if we have a backup utilization review, let's do it through the old regulations that were reasonable. We believe the Congress was reasonable in the original utilization review regulations. And we think the cost of that was also reasonable.

We recommend, however, that the doctors and the medical staff not be responsible for the fiscal determination of payment—for the obvious reason, there is a conflict of interest. And we urge the Government to go to the old regulations that gave a choice for the medical staff to say we will do our independent review, but the payment decision should be by other doctors employed by the hospital, paid for by Government, that make the decision as to payment.

We do not want to be in the middle as fiscal intermediaries for our patients. We do not want to be insurance adjusters for the Government.

So our plea is let us do our peer review. Let the Government do the fiscal accountability review. We call that outside utilization review, and we devote an entire chapter to that, which we had in place in 60 hospitals before PSRO, on page 33.

And, finally, if you decide to have no utilization review, I would dare say that it will always be there, because doctors do utilization review as peer review and had before PSRO. And I am sure Dr. Nelson would have done utilization review in Utah whether or not you had your PSRO program.

Dr. Nelson said so. It was there before PSRO.

So true peer review will continue. The Congress may not feel like allowing Federal payment without their man in the house for fiscal review, but it will not achieve significant savings.

So that, in summary, is our presentation. We would be happy to answer questions. If you would give us one and half minutes, Dr. Correll has some comments. It is up to you, Mr. Chairman.

Senator DURENBERGER. Thank you for your testimony. Your testimony certainly leads me to believe that all of the questions I might have will be answered in here somewhere. But for the sake of your time, I won't get into any further questions. And I thank you for the effort that you put in over the years to point out to this committee where its shortcoming may have been and for your testimony today relative to the future of peer review.

Thank you very much.

Dr. OLLER. Thank you, Mr. Chairman.

[The prepared statements of Drs. Oller and Correll follow:]

TESTIMONY TO THE SENATE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE
HEARINGS ON THE ADMINISTRATION'S PROPOSAL TO
PHASE OUT PSRO AND THE CURRENT UTILIZATION REVIEW REQUIREMENTS
PRESENTED BY JOSE L. GARCIA OLLER, M.D., CHAIRMAN
AND NOBLE CORRELL, M.D., PRESIDENT
PRIVATE DOCTORS OF AMERICA
MONDAY, MARCH 23, 1981
WASHINGTON, D.C.

SUMMARY

Mr. Chairman Durenberger,

REGULATORY OVERKILL

Private Doctors of America, representing 44,500 private doctors and our patients in 50 states, comes to Washington to support the Reagan Administration's commitment to end the 15 year old nightmare of federal regulation of the medical care of our patients which started with Medicare and is embodied in PSRO.

$677 MILLION WASTE

PSRO is progressively exacting a serious and increasing toll: not only in regulatory overkill, not only in the $677 million hemorrhage of wasted taxpayer funds todate, but in the accumulating toll of the lives and the suffering of the elderly, of the indigent, of our blind and disabled patients. PSRO is also blighting medical progress, as an army of doctors is chained to paper care, not medical care.

COST $34,212/PATIENT

In 1978, Dr. McSherry at Cornell-New York Hospital estimated it cost $34,212 to find a single patient who overstayed. He estimated a waste of doctors' time equivalent to the annual output of six medical schools the size of Cornell.

$28,000 MORE THAN UR

According to Testimony presented August 25, 1980 to the Ways and Means Subcommittee on Health by Maras, Veres and Pilasky, the Warren General Hospital Board estimated PSRO would spend $28,000 more than the current cost of UR in their hospital alone.

PAPER CARE

Dr. Levine, a Michigan delegated PSRO physician stated, "the PSRO has dramatically increased the cost of review . . . PSRO has caused our review program to deteriorate . . . we are now pushing paper rather than improving patient care".

BLIND TRAVEL

Montana opthalmologist Ullman testified that blind patients had to be driven 200 to 600 miles to obtain second opinions as required by the PSRO.

RETARDED DENIED

Doctors Sims and Skinner for a mentally retarded school, testified as to PSRO discrimination "against a helpless, mentally retarded population . . . fraud, deceit, personal vendetta.

COST IN LIVES

Kentucky attorney Reeves testified that "the major cost has not been mentioned . . . that is the cost in human lives . . . because . . . of PSRO". "Over a year and a half (later) the family has still not been told . . . whether it will receive Medicare benefits. This delay is no concern to (the patient) . . . She died . . . 43 days after being told she did not require hospital care."

TRAGEDY OF ERRORS

A Louisiana internist, Lutz, testified that his patient with a fulminating first stroke and massive complications was described by the PSRO reviewer as a chronic case who had a fall. He was denied three times, each time followed by a catastrophic complication. It took one year to reinstate the full 83 days of care - which came as the patient died.

$1.25 BILLION A YEAR COST

Mr. Chairman, PSRO has been estimated by the Institute of Medicine to cost 1.25 billion dollars a year (1976), if fully implemented.

$8 BILLION HOAX

On the other hand, according to Sen. Bennett in 1970, PSRO should be adopted by Congress as the "principal answer to control medicare and medicaid costs". PSRO's testimony offered savings of $1 billion a year. To-date, CBO estimates it has saved close to $0. After eight years, PSRO is an $8 billion hoax.

THE PSRO RECORD OF FAILURE

Since 1970 PDA has repeatedly appeared before this and other Committees in Congress to expose the failure which is PSRO. Here follows a brief Summary of the PSRO Record of Failure, which is extensively documented in the full Testimony in the PDA Text, "The PSRO $8 Billion Hoax".

PDA TESTIMONY

TABLE OF PSRO FAILURE

1. 1970 — PDA study - No savings 1966-1969 from "certification of necessity", expanded in Bennett PSRO amendment

   1975 — HEW/SSA Study confirms PDA 1970 study of no savings

2. 1973 — Arthur D. Little "PSRO" Study - the value of:
   - precertification of hospital admissions not documented.
   - cost of concurrent review of all hospital cases would be prohibitive.

3. 1973 — Arthur D. Little "EMCRO" study - prototype PSROs - no validation of net savings of nine prototypes.

4. 1973 — PSRO study of Maricopa Foundation prototype: $2.37 spent to save $1. (Spent $1 to save 42¢ - this is similar to CBO study estimate in 1980). PDA estimate of PSRO national cost: $600 million to $1.5 billion.

5. 1973 — PDA UPRO on site visit. No savings claimed by UPRO.

6. 1976 — Arthur D. Little Study - "UPRO had no ... effect on medical costs and utlization" "no positive impact found"

7. 1976 — Dr. Paul Bonner, dissertation on UPRO - "no ... positive impact of concurrent review ... on average length of stay, admission rates, or days of care per eligible"

8. 1976 — Institute of Medicine Report to Congress:
   - 19 PSROs evaluated
   - "None of the PSROs had any validated data as to savings or cost"
   - no effectiveness in concurrent review programs visited
   - no data available from UPRO, and Multnomah
   - Colorado Foundation not cost effective
   - total cost of PSRO could exceed $1.25 billion (per year)

9. 1977 — OPEL Study - cost $1.07 million, 13 volumes, review of 18 PSROs
   - "No significant overall effect was found", cost of original UR is estimated at $81.3 million. PSRO hospital review estimated at $268.5 million, PSRO is not now cost effective

10. 1977 — OMB - recommended that the PSRO program be eliminated from the 1979 Budget

11. 1977 — Inspector General Report, November 18, 1977 - "34 of 39 PSROs show inadequate accounting of funds"

12. 1978 Sanazaro, New England Journal of Medicine - PSRO in 24 hospitals, concludes: "not certain that this large effort enhanced the quality of care"

13. 1978 GAO Testimony of OPEL 1977 (June 15) - "Savings allowed by OPEL unsubstantiated, in New York, Wyoming, Southeast Massachusetts, San Joaquin, QUAD River and Baltimore

14. 1978 GAO Report to Congress - "savings ... were grossly overstated"

15. 1978 Nashville Tennessee PSRO terminated by HEW - overbillings of $200,000, refused to give HEW access to documents to verify expenses

16. 1978 U.S. House Committee on Appropriations Report:
- "The costs of the program are out of control"
- PSRO "hospital review ... could exceed $500 million eventually"
- questions whether it works any better than the less expensive UR

17. 1978 HCFA/HEW PSRO Program Evaluation - "PSRO saved $4.6 million", "cost effective by a 1.1 ratio"

18. 1978 CBO review of HCFA Evaluation - No savings, "spent $1 to save 70¢". No evidence that PSROs grow more effective over time

19. 1979 HCFA - terminates five PSROs, warns three

20. 1979 HCFA PSRO Evaluation - $21 million savings claimed, reduced days in the North, increased days in the South

21. 1980 HCFA - 20 PSROs may be terminated

22. 1980 CBO Review of 1979 HCFA Evaluation:
- PSRO "saves 70% less than it costs"
- increases utilization in the South
- costs "dramatically more than UR"

23. 1980 Massachusetts Bay State PSRO given notice of termination. One year reprieve in June 1980 if: Medical Director, Executive Director, Associate Executive Director are fired, Board President leaves.

24. 1981 CBO, January Update of 1979 Evaluation of PSRO costs

- PSRO ... saves the government ... little more than the cost of the review itself
- PSRO achieves this reduction in part by transferring costs to private patients
- PSRO increases the cost of medical care to society as a whole

RECOMMENDATIONS

Mr. Chairman, our full Testimony provides documentation of the widespread failure of the mature PSRO program including repeated detailed government audits by OPEL, CBO, GAO over the past six years. Eight years after enactment, with many large programs over five years in operation, with some prototypes now 12 years performing review, PSROs must be declared as a failure in cost-effectiveness.

1. The Reagan Economic Program recommends a three year phase-out of PSRO funds. On the basis of the evidence, however, we believe PSRO funding should be stopped at the end of this fiscal year 1981. We see little excuse to fritter away $134 million in FY 1982 and 1983 in a program benefitting no one except those employed by the PSRO, a "welfare for doctors and bureaucrats program". PSROs who claim success and support by the community doctors should continue without federal funds.

2. PSRO is sham review, 99% practical nurse review, 1% doctor-on-the-telephone review-without-ever-reading-the-chart. PSRO is unscientific, unethical, non-medical review. It is a disservice and injures our patients.

3. As doctors begin to respond to the injustice of PSRO to our patients, the cost of medical care will inevitably escalate, because a new pattern of "defensive medicine" against PSROs is inevitable.

4. Repeal of PSRO may be useless, however, unless the quiet and relentless doctoring of the Utilization Review Regulations by the HHS bureaucracy is exposed and invalidated immediately. UR is now PSRO!

5. The original Medicare Law set forth reasonable requirements for certification of need of inpatient hospital care and of utilization review (S. 1814 (a) 3 - certification; S.1866 - 20 day rule; and S. 1861 (k) - UR).

6. The bureaucracy, however, immediately set to work and as documented since 1969 by PDA to the Senate Committee on Finance, used the device of the Federal Register, of Intermediary Letters and of Agency Manuals, to change the law and even its own regulations. HEW has radically, and we believe illegally, altered certification and Utilization Review requirements to transform them into PSRO.

   On 1975, PDA filed suit against the 1974 UR Regulations changes made by HEW which changed the nature of UR into a PSRO program. The AMA later also filed suit. The courts stopped the HEW UR Regs.

   a. However, on March 3, 1980 HEW proposed (FR, Vol, 45, No. 43, 42 CFR, 405, 440, 456 and 482), UR changes again radically change original UR into a full PSRO program.

   b. Again, on June 30, 1980 HEW proposed (FR, Vol 45, No. 121, 42 CFR, Part 482, Subparts A & B) rules on the Conditions of Participation of Hospitals, make Medicare UR the compulsory

responsibility of the Medical Staff, instead of the hospital, thus changing the nature of both the Medicare program and of UR. Changes go even beyond PSRO, where review by staffs is voluntary.

7. If we are to avoid further abuses by the bureaucracy as documented here, the bureaucrat must be subject to Judicial review. PDA filed suit on HEW for its excesses - the Court commented on the probable merit - but a recent decision elsewhere two years into the suit ruled HHS immune from suit on any regulatory action.

   We recommend amendment of S. 405 (h) of 42 USC to allow jurisdiction for medical staffs to seek judicial relief whenever the bureaucracy imposes interpretations and rules which change the intent of Congress, or violate even HEW's own regulations.

Thank you, Mr. Chairman

PRIVATE DOCTORS OF AMERICA T.M.

Est 1980 CMS

WRITTEN RESPONSES TO CONGRESSMAN PHILIP M. CRANE'S QUESTIONS
SUBMITTED BY
PRIVATE DOCTORS OF AMERICA, JOSE L. GARCIA OLLER, M.D., CHAIRMAN
September 22, 1980

PDA

Mr. John M. Martin, Jr.
Chief Counsel
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Martin:

As per Chairman Rangel's letter to me of September 3rd, copy attached, I am pleased to respond to Congressman Crane's written questions as follows:

QUESTION 1: Those who oppose repeal of PSRO's argue that nothing would replace them. Yet Section 1861 of the Social Security Act would continue to require utilization review. How would utilization review replace the PSRO program?

ANSWER: Private Doctor of America recommends to Congress that:

1. The Nurse-with-the-Rulebook review and the-PSRO-Doctor-on-the-telephone Review be discontinued, now.

2. Believable review must be performed by doctors who actually read the patients' charts, in the hospital. No "rulebook" of criteria, norms and standards will be necessary, because doctors apply individual professional review.

3. 5% Sampling review of both hospitalized (concurrent review) and discharged patients (retroactive review) should be made, plus review of all stays longer than 21 days, and certifications of stay at 14 days, according to the Medicare Regulations prior to 1974.

4. Rescind all UR regulations promulgated 1974 and thereafter, whose sole purpose was to change Utilization Review into the failed PSRO.

5. Stop the March 3, 1980 Federal Register proposed UR regulations, which are 100% PSRO and that would eliminate UR.

6. Stop the June 20, 1980 Federal Register proposed "Conditions of Participation of Hospitals" which eliminates UR and change it into PSRO.

QUESTION 1 (a): Based on your experience with utilization review before 1972, how do you feel the costs of utilization review would compare with the PSRO program?

ANSWER: Our experience with the cost of hospital Utilization Review prior to 1972 is estimated at one-fifth of the PSRO. In the Hearings we heard testimony from Warren General Hospital that today continues on Utilization Review and not on PSRO. Mr. Richard Maras, President of the Board, testified that the 1978-1979 actual cost of UR in his Warren, Ohio hospital is $28,040.90, while the local PSRO is spending $106,187.17 per hospital per year. The PSRO has shown no improvement in quality or costs. The Warren Utilization Review has been cited as an outstanding review program.

In Singing River Hospital, Pascagoula, Mississippi, UR before 1972 cost about $20,000 a year. Today, under delegated PSRO, it costs $101,770.00. $48,325 is reimbursed by the federal government, the rest is hidden PSRO costs which are shifted as a burden onto private patients.

1. PSRO costs are dramatically higher than utilization review, and if PSRO were allowed to continue to full implementation, the costs will be staggering - into the billion dollar level. PSRO has already wasted $677 million.

2. According to the CBO testimony at these Hearings, PSRO already spends $1 to save 40¢.

3. In its report of March 10, 1980 to Congressman Natcher, the CBO further stated - noting the HEW/HSA/OPEL's own 1977 evaluation - "For the most part, every function in PSRO UR tends to cost more than the analogous function in new UR ... when the additional costs of PSRO operations is added to the hospital costs, overall UR costs are dramatically higher."

   "Dr. Helen Smits, Director HSQB/HCFA has argued alternatively that PSRO review costs no more than pre-PSRO review ... those assertions are not consistent with the available data on pre-PSRO UR costs."

This is the PSRO program that Senator Bennett promised would stop health care inflation; and the PSRO prototypes in 1972-1974 were already boasting of saving "$2.53 - $8.50 for $1 spent"! (Ref: Statement of Kenneth A. Platt, Medical Director; Colorado Foundation for Medical Care, Senate Committee on Finance, May 1974 Hearings on PSRO Legislation Implementation, page 405.)

QUESTION 1 (b): How much do you feel the PSRO program would cost if fully implemented? How does your estimate of these costs compare to other estimates of the full cost of the program?

ANSWER: The huge and intolerable PSRO cost overrun predicted by PDA in 1972 is now confirmed. Senator Long estimated the PSRO program would cost $60 million in 1971, Senator Bennett $100 million for the full

program. We estimated $1 billion, confirmed by the IOM estimate in 1976 as follows:

TABLE I

ESTIMATES OF PSRO PROGRAM - FULLY IMPLEMENTED

1.	Senator Long	1971	$ 60 million	(SCF 1971 Hearings)
2.	PDA (CMS)	1973	$ 1 billion	("PSRO" PDA 3rd Ed.)
3.	Senator Bennett	1974	$ 100 million	(SCF 1974 Hearings)
4.	Institute of Medicine	1976	$1.25 billion	(Nov. 1976 Report)

The above "Fully Implemented PSRO Estimates" include: Hospital review, nursing home review and ambulatory review. For Hospital PSRO review only:

TABLE II

ESTIMATES OF PSRO PROGRAM - HOSPITAL REVIEW

1.	CMS/PDA	$500 million	Only Federal beneficiaries
2.	Institute of Medicine '76	$500 million	Total population
3.	House Appropriations Cmte '78	$500 million	Only Federal beneficiaries

It is clear that the $60 million of Senator Long's Senate Committee on Finance estimate was an underestimate of $1 billion...

QUESTION 1 (c): Who would do the actual review work under the utilization review program? How does that compare with nurse review under PSRO's?

ANSWER: In our recommended UR program - "OURFA" - under regulations prior to 1975 Interim Regulations, the review would be performed by two or more physicians who actually review the records in the hospital and make each and every determination of approval or denial. These doctors would be "government examiners" paid for by government.

At present, PSRO is not Doctor review - it is nurse review. 98% of all approvals for payment are made by PSRO nurses without ever calling the PSRO doctor. In 2% of cases, the PSRO doctor is consulted on the telephone. He does not have to read the chart to deny the case.

This is not professional peer review, it is SHAM REVIEW. It is nurse rulebook rationing and control of medicare dollars and denial of patient care.

QUESTION 2: I am concerned about Section 1155 (a) (2) of the Social Security Act. ("each PSRO shall have authority to determine in advance ... (if) any elective admission ... (should take place)"). Is this provision actually implemented anywhere?

ANSWER: Yes! Pre-Admission Certification is indeed being implemented, with a vengeance.

1. The Montana PSRO (statewide) is requiring blind patients to travel 200 miles to 600 miles for a second physician certification of necessity. If this second opinion disagrees, a third opinion and another 200 mile trip is required. The expense is to be born by the patient!. Dr. Ullman, an outstanding, qualified surgeon, has been placed on pre-admission certification of all cases. Only eight out of 300 cases have been turned down - 2.6% difference of opinion.

2. California Medicaid ("MediCal") has pre-admission certification of all cases.

3. New York PSRO pre-admission certification for "certain diagnoses" and procedures, and for all Medicaid admission, compulsory second opinions for certain procedures.

For further details, please see our written testimony, Chapter 6, pages 28 to 30. The Pre-Admission Certification abuse of patients and doctors, without any cost effectiveness, must be repealed now.

QUESTION 3: Medicare was enacted with promises that the Federal Government would not become involved with monitoring health care (Section 1801 of SSA). Does PSRO review undermine the intent of Section 1801?

ANSWER: In enacting the Medicare law, Congress made a solemn compact, written into Section 1801:

> "Nothing in this title shall ... authorize any supervision or control over the practice of medicine ... or ... over the ... operation of any ... institution."

This compact is now in shambles. The PSRO Law, enacted in 1972, without any hearings in the House of Representatives, set free an army of nurses and social workers - armed with rulebooks for the diagnosis, care and treatment of all disease - to make determinations as to necessity of hospitalization before admission and every few days after, of 17 million Medicare and Medicaid admissions a year - with the help of a doctor on the telephone.

No wonder that this law was called "the most radical medical legislation in history". The Secretary of HEW in 1978 called it "a revolutionary program".

But, PSRO did more than that: it set the stage for an $8 billion hoax and a tax expenditure to date of $677 million dollars.

QUESTION 4: As you know, I have long been concerned about the privacy of medical records. Yet Section 1155 (b) (3) gives PSRO's access to any medical records without restrictions. If nurses are actually doing the review, are medical records actually held confidential? As a doctor, pledged to uphold the Hippocractic Oath with its pledge of privacy, are you bothered by this aspect of the PSRO problem?

ANSWER: Privacy and confidentiality of medical records is the Keystone of the arch of medicine. No patient will confide in a doctor, when it becomes known that medical records are but a conduit to the government computer.

The very right to life of citizens - their employment and station in life - is endangered when their intimate and personal privacy becomes the property of the government and the bureaucrat. PSRO is the ideal means for government bureaucrats to destroy privacy of all citizens - and thereby achieve control. Privacy is lost the moment government agencies view medical records. Whether viewing is by nurses or doctors - if these nurses and doctors are agents of government thru PSROs, the government computer has the private information. PSROs are controlled by the Secretary of HHS.

The coverup of this assault on privacy of all citizens is the statement "but only authorized government personnel will have access - and they are bound by secrecy under law" - when the HEW bureaucracy, the PSRO bureaucracy, the Blue Cross-Blue Shield personnel, other insurance, the HSAs, and other "authorized" persons have reviewed the chart, the record has now passed into the hands of government. PSRO would not last a single month if the people became aware that private office records would be reviewed by agents paid by government (whether lay reviewers, insurance, nurses or doctors).

QUESTION 5: I am sure that you have seen the CBO report of May 2, 1980. I would like to quote from that study: "Although PSRO's appear to reduce medicare utilization, the program consumes more resources that it saves. The 1978 data indicate that for every dollar spent on PSRO review of medicare patients, only $.40 in resources were recouped, for a net loss of $.60 per dollar spent. This corresponds to a savings-to cost ratio of .4 to 1. In other words, the PSRO program, by increasing the quantity of resources consumed, makes the health care system less efficient."

ANSWER: Agree with the CBO: PSRO adds an unnecessary and extremely expensive layer of bureaucracy to the review process. As our President, Dr. Noble Correll testified in the Hearing's, the Broward County PSRO spent most of two years discussing the retirement, salaries and fringe benefits of the staff.

As testified by Dr. Brobson Lutz, the New Orleans PSRO (SELAQRMF) bureaucracy retirement program is vested in six months! Doctors are paid

to do the Ulitization Review that they did do for years for free - $60 per hour for routine meetings of the PSRO Board.

There is also the hidden costs of PSRO - the transfer of unreimbursed hospital review cost to the private patient.

A new and mounting cost is being generated by PSROs: defensive medicine against PSROs. Doctors are now ordering tests and consultations "to keep the PSRO reviewer off their backs" while they can observe the patient's hospital course without harassment.

QUESTION 6: Perhaps the most important concern of this Subcommittee should be to protect the quality of health care. I worry that PSRO's may be interfering with quality provision of care by setting Federal standards. Is that so?

ANSWER: PSRO cannot improve quality, if can only destroy quality care.

1. If PSRO is allowed to continue, the Medical Record will become a farce. No doctor respectful of his patient's privacy will ever again write down any personal or medical - information that could harm his patient when viewed by government agents. Quality care suffers.

2. The medical record will be worthless for research, as information will be unreliable. This is happening now because of PSRO.

3. Precious physician time will be spent in documenting records for the care and feeding of the reviewer and the computer profiles. More time will be spent for the PSRO chart than on the patient, as in socialized countries.

4. Consultant talent and time is being wasted in unnecessary pre-admission certification and second opinions.

5. Patient confidence in their doctor is destroyed by second opinions and by the knowledge of the PSRO review system surveillance.

6. Without patient confidence, many patients will simply not show up for necessary treatment and, certainly not for "preventive treatment".

7. The soul of the medical profession will be poisoned by PSRO. Thru PSRO harassment, denials, demands for certification, promises of reward for "conformity", the independent professional judgement that is necessary for quality medical care will be a thing of the past. Because of PSRO, quality care will soon be available only to non-government patients.

José L. García Oller, M.D.

TESTIMONY TO THE HOUSE SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON WAYS AND MEANS
PUBLIC HEARINGS ON PSRO
PRESENTED BY JOSE L. GARCIA OLLER, M.D., CHAIRMAN
PRIVATE DOCTORS OF AMERICA
MONDAY, AUGUST 25, 1980
WASHINGTON, D.C.

SUMMARY

In enacting the Medicare law, Congress made a solemn compact, written into Section 1801:

> "Nothing in this title shall...authorize any supervision or control over the practice of medicine...or...over the...operation of any... institution."

This compact is now in shambles. The PSRO Law, enacted in 1972, without any hearings in the House of Representatives, set free an army of nurses and social workers - armed with rulebooks for the diagnosis, care and treatment of all disease - to make determinations as to necessity of hospitalization before admission and every few days after, of 17 million Medicare and Medicaid admission a year - with the help of a doctor on the telephone.

No wonder that this law was called "the most radical medical legislation in history". The Secretary of HEW in 1978 called it "a revolutionary program".

But, PSRO did more than that: it set the stage for an $8 billion hoax and a tax expenditure to date of $677 million dollars.

THE PROBLEM

First, why was PSRO enacted by Congress in such a hurried fashion? Because in 1972, the Medicare program would have been in "bankruptcy". In 1970, the Senate Committee on Finance was advised that it was facing a $216 billion overrun in the next 25 years.

In this crisis, Senator Bennett in 1970 offered PSRO as a program that could "stop" the health care inflation caused by Medicare/caid and serve as "the principal answer to controlling Medicare and Medicaid costs...".

This Promise meant:		
- in 1970	a savings of	$953 million
- in FY 1977	a savings of	$1.94 billion
- over 25 years	a savings of	$5.2 billion/yr.

Senator Bennett was promising $1 to $5 billion saving per year - $8 billion minimum total by 1980.

PSRO has saved $0.

This Book was written in response to the need for public knowledge of the promises behind the PSRO Law and its 8-year failure in cost-effectiveness. Hence, this Testimony to demand for Congress to Repeal PSRO.

THE PSRO FOUNDATIONS PROMISE

And, where did the Senator obtain his faith in PSRO? From two medical groups in California: San Joaquin and Sacramento, who had organized to sponsor "prepaid" HMO-IPAs and had contracted with Medicaid in California. They came to Washington to seek federal funds for their programs and a Medicare contract. They received the federal contracts (EMCRO's). Their estimates, and that of the related EMCROs as the "Foundations" testified before the Senate:

1.	Sacramento: ('74 est.)	"$4-$5 Billion for all population (1/4 Medicare/aid = $1 billion/yr.)
2.	Colorado: ('74 est.)	$2.53 - $8.50 per $1 spent. (For $150 million 1980 PSRO Budget, savings = $345-$1.28 billion)
3.	New Mexico ('74 est.)	$3-$5 per $1 spent (For $150 million PSRO budget, $450-$750 million)
4.	Georgia ('72 est.)	$1 billion nationally

From 1974 thru 1979, PSRO national savings for all 186 active PSROs is $0. The $8 billion hoax persists.

THE COST OVERRUN

Overrun of the political estimates: $400 million to $900 million. In 1971, Sen. Long stated the PSRO Program total cost as $60 million. In 1974, Sen. Bennett said: $100 million. The 1976 Institute of Medicine estimate of hospital and ambulatory review of PSRO Program: $525 million for Medicare/aid, $1.25 billion for the total population. In 1978, the House Appropriations Committee estimated up to $500 million just for hospital review. (The rest of the program would double this cost, or $1 billion.)

THE PREMISE, THE FRAUD, THE FALLACY

1. PSRO is partly based on the Certification Regulations Fraud by HEW in 1969-1971, exposed by PDA. HEW falsely claimed that physician certification of necessity could save $400 million a year. Why not "certification on demand" - PSRO? (Figure 1).

2. That an HMO rulebook to ration and limit hospital care saves $1 billion a year and improves quality.

The Fallacy: decreased hospitalization does not necessarily mean decreased cost of medical care. One must still treat the patient - additional alternate care, at home, office, and nursing home has to be paid. The huge cost of ever-expanding bureaucracy, its retirement and other fringe benefits, the regulatory machinery at all levels, plus the cost of an army of reviewers must be factored.

There was no validation of cost savings for any of the prototypes either before, or 4 years after the law was passed. Today, Sacramento HMO charges higher rates than fee-for service doctors. "San Joaquin" had to tighten its rationing as it went into red ink.

THE GOVERNMENT AUDITS: OPEL, GAO, CBO – NO COST EFFECTIVENESS

1. In 1976, the ION Evaluation - No...effectiveness...demonstrated in any of the programs visited, including Colorado.
2. OPEL, in 1977, a two year, $1.05 million 12 volume study of the PSROs concluded: PSRO is not now cost effective as a cost-containment mechanism.
3. 1977-OMB recommended elimination of PSRO from budget.
4. 1978-HEW Inspector General: inadequate accounting and control of funds.
5. 1978-GAO so-called "savings" of 6 PSROs allowed by OPEL, were grossly overstated, and doubted any savings.
6. In 1978, Nashville PSRO "one of the best" - terminated for allegations of fraud.
7. 1978 House Appropriations: Program costs out of control.
8. 1978 HCFA Study: $4.6 million saved.
9. CBO review of HCFA: no savings allowed .. spent $1 to save 70¢.
10. 1979: five PSROs terminated.
11. 1980: 20 PSROs may be terminated.
12. 1979 HCFA Evaluation: $21 million claimed
13. CBO and GAO: No savings. Spent $1 to save 40¢. Increased stays in south. No impact in west. Costlier than Utilization Review.
14: 1980: Massachusetts PSRO saved from termination by firing the Executive Director and associates.

RATIONING INSTEAD OF REVIEW

PSRO is now phasing out expensive concurrent review, transformed itself into automatic certification, retrospective, old "Utilization Review". Still, PSRO is asking for a budget three times the cost of UR, $200 million for FY 1981. Direct Rationing measures are being instituted to accomplish wholesale denials for visible political savings. The National PSR Council takeover by the bureaucracy is complete, placed under a professional government planner as Chairman by the Secretary of HHS.

THE ALTERNATIVE: OURFA

1. "Outside Doctor" Utilization review - not representing the medical staff, to avoid inherent conflict of interest; paid for by government thru the insurance carrier or the hospital.
2. Doctor - not nurse or social worker - performs sampling and retroactive review by reading the charts at the hospital.
3. No rulebook, criteria or standards. Instead, professional individual review.
4. No retroactive denials.
5. Fraud and abuse control thru report to carriers and to State Fraud/Abuse Units and to Federal Project Integrity.
6. Regulatory reform: Amendments offered for accountability of the bureaucracy in the federal courts.
7. Stop Proposed 1980 "UR Regs" and Conditions of Participation for Hospitals, which institutionalize PSRO and eliminate UR.
8. Return to UR Regs before the 1974 HEW - PSRO changes.
9. Repeal PSRO now. PSRO is welfare for doctors and bureaucrats.

PSRO is a $677 million loss, a $200 million a year drain on the taxpayer with costs running out of control. The progressive escalation of costs by a wave of defensive medicine against the tightening PSRO rationing and denial will be the fatal chapter in the $8 billion PSRO HOAX. REPEAL PSRO. INSTALL CREDIBLE, REASONABLE REVIEW: OURFA.

Thank you, Mr. Chairman.

Chapter 1: "The Primary Mechanism to Control Costs"

I. WHY WAS PSRO ADOPTED BY CONGRESS?

PSRO, P.L. 92-603, was enacted as an 18-page amendment to the mammoth (1282 page Report of the Senate Committee on Finance on HR 1)[1] Social Security Amendments on the last day of Congress, October 30, 1972, without any Hearings in the House of Representatives.

IMPENDING MEDICARE BANKRUPTCY

Why was such a sweeping, radical law as PSRO passed with such little Congressional inquiry? PSRO was enacted because of the apparent "bankruptcy" of the medicare programs. In the 1970 Medicare Hearings,[2] the Chief Actuary of HEW advised the Senate Committee on Finance that the Medicare programs would run out of funds in 1972. Senator Russell B. Long commented[3]:

> "This Medicare program is completely out of hand, ... I stated for the record in 1965 before the program was enacted that it would cost more than the estimates... But I had no idea that in the short span of five years we would be looking at a deficit in this single program that would exceed the deficit in the national debt accummulated over the last 156 years of this Nation's existence..."

> "Yesterday, I made the statement that the medicare program was suffering from $131 billion of cost overruns for the next 25 year period. ...the committee learned that new estimates place the cost at $216 billion."

II. PSRO - "THE PRIMARY MECHANISM TO CONTROL COSTS" - SEN. BENNETT

In this bankruptcy crisis atmosphere, Senator Wallace Bennett rose to offer PSRO as the key to stop the escalating cost of federal health care. Listen to Sen. Bennett's speech introducing PSRO to the U.S. Senate, August 20, 1970[4]:

> "That amendment, which I am submitting today, would authorize the establishment of professional standards review organizations, generally at local levels, as the primary mechanism to control and moderate the soaring costs of medicare and medicaid."

and, again on October 13, 1970[5]:

THE PROMISE OF SAVINGS TO STOP MEDICARE ESCALATION OF COSTS

> "The taxpayers - the average citizen and his employer - are on a treadmill when it comes to financing medicare and medicaid. They are asked to pay more and more simply to maintain present benefits levels."

"My amendment to establish professional standards review organizations was intended as a responsible effort to establish a comprehensive commonsense means of slowing down - perhaps even stopping - the taxpayers' treadmill."

"The principal answer to controlling medicare and medicaid costs which had been offered until introduction of my amendment was... The Bennett amendment provides, I believe, a more rational - more professional - more acceptable - and more effective alternative."

With this offer of PSRO as the effective means to stop the inflation of cost caused by Medicare, a desperate Senate Committee on Finance adopted the measure. Without hearings in the House, PSRO became law. It was hailed by each subsequent Secretary of HEW as the cost-control mechanism which would justify each new proposed program expansion by HEW.

It appears Senator Bennett had a retrospective change of mind. In 1975 when the PSRO Programs were being challenged as to cost-effectiveness, Senator Bennett then wrote in his article "PSRO - The Pressure and the Promise"[6]: "As long as I have raised the subject of money, allow me to reiterate that PSRO was not enacted as a cost-cutting program".

* * *

UNVALIDATED CLAIMS OF PSRO SAVINGS

No one bothered to check on the documentation of Senator Bennett's sweeping claims that PSRO would actually be effective in saving costs. No one except Private Doctors of America (founded as the American Council of Medical Staffs), who researched and exposed the lack of reliable validated data required to justify any confidence, at the time of its passage by Congress, that PSRO would ever save money. Since 1970, we testified that PSRO, as a huge new bureaucracy, necessarily would increase the cost of care, and thru the intimidation of government approved rulebooks, would decrease quality and stultify progress. We demanded audits. We were answered with the plea "to let the PSRO program have more time let it mature". Senator Long said, "if it doesn't work, we'll discontinue PSRO". Well, it is now 8 years since the passage of the Law. Nearly every outside study of PSRO since its enactment has shown the program to be a dismal failure in cost containment. It is time for Congress to stop funding this wasteful and inflationary PSRO bureaucracy.

A. THE PROMISE = $1.5 BILLION/YR. VS. ACTUAL = $ ZERO SAVINGS

First, let's examine Senator Bennett's claim that PSRO would stop the escalating costs of Medicare and Medicaid. Consider the numbers. To offset the 1969 HEW estimate for 1970[7]: 15% hospital inflation rate, $6.355 billion hospital federal costs in medicare and medicaid, PSRO savings would have to amount to $953.25 million. For the latest full year statistics available (1977)[8]: $18.65 billion for hospital care in both programs and 10.4% hospital inflation, PSRO savings would need to be $1.94 billion to fulfill Senator Bennett's PSRO promise. Or $970 million for 50% PSRO implementation in 1977.

The audits by GAO and CBO report a PSRO net loss, not a savings, from 1977 thru the 1979 Evaluation. They refute any HCFA claims of PSRO savings of $4.5 million for 1977, and $21 million for 1978. Eight years after the law has been enacted, PSRO is a dismal failure in savings, at least a cumulative $8 billion less than predicted.

To equal the $131 billion/25 year medicare overrun estimated in 1969, PSRO would need savings of $5.2 billion a year in a $5.8 bil. Medicare hospital program in 1970. This estimate was increased in 1970 to $216 billion, or $8.6 billion a year. Will PSRO savings match this figure?

B. PSRO COST OVERRUN: $60 MILLION VS. $1.25 BILLION

We are told by HCFA that PSROs are underfinanced, and that's why they failed. In 1972, Senator Long stated in the Hearings that the entire PSRO program would cost $60 million[9]. In 1974 Senator Bennett estimated $100 million[10]. In 1980, PSROs and HHS are asking for an increase of $51 million. The 1981 budget request is $200 million for partial program implementation. The program thus far (1973-1980) has cost $667.7 million[11]. And these budgets cover only part of the hospital component

of the PSRO program - about 3,000 hospitals[12] are not yet on PSRO. The House Appropriations Committee Report[13] estimated in 1978 that PSRO could easily run $500 million just for hospital review. The Institute of Medicine in 1976[14] estimated the full PSRO program in 1977 dollars could cost $1.25 billion - PDA estimated $500 million to $1.5 billion in 1973.

• • •

Chapter 3: PSRO and HEW Certification Savings Fraud

PSRO is "certification on demand" of the necessity of hospital stay. It is based on the fraudulent deception by HEW from 1969 thru 1972. It started with 1969 news releases of claims that the physician certification regulation in Medicare could save $400 million by shortening certification intervals. HEW referred to its study showing "success" of the Medicare certification regulation in preventing alleged overutilization by doctors responsible for "unnecessarily prolonged hospital stays", allegedly detected by the regulation's effect. Partly as result of this HEW deception, PSRO was adopted, set up to require many more certifications: before admission, 72 hours after admission and every three days after the 50th percentile of the length of stay.

THE PROMISE = $400 MILLION VS. TOTAL = $ ZERO SAVINGS

1. PDA first exposed this deception in our 1969 Certification Monograph to HEW [15]. We proved there could be no "$400 million savings". HEW's chief actuary agreed with our figures.

2. In our 1970 testimony to the Senate Committee on Finance on PSRO - two months after the introduction by Senator Bennett of PSRO - we documented that HEW knew that the news release-projected savings of $400 million were grossly deceptive. The Department had been warned promptly by its own Chief Actuary, Dr. Robert Myers [16,17]. His letters to the Head of Social Security Administration, Mr. Robert Ball stated:

   > "On the day after the HEW news release was made saying that the doctors were keeping their patients too long, I brought out that the savings of this change will probably be about $5 million a year. I think that the method of presentation is most misleading and tends to create a credibility gap for the present administration that could have been avoided."

   HEW therefore knew that the $400 million in savings in the news release was deceptive - and did not correct it. Instead, HEW implemented regulations requiring increased certification demands, escalating the statute requirements.

3. In our 1971 Monograph [18] to HEW and in Testimony to the Senate Finance Committee in February 1972, [19] PDA presented proof that the so-called "discharge peaks" were not related to certification requirements. PDA data showed that the "weekly certification effects" were present before Medicare, before any certification regulations. The HEW claim of savings in certification regulations was fraudulent and non-existent. In summary, by 1972 when PSRO was enacted, PDA had proven that there would be no savings from certifications of necessity regulation, that there was no proof of overutilization by doctors, or of unnecessarily prolonged hospitals stays; the hospital stays had already been shortened by doctors without relation to certification, as shown by comparison with pre-Medicare

data. This is shown in Figure 1,[20] which is the PAS data on the discharge ratio of days of stay in the hospital.

Mr. Thomas Tierney, then Bureau of Health Insurance (BHI) Director and head of SRS, after conference with PDA called by Majority Whip Congressman Boggs, took no action, just asked "for more time to study". The Senate Committee on Finance and the HIBAC advisory Medicare Committee (where PDA testified in 1971 and 1972) let the deception continue. The certification regulation was made even more stringent by Social Security's Mr. Robert Ball. It set the stage for PSRO.

4. On October 30, 1972 PSRO was enacted, requiring many more such "certification of necessity".

5. The correction by HEW and the admission of failure to effect any savings or any earlier discharges thru shortening of certification dates by their "certification savings" error came too late, in a Social Security study in 1975[21], this time without widespread public releases. As summarized in the Institute of Medicine's "1976 Evaluation of PSRO"[22]:

> "The effect of certification was reconsidered in 1975, based on certification at the 12th and 18th days. SSA found 'no significant difference in the patterns ... no evidence of minor or secondary peaking on the 12th and 18th day ... In sum, even though mean length of hospital stay decreased between 1968 and 1971 under Medicare, there is no demonstrable evidence that the physician certification and re-certification regulations influence the distribution of short-stay hospital discharges in that period'."

6. Those involved in the false certification allegations and demand for additional regulations have advanced: Dr. Ernest Saward, from the Kaiser Permanente Clinic and head of the HIBAC Committee, became Chairman of the National PSR (PSRO) Council; Mr. Robert Ball, Social Security Commissioner became Senior Scholar in Residence at the Institute of Medicine; Mr. Thomas Tierney, after retiring from Medicare's BHI, is now head of the Provider Reimbursement Review Board for HHS.

CERTIFICATION FRAUD SUMMARY

Summary: 11 years ago, HEW issued a fraudulent claim that the Medicare regulation requirement of certification of length of stay would save $400 million. PDA publicly exposed the HEW error and deliberate deception in Testimonies from 1969 thru 1972. The failure to achieve any savings was admitted by HEW. Nevertheless, the useless certification requirement was not only incorporated into the PSRO law, but it was multiplied many-fold. The PSRO multiple certification requirement represents a useless waste of precious manpower. It produced no savings. It was based on fruad by the bureaucracy. It should be repealed, now before the program costs continue to run hopelessly out of control.

* * *

Chapter 4: A Radical Law without a Successful Pilot

MOST RADICAL MEDICAL LEGISLATION IN HISTORY

On July 15, 1978, the Secretary of HEW officially characterized "the PSRO program as Revolutionary"[23]:

> "The PSRO program is in many ways revolutionary... The GAO report does not indicate the degree to which... PSRO represented a significant departure from what the government had previously required of physicians in quality assurance and utilization control."

The PSRO law introduced three new review requirements:

1. Pre-Admission Certification and Approval of Hospital Stay (CHAP).

2. Assignment of Length of Stay by regional averages for all admissions (ALOS).

3. "Criteria Guidelines" for review - the PSRO "standards rulebook" for all elements of diagnosis and care, in hospital, home or office - even the phone calls.

Together, these three mechanisms broke the solemn pledge of Congress written into Sec. 1801 of the Medicare Act against "supervision or control over...medical services...". The PSRO Law created a national network of massive interference and control of the practice of Medicine. PSRO is case-by-case review of every detailed element in the care of each patient, before, during and after admission. For patients, PSRO represents an unprecedented assault on the privacy of one quarter of the nation's population.

PSRO has aptly been termed "the most radical medical legislation in history"[24].

1. PSRO authorizes total review, regulation and control of every step in medical care, diagnosis and treatment for federally reimbursable services. This control is centered in government-paid, Secretary of HEW-regulated committees called "PSROs", to be headed by "practicing doctors" willing to perform as government contractors in quasi-government agencies.

2. PSRO means the "voluntary" subjugation of a physician's judgement decisions on a case-by-case basis to such a federalized committee.

3. PSRO changes private, professional, educational "peer review" into a government tribunal system leading to Secretary of HEW sanctions, fines and termination from the program.

4. PSRO radically changed the process of "peer review" performed by doctors reading the chart at the hospital - to a government-contract PSRO review, 95% by nurses or social workers, with a Federal

Rulebook of guidelines for diagnosis, care and treatment of all disease, and a physician "advisor" on the telephone.

5. The Courts have held PSRO is constitutional - as long as it is "voluntary" for private doctors who refuse federal payment, and applies only to patients and doctors who receive federal funds.

Where did these review and control mechanisms come from?

Senator Bennett, introducing the PSRO legislation, stated that PSRO was patterned along the lines of the Sacramento and San Joaquin "Foundations". These were 800 doctors in only two medical societies doing "PSRO" review for Medicaid in only one state. These medical society sponsored corporations "were formed...to stimulate prepayment programs for all segments of the population"[25]. They established HMO-IPAs (Health Maintenance Organization - Independent Practice Association), contracting first with commercial insurors, and in 1968 with Medicaid.

These HMO doctors agreed to serve as insurance review committees in exchange for the HMO contract for patients. They also agreed to limit their services to those approved by the Foundation review committee, based on written criteria for length of stay and treatment or for admission. The "criteria" were the rationing, control and review devices to limit hospitalization for the HMO.

Senator Bennett's three errors in PSRO:

Most doctors in truly independent private practice will not voluntarily agree to restrict their services to the decisions of any committee of doctors. They would agree with the Supreme Court Statement[26]:

> "Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

But prepaid, HMO doctors are different in philosophy. They will agree to subjugate their judgement to the HMO Committee. In 1969 they won an HMO contract with Medi-Cal for the state. In 1970 they came to Washington after a Medicare HMO contract.

1. PSRO CAME FROM A SMALL GROUP OF HMO DOCTORS FROM TWO SMALL CITIES

   Senator Bennett's fundamental error in PSRO was in not assessing that these two solitary "PSROs" were a small minority of HMO doctors in only one state, who wanted to compete with other HMOs (Kaiser). They were successful in obtaining large sums in government grants as prototype PSROs or "EMCROs". Sacramento received $595,000 for a two year grant (1971-1973)[27].

   Senator Bennett's PSRO law imposed this minority HMO-IPA rationing device for the entire Medicare and Medicaid population, a device that was and is unacceptable to the majority of doctors in private practice except under coercion of "it's the Law". The failure of PSRO masquerading "as a private doctors' organization" was predictable.

2. "SAVINGS" IN HOSPITAL STAYS NOT EQUAL TO NET DOLLAR SAVINGS

His second error was that he did not validate the claims of "shorter length of stay" in terms of actual dollar "savings" made by the PSRO foundations. PDA study of testimony in 1970 shows that the Foundations themselves stated that their claims of savings did not have statistical validity. A series of government audits since 1976 have found the claims of dollar savings to be without any reliable documentation and no net savings have been found.

3. "GROSS SAVINGS" MAY YIELD A NET DOLLAR LOSS

Senator Bennett's third and most important error, was the failure to audit the PSRO accounting methods and administrative use of the millions of dollars in Federal grants, that have come to haunt the PSRO programs after implementation. Scandals of incompetent accounting, all the way to billing fraud have been repeatedly uncovered by government audits of PSROs. PDA warned the Senate Finance Committee of these serious validation deficiencies in the PSRO proposal. We repeatedly asked for audits in 1970, 1972, and 1974, but none were forthcoming until 1976.

I. THE SACRAMENTO FOUNDATION CLAIMS - 1970

A. INVALID CLAIMS OF SAVINGS: PRE-ADMISSION APPROVAL (CHAP)

"NOT STATISTICALLY VALID – 1970

In its 1970 Testimony before the Senate Committee on Finance, Medicare and Medicaid Hearings,[28] "Sacramento" claimed that the savings by their original "Certified Hospital Admissions Program" (CHAP) in a "recently filed" contract with Medi-Cal amounted to a "27.1% apparent reduction in hospital days used". But then it cautioned:

> "Due to the small number of hospitalizations generated under this plan to date, the utilization figures developed do not have true actuarial validity, therefore no firm conclusions can be drawn from them. They do, however, indicate a definite trend."

And added:

> "Statistically valid data is being developed and will be available in the near future."

NO COST DATA FOR SACRAMENTO – "EMCRO" STUDY – 1973

EMCROs are prototype PSROs financed by the federal government, including Sacramento. Funding started in 1970 when Senator Bennett introduced the PSRO amendment. A similar claim of savings was made by Sacramento for the "EMCRO Program Study" as reported by Arthur D. Little study[29] in

1973, of a "33% reduction in hospital days". But, the Little study concluded that there was as yet no data available to determine net dollar savings from Sacramento.

PRECERTIFICATION STILL EXPERIMENTAL - 1973

The "EMCRO" book by Little also reports that pre-certification programs were also instituted by New Mexico (HAPP) and Illinois Foundations (HASP), but were also experimental and incomplete in 1973, after PSRO was law. The HASP foundation was studied in 1972[30]. It spent $4 to review to save $1 in costs.

SACRAMENTO SAVINGS UNDOCUMENTED - "PSRO" STUDY - 1973

The 1973 book, "PSRO" by Arthur D. Little company,[31] summarizing the study of Pre-Admission Certifications in Sacramento, Illinois, New Mexico, and New Jersey Blue Cross, states: "the value of precertification programs has not yet been fully documented". The Blue Cross initial decrease in Length of Stay (LOS) "was not maintained over time".

CONCLUSION

There was no validation of the Sacramento claim of savings by Pre-Admission Approval before PSRO became law. There was no audit of the reliability of their data or accounting methods. Yet Senator Bennett and Senator Long accepted in 1972 that Foundations had proved the success of PSRO - and the law was passed. To date the situation is still the same - eight years later - there is no proof of savings by the national PSRO program.

B. INVALID CLAIMS OF SAVINGS: LENGTH OF STAY (LOS)

DECREASED STAYS DO NOT MEAN NET DOLLAR SAVINGS

Although it is known that HMO hospital stays may be shorter, it does not follow that the total cost of care to the HMO, or to Medicare or Medi-Cal, is any less. Therefore, no savings may result. This is the fundamental fallacy of HMOs and PSROs:

1. The cost of necessary alternate treatment in outpatient and nursing home care must be subtracted.

2. The more frequent admissions, due to premature discharges, is an added cost.

3. Premature discharges may lead to a subsequent and more expensive readmission of a sicker patient.

4. More tests are jammed into fewer days, increasing cost and also complications.

5. "Late" hospital days "cut" cost far less than the first intensive treatment days.

6. For more intensive care days, hospitals must hire more personnel. This increases costs.

7. One less hospital day saves only 40% of Medicare per diem (GAO, HCFA).

8. Hospital costs increased due to employment of additional "paper-care" personnel for federal accountability.

9. The PSRO itself begets more expensive regulation and increases the cost of health care. As the cost of PSRO reaches into the hundreds of millions in Medicare, the taxpayer simply pays more thru increased Social Security taxes. Politically, PSRO failures are simply ascribed to "underfunding" and "lack of maturity", with demands to "double the personnel and double the budget", "to do a better job next year", as the Medicare Trust funds for the care of the sick are again raided for welfare for the PSRO employees.

EXAGGERATED CLAIMS – THE GAO REPORT – 1978 & 1979

Sacramento claimed a savings of $3 million in 1970[32] in the first year of Medi-Cal operation and extrapolated a national figure for "all patients" in all hospitals of "$4 or $5 billion". The 1978 U.S. General Accounting Office (GAO) Study of PSROs to the Ways and Means Subcommittee on Oversight,[33] and the July 1979 GAO Report[34] made a special study of Sacramento's savings claims of $103,081. GAO allowed only $55,758 net savings for this prospective one year thru September 30, 1972, reported in 1978. GAO stated further:

> "records on the use of alternate services... were not available...no adjustment could be made for these costs."

GAO Comment: "we still believe there is a need for HEW to assure validity of the PSRO data".

CHARGES HIGHER THAN FEE-FOR-SERVICE – HCFA STUDY – 1980

A recently released 1980 report by HHS's HCFA[35] investigated the claim by the Sacramento Foundation HMO that they charged rates above the fee-for-service per capita costs because of "adverse selection of patients". The HCFA report concluded instead, "that the Foundation, in fact, had a somewhat favorable selection".

CONCLUSION

10 years after claimed PSRO Medi-Cal program savings of $3 million in 1970 with preadmission certification and 50th percentile length of stay reviews, they saved only $55,000 in 1972 by GAO standards. Sacramento HMO now has to charge fees higher than fee-for-service doctors. It is not surprising that there are no significant savings with the PSRO law. It is surprising that the government audit for Sacramento for 1972 was reported in 1978 and corrected in 1979 by 50% less savings.

LENGTH OF STAY CRITERIA: CORONARY OCCLUSIONS

As the single example of how the Length of Stay Program (CHAP) pre-assigned the length of stay, the 1970 Sacramento testimony gave[36]: "Acute Coronary Occlusion, 50th percentile, age 0-19 years, 5 days".

PDA Comment: Acute coronary occlusion is a devastating illness with a high mortality. Is it reasonable to assign a 5-day stay for a catastrophic heart attack? Is this "quality" control? (See below for follow-up in 1974 testimony.)

II. THE SAN JOAQUIN FOUNDATION CLAIMS - 1970

A. SAVINGS

SAVES DOLLARS - BUT RUNS OUT OF FUNDS

In the 1970 Senate Finance Committee Hearings above,[37] San Joaquin claimed "12% less cost of care per patient". Again, there was no documentation of the total net savings as against the total expenses of the program, including federal subsidies, alternate care, accounting methods, etc. But in the second year of its Medi-Cal contract, San Joaquin ran out of funds[38]. It tightened rationing and next year it was in the black. But this was dollar-motivated review, after the red ink, not professional peer review.

GAO REPORT - 1978

In the GAO, June 15, 1978 Statement to the Oversight Subcommittee, Mr. Gregory Ahart, GAO Director of Human Resources Division, the validation of San Joaquin's alleged $1.2 million savings states[39]:

"(The) methodology was not susceptible to verification."

GAO REPORT - 1979: SUBJECTIVE ESTIMATE OF SAVINGS BY NURSES

This Report is very explicit[40]:

"We were unable to validate the claim of estimated savings because the basis for the savings is the PSRO nurses' estimate of the number of days that were saved as the result of various days that were saved. In our opinion these estimates are subjective."

B. "CRITERIA" FOR DIAGNOSIS AND TREATMENT

SAN JOAQUIN EXPENSIVE AND DANGEROUS - 1970

In the 1970 Senate Committee on Finance Hearing,[41] San Joaquin gave examples of their criteria method of producing savings, which was to be adopted by the PSRO Law. "Review Criteria" were minutely spelled out for 26 diagnostic categories, every element of care, tests, treatment,

including the number of phone calls. This review of every minute decision made by an army of nurses reading patient charts was reported to achieve savings by denying hospitalization certification, or by "modifying physician behavior" by not paying the doctor's bills.

CRITERIA FOR COMMON COLD COSTS $34 BILLION

In Figure 2 are the San Joaquin Criteria as given to the Senate Finance Committee,[42] for the treatment of the common cold "Uncomplicated Upper Respiratory Infection". At 1970 costs, PDA estimated that each cold treatment with the Criteria would amount to $41.00[43]. Nationally, this amounted to $34 billion - exceeding the cost of all doctors' bills for that year. "Chemotherapy" is approved for colds - malpractice?

In follow-up Testimony before the Senate Committee on Finance Hearings on PSRO (May, 1974, page 141-143):

EXCUSE – CRITERIA "OLD". CURRENT, QUOTES PDA

1. Dr. Harrington, President of San Joaquin Foundation for Medical Care and of the American Association of Foundations for Medical Care, stated in regard to the guidelines criteria for the common cold given to Congress in 1970 as examples of automatic certification for payment, "this document was developed back in 1956...".

   PDA Comment: Dr. Harrington would like us to believe that these were 14-year old examples he gave to Congress, which criteria he now would change.

   a. Question: Why was a 14 year old Criteria used for an example to Congress?

   b. Fact: The Criteria were current. Dr. Harrington's 1970 testimony criteria state: "The following criteria...are being used at the present time.. are referred to Medical Review Department. These guidelines were part of the "Summary" of their Medi-Cal Project. San Joaquin's Medi-Cal Review contract was in 1969. The guidelines were not outdated. They were indefensible guidelines.

ACKNOWLEDGES WRONG CRITERIA

2. Dr. Harrington acknowledged that:

   "I think we would eliminate... 'chemotherapy'...".

COLDS ARE 40% OF PEDIATRICIAN PRACTICE

3. Dr. Babich, President of Sacramento PSRO, a pediatrician, responding to Senator Bennett's question was sustainable,

   "In the wintertime, it's about 40% of our practice. And the average pediatrician sees...25 to 30 patients a day".

PDA Comment:

a. Cost of Colds by 1974 Foundation data seen by Pediatricians

20,000 U.S. Pediatricians x ((40% of 30 patients/day) x (300 working days) - (16% for non/winter patients)) = 60 million colds x $10/visit ($7/visit + $3/Rx) = $600 million.

b. If San Joaquin cost of $41 per cold, the cost would equal $2.46 billion. If PSRO criteria followed, the increase in cost would equal $2.46 billion per year.

c. Any "automatic payment" computer criteria of a very common illness will dramatically increase the cost.

"OBESITY" CRITERIA ARE MALPRACTICE

San Joaquin's "Example case no. 9" [44] was "Obesity". They recommended Diuretics and Thyroid. This amounts to malpractice. PSRO "quality" control, anyone?

CONCLUSION

We see no hope of savings thru adopting rulebooks that "approve" the full scope of possible diagnosis and treatment. This rulebook - upon which payment approval eventually rests, must of necessity become the norm. Doctors will eventually be forced to overutilize in order not to become PSRO "exceptions". The PSRO Criteria will eventually increase costs, as it becomes a standard of practice, as well as a blueprint for fraud. As noted, the PSROs approved dangerous, life-threatening treatments for obesity and the common cold.

The PSROs claim that the "Criteria" rulebooks are merely necessary as "checkpoints" for nurses to review charts. On the other hand, Dr. Alan Nelson, from UPRO, in testifying before Senator Bennett in 1974, called them "textbook medicine" [45].

PDA believes the PSRO review - where 95% of all final decisions are made by the nurse reviewer - is in fact, sham review to avoid doctor review. PDA believes that only Doctors should review charts of doctors. With doctor review, there is no need for the expensive boondoggle of an army of nurses with rulebooks and length of stay norms and standards. PSRO is unnecessary if doctor Utilization Review is properly designed and implemented as recommended by PDA in Chapter 8.

Chapter 5: The PSRO Record of Failure: A Review 1969 – 1980

I. SUMMARY LIST OF PSRO EVALUATION STUDIES

1. Nine PDA Certification and PSRO Monographs and Testimonies 1969-1974, see References numbers [10, 15, 16, 17, 18, 43, 46, 47 and 48].

NO SAVINGS FROM 1966 CERTIFICATION REGULATIONS

PDA proof that Physician Certification Regulations initially in Medicare - expanded in PSRO - did not result in any savings, did not shorten hospital stays in 1966 - 1967.

Proof of HEW fradulent use of data to support invalid $400 million "savings" and claim of "overutilization" by doctors.

2. HEW/SSA Study, 1975 [21]:

NO SAVINGS FROM FROM 1969 CERTIFICATION REGS

HEW admits no saving or change in utilization from 1966 to 1969 Certification Regulations.

Conclusion: no savings effected by new 1969 regulations requiring earlier Certifications, on the 12th and 14th day. After its implementation, the regulation had no effect to shorten hospital stays.

3. Sacramento Foundation 1970 Senate Committee on Finance testimony[2].

INVALID DATA

"No true actuarial validity" to the claim of "27.1% apparent program savings", according to Sacramento's own testimony.

Only San Joaquin and Sacramento PSRO prototypes were performing review in 1970 for Medicaid when Senator Bennett announced his PSRO bill.

4. EMCRO [29] - HEW Study by Arthur D. Little in 1973 of PSRO prototypes

9 PSROS: NO SAVINGS

No validation of net savings: not a single final report of EMCRO programs to support claim of "savings" had been delivered to HEW by 1973. All of these prototypes were in low population areas, moderate size cities, mostly medicaid, not mainstream practice or medicare. In 1973, the EMCROs included nine prototype PSROs; Albemarle (VA), Georgia, Hawaii, Mississippi, Multnomah (OR), New Mexico, Utah PRO, San Joaquin and Sacramento (CA).

5. "PSRO: Organization for Regional Peer Review",[37] 1973 book by Arthur D. Little and Company, a government financed study.

NO DOLLAR SAVINGS. NO DATA ON COSTS AND EXPENDITURES

a. Pre-Certification of Hospital Admissions: NOT DOCUMENTED

Page 7 "PSRO is a form of non-price rationing"

Page 37 "The value of precertification programs has not yet been fully documented." As they existed in Sacramento (CHAP), New Mexico (HAPP), Illinois (HASP), and New Jersey Blue Cross (AID).

"Physicians rapidly learn how to avoid denials of precertifications."

"..the initial decrease in length of stay...was not maintained over time."

b. Concurrent Review: PROHIBITIVE COSTS

page 39 "The manpower required for On-Site Review of all hospitals' cases would be prohibitive." "Guidelines will need to be developed to specify the sample of cases to be reviewed for the program; for example, all long stays and a ± 10% sample of other cases..."

c. Retrospective Review Audits: UNTOUCHED BY HUMAN MIND

page 40 "Retrospective medical audits, in hospitals, have been conducted since 1914 by appropriate committees".

page 43 Regarding computerized PAS and other abstract systems of length of stay by age, sex, diagnosis, etc: "Despite laudable goals, they have been accused of producing a vast amount of data untouched by the human mind."

PSRO length of stay programs are based on initial admitting diagnoses, but PDA studies are based on discharge (final) diagnoses.

d. San Joaquin PSRO Results: RAN OUT OF FUNDS IN MEDI-CAL

page 173 Regarding the San Joaquin Medi-Cal HMO Contract with Foundation review controls: "The second year, funds ran out in the last month, and bills over the last month were prorated as a result."

6. "Maricopa Foundation" - American Medical News - August 27, 1971.

MOTOROLA – NO SAVINGS

The Motorola spokesman clarified his earlier statement that the Maricopa Foundation program had saved the company $461,500, qualifying this as a gross figure.

If the costs of the program "..payments to the Foundation or of additional outpatient benefits" were considered, "I'd say we're coming out even, or maybe a little ahead of the game. But I can't give you any figures; we are going too fast".

7. Maricopa Foundation, PDA On-Site Visit, 1973.

INCREASED COST OF CARE 7½%, CUT DOCTORS 6%

In the spring of 1973, PDA on-site visit found that:

a. $2.37 were spent in reviews to save $1 ($300,000 cost of the program vs. "savings" of $126,574.92 from July 1 to June 1972.) If half of the cost is allowed for "peer review" ($7.50 per case), $1.18 was spent to save $1.00 by "peer review". See Figure 3.

b. If Maricopa private "review" cost $300,000 for one year, then for 200 PSROs, the cost would be $60 million. PDA estimated the cost of PSRO at $500 million to $1.5 billion. The latter figure reflects the multiplier introduced by the added cost of federal bureaucracy and regulations.

c. Although most of the doctors "participated" in the Foundation, the total number of claims reviewed (about 20,000) represent the equivalent of only a few busy doctors' full practice. The "Foundations" patients represented a very small portion of Phoenix doctors' practices.

8. "PSRO"[43] - PDA 1973 study and analysis of the law.

$34 BILLION COLD

Analysis of San Joaquin's "Criteria Guidelines" for length of stay and treatment for the Common Cold given by San Joaquin in 1970 to the Senate Committee on Finance shows the cost of the common cold treated by PSRO criteria could equal $34 billion, would exceed the cost of all doctors' bills for all diseases. See Figure 2.

9. UPRO On-Site Visit, 1973, PDA.

NO SAVINGS

PDA's personal visit by Dr. F. Michael Smith, Jr. and Dr. Elmo C. Boyd of Louisiana found "No net dollar savings were claimed by "UPRO".

10. 1974 PSRO Senate Hearings:[10] New Claims of savings by PSROs

COLORADO CLAIMS EQUIVALENT TO $1.25 BILLION 1980 PSRO BUDGET SAVINGS

In the 1974 Senate Committee on Finance PSRO Hearings, Colorado Foundation estimated its savings to be "$2.53 savings for every $1 spent", and probably "$8.30", or $9.5 million a year, (page 405).

PDA comment:

a. For a $150 million national PSRO budget (1980) this would yield a savings of $150 million times $8.30 = $1.25 billion in PSRO savings, or, at least $150 million times $2.53 = $379.5 million in savings. PSRO overall has saved not a single dollar as of 1980.

SACRAMENTO: $5 BILLION SAVINGS ANNUALLY

b. Sacramento (page 122) claimed actual $3 million savings in Medicaid in one year. Nationally, they predicted a savings of $4 or $5 billion for all hospitals, probably including private patients.

c. The Illinois "HASP" data on "savings" was not forthcoming when requested by the Committee.

d. Utah PSRO, reviewing since September 1971, offered no data of net savings. They stated that only one admission per 1,000 reviewed was denied approval (20 of 20,000 - page 363).

PDA NOTE: None of the above claimed dollar savings - or any savings - were validated. See audits to follow: Institute of Medicine and OPEL Reports.

11. 1976 - UPRO - Arthur D. Little Study [49].

NO SAVINGS IN UPRO

This multi-volume study for the National Center for Health Services was unavailable at HEW, or at UPRO, or at Arthur D. Little when PDA requested it. According to an AM News article 3/18/76,

"UPRO had no program effect on medical costs and utilization."

12. UPRO [50] - 1976 - Dissertation by Paul Bonner

NO IMPACT

"The analysis indicate no statistically significant evidence of positive impact from concurrent review as measured by average length of stay, admission rates, or days of care per eligible."

1976 PSRO EVALUATION

13. 1976 Evaluation Report [14] by the Institute of Medicine.

NO SAVINGS NOW - OR EVER

In this study, reported in 1977, 19 PSROs were reviewed which included: San Joaquin, Sacramento, Colorado, New Mexico, UPRO, Multnomah, National Capital, Minnesota Foundation, Overlook-New York, Mt. Sinai, Bethesda and Kaiser.

NO VALID DATA

a. By 1976 none of the PSROs had any validated data as to net savings or cost.

b. "In general, available information does not demonstrate convincingly the effectiveness of the concurrent review programs visited. Related literature is similarly pessimistic."

c. In Utah, "UPRO has not provided data to evaluate changes in Utilization or costs".

d. The same may be said for Multnomah in Oregon.

e. Regarding Colorado's claim of $9.1 million savings in 1974: "There is insufficient evidence that the Colorado Foundation for Medical Care utilization review is cost effective" (page 72).

PSRO COST = $1.25 BILLION

f. In the final evaluation, "The total cost (of PSRO)...could exceed $1.25 billion...for the total population".

g. UPRO does not conduct pre-admission certification and is not convinced of its value.

1977 OPEL REPORT

14. The 1977 OPEL Study, "1977 PSRO Evaluation Draft"[51]. A gigantic government study by OPEL, HEW, State governments and local PSROs.

STUDY COST = $1.07 MILLION – PSRO SAVINGS = ZERO

This 1977 draft by the Office of Planning, Evaluation and Legislation, cost $1.07 million, fills 13 volumes and reviewed 18 PSROs. Findings:

a. "No significant overall effect was found".

b. Cost of fully implemented acute hospital PSRO program is $268.5 million.

UR COST $81.3 MILLION

c. Therefore, PSRO "..is more expensive than its utilization review predecessors". The cost of original UR "..estimated at $81.3 million"; with revised 1974 UR regulations, $107.6 million.

d. "In order to recover its costs ... (PSROs) would have to reduce utilization rate by 1.6 to 2.05%."

e. "PSRO is not now cost-effective and thus is not yet serving as

a cost-containment mechanism." Delegated review is more expensive than non-delegated.

15. The 1977 OPEL Study: "Final Report, February 1978"[52].

NOT COST EFFECTIVE - EVER

a. "The PSRO Program is not now cost-effective." "..PSRO implementation alone...is not apt to cause significant changes in either hospital utilization rates or associated government expenditures."

b. The PSRO Program is more expensive than its utilization review predecessors (same as in 1977 draft).

OMB 1977

16. Office of Management and Budget, December 1977[53].

STOP PSRO PROGRAM

OMB recommended that PSRO program be ended, "eliminating federal funding of PSROs from the fiscal 1979 Budget" as stated in a Washington Post article of December 13, 1977.

Mr. Califano, then Secretary of HEW defended the program. 1980 Medical World News quotes[54] Mr. Califano as having been commended by Under Secretary Champion (since resigned) to keep PSROs:

"because we need to maintain contact with the medical community."

PDA comment: There is no constituency for PSRO in the medical community. Doctors join because "it's the law".

17. Inspector General Report, HEW Audit Agency, November 18, 1977[55].

NO CONTROL OF FUNDS

a. 17 PSROs had problems separating private from federal business activities.

b. Review of 34 of 39 PSROs show inadequate "accounting systems to provide accurate financial data or effective control over all their funds...or an adequate system for budget preparation and control".

18. Sanazaro study, New England Journal of Medicine, May 15, 1978[56].

NO QUALITY IMPROVEMENT

PSRO review in 24 hospitals in five PSRO areas, concludes that it is "not certain that this large effort enhanced the quality of care".

1978 GAO RE OPEL 1977

19. General Accounting Office Testimony to Oversight Subcommittee, June 15, 1978 [39]. Reviewed and denied savings allowed by OPEL report for six of 18 PSROs.

GROSS EXAGGERATION BY PSROS

PSRO savings allowed by OPEL generally unsubstantiated, as follows:

OPEL VS. GAO

	OPEL "savings" in millions		But, GAO Computed
a.	New York	$3.06	Loss of $4.56
b.	Wyoming	$2.7	Only $0.45
c.	South East Mass.	$3.0	Loss of $2.65

d. San. Joaquin "methodology not susceptible to verification".

e. QUAD River, IL, cannot be considered cost beneficial.

f. San Joaquin and Baltimore PSROs increased utilization. Multnomah "may be" cost-effective.

GAO TO CONGRESS

20. Report of General Accounting Office to Congress on PSROs, September 12, 1978 [23].

SAVINGS GROSSLY OVERSTATED

Reviews of 103 PSROs, 1972-1977, PSROs in 1977 included 38 percent of hospitals (2,650) and 32 percent of 14.5 million discharges (4.6 million) in the three federal health care programs (page 9).

> "the results of a validation of claimed savings by six PSROs, the claimed savings, in most cases, were grossly overstated because of deficiences in the data used, computations made and the methodologies applied."

ONE OF THE "BEST"

21. Nashville, Tennessee PSRO: Terminated by HEW October, 1978.

ALLEGED FRADULENT ACTIVITY BY TENNESSEE PSRO

The termination decision by HEW followed a newspaper publication of the HEW 1977 audit report on Tennessee PSRO, which set up the scandal of the alleged fraud.

NASHVILLE TERMINATED

HEW charged not only inadequate documentation, but overbillings of $200,000[57].

a.	In Computer costs	$135,000
b.	To Doctor advisors	$ 22,000
c.	For equipment already purchased	$ 11,000
d.	Salaries, and printing for private work and excessive fringe benefits to Ex. Dir. Tribble and his deputy	$ 35,000
e.	Overcharge for consultants	$ 22,000

The Court denied the injunction against Termination requested by Nashville PSRO because the PSRO refused to give to HEW or to the court the necessary access to the documents for the accounting necessary of the use of funds. A federal grand jury was impaneled to look into possible fraud.

In January 1978 Tennessee PSRO had described itself as "one of the leading PSRO's in the nation". Its brochure[58] claimed $4.5 million in savings in Tennessee, and extrapolated $371 millions saving nationally in hospital review.

In November 1978, its funds were terminated by HEW. The HEW-PSRO trial is still in court.

22. U.S. House Committee on Appropriations Report,[59] June 1, 1978.

PROGRAM COSTS OUT OF CONTROL

In the Report by the committee to accompany HR 12929, it found on PSRO:

a. "The costs of the program are out of control" (page 65-66)

$500 MILLION COSTS

b. "The total cost (of the hospital review program) ... current estimates are $220 to $250 million...could exceed 400 to 500 million annually."

c. "..the question must be raised as to whether the results of this program justify an investment of this size...".

d. Questioned "..whether the program works any better than other, less expensive, systems of utilization review".

e. "..allocated $450,000 to update the 1977 OPEL study...to be submitted prior to the transmittal of the 1980 PSRO Budget to Congress."

HCFA/HEW 1978

23. The 1978 HCFA/HEW Study: "1978 PSRO Program Evaluation", Reported in 1979 [60].

HEW CLAIMS $50 MILLION SAVED

This HEW study claimed:

a. "The program's concurrent review activity now pays for itself."

b. "PSRO saved $4.6 million over the cost to administer concurrent review" ($45 million); due to reduction of 1.5% in days of care per 1,000 enrollees.

c. "PSROs are therefore cost-effective by a 1.1 ratio" (new HCFA Director).

d. "mature PSROs are more effective".

e. "MCE data... are not yet adequate to relate the MCE process to changes in quality of care."

CBO & HCFA 1978

24. Congressional Budget Office (CBO) Review of the 1978 HCFA Report, "the Effect of PSROs on Health Care Costs", June 1979[61].

In reviewing the 1978 OPEL Report the CBO found:

CBO DENIES ANY NET SAVINGS

a. "..no impact on utilization by length of stay (page 26).

b. "A CBO reanalysis of the (HCFA 1978 REPORT) data revealed... No net savings at all..." (page X).

c. "..savings..fall far short of their costs". Spent $1 to save 0.70 ("0.7 - to - 1", page 38).

NO FUTURE SAVINGS

d. "... no..evidence that PSROs grow more effective with time"

e. "A better evaluation is unlikely to be forthcoming, because of the continued expansion of PSRO review of this type will soon make any sort of reasonable comparison group impossible."

25. HEW Bureau of Quality Assurance 1979 acts on PSRO failures[62]:

TERMINATIONS

a. 1979 PSRO closings:
   1. Nashville, Tennessee
   2. Long Beach, California Area XIX
   3. South Maryland (withdrew)
   4. Highland, Indiana, Calumet Area
   5. Erie Region, Pennsylvania

b. 1979 PSRO warned: Buffalo, New York, "poor management"
Cheyenne, Wyoming, "poor management"
Cuyahoga County, Ohio: Spent $2.3 million in 3 years, no reports on impact, no annual audits, paid on "projected hours" worked, not on actual hours.

c. 1980: The President's budget: Termination considered for 20 ineffective PSROs[63].

1979 GAO RE OPEL 1978 & 1977

26. Government Accounting Office, Report on PSRO, July 19, 1979[64].

This report by the Comptroller General invalidated claims of savings of seven PSROs, six of which OPEL had evaluated as cost-effective.

PSROS INCAPABLE OF ACCURATE ESTIMATES OF SAVINGS

a. 7 PSROs savings of "$21.7 million are overstated by $16.7 million...the remaining savings highly questionable".

b. PSROs "do not have the capability to develop accurate estimates of the cost of a hospital day saved".

c. HEW should discourage PSROs from making any estimates of savings to the public or to Congress.

e. In San Joaquin estimates of dollar savings are made by nurses' subjective estimates as to days saved without data to substantiate or verify.

HCFA PSRO REPORT 1979

27. HCFA 1979 PSRO Program Evaluation, Reported in 1980, this HCFA study of 1978 data concluded[62]:

a. no statistically significant impact on hospital days of care per 1,000 aged medicare beneficiaries nationwide (page xi)

b. PSRO may have a regional impact: reduced days in North, increased days in the South (page xi).

c. In four diagnoses (myocardial infarction, cholecystectomies

days of care per 1,000 aged Medicare beneficiaries days (page xii)

d. In the Foreword, Schaeffer stated: "In 1978, the estimate of PSRO savings (over cost to administer concurrent review) is ...$21 million over administrative costs".

e. Quality changes cannot be assigned to PSRO's MCE's "since no comparison groups available" (page xiv).

1980 CBO RE 1979 HCFA

28. Congressional Budget Office (CBO), Review of the 1979 HCFA PSRO evaluation [65].

In a March 10, 1980 CBO Letter to Congressman Natcher, of the Subcommittee on Labor and HEW, CBO stated:

COSTS $1.00 TO SAVE 40 CENTS

a. "the program saves 70 per cent less than it costs" (vs. HCFA which said: it saves $1.3 to $1 or 30% greater than it costs.

b. Part of "savings HCFA" really transfer of cost to non-Medicare patients - no hospital costs savings.

c. Saves "13% less than the program's cost", is the CBO estimate of gross savings in Medicare reimbursement costs (disregarding transfer of costs to private patients).

PSRO INCREASES STAYS IN THE SOUTH

d. PSRO has no effect in the West, it increases utilization in the South.

e. The Administration request for $51 million increase in PSRO funding will not be offset by PSRO savings. Only about $15 million offset.

f. HCFA uses "double counting: the fixed bed costs are already included in HCFA analysis".

COSTLIER THAN UR

g. PSRO costs dramatically more than Utilization Review: "Every function in PSRO UR tends to cost more than the analogous function of new Utilization Review (after 76 Regs).

29. HCFA, Division of Peer Review, 1980.

PSRO IN HALF OF NATION'S HOSPITALS

Beverly Christian, program analyst for HFCA's Division of Peer Review states in an article in "PSRO Reports" March 21, 1980 [66]:

a. 3,000 hospitals are still without binding PSRO review as per Federal Register, 3/3/80 UR Regs[12]. Compare with HCFA 1979 evaluation figure, p. 13, of 4,529.6 (82% of 5524)[62].

b. Proposed New 1980 UR regulations change UR to PSRO. Medical necessity decision to be made by a single physician reviewer if the attending physician does not object, instead of two as currently required.

30. New HCFA Termination action, May 1980.

PSRO in Colton, California now in appeals process for defunding by HHS.

MASSACHUSETTS PSRO DEBACLE

31. Bay State PSRO (Massachusetts) 1980[66].

After six years in operation, as of June 28, 1980, the PSRO was recently given termination notice. The Bay State PSRO then agreed to: fire the Executive Director, the Medical Director and the Associate Executive Director. The PSRO President is to leave in August. The PSRO was then allowed to continue until May 1981 - but this was found to be illegal. Bay State is now six years old, and by law has to be either defunded or upgraded to "fully designated status". But it lacks the good-record requirement for upgrading.

HHS lawyers came up with the answer - have Bay State change its name, re-incorporate. It can then start anew, as if it never existed. Bay State refused. Undaunted, HHS lawyers simply declared the previous "conditional status" granted in 1974 to have been a "HEW mistake". Bay State, a "born-again" PSRO, can continue till 1981.

GAO 1980

32. GAO June 12, 1980 Report[67] to Congressman O'Brien re PSRO.

a. CBO report concluded that PSRO spent $1 to save $0.40 overall.

b. If the shift of cost to private sector is disregarded, PSRO savings are 90¢ per dollar spent.

II. CONCLUSIONS ON GOVERNMENT EVALUATIONS OF PSROS

The record of PSRO is now clear. Eight years after enactment, 50 PSROs have completed four years of operation. Four PSROs have now completed six years and must be defunded or fully designated this year. Government audit after government audit concludes:

1. PSROs have not saved money when program costs are considered.

2. PSROs have not measurably decreased utilization.

3. PSROs are not reasonably expected ever to save money or impact utilization significantly.

4. PSROs are incapable of making accurate estimates of "savings" and should not publish such "estimates" to Congress or to the public.

5. After each and every audit, HHS has requested for Congress to wait for next years reaudit. And after each yearly new audits, GAO and CBO conclude that PSRO has failed to save costs.

6. From 1970 thru 1974, PSRO's own estimates recorded in Congressional Testimony and their public releases promised to save billions. PSRO is now in place nationwide in over 3,000 hospitals (half of all non-federal hospitals). Many PSROs are over 6 years old, the two prototypes are 11 years old in government review. Yet the most favorable and debatable estimate by the HCFA proponents claims only $25.6 million of cumulative savings, 1972 thru Fiscal Year 1978, in a program that so far has spent over $677 million and was to have saved billions.

7. The record of PSROs is now riddled with instances of incompetence to alleged fraud. Twenty PSROs are being considered for termination in 1980. Four PSROs have been terminated. One, Nashville, Tennessee had been previously hailed as one of "the nation's best" - and now is in court; it was terminated; has charges pending of fraudulent overbilling. The Bay State PSRO, the nation's "second best PSRO", after six years was given notice in 1980 for termination by HHS. It has been "saved" by the last-minute firing of the medical director, and the executive director, the assistant director and of the president of the corporation. The corporation was even asked by HEW to "change its name" so that they could "start anew". Thus, it would not be terminated, as required by law after six years of conditional status, because it is now "a new entity".

* * *

CHAPTER 6: The Noose Tightens. Phase Out Review. Install Direct Rationing

A. INTENSE DIRECT RATIONING ACTIVITY 1980

THE NOOSE TIGHTENS

In 1980, the PSROs are now desperate for survival. They are now imposing strict rationing rules to demonstrate "savings". Here are the new tactics, many of them documented in Testimony of the PSROs in the September 18, 1979 Senate Finance Committee Hearings on PSRO[68].

PHASE OUT REVIEW. FALSE CLAIMS OF SAVINGS

1. Concurrent Review has been given up in many hospitals. PSROs cut the number of reviews to 0 to 50% "focusing". 100% Concurrent Review - the reason given to Congress for the need for a PSRO program - is now "too expensive" just as PDA predicted in 1970 and Arthur D. Little concluded in 1973. By cutting the number of reviews in half, the PSRO program falsely claims costs to be less, while the cost per review is actually double.

2. The majority of hospitals in some states are being exempt from concurrent review, placed on "automatic certification". This saves all costs of concurrent review. This is PSRO "no review" - but the PSROs ask for an increase in budget nevertheless.

3. "Sampling retrospective review" only is now in place. Thus, instead of PSRO concurrent review, we have Retrospective Utilization Review - which PSRO had said needed to be eliminated because it was ineffective.

DIRECT RATIONING

4. "Intensive review" - strong direct rationing measures are now being imposed to promptly achieve identifiable PSRO savings: example, New York[69].

   a. Preadmission certification of all cases of "certain diagnoses" or procedures.
   b. No payment for weekend admission for Monday procedures.
   c. Pay for only one pre-operative day.
   d. Pay only for three-day post cataract stay (i.e.).
   e. Zero-in review on cataracts, laminectomies, etc.
   f. Preadmission authorization of all medicaid admissions: the poor get rationed first.
   g. Compulsory second opinion for certain procedures. Established advanced technology that is "expensive" and threatens cost-containment, i.e., lens implants and CAT scans, are labeled as "experimental new procedures".

h. No routine admission tests allowed (not just "obsolete" ones).
i. Outpatient surgery may be required.
j. "Carve out" [70] days for hospital-caused delays within the already approved Length of Stay.

Obviously, such strict rationing, and across the board non-payment approval rules will show "savings". But is this review, or rationing?

5. Attempts by PSRO/HHS (Dr. Helen Smits) to claim that PSROs cost the same as Utilization Review were promptly refuted by CBO: "PSROs cost are dramatically higher than UR" [61].

POLITICAL RATIONING

6. Dr. Paul Spear of Queen's County, New York in the 1979 Hearings stated [71]:

> "The political reality is that PSRO or physician peer review is in very serious trouble. If PSRO can document to both the State, Feds and Congress that it has done a "front end" review for surgical necessity and certified the need for such surgery, the climate may change."

B. TIGHTEN HHS BUREAUCRACY CONTROL OF NATIONAL PSRO COUNCIL AND LOCAL PSROS

The total independence of the National PSR Council from HEW was staunchly defended by Senator Bennett, when enacted. This is now changing into control by the Secretary of HHS, exactly as Senator Curtis had predicted in 1970 and 1974 Hearings [72]. The PSRO Council would have no power, he said, would be purely advisory, be appointed by HHS, and would have no independent budget or independent staff.

1. HHS (Dr. Helen Smits HSQB and OPSR) has demanded that NPSRC impose national goals and objectives on PSROs. Remember "local rule PSROs"? The NPSRC has objected, also local PSROs. Dr. Smits responded that, "We're too far down the road to go back to Schaeffer and say we don't want national goals" [73].

2. The Kansas PSRO wrote Senator Dole from Topeka for the September Hearings, "A continuous outpouring of rules and regulations issuing from the central office of HSQB" [74].

3. Dr. Ruth Covell, the chief architect of the original Medicare program regulations and a professional government planner, has just been appointed by the HHS Secretary as Chairman of the NPSRC.

4. Dr. Helen Smits, "anxious to return to clinical practice", has resigned as head of PSRO (HSQB) as of October, 3, 1980.

C. EMERGENCY PRSO HEARINGS - PREADMISSION CERTIFICATION FOR ALL

Quickly called hearings[75] were held July 31, 1979 by the House Oversight Subcommittee. The virtues of Preadmission Certification and of anecdotal "savings" by some PSROs were recited. These are precisely the kind of unaudited savings claims that the CBO and GAO has warned that PSROs should not be allowed to be presented to Congress or to the public without prior audit by CBO/GAO.

A panel from Motorola, John Deere and Washington Business Group on Health concluded:

"the findings are encouraging...yet sufficiently inconclusive..."

Preadmission Certification has been studied for ten years with no clear evidence of savings. After admission, the Utah PSRO testified[76] it had denied only "20 out of 20,000 admissions" or 1 per 1,000 (0.1%). Yet the Oversight Subcommittee staff, testifying in the 1979 Hearing, recommended that preadmission certification be widely required by PSROs because, "if only 1% of admissions denied...$200 million would be saved". This is 10 times the frequency of denials found justifiable in the UPRO experience.

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Chapter 7: The Patient: The Injustice of the PSRO Review Denial and Appeals Process to the Defenseless Blind, the Paralysed and the Sick Poor

PSRO is an inhumane, cruel system of denials and tribunal hearings, rehearings and appeals process which strip the blind, the poor, the disabled from the judgement of their personal physician.

I. EFFECT ON PATIENTS:

A PSRO nurse reads the chart, checks the rulebook, calls an advisor physician on the telephone. The PSRO advisor, without even reading the chart, denies the case after a cursory phone call to the attending doctor:

1. The 83 year old recent stroke patient may, if he wishes, ask for a hearing reconsideration, apppeal, appoint "agents". He develops pneumonia and a ruptured bowel. His wife has a nervous breakdown. The PSRO denies his hospitalization. Who speaks for the patient? Agents? Attorneys? For the blind, for the disabled and the poor? This stroke patient, one year later, posthumously, gets reversal of the PSRO denials and his bill is paid.

2. The 17 year old foster child Medicaid patient falls from a tree, sustains a broken back and paralysis. He undergoes extensive open spinal surgery with a team of orthopedists and neurosurgeons. In one week, the PSRO unbelievably but categorically denies further necessity for his hospitalization.

3. The 30 year old multiple sclerosis victim develops acute relapse of paralysis of bladder and of the extremities. Within 48 hours of hospitalization, PSRO denies medical necessity of hospitalization.

4. The 70 year old blind patient gets ready to travel 300 miles for a compulsory second opinion before her cataract surgery, under preadmission certification program.

5. The senior citizen cancer patient is denied medical necessity for hospitalization. He dies within days after. One year later, his hospitalization denial is reversed, thru the appeals of a lawyer donating his time and of his state congressman. How many lawyers, how many congressmen are needed to intercede in time?

6. The 90 year old Klebsiella pneumonia Medicaid patient is denied hospitalization on the 10th day - the computer says pneumonia gets well in nine days at age 65 years. Appeals and attorneys are in order, the patient is indigent. The Congresswoman supplies referral to legal services.

Other serious and growing defects of the hardening PSRO bureaucracy include lack of due process at PSRO Hearings. PSRO refusals to allow tape recordings, etc., should not be tolerated. The entire hearings, rehearings and appeals process is hardly practical for the very ill elderly patients.

The tragedy of PSRO is reflected - not only in the above routine examples of denials - but on the obvious fact that justice "one year later", or after death, is justice denied.

The above tragedies , we believe, are preventable with true professional peer review, where cost control is not the goal. Not only is the financial cost of PSRO prohibitive. Its real cost is injustice to patients, well-nigh unmeasurable.

II. OTHER DELETERIOUS PSRO EFFECTS

1. Harassment of doctors who stand up for their patients and support the appeals - and win. They are then "targeted" for intensive review by the PSRO chief doctor.

2. Private patient review, especially of doctors who challenge PSRO denial, is now actively sought by PSROs.

3. In Louisiana, the PSRO is suing the medical society for the society's review of the ethical, professional conduct of a PSRO physician advisor.

4. PSRO doctors have the inherent conflict of interest and temptation to "use" their power of intensive review, of compulsory second opinion, pre-surgery authorization to stifle their competitors. This is especially in new areas of competitors expertise, such as cataract lens implant, microsurgery, laminectomies. This is the key difference between true educational review and government-power PSRO. PSRO has the power of the state to destroy a doctor's reputation and practice - and its records are "secret".

5. The temptation to use PSROs for personal gain by PSRO doctors may be increased with the proposed access of PSROs to insurance carrier physician profiles and make decisions as to physician reimbursement. Is PSRO to become involved with payment decisions?

6. The psychology of the PSRO doctor, with a possible bias against the profession in general, may be reflected in the "Statement of John W. McMahon, M.D., Medical Director, Montana Foundation for Medical Care, Helena, Montana", made in the September 1979 Senate PSRO Hearings, page 364:[77]

> "I think those members of that team were just as willing to say bad things about their fellow physicians as we are in Montana if it seemed not to be appropriate; and I think that is the best way to decide whether a PSRO is operating effectively."

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Chapter 8: The "Alternative"

The PSRO $8 billion savings hoax must be stopped now. After eight years of implementation it has not worked, is not expected ever to work, and it has proven to be both prohibitively expensive and not cost-effective.

In fact, PSRO review is disappearing in front of our very eyes. Although we are paying for PSRO concurrent review, the taxpayer is getting pseudo-review: "focused review", "automatic certification", and "sampling retroactive audits", or no review at all. This "no review" is said to be the most cost-effective. PSRO is now doing old fashioned utilization review, and getting paid three times the cost of UR, for "PSRO".

What is now offered by PSROs for the proposed 1981 $200 million budget is sham review to stay with in the budget, plus straight rationing to give the appearance of effectiveness and save the program. PSROs start with the poor, as currently in New York and California Medicaid, by placing them all on pre-authorization before hospital admission; allowing only one day for preoperative stay; and disallowing any non-emergency weekend admission. Is this PSRO "review", or straight rationing?

PSRO therefore now offers a prohibitively expensive form of Utilization Review. It has now been proved beyond question that an army of nurses reviewing every chart with a PSRO rulebook is prohibitively expensive and doesn't work.

Private Doctor of America recommends to Congress that:

1. The Nurse-with-the-Rulebook review and the-PSRO-Doctor-on-the-telephone Review be discontinued, now.

DOCTOR - NOT NURSE - REVIEW

2. Believable review must be performed by doctors who actually read the patients' charts, in the hospital. No "rulebook" of criteria, norms and standards will be necessary, because doctors apply individual professional review.

3. 5% Sampling review of both hospitalized (concurrent review) and discharged patients (retroactive review) should be made, plus review of all stays longer than 21 days, and certifications of stay at 14 days, according to the Medicare Regulations prior to 1974.

4. Rescind all UR regulations promulgated 1974 and thereafter, whose sole purpose was to change Utilization Review into the failed PSRO.

5. Stop the March 3, 1980 Federal Register proposed UR regulations[78], which are 100% PSRO and that would eliminate UR.

6. Stop the June 20, 1980 Federal Register proposed "Conditions of Participation of Hospitals"[79] which eliminate UR and change it into PSRO.

AMENDMENT: THE HHS SECRETARY MUST NOT BE ABOVE THE LAW

7. Establish needed Regulatory reform and accountability by the unelected permanent bureaucracy. The HHS bureaucracy is responsible for the deception of the certification regulation success and the denial of objective outside Utilization Review (Option iii) which subverts its own regulations. To assure that these excesses beyond the law and their own regulations by the Bureaucracy be held accountable to the Courts, Congress must not allow the privileged position of the Secretary of HHS of being "above the Law". In our suit against the Secretary of HEW's escalation of its own regulations through its HMI-7 Manual, the U.S. Fifth Circuit Court of Appeals ruled on July 7, 1978,[80] that, although CMS position has substantial arguments, the Secretary of HEW could not be sued in court for claims under the Medicare Act. The PDA Amendment to the Law, Act 42 USC Sec. 405 (h), Figure 4, is hereby submitted to remove this current jurisdictional obstacle to justice.

8. To be objective, believable and workable, the above recommended Doctor Utilization Review should be "Outside Doctors Review", carried out by one or more doctors, who are paid government contractors, as provided for in Option iii of Regulations, 20 CFR 405.1035 (e)(1)(iii), and also in the Medicare Law, 42 USC Sec. 1395x(k)(B)(ii), also referred to as Section 1861(k)(2)(B) ii of the Medicare Act[81].

DISAPPROVE 1980 UR & C.O.P REGS

a. The reviewing doctor(s) for government shall not represent the medical staff nor medical society sponsored corporations, Foundations, etc. This eliminates an obvious conflict of interest. To assure such independence for the medical staffs, the proposed new 1980 Conditions of Participation of Hospitals Regulations[79] should be deleted. At 42 CFR, 482.21(e)(1), delete the illegal requirement for medical staff participation in PSRO review or in performance of Utilization Review. This must remain voluntary, as provided in both Medicare Act and by the PSRO Law (delegation vs. non-delegation).

NON-POLITICAL REVIEW

b. The Outside Review doctors are to be employed by the contracting Medicare and/or Medicaid insurance carriers or by hospitals and monitored by the State Agency that has a contract with the Secretary of HHS for certifying compliance with Conditions of Participation of Hospitals. Medicare regulation prior to 1974 provide for monitoring of Utilization Review at State and Federal level government agencies. Hospitals or carriers are to choose the contract doctor reviewers to avoid politicalization of the review thru State appointments, but the State agency monitors performance.

OURFA

9. To correct and substitute for the failed PSRO and the conflict of interest, we therefore recommend:

This program has already been successful in areas who thoughtfully implemented it ever since Medicare started in 1966.

As an example, Appendix 1 is a November 7, 1974 letter from the Singing River Hospital System, Pascagoula, Mississippi. It implemented Outside Review successfully since 1966 at minimum cost. In Testimony prepared for this August 25, 1980 Ways and Means Committee Hearings on PSRO, $104,700 was spent for PSRO "delegated review" in one year, only $48,325 was reimbursed to the Hospital. Here, PSRO is far more expensive than OURFA which would cost about $40,000 total. The private patients end up paying 60% of PSRO review costs and this is not reflected in the "PSRO cost" in cost-effectiveness surveys.

As described earlier in our book, this "Option iii Outside UR" was approved by dozens of Medical Staffs and hospitals nationwide under auspices of PDA, until the HEW bureaucracy refused to implement the law and its own regulations, and ruled" that "only hospitals with less than three doctors" in their staff could choose Option iii provision of the regulations.

ACCOUNTABILITY

In summary, PDA recognizes the principle that taxpayer fund expenditures paid to those who contract with government must be held accountable. We therefore recommend the implementation of an Outside Utilization Review Fiscal Accountability (OURFA) program which provides: Outside, arms-length, objective, non-medical staff, non-medical society, non-nurse, non-rulebook, hospital on-site professional review, by doctors contracting with hospitals and carriers and monitored by State and Federal agencies for compliance and performance; under the Medicare law and regulations before 1974, with two amendments to assure that the HHS bureaucracy will not sabotage the program and that HHS will not remain beyond reach of the courts.

PDA further recommends, that the lessons learned in the Medicare UR program be heeded by providing that:

FEDERAL UR A HOSPITAL FUNCTION – NOT MEDICAL STAFF

10. The Outside Utilization Review Fiscal Accountability Committee must not be overruled with retroactive denials to hospitals by Medicare/Medicaid insurance carriers (except under Fraud provisions for recovery of funds, below). The Medicare law should be amended to clearly state this policy under the Utilization Review Section of Conditions of Participation of Hospitals at 42 CFR Subpart A, 482.21 of the June 20, 1980, Proposed Rules for Conditions of Participation. It should also reinstate the UR requirement for the Hospital, which was deleted in Subpart B 482.21(e) (1), and providing therein for the OURFA committee to carry out federal program review, independent from the medical staff.

FRAUD

11. Information on identified suspected fraud and abuse - by hospitals, or by professional providers under assignment - will be reported by the OURFA doctors to the Carriers, hence to the State Fraud and Abuse Units under its Attorney General for investigation and action. Report to the Secretary of HHS in Medicare and Medicaid is made after determination that fraud does exist, for appropriate recovery of the defrauded funds, and other sanctions as already provided by law.

ONLY DOCTORS PAID BY GOVERNMENT (ASSIGNMENT) SUBJECT TO DISCLOSURE

12. The courts have ruled that doctors are free to refuse government payment and not participate in PSRO review. As provided in Regulations prior to 1974, Medical Staffs who are composed of privately practicing doctors, most of whom refuse government payment for their medical services to patients, shall not be required to participate in federal Utilization Review or OURFA review, which is an objective outside review of government funds paid to hospitals. Outside review is constitutional only in reference to services paid for by government. Only those doctors on assignment contracts with Medicare or Medicaid, may be required to respond to OURFA inquiry.

    Profiles of non-assignment physicians, not paid by government, must remain separate from government contract doctors, and are to remain confidential and not subject to disclosure. PDA has filed an Amicus curiae suit[82] to the Gesell decision on release of PSRO profiles in this regard.

I. IF PSRO IS "PEER REVIEW" BY PRACTICING DOCTORS", WHY OPPOSE IT?

Herein lies the fundamental deception, the key to why PSRO has and must fail, and the basis for a reasonable alternative.

A. WHAT IS TRUE "PEER REVIEW"?

True "Peer Review" is a voluntary professional educational review centered on the quality of care based on what is best for the patient's total individual needs, those of his/her family, and the requirements of his work and social status in life. Peer Review serves the individual patient's needs, what is economical and convenient and helpful to him or her.

1. The introduction of the primarily financial interests of the third party is the very opposite of peer review. It is Fiscal Review by doctors who accept contracts - paid or not - to become agents as claims reviewers. The review is now centered on what is profitable for the third party: for the insurance company - whose interest of profit is not to pay for services. Or, for the employer - whose interest is lower insurance premiums, based on fewer services. Or, for government, whose interest is to coverup the huge escalation

of cost overruns whenever government offers the provision of services "for free" which properly belong to the private sector.

2. PSRO is fiscal Review for the interest of the government, whose end purpose is a "PAY-NO-PAY" decision for cost containment by denying services based on what the government decides the patient should have. PSRO reviewers. It is fiscal rationing.

3. PSRO Physician Reviewers are not "peers" - they are government contractors, with a government interest and regulated by the Secretary of HHS and its bureaucracy. Their interest opposes the patient's interest.

4. PSRO is government review. In 17 pages of PSRO Law, the Secretary of HHS's power is spelled out. The "hooker" in PSRO is first, the government dollar which invites a huge and unnecessary bureaucracy and which invites fraud and deception. Second, the power of government is behind PSRO. PSRO can destroy the practice of any doctor, invites abuse, vendettas, anti-competitive activity, not education and rehabilitation.

5. PDA therefore urges that government review can not be medical staff review because of the fundamental clash of interest.

II. IS PROFESSIONAL REVIEW SUFFICIENT FOR QUALITY CONTROL?

The privately practicing doctors constitute the voluntary, unpaid medical staffs of all hospitals. Practically all medical staffs have up to 12 different committees for review of every aspect of patient care - and have had them for over 35 years.

LIST OF COMMITTEES FOR QUALITY REVIEW

Executive Committee	Medical Records Committee
Credential Committee	Emergency Department Committee
Disaster Committee	Patient Care Committee
Emergency Admissions Committee	Scientific Sessions Committee
Infections Committee	Tissue Committee
Intensive Care Committee	Pharmacy & Therapeutics Committee
Joint Conference Committee	

Private doctors in medical staffs will continue this private professional patient-centered review, regardless of government review and without remuneration. This is the only review that can work for quality, because doctors voluntarily submit to same by their elected peers. It cannot ration care. It cannot decide on approval for payment based on "necessity". That is coercion - and the profession cannot and will not respond. That is why PSRO is a failure.

What is recommended is the OURFA-Utilization Review Plan. The plan as developed by PDA, and implemented in many hospitals nationwide before PSRO, is printed herein (Appendix 2).

III. IS NOT PSRO NECESSARY "AS A DETERRENT TO FRAUD?

1. NO! There is no need for a Law for PSRO review. Doctors in San Joaquin and Sacramento and Utah were experimenting with all aspects of what is now "PSRO" without any government money. They had the control of the market place and the competition of other, less expensive, more effective systems.

2. NO! The government Medicare and Medicaid insurance carriers already have in their computers:

   every patient, every doctor and every service performed, every bill, every hospital, the power to survey any hospital chart, the power to deny any bill.

   In the 1972 Senate Hearings on HR 1, Senator Bennett presented "five Louisiana hospitals" with apparent record of fraud and abuse as an example for the need of PSRO. But the obvious fact was: the government had all this information already without PSRO; and had acted appropriately and some hospitals closed.

3. The government since 1970 has had Project Integrity with surveillance for fraud and abuse.

4. An HHS Inspector General is charged with fraud-abuse surveillance and control.

5. There is now and has been for some time, Fraud and Abuse Medicare-Medicaid Units in most states, under the Attorney General. PDA has supported the Louisiana Unit under Attorney General William J. Guste, Jr., who has been doing an effective job.

IN SUMMARY

PDA supports and encourages investigation and prosecution to the full extent of the law of Medicare Fraud and Abuse. But PSRO is a duplication of existing government resources for review and control. Let the government exercise its responsiblity.

* * * *

78-522 O—81——12

Chapter 9: In Summary

1. PSRO is eight years old, is prohibitively expensive. It has failed in its purpose of cost containment. It has a growing record of PSRO terminations for incompetence and fraud.

2. Exhaustive, multimillion dollar government studies conducted for four years (1976-1980) have concluded that PSROs are not and cannot be expected ever to become cost-effective for significant savings.

3. The Outside Utilization Review Fiscal Accountability (OURFA) is a reasonable, workable and believable alternative. It is recommended to be implemented instead. Operating under pre-1974 Medicare Law and its Option iii choice in the regulations, it provides arms-length fiscal accountability of taxpayer Medicare/Medicaid expenditures without conflict of interest, performed by government contracting doctors and under government agency monitoring. It will provide Fraud/Abuse referral to state and federal agencies. It prohibits Insurance carriers from retroactive denials except under final determination of provider abuse. The 1980 proposed PSRO type changes in Utilization Review and Hospital Regulations in the Federal Register should not be approved because they prohibit a choice of "outside utilization review" and require in-house medical staff utilization review for government accountability.

4. Outside Utilization Review Fiscal Accountability (OURFA) is a proven success where tried, and has the support of many hospitals and medical staffs nationwide. As stated above, the costs of UR rules prior to 1974 changes have been estimated at $81.3 million vs. $274.9 million for hospital PSRO review (up to $500 million estimated by 1978 Appropriations Committee).

5. OURFA is fiscal public accountability. The Medical Staffs will continue their own private, independent Quality Care Review Committees as they do today for educational peer review; which bears no relation or accountability to the federal or state government, to insurance companies or third parties; and at no cost to government.

There is today an opportunity for Congress to act responsibly on the evidence at hand - to stop the expensive PSRO program that has not delivered on its promise, but has discredited its purpose. Let us act in behalf of the beleaguered and long-suffering taxpayer. Repeal the unwarranted regulatory overkill that is PSRO. Then, implement an objective and workable and reasonable Outside Utilization Review Fiscal Accountability program.

.... Appendix 1 - 3 and footnotes made a part of the committees official files.

DISCHARGE RATIO BY DAYS' STAY IN HOSPITAL

Patients 65 and Older Pre- and Post-Medicare

PAS Data

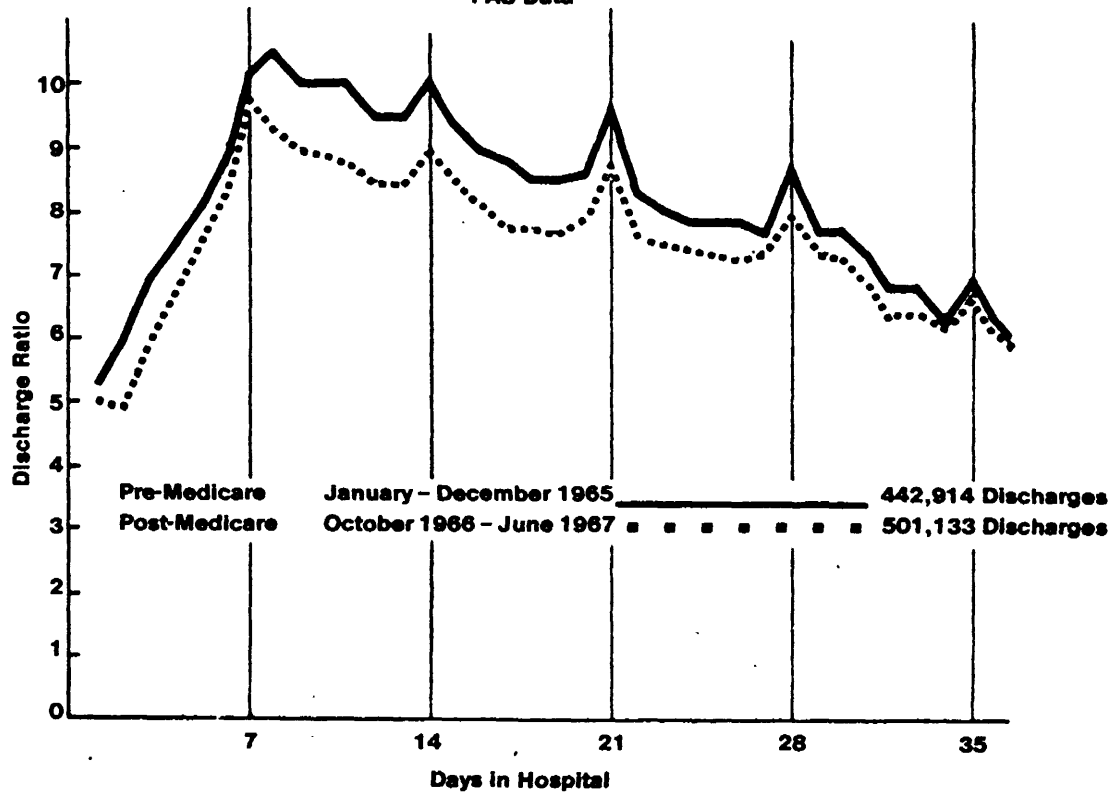

FIGURE 1

"Standards" for Care of the "Common Cold"

Example of "Professional Standards" presented by the San Joaquin Foundation for Medical Care to the "Hearings Before the Subcommittee on Medicare – Medicaid of the Committee on Finance, United States Senate, Ninety-First Congress, Second Session, Part 2 of 2 Parts, April 14 and 15, May 26 and 27, June 2, 3, 15 and 16, 1970, page 784.

"REVIEW CRITERIA AND METHODS OF REVIEW"

By Donald C. Harrington, M.D., President
San Joaquin Foundation for Medical Care

(Example Case No. 1)

DIAGNOSIS
Acute upper respiratory infection in the absence of a complicating factor.

VISITS
Either home or office, preferably office.

NUMBER OF VISITS
Between 2 and 4, or 1 and a phone call.

LAB & X-RAY
Seldom, X-ray of chest when complication are present. WBC and differential may be indicated. Culture may be indicated.

THERAPY
Analgesics, sedatives, anti-tussives, expectorants, anti-histamines, and chemotherapy.

DURATION
Seven to ten days.

* * * *

PDA: COST OF TREATING "COLDS" UNDER PSRO = $34 BILLION

A. "PSRO" TYPE GUIDELINES:	One cold, 1970.
Office visit	$ 7.00
Drugs (one cold)	7.00
WBC	7.00
Culture and sensitivity	20.00
TOTAL	$41.00

B. "PSRO" TYPE GUIDELINES: Cost for U.S. Population

The cost of treatment for colds for the U.S. population, 200 million with 4 colds per year at $41.00 per cold, plus one x-ray of the chest out of every 10 patients seen would equal $34 billion.

200 million X $41.00 X 4	=	$32.8 billion
200 million X 4 X $15 x-ray + 10	=	1.2 billion
TOTAL	=	$34 billion

These are criteria for AUTOMATIC PAYMENT BY COMPUTER, WITHOUT REVIEW. They will become the standard of care. PSRO will inevitably and progressively escalate the cost of care as the criteria become common knowledge. For the unscrupulous, PSRO will supply the legal framework for automatic computer payment fraud.

FIGURE 2

MARICOPA FOUNDATION FOR MEDICAL CARE

ACADEMY OF MEDICINE
3625 NORTH CENTRAL AVENUE
PHOENIX, ARIZONA 85004

TELEPHONES: 252-0850
230-6001

ALL GROUPS CLAIMS REPORT

July, 1971 through June, 1972

MONTH	CLAIMS RECEIVED	TOTAL DOLLAR AMOUNT PAID	NUMBER OF CLAIMS ADJUSTED PER PEER REVIEW AND/OR FEE SCHEDULE	DOLLAR AMOUNT OF THESE ADJUSTMENTS
July (1971)	915	87,121.54	346	5702.93
August	1103	101,396.02	496	7949.01
September	1122	137,311.07	546	9237.33
October	1250	151,900.95	331	10,763.15
November	1313	162,582.75	424	11,039.89
December	1422	194,029.85	429	16,326.86
January (1972)	1438	142,090.32	515	9277.42
February	1756	178,626.05	625	9401.05
March	2251	225,451.54	706	10,904.95
April	2162	169,207.84	571	9312.14
May	2472	266,596.34	865	13,787.29
June	2724	207,359.56	796	12,872.90
TOTALS	19,928	$2,023,673.83	6,650	$126,574.92

Established as a service to the community by the Maricopa County Medical Society

PDA NOTE:

The 1972 income was $300,000 + Savings $126,574.

The Foundation spent $2.37 to save $1.00

FIGURE 3

Amendment to Medicare Act

to Restore the Legal Accountibility of the Bureaucracy

(Secy HHS)

That Section 405 (h) of 42 USC be amended to read as follows: (one sentence change from present law underlined)

"(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. Except as herein provided, no action against the United States, the Secretary , or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim for benefits arising under this subchapter. <u>No provision hereof shall bar judicial review or action challenging the Secretary's authority to promulgate agency rules, regulation or guidelines.</u>"

As per a 1978 Supreme Court Decision, the Secretary of HHS is currently above the Law, cannot be sued for regulatory excesses beyond the law under the Medicare Act. (Weinberger vs Salfi, 422 U.S. 749 (1975). American CMS vs Califano Secy HEW U.S. 5th District Court of Appeals, 76-4156 (1978).

FIGURE 4

STATEMENT OF NOBLE CORRELL, M.D.

My name is Noble Correll. I am a privately practicing chest surgeon in Stuart, Florida, testifying as President of Private Doctors of America on behalf of all private physicians and our patients.

Section 1151, Part B, Title XI of Public Law 92-603, passed by the 92nd Congress on October 30, 1972, states that the intent of Professional Standards Review Organization was: ". . . to promote the effective, efficient and economical delivery of health care services of proper quality for which payment may be paid . . . under this Act," under Medicare and Medicaid Programs.

Now, eight and a half years later, what has been the actual effect of this law? I have met no one who believes that it has made medicine more effective except for those doctors who work within the PSRO organization and receive taxpayers' money as salary for this "work." Has the practice of medicine become more efficient? The answer is, "No." The private practice of medicine already was efficient, and it still is. The doctor treats his patient. The patient pays his doctor. There is no middle man. No coercion. No corruption. No pay-offs. No waste. Has the practice of medicine become more economical since 1972 and PSRO? Again, the answer is, "No." Every impartial study that has been made of PSRO's has shown them to be wasteful of taxpayers' money. Only those studies conducted by the PSRO's themselves, with their vested interest in appearing to be successful, have managed to arrange their figures to make it appear that they indeed are more economical than private practice. My friend and colleague Dr. Garcia-Oller, Executive Director and Chairman of the Board of Private Doctors of America, has written a book documenting the fact that PSRO's have not been cost effective, but have instead superimposed an extra layer of bureaucracy to add to the burden of the already overburdened taxpayer. More than 700 million dollars has gone down the drain in direct costs of PSRO's. Add to this the hidden costs of the physicians and hospital personnel satisfying the regulatory demands and paper work of such an organization, for which they receive no compensation from the PSRO, and the hidden costs exceed the direct costs, although they are difficult to document, as usually is the case with compulsory generosity.

Unfortunately, the ready availability of taxpayers' money for the establishment of PSRO programs has tempted some State and local medical societies and even the American Medical Association to "accept" these "free funds" to help defray the increased costs of their own burgeoning administrative overhead. They too have fallen prey to bureaucracy. Easy Federal dollars for creating PSRO's have helped to contaminate organizations which in the past have prided themselves upon being self-supporting.

American medical organizations should not need to be subsidized by the taxpayers. Private Doctors of America is one organization which refuses to sell its favors for Federal funds. The PSRO budget has likewise attracted a huge mass of non-medical administrative and clerical personnel that is needed in private industry, if you can believe the want-ads in the newspapers. These people would better serve themselves and their country working in such productive roles instead of being a burden to the taxpayers. I call this white collar welfare.

PSRO has been found to have failed its purpose by every impartial study. All of those organizations that are arguing for its continuation receive taxpayers' money and have a substantial financial interest in its preservation. You probably will be able to note that this is true in today's testimonies from various people and organizations. The only doctors I have ever met who think that PSRO is worthwhile are those on the taxpayers' payroll.

PSRO should be abolished, returning these employees to the private sector where they are needed. Private Doctors of America respectfully requests that the Congress repeal this bad legislation. We think that this should be done as quickly as possible before millions of dollars more of the taxpayers' money is wasted.

Senator DURENBERGER. The hearing is adjourned.

[Whereupon, at 10:20 a.m. the hearing was adjourned, subject to the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

DONALD W. RIEGLE, JR.
MICHIGAN

United States Senate
WASHINGTON, D.C. 20510

23 March 1981

Honorable Robert Dole
Chairman, Finance Committee
2213 Dirksen Senate Office Building
Washington, D.C.

Dear Bob,

I have attached to this letter a report prepared by the Professional Review Organization - GLSC, located in Flint, Michigan. Over the years I have had the opportunity to watch this organization grow and have every reason to believe that the work they have done has been of benefit to patients, medical practioners and taxpayers alike.

I respectfully request that this report detailing some specific activities, problems encountered and future objectives be included in this morning's testimony before your committee. I hope the experience of this determined and dedicated organization will be helpful as the PSRO program is evaluated.

With best wishes,

Sincerely,

Donald W. Riegle, Jr.

Professional Review Organization-GLSC
IMPACT ON LOCAL HEALTH CARE DELIVERY
(Flint, Michigan)

Professional Review Organization-GLSC is the federally designated Professional Standards Review Organization for Genesee, Lapeer, and Shiawassee Counties (PSRO Area V, Michigan; Region V) under Grant #97-P-99678/5-01. The 800 physicians in these counties (of which 520--or 65%--are PRO-GLSC members) annually admit nearly 40,000 Medicare and Medicaid patients to the nine area hospitals. Since September of 1975, PRO-GLSC has had binding authority as a conditional PSRO for reviewing both the quality and necessity of the medical care provided to local Medicare, Medicaid, and Maternal/Child Health patients. Through such review, PRO-GLSC is promoting optimal levels in the quality, quantity, accessibility, and cost of health care for area residents. Genesee Medical Corporation, which shares PRO-GLSC's staff, conducts similar review for a total of approximately 60,000 Blue Cross/Blue Shield and other private insurance admissions.

DATA ANALYSIS

Trend analysis of existing data for the PRO-GLSC area from 1974--i.e., one year prior to the initiation of PRO-GLSC review--through 1980 indicates a decrease of 2.2 days in the average length-of-stay (ALOS) for Title XVIII discharges and a corresponding decrease of 1.3 days in the ALOS for Title XIX discharges. Current PRO-GLSC data shows a decrease of .4 day in the overall ALOS for Title XVIII/XIX discharges from 1978 to 1980 alone, in addition to which the decrease trend appears to be accelerating. The Title XVIII average LOS decreased 4.2% from 1979 to 1980 (representing an overall decrease of .8% from 1978-1980), while the Title XIX average LOS decreased 5% from 1979 to 1980 (representing an overall decrease of 9.5% from 1978-1980):

Professional Review Organization-GLSC
MEDICARE (Title XVIII) & MEDICAID (Title XIX)
AVERAGE LENGTHS OF STAY

CALENDAR YEAR	MEDICARE	MEDICAID	TOTAL
1974*	13.6	7.0	N/A
1978**	11.5	6.3	9.5
1979**	11.9	6.0	9.4
1980**	11.4	5.7	9.1

PRO-GLSC level-of-care determinations during 1980 resulted in 1189 cease benefits decisions regarding Title XVIII/XIX patients, with a corresponding total of 1,882 hospital days denied for third party reimbursement; in addition, Title XIX reimbursement for another 491 hospital days was substantially reduced due to PRO-GLSC documentation that the patient dropped from an acute to skilled or basic care level.*** A greater number of hospital days never occurred because PRO-GLSC's contact to the attending physician and/or cease benefits decision resulted in an immediate discharge of the patient.

*Data Source: GLS-HSA. Represents one-year period immediately prior to initiation of PRO-GLSC review.

**Data Source: PRO-GLSC. ALOS for 1980 based on 97% of all Title XVIII/XIX discharges. Other 3% (approximately 1,000 cases from 4th Q '80) not yet available for input into PRO-GLSC's data system.

***Skilled/basic rates under Title XIX currently range from approximately $26-32/day in the state of Michigan.

NARRATIVE SUMMARY OF SELECTED ACCOMPLISHMENTS (1979-80)

Professional Review Organization-GLSC is an excellent example of local physicians working together to improve the quality and impact the cost of health care. PRO-GLSC's 520 physician members are committed to providing the incentives and education needed to make positive changes in our health care system. Over 200 physician members have served as a PRO-GLSC Board Member, Committee Member, or Physician Advisor during the past two years alone, contributing a total of nearly 7,000 hours to these important activities. The following represents a narrative sampling of selected PRO-GLSC accomplishments during 1979-1980.

Concurrent Review = admission certification and continued stay review performed prior to and/or while a patient is actually hospitalized.

MCE = medical care evaluation study, usually performed retrospectively (i.e., after patient discharge) on a random or selected sample of medical records to assess quality of care.

Profile Analysis = analysis of individual data profiles generated from aggregate data. Specific profiles may relate to individual diagnoses, physicians, hospitals, PSRO area, region, state, or nation.

Delegated Status = performance of review activities by an individual hospital (rather than PSRO staff), with periodic monitoring of the hospital's effectiveness by the PSRO.

1. In late 1979, PRO-GLSC implemented intensified medical screening criteria at all hospitals in conjunction with focusing review efforts on those areas of local health care delivery identified as having the greatest potential for positive impact. This new review system has proven to be clinically sound in assuring that acute care hospital beds and services in the PRO-GLSC area are used only when medically necessary. PRO-GLSC's denial rate at area hospitals has correspondingly increased 200% (i.e., from 587 to 1189 denials) during the past year compared to the one-year period immediately prior to establishment of the new system. PRO-GLSC has continually increased the effectiveness and efficiency of our concurrent review process. Major efforts have been devoted to establishing a review system that closely parallels the practice of medicine while decreasing the administrative costs of review; in addition, successful efforts have been made to continually upgrade Physician Advisor effectiveness.

2. PRO-GLSC's Board of Directors instituted an important set of policy statements regarding the utilization of inpatient hospital services. The policy statements provide a firm stance on days awaiting consults, inpatient evaluations (after need for acute care ceases), incidental or nonplanned surgery during hospitalization, and patient leaves of absence. The policy statements have served as an educational tool, in addition to being utilized as adjunctive screening guidelines for performing concurrent review (see Attachment).

3. PRO-GLSC's Board of Directors established an inpatient preoperative length of stay (LOS) standard of one day for hospitals in the PRO-GLSC area, stipulating that all preoperative consults or medical evaluations should be completed on an outpatient basis. Patients may be admitted more than 24 hours prior to surgery only if the need for medical therapy or medical evaluation is documented by the attending physician and cannot be performed as an outpatient. PRO-GLSC correspondingly performs intensified review of inpatient surgical procedures if 1) a surgery is not preboarded, 2) potentially excessive preoperative time will

occur, and/or 3) the surgery is scheduled but cancelled. This procedure helps to assure that preoperative days are not certified unless medically necessary. Questionable preoperative time related to individual cases is also documented as special data for profile analysis by hospital, medical specialty, and individual physicians. These PRO-GLSC activities are proving to be valuable tools in increasing physician awareness, as well as changing physician practice patterns when indicated.

4. PRO-GLSC implemented screening guidelines for the inpatient vs. outpatient performance of 25 major diagnostic procedures and conducted a sixty day pilot study on hospital admissions for 13 of the 25 procedures that can be safely and effectively performed on an outpatient or ambulatory surgery basis. Although the full results of the study are not yet available, it appears that the inpatient performance of the 13 procedures at some area hospitals has decreased substantially, indicating a change in physician practice patterns. The study was designed to increase physician awareness concerning the outpatient safety of the 13 procedures and to evaluate the necessity of individual cases that occurred on an inpatient basis. In instances where it appeared that a procedure could be performed safely and effectively in an outpatient setting, a letter was sent to the attending physician asking whether additional information existed to substantiate the patient's need for hospitalization. During 1980, PRO-GLSC reviewed all admissions for the 13 procedures and concurrently denied, when feasible, the hospitalization of any patient whose condition did not require acute care. In some instances, however, patients are admitted and discharged before a concurrent termination of benefits can take place. PRO-GLSC is therefore continuing the educational aspect of the 13 procedure study during 1981 as a possible precursor to the institution of preadmission certification or a retroactive denial mechanism.

5. PRO-GLSC played an active role in the recent formation of the Greater Flint Area Hospital Assembly's RUN program (Reduce Utilization Now). The RUN program was created to reduce the area demand for inpatient hospital services as an important step in assuring that current hospital bed reduction plans for the PRO-GLSC area will not adversely affect the availability and accessibility of local health care. The following RUN initiatives have been designated as high priority areas: prior approval of elective admissions; ambulatory surgery; improved discharge planning; and factors influencing demand.

6. PRO-GLSC performed comprehensive onsite monitors at all area hospitals. PRO-GLSC monitoring has proven to be a valuable process for assessing and effecting change, particularly since the hospitals are required to respond to monitor performance reports. A great deal of time and energy have been expended on the part of both PRO-GLSC and area hospitals in addressing the reports. Overall, the net results have been positive. At one hospital, for example, PRO-GLSC participated in a series of meetings with the hospital's specially appointed Physician Task Force following an unfavorable onsite monitor report. The hospital's initial response to PRO-GLSC did not adequately address problem areas concerning hospital/ancillary services overutilization, questionable quality of care, and inappropriate/untimely consultations. PRO-GLSC continued working with the hospital's Task Force to foster a joint effort in educating the medical staff on proper utilization and resolving the identified deficiencies.

7. PRO-GLSC performed an indepth 30-day study concurrently at one area non-delegated hospital based on the identification of questionable inpatient consultation patterns (i.e., lack of inpatient necessity and timeliness). As a result of the study, the Utilization Review Committee (URC) instituted a "point system" at the hospital. On a monthly basis, the URC receives referrals from PRO-GLSC staff on cases involving potential problems in utilization and

quality of care. If the URC determines that a particular case represents inappropriate utilization or quality of care by a physician, a "point" is assigned to that physician. If the physician accumulates 6 "points" in a quarter, he/she is suspended from admitting and management priveleges for two weeks. The period of suspension of priveleges increases if additional points are accumulated in subsequent quarters. A letter is also sent by the hospital to all physicians assigned "points," citing the area of utilization or quality of care questioned and recommending the corrective action to be taken. This interaction between PRO-GLSC and the hospital has resulted in medical staff awareness of the consultation (and other utilization) problems and subsequent physician education/modification of behavior. It has also resulted in the hospital: 1) actively recruiting more specialists as members of the medical staff, 2) stipulating that all specialists on the medical staff must maintain a nonhospital based office for performing outpatient consultations, and 3) instituting a rule that inpatient consultation requests must be routinely responded to within 24-48 hours.

8. PRO-GLSC removed the delegated status of one area hospital due to a lack of corrective action on the part of the hospital in dealing with questionable physician practice patterns related to utilization, quality of care, and medical records documentation. PRO-GLSC's decision to remove delegated status was made following an extended probationary period, intensive inservice, and technical assistance to the hospital's review staff. Follow-up monitor results did not demonstrate any significant improvement in the hospital's capability to perform effective peer review. After rescinding delegated status, PRO-GLSC provided additional data to the hospital regarding the aberrant utilization practices of specific physicians. The hospital's admission and continued stay denial rates subsequently decreased significantly (i.e., more than 50%). PRO-GLSC also identified a significant number of inadequate responses to quality of care referrals at the hospital. A subcommittee of three PRO-GLSC physicians was therefore formed to review the original referrals and corresponding responses with members of the hospital's administration and Quality Assurance Committee. Data profiles reflecting the quality of care patterns of individual physicians and the corresponding rationale for the quality of care referrals made (i.e., potential deficiency areas) were also provided to the hospital. This process has resulted in more active surveillance by the hospital's Quality Assurance Committee. The hospital is making a sincere attempt to resolve identified problems by reviewing individual PRO-GLSC referrals, taking action when necessary, and providing PRO-GLSC with timely responses. Quality of care referrals at the hospital have correspondingly decreased substantially (i.e., approximately 50%).

9. PRO-GLSC developed and conducted ancillary service studies on the therapeutic use of intravenous Heparin, discharge planning, and physical therapy. To date: 1) PRO-GLSC's initiation of ancillary services review (ASR) has resulted in increased emphasis on the ancillary services component of onsite monitor reports and an acceleration in the number of concurrent hospital committee referrals made for delayed or unnecessary ancillary services. In addition, one area hospital instituted special surveillance of its house staff to decrease the overall number of laboratory tests and x-rays ordered; 2) Several area hospital pharmacists reported significantly altered patterns (i.e., a decrease) in the questionable use of intravenous Heparin during and following PRO-GLSC's IV Heparin study; 3) Area social workers and discharge planning (DP) personnel have increasingly asked for PRO-GLSC input into DP programs as a result of the DP study performed. PRO-GLSC has correspondingly assumed a position of leadership in a recently formed Nursing Home Task Force composed of representatives from area hospitals, nursing homes, alternative service organizations, and the local HSA. The primary purpose of the Task Force is to explore the

numerous problems inherent in discharge planning and work toward meaningful solutions on a local level; and 4) As a result of PRO-GLSC's ancillary study on physical therapy, hospital physical therapists started making direct referrals to PRO-GLSC staff regarding patients whom they feel are receiving unnecessary (or otherwise inappropriate) PT services.

10. PRO-GLSC continued extensive involvement in quality assurance activities at area hospitals. PRO-GLSC's role in quality assurance (QA) has been threefold: 1) to concurrently identify inappropriate patient care for referral to hospital committees; 2) to retrospectively analyse quality of care through the performance of MCE studies; and 3) to assure, in all instances, that effective corrective action takes place as indicated. During the past year, PRO-GLSC worked cooperatively with area hospitals to align quality review activities with recent revisions in DHHS and JCAH requirements; intensified concurrent quality of care review through the implementation of ISD (i.e., Intensity of Service, Severity of Illness, Discharge Screens) Criteria; established further refinements in the concurrent Q of C referral process; and addressed quality of care deficiencies at area hospitals through the performance of comprehensive onsite monitors.

11. PRO-GLSC submitted a formal sanction report to the Michigan Statewide Professional Standards Review (PSR) Council regarding continuing, substantial deficiencies in one area physician's utilization and quality of care--i.e., only after a PRO-GLSC approved preceptorship instituted by the hospital for this physician was unsuccessful in correcting the identified problem patterns. As a result of PRO-GLSC's intervention, the Regional Office of Program Integrity has recommended that the physician be temporarily excluded as a Medicare/Medicaid provider for a period of five years, after which the physician must demonstrate prior to reinstatement that he is capable of practicing medicine in accordance with community standards and that the reasons for exclusion will not recur. At the present time, this recommendation by OPI is awaiting formal clearance through DHHS Secretary Richard Schweiker.

12. PRO-GLSC was instrumental in developing Quality Assurance Subcommittees of the Utilization Review Committees at two nondelegated hospitals. PRO-GLSC review staff are actively involved at area hospitals as an integral part of each hospital's quality assurance team.

13. As a result of individual quality of care referrals made by PRO-GLSC to hospital committees: 1) Area hospitals suspended, limited, and in some instances permanently rescinded the hospital staff priveleges of certain area physicians; 2) The Coronary Care Unit (CCU) Committee at one area hospital instituted automatic stop orders for daily chest x-rays and EKG's in CCU after 72 hours; 3) Inservice was provided to a staff physician at one area hospital regarding the appropriate use of nephrotoxic drugs as indicated by BUN and creatinine levels (in addition to which PRO-GLSC's referral resulted in the hospital's Antibiotic Surveillance Committee performing a corresponding MCE study); 4) The questionable use of therapeutic low-dose Heparin significantly decreased at one area hospital (in addition to which PRO-GLSC plans to conduct an areawide MCE study on the therapeutic use of intravenous Heparin during 1981); and 5) Other corrective action was initiated by area hospitals as indicated on an individual case basis.

14. PRO-GLSC instituted a special quality of care review for psychiatric patients at one area hospital for a period of five months, based on specific guidelines recommended by the Chairman of the hospital's Psychiatric Unit. PRO-GLSC findings associated with the special quality of care review were presented to the hospital's Executive Committee for evaluation. As a result, appropriate changes were made in the Psychiatric Unit's policy for patient passes, medical

record documentation for psychiatric patients improved (i.e., contributing to improved coordination of patient care), and the Psychiatric Department formulated corrective action regarding the questionable practice patterns of one staff psychiatrist.

15. PRO-GLSC elicited input from area hospital infection control committees that resulted in a recommendation for the hospital performance of MCE studies on antibiotic usage. The initial MCE study findings on cephalosporin usage at one area hospital resulted in the performance of a secondary MCE on gentamycin usage at the hospital. Deficiencies identified during the gentamycin audit were subsequently addressed through corrective inservice to the entire medical staff on the correct use of aminoglycoside antibiotics, including the appropriate duration of treatment and the best type/frequency of laboratory tests to measure patient kidney function during administration. Problem identification and prioritization at other area hospitals resulted in individual MCE studies and corrective action (as indicated) on a wide variety of diagnoses, procedures, and other topics, with important implications for patient care.

16. PRO-GLSC worked closely with the social service departments and discharge planning personnel at area hospitals to facilitate coordinated, effective discharge planning (DP). As a result of significant PRO-GLSC leadership, individual DP referrals, and technical assistance in this area: 1) Specific DP personnel have been added to the staffs of four area hospitals; 2) one area hospital employed an outside consultant to develop a comprehensive plan for improving DP efforts; 3) At one nondelegated hospital, a monthly log is maintained on PRO-GLSC DP referrals that occur prior to discharge planning being initiated by a member of the hospital's staff (e.g., DP personnel, medical staff, or nursing). The hospital's Coordinator of DP Services utilizes this input from PRO-GLSC as a concurrent tool for assessing the effectiveness of the hospital's DP program--i.e., in order to stress the importance of early DP referrals to avoid unnecessary delays when a patient is ready for discharge; 4) PRO-GLSC monitor findings at one area hospital revealed utilization problems involving extended lengths of stay for elderly patients. There appeared to be corresponding deficiencies associated with early discharge planning efforts. PRO-GLSC staff subsequently met with the hospital's administration and DP personnel on a monthly basis to discuss and successfully address discharge planning program needs; and 5) At another area hospital, the UR Committee instituted a policy that discharge planning could be initiated without a written physician order as the result of input by the PRO-GLSC staff there. A PRO-GLSC monitor report to the same hospital outlined specific discharge planning deficiencies, in addition to which technical assistance materials on DP were provided. In response, the hospital conducted an MCE audit on DP for patients admitted with a primary diagnosis of CVA (i.e., stroke). The MCE study confirmed a lack of early discharge planning for a significant number of patients and, in some instances, the absence of any discharge planning. The hospital subsequently planned a group inservice on DP for the medical staff and other hospital personnel involved in patient care (e.g., nursing). A follow-up monitor by PRO-GLSC and an MCE reaudit will be performed in the future for reevaluation.

17. PRO-GLSC monitoring of nurses notes resulted in the nursing departments of several hospitals requesting PRO-GLSC inservice on nursing documentation, primarily in the areas of patient assessment, patient status, and discharge planning. PRO-GLSC contacts with hospital physical therapy departments have similarly resulted in more complete and timely physical therapy notes for ascertaining level of care.

18. PRO-GLSC developed and implemented a multidisciplinary Patient Transfer and Assessment Form at area hospitals for use in conjunction with transferring

patients from the hospital setting to area nursing homes. The transfer form was developed in response to the findings of a process MCE study on transfer documentation performed by PRO-GLSC to assist in identifying specific problem areas in patient information sharing between acute care and long-term care facilities. The specific information required for completion of this form has served a threefold purpose in: 1) establishing guidelines for assessing patients at discharge; 2) enhancing continuity of patient care; and 3) contributing to the overall timeliness of area hospital discharge planning activities.

19. PRO-GLSC organized and conducted two meetings with area specialists during early 1981: One meeting was held with area urologists and anesthesiologists to formulate appropriate guidelines for the inpatient vs. outpatient performance of cystoscopies (including cystoscopies that precede a TUR-prostatectomy). Valuable information was exchanged at the meeting; and a medically sound, cost effective approach was developed--i.e., not only for the inpt. vs. outpt. performance of cysto's, but also for facilitating the patient evaluation and documentation process prior to surgery. A similar meeting was held with the area physicians who primarily treat alcoholic patients and the director of a local alcoholism rehabilitation program to establish explicit screening criteria for reviewing the hospitalizations of patients admitted solely for alcoholism therapy. PRO-GLSC is currently working with area physicians to develop screening guidelines for the inpt. vs. outpt. performance of D & C's, as well as the admission/discharge of patients in comprehensive rehabilitation units. Through these types of activities, PRO-GLSC is creating positive change in physician practice patterns on a community level. No other mechanism presently exists for addressing such issues in an organized manner while assuring local physician input.

PRO-GLSC IMPACT OBJECTIVES FOR 1981

Five National PSRO Program Priorities were recently established by the National Professional Standards Review Council as a basis for individual PSRO objective setting:

1. Identify and address the problem of substandard quality care.

2. Correct locally identified problems concerning hospital utilization, taking into consideration national data sources.

3. Correct inappropriate incidence of surgical procedures identified by the PSRO, taking into consideration national data sources.

4. Correct inappropriate and medically unnecessary utilization of ancillary services.

5. Maximize program effectiveness and efficiency within the budget allocation.

In response to the National Priorities and PRO-GLSC problem identification on a local level (i.e., utilizing local, state, regional, and national data sources), PRO-GLSC's Board of Directors has established the following impact objectives for 1981:

1. Reduce the number of cystoscopies and D & C's performed on an inpatient basis.

2. Reduce the preoperative average length of stay (ALOS) for TURP's and hysterectomies.

3. Justify the incidence of hip arthroplasty or reduce inappropriate rate.

4. Reduce the ALOS for CVA (including related diagnoses) and adult onset diabetes mellitus.

5. Reduce the inappropriate utilization and laboratory monitoring of therapeutic IV Heparin.

6. Promote effective peer review, while maintaining or reducing overall review costs.

Genesee Medical Corporation/Professional Review Organization-GLSC

POLICY STATEMENTS

The Social Security law specifies that a PSRO may certify payment only for inpatient hospital services that are medically necessary and cannot be provided on an outpatient basis or in a less costly inpatient facility such as a nursing home. PRO-GLSC's Board of Directors has adopted an important set of policy statements regarding the utilization of inpatient hospital services. The statements have also been reviewed by the Chief Physician Advisor and Hospital Liaison Committees. In addition, copies have been mailed to each hospital's Chief of Staff and administration. PRO-GLSC's Board urges all area physicians to not only adhere to the policies, but to actively support them.

1. DAYS AWAITING CONSULTS

Necessary consults in an acute care facility should be completed* within 24 hours of the request except in unusual circumstances.

*"Completed" - consulting physician sees the patient, reviews the medical record, conducts and documents the appropriate initial history and physical examination, documents his initial impression(s) and initiates evaluation and/or treatment if requested or appropriate. "Completed" does not refer to the completion of all necessary diagnostic or therapeutic intervention by the consultant.

Rationale: "Acute care" by definition necessitates the prompt action of all physicians in order to provide the best possible care to the patient.

2. INPATIENT WORKUPS

Inpatient workups are not allowable unless the workup cannot be provided on an outpatient basis without danger to the patient's health or safety. When an inpatient workup is required, the attending physician should schedule the necessary tests/procedures so that they will be completed as soon after admission as possible, and the attending physician should document in the patient's progress notes the reasons that the workup could not be completed as an outpatient.

Rationale: It is recognized that on occasion patients cannot be worked-up on an outpatient basis. All unnecessary acute days should be eliminated by prior scheduling while providing for the health and safety of the patient.

3. PREOPERATIVE CONSULTS/MEDICAL EVALUATION

Preoperative consults or medical evaluations should be completed on an outpatient basis. The attending physician should schedule all laboratory, x-ray, consults, etc. prior to admission or for the day of admission. Patients may be admitted more than 24 hours prior to surgery only if the need for medical therapy or medical evaluation is documented by the attending physician and could not be performed as an outpatient.

Rationale: Same as that for #2 above.

4. INPATIENT EVALUATION (after need for acute care ceases)

A patient no longer requiring acute care should be discharged to complete any medical evaluation or additional studies as an outpatient unless there is danger to the patient's health or safety.

Rationale: It is extremely costly for a patient to remain hospitalized for testing that could be provided as an outpatient, even though it may be the most convenient method to both patient and physician.

5. INCIDENTAL OR NONPLANNED SURGERY DURING HOSPITAL STAY

Patients scheduled for surgery during the hospital stay should be discharged and readmitted 24 hours prior to surgery, unless scheduled within 48 hours or other acute medical care is being rendered.

Rationale: Although convenient for physicians, patients, and families, it is extremely costly for patients to remain hospitalized awaiting the availability of surgical suites.

6. LEAVE OF ABSENCE

LOA's are not acceptable during acute care hospitalization except in the following specified circumstances: 1) Personal emergency and/or extenuating circumstances documented by the attending physician; 2) Procedure/test or consultation not available at facility; 3) As a definitive part of treatment plan for psychiatric or rehabilitation patients as specified in the protocol for the program.

Rationale: "Acute care" by definition requires the continual monitoring and care by trained professionals not available in any other setting.

7/80

AMERICAN DENTAL ASSOCIATION,
Washington, D.C., April 6, 1981.

Hon. DAVID DURENBERGER,
Chairman, Subcommittee on Health, Senate Finance Committee, Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR DURENBERGER: The American Dental Association appreciates this opportunity to comment on the recent proposal of the Administration to phaseout the Professional Standards Review Organization (PSRO) program.

As member of this Subcommittee are aware, the Administration proposal would in effect repeal Public Law 92-603, which originally established the PSRO program. Specifically, the Administration has recommended that federal funding be continued only through fiscal year 1983 for those PSROs judged effective in "controlling health care costs". After fiscal year 1983, it would be expected that the most efficient PSROs would be supported by private systems of health care which contract for their services. In addition, the Administration has also proposed the elimination of the requirement for utilization review committees for providers not covered by PSRO review.

Since the inception of the PSRO program, which was established to utilize peer review to assure the quality and necessity of health care services provided under Social Security health programs, the dental profession has been involved in efforts to assure the proper participation of dentists in reviewing dental care services subject to PSRO review.

In this connection, the Association commends members of the Subcommittee and the 96th Congress for enactng amendments to the PSRO law, as part of the Omnibus Reconciliation Act of 1980, Public Law 96-499, which would expand dentistry's participation in the PSRO program at the national, state and local levels. Specifically these statutory changes mandate dental membership on the National Professional Standards Review Council and Statewide Advisory Groups. In addition, these amendments would allow PSROs to include dentists as members at the local level.

The dental profession was encouraged by these legislation initiatives as steps towards recognizing that dentists, as the primary providers of oral health care services, must be provided the responsibility for reviewing dental care services.

With respect to the Administration's proposal to phase-out federal funding of the PSRO program, the Association recongnizes and agrees with the necessity to reduce federal expenditures, while maintaining essential health care services, including dental care, for the elderly and needy of our society.

Because of the previous exclusion of dentistry from a meaningful role in the program, it is not possible for the Association to make a judgment as to its effectiveness.

We do agree that the Congress should carefully evaluate the past record of this program to assess whether or not PSROs have been accomplishing their stated goals of quality assurance and necessity of health care services without unduly interfering with appropriate judgments made by professional health providers or adversely affecting peer review mechanism already developed and supported by the dental profession as well as other providers of services.

If the PSRO program fails to demonstrate that it has been a viable peer review mechanism in assuring quality care services, the federal funding for the program should be phased-out according to the Administration proposal.

In any event, the Association recognizes the responsibility of the profession to assure quality dental care services through appropriate peer review for the people of this nation. It is essential that no matter what form of peer reveiw mechanism evolves, either in the private sector or a government sponsored program, dentists, as the primary providers of oral health care services, must be delegated the ultimate responsibility for making the appropriate professional judgment in connection with the review of such services.

Despite the enactment of the amendments noted above it is clearly discriminatory to allow the PSRO law and its implementation to stand as it presently exists with regard to the dental profession. It is wholly contrary to any rational understanding of peer review to mandate review of dental services without a mandate of equal force that dentists shall conduct such review.

Members of the dental profession believe that changes providing for full participation of dentists in the peer review process are critical if the PSRO program is to be effective and equitable with regard to dental care. If such equitable changes are not adopted by Congress, we view the current deficiencies in the PSRO law as overwhelming flaws with regard to the review of dental services.

The Association appreciates this opportunity to submit its comments on the PSRO program.

Sincerly,

WILFRED A. SPRINGER, D.D.S.,
Chairman, Council on Legislation.

AMERICAN HEALTH CARE ASSOCIATION
Washington, D.C., April 7, 1981.

Mr. ROBERT E. LIGHTHIZER,
Chief Counsel, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. LIGHTHIZER: On March 12, the Committee on Finance's Subcommittee on Health held hearings on the Administration's proposal to phase-out Professional Standards Review Organizations and eliminate federally mandated utilization review.

The American Health Care Association is the nation's largest federation of licensed nursing homes and allied long term care facilities. As such, we would like to submit the attached statement describing our views on this subject for inclusion in the printed record of the hearings.

If there are any questions, please contact Maureen Noonan on staff.

Sincerely,

WILLIAM HERMELIN,
Administrator, Government Services Department.

Enclosure.

The American Health Care Association (AHCA) is the nation's largest federation of licensed nursing homes and allied long term health care facilites. Our 7,000 facility members care for more than 700,000 residents. Many of our members and state affiliates have had extensive experience with PSRO long term care review. All providers of long term care have participated in utilization review.

AHCA is aware of the Administration's intent to phase out Professional Standard Review Organizations (PSROs) and eliminate federally mandated utilization review. We endorse the concept of eliminating unnecessary spending and federally imposed duplicative review systems. We also realize that the goals of PSROs and utilization review—ensuring quality and appropriateness of care—will and should be retained. We will address the strengths and weaknesses of the long term care PSRO program and utilization review and make recommendations for substantial changes that will be necessary to assure that essential, fair and cost effective review of patient care and placement occurs.

THE CURRENT SYSTEM

State Medicaid agencies conduct annual certification surveys of nursing homes to determine compliance with standards and conditions of participation in Medicare and Medicaid. These standards address staffing, staff qualifications, policies, procedures and the physical plant. Surveys also include a review of patient charts in areas where PSROs are not conducting long term care review. State agencies also conduct "inspections of care" (formerly called "Medical Review" and "Independent Professional Review") where the needs and services provided all patients are reviewed at least once a year.

These inspections of care and certification surveys both address the quality of care. Appropriate patient placement is addressed by the inspection of care and the facility standard that requires utilization review by a team of physicians in facilities. In most states, surveys and care inspections are carried out by separate agencies; in a few states, the two inspections are carried out by separate agencies; in a few states, the two inspections are coordinated through a single agency.

Fifty-four PSROs currently perform long term care review. They are located in 27 states. Fifteen statewide PSROs are involved in long term care review. When a PSRO is authorized to conduct binding long term care review, its review replaces facility utilization review and the state inspection of care. PSRO review of long term care patients may begin in a hospital where a PSRO reviewer or hospital reviewer (in a delegated facility) recommends discharge to a different level of care.

PROBLEMS WITH CURRENT SYSTEM

The above description of the current system points to the most obvious problem—duplication. When a PSRO is conducting long term care review, both the PSRO and

the certification survey team reviews quality of care. When these two groups have different standards and interpretations of quality of care, their findings are contradictory and conflicting. A similar problem exists when a state run inspection of care survey is in place rather than a PSRO. The inspection of care team and certification team may disagree on recommendations to facilities. The inspection of care review of patient's appropriate placement duplicates the efforts of facility utilization review committees. Most PSRO and state review systems are heavily dependent on paperwork documentation and therefore, place a significiant paperwork burden on facilities.

Before the current system of Professional Standards Review Organizations and other utilization review programs are discontinued, we suggest that a careful examination of the strengths and weakness of these programs be conducted.

PSRO IN LONG TERM CARE

Earlier this year, AHCA conducted a comprehensive survey of state health care associations where PSROs were conducting long term care review. These state associations identified the following problems:

PSRO findings often contradict other agency findings, leaving providers confused over needed corrections.

Some PSROs extend their review to areas clearly the responsibility of certification teams, causing inefficient and costly duplication of efforts.

PSRO sanction authority removes from the appropriate state regulatory department the responsibility to correct unsatisfactory health care services.

In an apparent effort to prove their cost effectiveness, some PSROs have caused large-scale decertification to lower levels of care without considering bed availability.

Some facilities have found that the frequent visits by PSRO reviewers necessitate excessive expenditures of facility staff time to help the reviewer.

The accuracy and acceptance of level of care determinations that are made by acute care hospitals PSRO delegated reviewers have presented problems. In some instances, individuals assessed by delegated acute care staff as needing skilled care care, upon admission to a skilled nursing facility, changed by the PSRO to an intermediate level of care.

Because hospitals are reimbursed for skilled level and not intermediate level patients, some hospitals are assessing intermediate level patients as skilled level patients.

Long term care's experience with Professional Standard Review Organizations has had positive as well as negative aspects. When the PSRO has invited involvement on long term care professionals in program design and implementation and has strived to be cost effective, the review has proved to be efficient, constructive and has shown peer review in its best form.

State affiliate members of AHCA reported the following benefits of effective PSRO long term care review:

PSROs take an educational approach to bring about change through cooperative relationships with providers.

The peer review component is of particular advantage to the program as the individual physician is more likely to respond and improve his practice if review is conducted by local practicing physicians. Also, the review is more credible to the local practitioner when local program control and the peer review process lead to realistic and legitimate goals.

Unlike state regulatory activities, PSRO long term care review fosters greater physician involvement in long term care because it holds physicians accountable to their peers for the quality of their practices.

The review is outcome-oriented because it identifies specific approaches for improvements.

PSROs may perform quality assurance review that is both timely and realistically centered on patient care rather than on documentation.

PSRO reviewers with recent long term care experience understand the realities of long term health care provisions.

Some innovative PSROs have begun "focused" review where only those patients in need of assessment for continued stay are reviewed. These PSROs have also established mechanisms for conducting some reviews by phone and through the mail, thereby reviewing patients efficiently without interrupting facility activities.

AHCA RECOMMENDATIONS FOR FUTURE REVIEW SYSTEMS

The American Health Care Association believes that the Federal plan for the elimination of PSROs and the withdrawal of other utilization review requirements

will have a significant impact on the long term care system. We believe that a new utilization review system must be developed and we recommend that four principles be followed in establishing the system: (1) the system should be cost effective; (2) the utilization review system must acknowledge the ability of providers to deliver services; (3) the utilization review process must not be used as a tool to arbitrarily reduce Federal and State program costs by unfairly limiting patient access to services; and (4) the system should include minimum Federal standards with State flexibility for implementation.

1. Cost effectiveness

Review of patient need for services should not require excessive administrative costs, duplicate other review systems or include unneeded activities.

We suggest that States be limited in the amount of Federal funds that can be expended for administration, rather than patient services. In addition, facility administrative requirements for conducting review should be subject to Federal paperwork burden reviews so that facilities are protected from unnecessary requirements.

AHCA questions the value of including quality assurance as a part of utilization review. We recommend that quality assurance be eliminated from current PSRO and utilization review systems and be left to the responsibility of licensure and certification offices.

New systems of review should also eliminate the requirement that all patients be reviewed at frequent intervals, no matter what their condition or prognosis. Data collected during past experience with PSRO and utilization review should be used to establish time tables for review. Certain patient conditions should suggest benchmark time periods for the need for review. Patients who are terminally ill, whose condition is deteriorating or who have little potential for improvement should not be reviewed after such medical determinations are made.

2. Recognition of facility abilities

Utilization review must disallow both over and under utilization. In order to control health care costs, services must be provided in the most cost effective setting. For example, when a patient needs the services available in a skilled or intermediate care facility, those services should not be provided in an expensive acute care setting.

Under utilization must also be a concern of an effective utilization review system. For example, when twenty-four hour nursing services in a skilled nursing facility are needed, an intermediate care facility placement should be viewed as inappropriate. A patient should not be prematurely discharged from a hospital if a long term care facility does not provide the services needed by the patient. Patients should not be denied institutional services if community services cannot meet the patients needs after discharge.

We are suggesting, therefore, that utilization review be the responsibility of a total system that considers the entire continuum of care. A fragmented system that looks at one level of care at a time would be a disservice to the facility involved, if it places unrealistic expectations on that facility. Fragmentation would also be a disservice to patients if it resulted in appropriate placement.

3. Utilization review must not be self-serving

We fear that utilization review could be used by States or others to arbitrarily limit the availability of services, in order to save program costs. New review systems must not be permitted to use, as a major criterion, available health program dollars.

Utilization review is a gate keeper process. The process assigns or denies patients to a level of care and setting. An irresponsible system could lead to:

Large scale reduction in level of care assignments to prove the cost effectiveness of the utilization process.

Denials of services because of program funding limitations.

Hospital retention of patients not necessarily needing acute care in order to maintain census levels, or to maximize the use of Medicare rather than Medicaid funds.

Transferring patients in need of skilled or intermediate care to board and care or residential facilities as a means of transferring the cost of the services from Medicaid to the Supplemental Security Income System.

Retroactive denial of payment when program funds are found to be insufficient.

Utilization review should serve as part of the protective net that assures that patients receive the services they need. Cuts in Federal and State health spending programs could encourage denial of services that are truly needed. We suggest that

new utilization review programs should be responsible for assuring that needed services, at the appropriate level, are not denied.

4. Minimum Federal standards

A basic problem with the PSRO and other utilization review programs has been Federal interference with program implementation. We suggest that broad outcome oriented standards, such as those factors which we have discussed should be mandated by the Federal Government. Specifics of program implementation should be the responsibility of State agencies. There must be a common understanding of utilization review concepts by Federal and State governments, providers of care and program beneficiaries.

Federal standards should be designed to protect the welfare of patients and to assure that States meet their responsibilities to those in need. Within general Federal guidelines, States should shape their own review systems, giving providers of care specific instructions for carrying out the program.

CONCLUSION

The American Health Care Association recommends that considerable study and planning be undertaken prior to major changes in the utilization review system. We suggest that minimal Federal guidelines be developed and designed to protect the integrity of the long term care system and to ensure that patients needing long term health care receive services in the appropriate setting. We believe that States should be able to retain effective PSROs and other State review systems where they meet basic standards.

In addition we believe the utilization review system should be in the physician community and not in the political community.

AHCA would welcome the opportunity to participate in the development of Federal standards for a new system of review.

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION TO THE SUBCOMMITTEE ON HEALTH OF THE SENATE COMMITTEE ON FINANCE ON A PROPOSAL TO PHASE OUT PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS, MARCH 31, 1981

The American Hospital Association (AHA), which reprsents more than 6,100 member hospitals and health care institutions, is pleased to have this opportunity to present its views and recommendations on the Reagan administration's proposal to phase out federal financial support for the Professional Standards Review Organization (PSRO) program.

We support the administration in its efforts to withdraw federal support from the program and urge the Congress to take the next step: to repeal the program's legislative authority (Title XI, Part B of the Social Security Act). Last month, the AHA House of Delegates voted to "actively seek repeal of the PSRO law." This vote was a rejection of an ineffective federal program, and not an abandonment of our historic commitment to assure the quality of care patients receive in our nation's hospitals. The House resolution went on to reaffirm and strengthen this commitment by adding that PSRO repeal must "be accompanied by concerted action by the AHA to assist member hospitals in upgrading their patient care appraisal capabilities where such deficiencies exist." Later in this statement we will describe some private programs that are being developed.

The AHA has consistently supported quality assurance as a function of health care institutions, and has also actively urged and encouraged physicians and other health professionals to participate in quality assurance activities conducted within institutions. The Association published its own "Quality Assurance Program for Medical Care in the Hospital" in 1972, setting forth the administrative framework to assist institutions to develop and implement a systematic approach to the assurance of high quality health care services in the institutional setting. We also have adopted separate policy and guideline statements on "Quality Assurance in the Health Care Institutions and Utilization Review in Health Care Institutions." These were recently revised and updated, and adopted by our membership. They declare that health care institutions should conduct quality assurance programs, including mechanisms for establishing standards for proper health care that are appropriately and reasonably consistent with those developed by professional, accrediting, and governmental bodies to determine the quality of care being provided and to correct identified deficiencies. They also say that health care institutions should evaluate the medical necessity, appropriateness, and efficient use of health care services and facilities for all patients as a means of improving the cost effectiveness of the health care delivery system.

While the AHA has a number of concerns about the PSRO program, foremost among them is cost effectiveness. We are sure this Subcommittee is aware of studies done by the Congressional Budget Office and General Accounting Office which show that the cost effectiveness of the program is marginal at best and that the program may cost society more than it saves. The lack of proven cost effectiveness, coupled with rigid federal demands placed on hospitals and the refusal by the government to pay adequately for delegated review, has led us to believe that the best policy is to seek repeal of the program. We believe that, while utilization review and quality assurance activities are necessary, they are best conducted at the institutional level without rigid federal regulation and interference which hinder, and may even prevent, individual hospital adaptation.

The administration also is proposing to repeal the federal utilization review requirement. We are studying this proposal and are not yet ready to comment on it.

As indicated by our House of Delegates' position, the AHA believes that initiatives in the private and voluntary sectors should form the foundation of quality assurance activities. National and state organizations, and individual hospitals, have developed, and will continue to create, programs to expand and improve institutional quality assurance programs. These activities promote innovation and flexibility in response to local needs of the health delivery system. Future national policies should support these efforts to strenghten quality assurance at the provider level.

In this context, we would like to indicate to this Subcommittee our support of the new quality assurance standard of the Joint Commission on Accreditation of Hospitals (JCAH). The standard requires that each hospital, in order to be accredited, must develop an organized, integrated quality assurance program pursuant to a written plan, maintain ongoing objective assessment of patient care, and correct identified problems. The AHA supports JCAH efforts in this area and believes that federal programs also should support them.

In addition, the AHA is involved in the development of several programs and activities designed to improve hospital quality assurance programs in accordance with indentified needs. One such effort is the AHA's "Quality, Trending, and Management for the 80's" (QTM-81), a series of programs designed to enhance the theory and practice of quality assurance and risk management at the institutional level. Emphasis has placed on incorporating these activites into the development of comprehensive management information systems. We believe that the development and support of programs such as QTM-81 are important components of future strategies in utilization review and quality assurance.

Quality assurance and utilization review activities are designed to ensure that all services rendered to patients are necessary. Therefore, we believe that all purchasers of care, including government, voluntary prepayment and private health insurance carriers, and self-paying patients, should pay their proportional share of the full costs of conducting utilization review and quality assurance programs in hospitals. Payment policies should be designed with sufficient flexibility to respond over time to needed adjustments in such programs. We believe that this principle must be considered explicity in the development of future federal policies in this area.

CONCLUSION

The American Hospital Association supports the Administration in its efforts to phase out federal support for the PSRO program and urges the Congress to repeal its legislative authority. We intend to continue to promote vigorous quality assurance and utilization activites at the level where they most properly belong—in the institution. We welcome cooperative efforts to develop local utilization review and quality assurance mechanisms that will serve the needs to federal health benefit programs.

We thank the Subcommittee for this opportunity to present our views and would be pleased to provide any further information or assistance that its members might request.

COMMENTS SUBMITTED BY THE AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

INTRODUCTION AND BACKGROUND

The American Society for Medical Technology (ASMT) appreciates this opportunity to share with you our views on impending action in the Congress on the Professional Standards Review Organization (PSRO) program. The American Society for Medical Technology is a national professional membership organization representing more than 22,000 health care professionals who are engaged in the delivery of clinical laboratory services. ASMT membership represents a diversity of clinical

laboratory specialists and generalists within the clinical laboratory sciences. It includes clinical laboratory administrators, supervisors, educators, technologists, technicians, assistants and such specialists as hematologists, immunohematologists, microbiologists, clinical chemists, cytotechnologists, histotechnologists and nuclear medicine technologists. ASMT members are highly skilled clinical laboratory scientists who perfrom or supervise clinical laboratory tests and assume responsiblity and accountability for precise and accurate results. Consistent with our "scope of practice," our members are responsible for assuring reliable test results, including the integration, correlation and interpretation of test data. As generalists and specialists, we work in a wide range of governmental and non-governmental laboratories. Members' places of employment include blood banks, private or independent laboratories, physicians' offices, clinics, research institutes, hospitals and commercial firms that manufacture and distribute technological or pharmaceutical products. Approximately 85 percent of ASMT's membership currently hold academic degrees at or above the baccalaureate level.

In 1977, hospital and clinical laboratories performed an estimated 5 billion tests at a cost of approximately 11 billion health care dollars.[1] Between 1970 and 1975, the number of laboratory tests performed increased at an average annual rate of 13.8 percent in hospital laboratories, and 15.6 percent in independent (non-hospital) laboratories.[2] It is safe to assume that this rate of growth in laboratory services has not abated over the intervening five years, and indeed, in 1980, some 10 billion laboratory tests probably were performed in the nation's hospital and clinical laboratories at an estimated cost of some $20 billion. Indeed, the rate of growth in performed laboratory tests has been remarkable. For example, according to a 1977 report published by the National Center for Health Services Research, "the average number of laboratory tests for perforated appendicitis increased from 5.3 in 1951 to 31.0 in 1971. For maternity care, the number of tests rose from 4.8 to 13.5 during this period. For breast cancer, the number of tests increased from 5.9 to 27.4."[3] Given the continued fear of malpractice litigation, the "need" to practice defensive medicine, and the unique role physicians play in the creation of "demand" for health services that have a strong relationship to their earning capacity, it probably would be prudent to assume that the growth of laboratory service use will continue.

Unquestionably, concern about the impact of the growth in the use of laboratory services on private sector health care expenditures is even greater when considering the nature of the constituency served by federally supported health care programs. The aging of America's population will continue to increase that sector which may have the greatest need for health care services that are purchased, in part, with public resources. Increasing sophistication in measures to diagnose medical problems or to monitor measures used in medical treatment portend a continued reliance on clinical laboratory services. Indeed, modern medical diagnosis and treatment are dependent on reliable laboratory measures.[4] It only follows, then, that as providers of hospital and clinical laboroatory services, we at ASMT are especially interested in assuring the quality and necessity of these laboratory services that account for a significant portion of our nation's health care bill.

The Society, on behalf of its members and others in the clinical laboratory community, has been an active participant in congressional inquiries regarding clinical laboratory improvement, cost containment, fraud and abuse within the Medicare and Medicaid system, areawide health planning, and peer review. We believe we have established a respectable record in seeking to advocate for appropriate availability of high quality and cost-effective clinical laboratory services for all Americans, which is consistent with the major goals of the PSRO program:

> To assure that health care services are of acceptable professional quality;
> To assure appropriate utilization of health care facilities at the most economic level consistent with professional standards;

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[1] Kosowsky, D. I., New Opportunities in the Clinical Laboratory Industry. Arthur D. Little, Inc., Executive forum on Healthcare under the Carter Administration, 1977; Smithson, L. H., The Clinical Laboratory Report, prepared for the Long Range Planning Service, Stanford Research Institute, 1975; Fineberg, H. V., Clinical Chemistries: The High Cost of Low-cost Diagnostic Tests. In S. H. Attman and R. Blendon (eds.), "Medical Technology: The Culprit Behind Health Care Costs?" DHEW Publication No. (PHS) 79-3216, Washington, D.C., U.S. Government Printing Office, 1979.

[2] Zucker, B. (ed.), National Survey of Non-Hospital Clinical Laboratories. "Laboratory Management," 1976; Mohr, J. W. (ed.), National Survey of Clinical Labs. "Laboratory Management," 1971; Fineberg, H. V., op. cit.

[3] Goldfarb, M. G., Hornbrook, M. C., Kelly, J. V., and Monheit, A. C., Health Care Expenditures, In "Health Care United States 1980." DHHS Publication No. (PHS) 81-1232, Washington, D.C.: U.S. Government Printing Office, 1981.

[4] Jones, R. J. and Palulonis, R. M. (eds), "Laboratory Tests in Medical Practice." Chicago: American Medical Association, 1980.

To identify quality and utilization problems in health care practices and work toward their improvement;

To assure uniform and effective utilization review policy and practices;

To attempt to obtain voluntary correction of inappropriate or unnecessary practitioner and facility practices and, where unable to do so, to recommend sanctions against such practitioners and facilities; and,

To improve health care through education.

PSR: SOME PLUSSES AND MINUSES

The Society's involvement in the PSR program began with our efforts to apply voluntarily the concepts developed in the federal PSR program to activities within the clinical laboratory. ASMT participated with eleven other organizations representing health care practitioners other than physicians to develop a training paradigm to prepare health care professionals in the conduct of a retrospective review of health services (i.e., patient care audit). Subsequently, ASMT developed and conducted regional workshops nationwide, with federal support, to disseminate information on the use of the peer review program.

As a result of our involvement with these activities, we developed criteria and standards and selected norms to be used in the review of services provided by medical technologists and other clinical laboratory practitioners. The criteria developed addressed appropriately the standards relating to clinical laboratory personnel and laboratory operation.[5] These peer review criteria represent standard operating procedures for an effective and efficient laboratory system. These criteria are useful as a management, educational, or self-assessment instrument. They can be used as a guide for appropriate administrative, technical and professional standards for laboratory operation and as a vehicle for the development of management systems, techniques and policies.[6] In short, our Society has gained a great deal from its participation in activities developed as a consequence of the federal PSR program.

It is unfortunate that many of those who criticize the PSR program emphasize exclusively the perceived lack of success of PSROs relative to cost containment. We believe that there may be too much emphasis on the need for PSROs to demonstrate costs saved and insufficent emphasis on the quality assurance benefits derived from the program. At least as far as clinical laboratory practitioners are concerned, we feel confident in saying that the peer review process has heightened practitioners' awareness of the need to monitor job performance to avoid unnecessary or wasteful practices that do little to ensure top value for every dollar spent on clinical laboratory services. Unfortunately, the PSRO program does not have measures sufficiently sensitive to document how professionals' attitudinal and behavioral changes have resulted in the avoidance of costly, wasteful, needless or questionable laboratory practices.

Concern only with the cost savings aspect of the PSR program also occludes perception of the appropriate role the federal government has played in the development of professional peer review. The popular call today is to limit the role of government to attend to those public needs that cannot be attended to by state or local governments or by private concerns. Before Congress initiated the PSR program, there was not great interest in the peer review process as a means for monitoring and improving the quality of health services or as a means for thoughtfully reviewing "routine" procedures in terms of their necessity or effectiveness. The need to encourage widespread use of a peer review mechanism was not addressed adequately by state, local or private interests. Consequently, the federal government's involvement as a stimulator of professional interest was necessary and appropriate. In fact, the educational nature of many federal PSR activities with national, state and local provider organizations probably has been the most valuable aspect of the PSR program.

For instance, on March 19-20, 1981, Executive Resources Associates, on a contract funded through the Health Standards and Quality Bureau (HSQB) of the Health Care Financing Administration (HCFA), conducted a conference on PSROs and peer review. Representatives from 29 organizations of health professionals attended. In almost all instances, the message was the same:

(1) There is increasing interest in using the peer review process as a means of assuring cost-effective quality health services delivery.

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[5] Barros, A. (ed.), "The ASMT PSRO Manual," Houston, TX: American Society for Medical Technology 1975.

[6] Barros, A. Clinical Laboratory Scientists and the Peer Review Process. A paper presented at a conference on PSROs conducted by Executive Resource Associates, Washington, D.C., March 20, 1981.

(2) Health professionals are only beginning to learn the value of PSR concepts as a tool for improving professional services delivery and professional education and preparation.

(3) The educational stimulus provided by the PSRO program was appropriate and needed—and without it, it would have taken even longer for the peer review idea to catch on.

(4) While changes need to be made to enhance the value of PSROs relative to the interests and needs of non-physician health professionals, the program has heightened professional awareness of the need to review procedures and practices in terms of their necessity and cost effectiveness.

In other words, the seeds planted by federal involvement in the PSR program are only beginning to bear fruit for the over 500,000 primary and ancillary health care providers who are not doctors of medicine or osteopathy. With some changes in the current PSRO program and with continued federal assistance, the value of the federal involvement in this activity could be enhanced.

This is not to say that we have not perceived any shortcomings in the current PSRO program, because we have. Indeed, some of the positive benefits we have derived have been diminished by aspects that are the direct result of Congress's original design. For instance, a tenet of the PSRO concept was that physicians were in the best position to monitor the quality and necessity of services rendered in the health care delivery system. Consequently, only physicians (doctors of medicine or osteopathy) may be members of a PSRO and fully participate in the overview of specific health services. Care delivered by other health professionals may be subject to the PSRO review process, but only since 1978 have health professionals other than physicians even been allowed to sit on PSRO boards or make decisions relative to review findings.[7] Congressional changes in the original PSRO authorization did not require, but simply permitted, the participation of non-physician health providers on PSRO boards. Even today, a substantial number of PSROs continue not to have non-physician health professionals represented on their boards.[8]

This is unfortunate since the quality and cost effectiveness of health services rendered today are dependent on the efforts of a multiplicity of health professionals and not solely on physicians. Laboratory practitioners, nurses, pharmacists, dieticians, rehabilitative specialists, psychologists, optometrists, dentists, social workers and others play important roles in the provision of care every patient requires. Physicians must rely on the judgment of other health professionals with training and experience in areas which are not emphasized in physicians' training or are not a regular part of physicians' daily practice.

The continued physician-centered focus of PSRO boards, in part, has frustrated repeatedly the efforts of non-physician clinical laboratory practitioners to contribute fully to the peer review process. For instance, no one knowledgeable of the methods of clinical laboratory services delivery would contest the essential role medical technologists and other laboratory professionals play in rendering those services.

Non-physician clinical laboratory scientists, however, have been rebuffed repeatedly from participating in the hospital laboratory peer review process on the premise that the physician-pathologist alone is the responsible agent for laboratory services delivery. PSRO board physicians and hospital administrators continue to fail to recognize the positive contributions clinical laboratory scientists can make in such areas as timeliness of care, appropriateness of physician-ordered laboratory measures, and the preadmission review of those ancillary services that influence admission decisions.

The quality and cost of the health services every hospital patient receives is influenced by the participation of every health professional who provides for that patient's care and not solely by the participation of the attending or consulting physician. It would follow, then, that all of those who rendered that patient's services should be a part of that process which reviews that care. It is not sufficient to audit only physicians' contribution in surgery to evaluate the quality of surgical care. It also is necessary to evaluate the roles of nurses, respiratory therapists, radiologic technicians and clinical laboratory practitioners who also are involved in the delivery of key facets of patients' surgical care.

COMPETITION—UNTIL THEN

Critics of the PSRO program quickly point out that "competition" in the health care delivery system would supplant the need for federal regulatory activity relative to areawide planning and enforced peer review. Perhaps this is so. If indeed this

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[7] Altieri, A. J. Non-physicians Join Team in Reviewing Health Care. "Forum: Health Care Financing Administration." October 1980.

[8] Ibid.

proves to be the case, competition would be preferable to needless federal regulations and encumbrances. We are reluctant, however, to support the rapid phase-out of PSROs wthout the assurance of enacted federal legislation designed to make the health service delivery system a competitive environment. While there are disagreements among the experts, some health economists have estimated that it might take at least ten years to create an environment that would be truly competitive. In the meantime, it might be more prudent to seek an appropriate balance between current and future federal legislative and regulatory programs until there is sufficient evidence that nonregulatory approaches will suffice. We fear that swift abandonment of the PSR program might result in a void that cannot be filled by a more appropriate mechanism designed to assure the delivery of high quality and cost-effective health services. Precipitous abandonment of the PSR program also might erode the inroads many concerned health professionals have made in convincing their colleagues of the need to monitor and improve their own practices.

At the very least, we hope the Congress recognizes the value of doing what it can to make sure that health care practitioners in the private sector continue (or in some cases, begin) peer review activities even without federal monetary support. There is no reason why competent health care professionals should not be expected to develop and engage in a process designed to help ensure that consumers receive appropriate and cost effective health services.

SUMMARY

In summary, then, the American Society for Medical Technology:

Believes that our involvement in federally supported PSR activities has heightened clinical laboratory practitioners' awareness of the need to monitor daily job performance to avoid unnecessary or wasteful practices;

Believes that this heightened professional awareness has resulted in the *avoidance* of practices and procedures that would have wasted valuable health care dollars;

Believes that the avoidance of needless costs needs to be more accurately assessed to determine the true cost savings resulting from federal PSR program involvement;

Believes that the continued physician-centricity of many PSRO boards has limited significantly the valuable participation of health professionals in PSR activities;

Contends that the involvement of *all* health professionals in *all* levels of the PSRO program is essential to the success of the peer review process;

Emphasizes the need for PSRO boards to recognize the positive contribution of health professionals other than physicians to the delivery of high quality and cost-effective health services;

Notes the very valuable educational stimulus the PSR program has given to national, state and local health care provider organizations;

Believes that congressional support for PSROs should not be abandoned without first enacting and implementing a health service delivery mechanism based on a competition approach; and

Believes the Congress should require all health providers to participate in peer review activities as a condition of participation in federally-supported health programs.

STATEMENT BY BEVERLEE A. MYERS, DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES

Thank you, Mr. Chairman and members of the Committee. My name is Beverlee A. Myers. I am the Director of the Department of Health Services which is the single state agency for title XIX in California. I was formerly the Director of the New York State Title XIX Agency and have spent eleven years in various capacities with the federal government. We appreciate this opportunity to present our views on the Professional Standards Review Organization (PSRO) program and utilization review efforts in general.

We agree that federally-funded health care programs must be reformed if we are to meet the challenge of curtailing continued cost escalation. Our primary concern is with the Administration's short-sighted proposal to dismantle requirements for utilization review systems[1] without a well-defined plan to reform federally-funded

[1] The Committee's invitation to provide testimony expressed interest in ". . . receiving testimony relevant to . . . the Administration's proposals to . . . eliminate the requirement for utilization review committees in providers not covered by PSRO review . . ."

health programs. Without controls, the perverse fiscal incentives currently existing in the fee-for-service delivery system will exacerbate the continuing escalation of health care costs. It is a quantum leap from discomfiture with the performance of some PSROs to the conclusion that utilization review efforts are without any redeeming social value.

Utilization review efforts should be expected to produce at least a "sentinel effect" [2] if not actual monetary savings. In California, we have a utilization review system which produces a sentinel effect and monetary savings to government programs and society as a whole. Using the same assumptions the Health Care Financing Administration (HCFA) uses in developing its benefit-cost estimates for the PSRO program, we derived an approximate 12:1 benefit-cost ratio.[3] If we apply the Congressional Budget Office theory [4] of utilization review impact on "resource savings" (changes in the total societal expenditures of resources for health care) instead of "reimbursement savings" (changes in government outlays for health care), we estimate the benefit-cost ratio would be reduced to approximately 6:1. These results were produced by state-employed physicians and nurses in a non-focused, non-delegated review mode of extensive pre-service and onsite concurrent review. Current benefit-cost estimates can be expected to increase to the degree that anticipated automation of our field offices will allow us to systematically focus our review resources on documented problem areas.

It should be pointed out that there are other potentially profound influences on all benefit-cost estimates of utilization review systems. Primary among these influences are the "Roemer effect" (postulated tendency that excess hospital bed supply articially inflates demand) and the "spillover effect" (tendency for physicians whose behavior under government health programs is modified by utilization review intervention to transfer that modification to treatment of private patients also). In the absence of conclusive information on the magnitude of these two influences, we are assuming they negate each other as HCFA assumed in its most recent PSRO program evaluation.[5] In summary, we believe that utilization review will continue to be necessary in advance of systematic reform of the health care delivery system in federally-funded health programs. The need for ongoing intensive utilization review efforts may eventually be abated to the degree that reform can permit competitive forces to negate the perverse incentives in the current fee-for-service system. In the meantime, we will continue to perform utilization review, attempt to improve its efficiency and effectiveness, and cooperate fully in further reform efforts.

We would invite you to conduct your own independent evaluation of our utilization review system. We believe it has many cost-effective, quality-sensitive facets that could be applied to other federal health care programs.

Statement on Professional Standards Review Organizations Submitted by Connecticut General Life Insurance Co., Hartford, Conn.

STATEMENT

The Senate Finance Committee is considering the question of continued funding for concurrent hospital utilization review programs performed by professional standards review organizations, as mandated by Public Law 92-603. The following information may be pertinent to that deliberation.

In 1978, Connecticut General began working with PSRO's in establishing programs of concurrent hospital utilization review for our privately insured customers. This effort was part of an overall program that contains other elements, such as contract design, second opinion surgery, employee education and management information. This overall program was designed to provide our customers a means of retarding the escalation of their health care costs by attempting to impact those

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[2] "The Sentinel Effect is not a new phenomenon as it has been shown repeatedly in medical and sociological studies that knowledge of the existence of surveillance or monitoring influences the behavior of those being observed or monitored."

Source: HCFA Report entitled "Eight Years' Experience With A Second Opinion Elective Surgery Program: Utilization and Economic Analyses", pg. xii (March 1981).

[3] "Benefits and Costs of Medi-Cal Prior Authorization of Acute Hospital Days", California Department of Health Services, Medi-Cal Operations Division, Utilization Control Section (February 1981).

[4] "The Impact of PSROs on Health-Care Costs: Update of CBO's 1979 Evaluation", Congressional Budget Office, pg. 15 (January 1981).

[5] "Professional Standards Review Organization 1979 Program Evaluation", HCFA Office of Research, Demonstration, and Statistics, pg. 84 (May 1980).

costs before or as they were being incurred, as opposed to the more traditional approach of reviewing them on a retrospective basis. We began working with our larger customers, gradually expanding these programs to include our general book of business.

One of the key elements has been contracts with review organizations who have generally developed their own process and experience through their efforts with the Federal PSRO program. We have or have had contracts with the Hartford County Health Care Plan, the Mid-West Foundation for Medical Care, the Colorado Foundation for Medical Care, and the Southeast Wisconsin Foundation for Medical Care. We have been actively negotiating contracts with review organizations in Cleveland, Columbus and Miami. We've received proposals for private sector review from Iowa, Washington and upper Michigan.

What is needed is a basic support of the Federal Government until these efforts can gain in strength as well as the encouragement of the Federal sector for the initiation and implementation of such programs. We would, therefore, make the following recommendations:

1. The Federal Government should eliminate those PSRO's that have been ineffective.

2. The Federal Government should provide continuing financial support to PSRO's only if the following conditions are met:

That they have a proven record of effective operation;

That they develop and offer concurrent hospital utilization review to the private sector, and can produce evidence of actual participation by the private sector.

3. The PSRO program should contain cooperation and appropriate incentives to encourage hospital in concurrent utilization review programs.

From a study concluded here in Hartford, we are convinced that concurrent utilization review process has significant savings attached to it. Copies of the full study and the Executive Summary have been provided to Committee staff. We have provided data to a large customer in the Connecticut area that shows that the nine hospitals under review have an average length of stay of approximately one day shorter than the confinements the rest of their employees experience throughout the state of Connecticut. Since an identical medical plan is provided to all of their employees, the only variable seems to be the presence of concurrent hospital utilization review in Hartford County. This experience appears to be confirmed in materials published by other employers in the Mid-west who are also participating in concurrent utilization review programs.

While PSRO's have often been willing to provide concurrent review on a fee-for-services basis, a major stumbling block has been their inability to convince hospital administrations to participate in this voluntary program. Success, where it has come, has generally been the result of the leverage of a large customer in a given area who is convinced of the value of these programs. Even then, dialogue has often gone on for upwards of a year.

We are convinced of the value of the concurrent utilization review process and feel that, if the private carriers can be included in the program, economies of scale could be achieved that would provide reduction in Federal expenditures while making the programs more efficient. Additionally, the President's objectives of involving private sector and lessening the regulatory burden could be achieved through this local involvement. The evolving business groups on health are evidence of the greater interest in community-oriented action to resolve some of these health care cost issues.

What is needed is a basic support of the Federal Government until these efforts can gain in strength as well as the encouragement of the Federal sector for the initiation and implementation of such programs. We would, therefore, make the following recommendations:

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That they have a proven record of effective operation;

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3. The PSRO program should contain cooperation and appropriate incentives to encourage hospital cooperation and participation in concurrent utilization review programs.

FOUNDATION FOR HEALTH CARE EVALUATION,
Minneapolis, Minn., March 20, 1981.

Hon. DAVID DURENBERGER,
U.S. Senate,
Washington, D.C.

DEAR SENATOR DURENBERGER: Thank you and your staff for identifying the Foundation as a potential speaker before the March 23, 1981, Senate Finance Committee hearing on PSRO. The preparation time afforded us was insufficient to develop testimony of the scope and detail warranted. Instead, we are writing to express our interest in your deliberations and to outline a few themes which we would hope to discuss with you in the immediate future.

The Finance Committee will hear ample and conflicting testimony on the cost-effectiveness of PSRO. It is not our purpose to cloud the decisions you face with methodological debate or with instances of individual achievement. Our purpose is not to justify the status quo but to offer possibilities for future direction.

The Foundation for Health Care Evaluation has spent half of its organizational life as a PSRO. Regardless of administration or approach, we will continue to grow as a physician organization dedicated to quality care at reasonable cost and committed to community involvement. From this perspective we have evolved certain beliefs pertinent to the future of peer review:

We believe that the basic purposes of PSRO resound as clearly today as when Public Law 92-603 was enacted.

We believe that the nation has made a substantial investment in PSRO which should be used.

We believe that efficient organizations can thrive in any environment as long as they effectively meet genuine needs.

The functions of peer review have a legitimate role to play in a pluralistic health care system. In the 1960s Congress responded to health care problems of accessibility and availability with legislation to increase the supply of services and to reduce financial barriers to access. In achieving success, such interventions helped stimulate new problems of excess capacity and overutilization. These new problems lead Congress to turn to controls. Now, marketplace incentives are proposed to deal with some of the excesses and costs of regulation. We are supportive of competition but urge caution in removing controls on utilization and quality before marketplace incentives fully take effect.

Moreover, we call attention to the fact that public accountability for health expenditures is not incompatible with competition. The metropolitan (Minneapolis/St. Paul) area is cited as a favorable environment for health care competition. Yet, its programs in rate review, PSRO and health planning are nationally recognized.

Continuing review of the care given federal beneficiaries can only enhance legislative initiatives aimed at stimulating competition. A peer review organization applies medical judgement equitably regardless of payment source or care setting. Providers thus compete on equal terms within this framework.

Professional standards review represents a substantial investment. The PSRO program has made a long-lasting contribution in developing utilization review techniques, health data, and regional standards of care. It would be unfortunate to see these resources withheld from federal beneficiaries just as they are being made available to providers and to beneficiaries of private plans. Successful PSROs also have relationships, organizational characteristics and skills which are not found in other agencies and which would take years to emerge in any new organization created to take their place. There are many examples of how a community values the unique resources and organizational traits of peer review. To remain competitive, nearly all health maintenance organizations have adapted peer review techniques from PSRO. Health data bases developed through PSRO are a critical resource for institutional planning and marketing. The Foundation, for example, has private data contracts with both the Minnesota Hospital Association and the Council of Community Hospitals. Insurance companies and employers are demanding utilization review from PSROs or are developing their own programs patterned after the PSRO model. In our area, we anticipate that 45,000 employees will be enrolled in private review by May 1, 1981. The companies purchasing this service are willing to pay more than the PSRO program. They are confident that the expanded and intensified review we offer will save health benefit dollars. As pressure to reduce utilization increases, quality assurance activities will ensure that regional medical standards do not falter as a result of cost containment or competition.

Any endeavor requires periodic revitalization to remain strong. Perhaps now is the time to explore alternative strategies for delivering peer review and health data services to the federal government. The functions and skills of PSRO are essential.

Certain organizational traits such as private management and physician participation are likewise essential. Other aspects of the present system are open to reform. We believe that the review methods and data now offered to major employers could be made available to the federal government. Such an offering could be made upon business terms without the encumbrance of many of the administrative rules associated with a federal program. We are exploring the ways in which such an arrangement could be effected. We hope to be able to offer some specific proposals in the coming weeks.

In summary, we urge you to accept the principle that assuring the quality, medical necessity and appropriateness of care regardless of payment source is a fundamental societal need. We encourage the federal government to join private employers in making better use of existing review resources. And, we ask that you thoughtfully reflect on the administrative form PSRO might take in the future.

Respectfully,

WILLIAM C. WOYDA, M.D.,
Medical Advisor.

SAMUEL W. HUNTER, M.D.,
Board Chairman.

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL,
Chapel Hill, N.C., March 30, 1981.

ROBERT E. LIGHTHIZER,
Chief Counsel, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. LIGHTHIZER: I received a notice of a hearing held by the Subcommittee on Health of the Committee on Finance on March 23rd. I regret that I was unable to testify at the hearing and send this letter and its attachment in support of continuation of systematic review of utilization and quality of care in some form.

It is recognized that effectiveness of PSRO's have not yet been clearly established. Nevertheless, I think that few thoughtful people would deny the importance of accountability in a system of health care as complex as ours.

Ambiguous or indifferent results of Professional Standards Review thus far may be traceable to either the still relative recency of a national program as complex as that now in existence, or, inherent weaknesses in the program, or both. It would seem that the prudent posture would be to continue critical review of performance of PSRO, as well as of other review programs, and to introduce modifications based on evidence of value of alternative methods.

The attached editorial discusses a review system that was inaugurated in New York City some years ago, and has been modified on the basis of experience. The editorial comments on the place of review in the system of health services, and on implications of the New York City program for that city, and for health service generally. The comments were based on a report of the program by M. Paris and colleagues published in the same issue of the American Journal of Public Health.

I enclose 5 copies of this letter and the editorial in accordance with specifications for comments included in the notice. You may wish to use these comments in preparing the record of the hearing.

Sincerely yours,

LEONARD S. ROSENFELD, M.D.,
Professor.

Enclosures.

MEDICAID MONITORING

Few would argue with the principle that any complex system needs monitoring to ascertain that it perform adequately and to guide change when performance is not satisfactory. The need for carefully designed monitoring is proportional to the complexity of the system.

In human systems, monitoring does more than provide information on performance: knowledge of the existence of surveillance influences the behavior of those being observed. The late Paul Lembcke noted, on the basis of experience in conducting a study of hysterectomies in three hospitals in Indianapolis, that the rate of these surgical procedures dropped dramatically even before results of the study were available, because the medical staffs of these institutions were aware that they were being observed.* He speculated that the presence of a stranger with horn

*Personal communication to the author.

rimmed glasses in the medical record room would probably have had a similar effect, regardless of the reason for the stranger's presence.

Indeed, the world would be a very different place if we each lived unobserved, and if deviation from socially acceptable norms did not evoke questions, the pointing of fingers, laughter, scorn, anger, or the application of sanctions. Mutual accountability is the essence of social organization.

Physicians, like other people, prefer a minimum of constraints. Freidson observed this in his studies of medical group practice which demonstrated that the satisfaction of participating physicians was inversely related to the degree of bureaucratization of the organization and accountability.[1] Indeed, the rear-guard action of organized medicine in opposing health insurance over the past 60 years is a manifestation of this attitude.

Methods of monitoring quality and utilization of health services are still of relatively recent vintage, and have not yet been sufficiently tested to take their place as accepted procedures. Evaluations of federally mandated utilization and quality review programs under the provisions of Medicare legislation and its amendments have not yet clearly demonstrated that the savings realized exceed costs of monitoring.

An article by Paris, *et al*, published in this issue of the Journal is the most recent of several papers which describe the development and effect of monitoring of ambulatory care in the New York City Medicaid Program.[2] The Evolution of the program from a hand review of vouchers submitted by providers, which was initiated by Lowell Bellin and Florence Kavaler, to a computer generated statistical system supplemented by other methods of surveillance was described in an earlier article.[3]

The system focuses on and selects those practices of providers that deviate significantly from norms. Further scrutiny of these practices by the New York City Department of Health through selected visits to offices, medical record reviews, interviews with and re-examination of patients and administrative review enables program administrators to identify evidence of poor care and abuse in a manner seemingly fair to the providers, the Medicaid beneficiaries, and the expenditure of public funds. These observations then become the basis for appropriate administrative action, which may include provider education, request for restitution of funds, or the application of sanctions. Information on these reviews is disseminated through the news media.

In the current report, Paris and his colleagues assess the effects of this system on subsequent behavior among those selected for review, as well as on the general universe of providers. They were able to demonstrate reductions in volume of service rendered by both groups and changes in practice resulting in closer conformance to accepted norms. They also demonstrate that the system is cost effective.

At a time of universal concern about cost containment in health care, and of contracting public funds for the various health and welfare services, these findings are of practical importance. The threat that these trends pose to adequacy and even the survival of health programs both in the United States and Canada highlights the importance of pragmatic and responsible systems of monitoring and administrative adjustment.

Federal Medicaid funding to Nebraska was terminated because of ineffective Medicaid fraud control.[4] The State of Alabama, after unsuccessfully seeking relief from the increasing burden of Medicaid costs, planned to terminate its program on June 1, 1980, a development closely watched by other states with similar budgetary problems. In Canada, a Royal Commission has been appointed to hear complaints from consumers and physicians. The former claim that ". . . more and more physicians are either billing their patients over and above the established Medicare** reimbursement levels, or are opting out altogether . . ." Physicians maintain that low levels of reimbursement are forcing them to see more patients and spend less time with each.[5]

The health economy is an integral part of the general economy. While one may debate the proportion of the Gross National Product that can be spent for health

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[1] Freidson E and Mann JH: Organizational dimensions of large scale group medical practice. *Am J Public Health* 1971; 61:786–791.

[2] Paris M. McNamara J and Schwartz M: Monitoring ambulatory care: Impact of a surveillance program on clinical practice patterns in New York City. *Am J Public Health* 1980; 70:783–788.

[3] Rosenberg SN, Gunston C, Berenson L and Klein A: An eclectic approach to quality control in fee-for-service health care: The New York City Medicaid experience. *Am J Public Health*, 1976; 66:21–30.

[4] *Washington Report on Medicine and Health*, 34(8): February 25, 1980.

** Term used to identify Canadian Health Insurance Program.

[5] American Medical News, April 11, 1980, p. 12.

care, it is obvious that these expenditures cannot increase indefinitely. Beyond a certain point, consumers may opt out of the system.

There is growing recognition of the need to revise the systems of incentives on providers of care and of mutual accountability, and to assure a more equitable sharing of risks among the public and providers of care, if we are to seriously entertain the prospects of National Health Insurance in this country. Pending such revision, the system of monitoring and administrative action described in this issue of the Journal deserves emulation by other jurisdictions, and further study in different settings.

Overview of the North Carolina SURE Program

The State of North Carolina, following a competitive procurrement for utilization review services in the state's Medicaid program, secured the services of its current fiscal agent, EDS Federal Corporation (EDSF). The state's program—Survillance, Utilization Review and Education (SURE) Program—encompasses various review functions:

Utilization Control.—This is a retrospective of postpay review of utilization patterns of all types of providers including physicians, dentists, hospitals, nursing homes, ambulance services, optometrists, podiatrists and chiropractors. MMIS reports are used to review the providers in detecting protential irregularities, misutilization or overutilization. Utilizations control staff also is responsible for conducting investigations, where allegations of fraud or abuse by a provider or recipient have been made. Investigations may include a desk review of claims and financial records and field audits including recipient reviews.

Monitoring PSRO's.—SURE also provides a system for monitoring PSRO activity state. PSRO inpatient claims are randomly reviewed to determine if the length of stay certified on the claim is acceptable. A report is prepared for the state listing all questionable claims, documentation for each claim and reviewing physician's recommendations.

On-site Review.—Selected teams of nurses, social workers and physicians conduct on-site reviews of services provided in long term care facilities, mental health clinics, public health departments and rural health clinics. Reviews are conducted annually to assure quality of care.

THE CONTRACT

The SURE program services were procured by competitive bid awarded in 1979. The state receives 75 percent federal financial participation for all payments made to the contractor for services performed by SURE.

THE STAFF

The SURE program staff includes four physicians, 36 registered nurses and 13 social workers.

SURE PROGRAM

Utilization control

Utilization control functions start with internal report review that may result in external field investigation and follow-up or peer review. In general, the utilization control section is responsible for the review and use of all SURE reports generated by the North Carolina MMIS. EDSF's technical approach, for this section, describes the review and auditing procedures for the following areas: Program integrity; pharmaceutical review; professional review; and PSRO monitoring.

If a problem or discrepancy is found, the unit then conducts field investigations to study and correct the problem at the site or develops the case for peer review. The unit continues its monitoring functions through follow-up activities and report review. The utilization control section works closely with the fiscal agent to ensure that information derived in the postpayment review process is utilized in developing effective prepayment controls. To successfully accomplish these varied functions, the administrative unit coordinates all activities within the utilization control section.

The administrative support services unit within the utilization control section has three primary responsibilities: directing all activities within the section, scheduling review committee meetings and conducting all provider education. Here again, EDSF can combine several common tasks such as report control and distribution with its fiscal agent operations to realize maximum efficiency with minimum cost.

The support services unit is also responsible for remaining aware of new changing federal and state UR policies. As part of its provider education tasks, this unit

ensures that providers are notified of these changing requirements. As the results of program integrity and SUR audits suggest the need for creation of new policy or revision of established guidelines, this unit notifies the state or the provider groups as appropriate. Whenever possible, UR information is sent to providers within the MMIS bulletins. Additionally, the support unit handles all provider inquires, providing complete and current information in a timely manner.

As potential or actual areas of overutilization or abuse are discovered, the responsible providers must be contacted individually. The support unit schedules these meetings with providers to resolve problems as they occur and to prevent continued problems. The support unit also maintains records, files and data resulting from these meetings and monitors any follow-up activities as well.

The utilization control administrative unit, in combination with the medical review administrative unit, is responsible for scheduling the standing committee meetings.

The program integrity unit is responsible for enforcing a strong, comprehensive fraud and abuse program to ensure that state funds are prudently utilized. This unit uses SUR reports and returned recipient explanations of medical benefits (REOMBs) to detect possible cases of fraud and abuse and conducts field reviews to prove and document cases. A field review for suspected provider fraud can involve several types of activities: interviewing recipients concerning services allegedly received, visiting the provider's facility to compare records with claims, and determining whether the equipment and staff necessary to perform the services billed are actually available.

Suspected fraud and abuse are frequently indicated by several patterns that the program integrity unit can detect by reviewing various MMIS SUR reports. The Treatment Exception Ranking Report, the Diagnosis Treatment Exception Report and the History Detail Report contain indicators that can reveal the following types of abuse:

Use of elaborate laboratory, radiology and other special medical procedures.

Inconsistencies of services billed with services billed by other providers for similar treatment. (This particularly applies to institutionalized patients, but can also apply to ordered laboratory and x-ray services.)

Excessive referral to practitioners or facilities with which the referring physician has a financial arrangement or in which he has a special interest.

Overtreating patients by excessive use of diagnostic procedures and overutilizing consultations to avoid charges of negligence and malpractice.

Use of institutional facilities for care suitable to office treatment or other forms of ambulatory care.

The program integrity unit analyzes SUR reports for this type of activity. In the event that fraud or abuse is suspected, this unit investigates the provider and develops a written report, with a documented case history, to permit the DMA to take appropriate action.

The program integrity unit also uses the SUR reports to detect cases of recipient misutilization. Using DMA-approved procedures, this unit investigates and documents all cases to permit further state action.

Misutilization by recipients also occurs when medical providers are used to meet nonmedical needs or when duplicate services are obtained. The program integrity unit is trained to associate the following factors with recipient misuse of Medicaid benefits:

Acquisition of drugs or supplies to be used for ineligible persons or to be sold for personal gain.

Acquisition of drugs to support narcotics addiction.

Use of contacts with medical providers for essentially social purposes.

Negligence in caring for items such as glasses, dentures and hearing aids.

When allegations of fraud or abuse are made concerning either a provider or a recipient, the program integrity unit records and investigates all such allegations. The investigations include a review of appropriate provider and recipient history reports in conjunction with a review of related claims. On-site visits to providers and contacts with recipients are an important part of such an investigation.

The state may also notify EDSF of certain cases of potential fraud and abuse. In these cases, the investigation will be conducted utilizing appropriate SUR reports and MMIS research materials. Where documentation indicates fraud or abuse, the program integrity unit may conduct field investigations. In these and other cases requested by the state, EDSF can flag the provider and/or recipient files within the MMIS so that review and investigation procedures can be performed prior to claim payment.

The program integrity unit will follow state-approved procedures in each investigation. In all cases, this unit will provide thorough documentation including claim

copies and appropriate SUR reports. In addition, this unit provides on-site audits to substantiate internal findings and to ensure a comprehensive review. Medical consultants are also utilized in cases requiring specialized knowledge. As required, EDSF performs all investigation and reporting in accordance with procedures established in the state's fraud and abuse manual.

Comprehensive review techniques using the MMIS reports enable the professional review unit to detect potential irregularities and to pursue corrective action. In addition to the individual case development procedures notes, we utilize auditing procedures to detect potential problems and constantly evaluate data to define new audits, both prepayment and postpayment, where appropriate. Parameters for the SUR subsystem are continuously reviewed and refined.

Provider Case Development: The first step in this process is to identify suspicious practices and to construct a working list of providers for whom further investigation appears warranted. This step is accomplished through a review of the Provider Ranking by Exception Weight Report for the appropriate category of service. The professional review unit conducts this review on at least the top ten providers in each speciality and subspecialty group. To maintain consistency, many providers with highly weighted practices are eliminated from the list; for example, low-volume providers for whom the research would not be cost-effective are not used. For providers practicing in the categories of service that are included in the treatment analysis reports, a review of the Treatment Exception Ranking Report is performed to establish the list of priority cases. Once the providers for review have been selected, case development for each individual begins. At each level of review described below, the reviewer decides whether the case should or should not be pursued further based on the information up to that point. If the decision is made not to research further, a record of the decision is made with an appropriate explanation placed in the provider's file.

Level I.—Notes the medical activity of the provider on the Ranking Report and on the Summary Profile Report. Identifies the specific areas in which exceptions occurred and gives special attention to those items marked as exception in more than one reporting period. Compares the provider to the Peer Group Activity Report if appropriate.

Level II.—For providers in certain categories of serfice, review the medical activity on the Treatment Exception Ranking Report and on the Diagnosis Treatment Exception Report. Notes the procedures and diagnoses on which the exceptions occurred. Determines which exceptions created the highest utilization and criteria weights. Compares the activity of this provider to that of his peer group for supportive documentation when this provider appears to have performed a majority of the services for this procedure.

Level III.—Reviews the provider's History Detail Report to identify and document the specific cases involved in the exception areas previously noted. Obtains claim copies where applicable. Reviews the Recipient Claims History Report for a cross-section of the provider's patients to identify other provider services, such as drugs and consultations linked to his practice. Patients who have been institutionalized by this provider are given special attention.

Level IV.—Summarizes the findings of the Level I, II and III reviews. Outlines recommended corrective action and presents the case package to the DMA. Whenever necessary, case is presented to the appropriate dental/medical or other Peer Review committees.

Level V.—The DMA renders a decision on the disposition of the case. Possible courses of action include provider education, warning notification, field reviews, more extensive documentation, recovery of funds or various punitive actions.

Level VI.—The action indicated by Level V is carried out. This could involve actual recoupment proceedings, installation of prepayment audits for claims monitoring, additional referral to the DMA or ongoing postpayment review to ensure that the problem has been resolved.

Recipient case development follows the above levels with the exception of presentation to Peer Review committees.

Based on the state-supplied formula, the PSRO monitoring unit establishes initial procedures by selecting a random sampling of 6 percent of inpatient claims in each PSRO area. This sample size is subject to adjustment when claims submission patterns change. Using criteria furnished by the state, either a nurse or a medical records technician reviews the claim to determine whether the claim is acceptable. If so, no further action is taken and the monitoring unit records the claim as acceptable.

Claims not satisfying the initial screening criteria undergoes a second level of review. For thorough, comprehensive review, medical records are obtained in all cases and are reviewed by a physician consultant. If, in the professional judgment of

the physician, the claim is acceptable, this unit records it as such and no further action is necessary. If the physician disagrees with the PSRO decision, the problem is discussed with the PSRO, which is given the opportunity to provide additional information or clarification. If the physician still does not agree with the PSRO, the claim is considered questionable and is referred to the DMA for final dispostion. If the rate of disagreement exceeds 10 percent of the claims sampled in a given quarter for a PSRO, and a solution cannot be reached between the PSRO and the state, the HEW regional office is notified.

When potential situations of abuse are noticed, the PSRO monitoring unit has the ability to implement audits on a test basis. These audits are designed to detect cases of possible abuse or attempts to circumvent established procedures. One such test audit if designed to detect admissions and readmissions within a limited time frame by a provider or recipient. For example, a patient might be discharged and readmitted within forty-eight to seventy-two hours. This could indicate an attempt to circumvent PSRO identification of an extended stay.

These automated tests audits enable the PSRO monitoring unit to expand its review activities to cover large segments of Medicaid activity resulting in a consistent and balanced plan of PSRO monitoring.

Long term care medical review

Long term care medical review utilizes a division of labor concept: External, on-site concurrent reviews are peformed within the medical review section and internal, desk-type retrospective reviews are accomplished by the utilization review section. The functions of each section are discrete and self-contained to ensure the correct concentration of necessary resources and to eliminate any joint or dual responsibilities across sections or units.

Although each section has separately defined functions, some common needs can be met quite effectively through the utilization of EDSF's fiscal agent resources. For example, necessary reports or data can be distributed with a minimum of time and effort because of the close proximity of fiscal agent and SURE operations. Also, as problems or questions arise that require the input of the fiscal agent, EDSF is able to respond quickly and to remain involved until a resolution is reached.

As stated, the medical review section is responsible for concurrent field review.

Clinic Monitoring Team (CMT)—responsible for all aspects of clinic review including examination of fees charged and services provided.

Independent Professional Review Team (IPRT)—responsible for the on-site review of all North Carolina intermediate-care facilities (ICF) and intermediate-care/mental retardation centers (ICF/MR).

The primary function of the MRTs and IPRTs is to perform all on-site medical reviews of participating LTC facilities. These reviews, conducted at least once a year, ensure that the care afforded each recipient is of a level and quality consistent with the patient's needs and is in compliance with all state and federal regulations. To provide thorough reviews by the most competent personnel the RT's are composed of at least one registered nurse with nursing home experience, a social worker and a physician. For ICF/MF reviews, the nurse has had training in mental retardation.

EDSF has approached LTC review by recognizing three major functions: the actual on-site review, the resulting determination of a proper level of care and the subsequent reporting and data maintenance.

Each review team is also responsible for the determination of the appropriate level of care for each LTC recipient as a result of the on site review. Following each review, EDSF uses its internal reporting mechanism to transmit level of care information to the MMIS. Thus, when the level of care data is input to update the bed registry or to generate other UR reports the MMIS is automatically notified. This feature ensures that all future claims are paid using only the most accrate data reflecting the current level of care for each recipient.

These review teams also conduct up to fifteen unscheduled on-site visits to various LTC facilities according to DMA directives. The DMA also has the flexibility to request EDSF to investigate various specilized areas in each unscheduled review to examine any unusual situations that may have prompted the review.

In addition to on-site reviews, both scheduled and unscheduled, the SURE program is also responsible for monitoring all LTC facilities through the review of monthly reports received from each facility. To provided comprehensive analysis, EDSF uses a state-approved sampling formula to determine the review subjects and schedule. This function ensures that local UR committee determinations and subsequent to and external professional analysis to assure quality of care for the recipients ans adherence to federal and state regulations among facilities.

The final function of internal operations involves conducting reconsiderations according to state and federal policies. Acting upon requests from the Health Care

Professional Committee and other authorized agencies, EDSF holds one reconsideration of a determination made by EDSF's on-site review teams. In addition, we conduct one reconsideration of a determination made by a local UR committee as requested by the attending physician. In all cases. we thoroughly document the appeals and we make this documentation available for the state's use in its appeal operations.

To facilitate operations within the medical review area, EDSF has established an internal administrative branch responsible for all medical review support. The medical review supervisor is assisted by the support services group in accomplishing all support functions within this section. Through the scheduling and notification system, this group will coordinate the scheduling of all on-site reviews, maintain relevant program statistics and dispenses information to the appropriate area, Common function, such as report distribution, which are currently performed within the fiscal agent operation have been expanded to serve both programs.

Another important function performed by the administration unit is the maintenance of a central bed registry for all SNF, ICF, ICF-MR and rest home beds within the state of North Carolina. A schedule of weekly telephone inquires to each LTC facility to determine what, if any, change has occurred during the preceding week. The administrative support services uses the result of each day's inquires to update the bed registry file daily. Ths bed registry file provides fast, accurate retrieval of registry data. EDSF also provides a statewide toll-free telephone line to handle inquires concering the status of bed registry. The combination of a registry file, daily updates and free telephone access ensures the ready availability of the most current bed registry information.

The medical review support group is also responsible for the preparation, publication and distribution of the LTC facility listing. According to procedures and schedules approved by the state, EDSF publishes this listing at a minimum of once a year. To prepare the listing, the support group obtains date and reports from the MMIS that contain imformation of all LTC resources and facilities throughout the state, by county. The support group then assimilate and edits the data to ensure the completeness and accuracy of each published listing. The support group also periodically reviews the listing and maintains a file of changes and udates so that subsequent listing may be rapidly assembled.

Other functions performed by the support services group include the preparation, printing and distribution of all forms and publications related to medical review.

The area of clinic monitoring is relatively new within the state of North Carolina. Thus, EDSF developed a comprehensive yet feasible plan to ensure accurate and productive monitoring of all mental health clinics, local health departments, free-standing clinics and migrant clinics.

The primary functions of the CMT's include the yearly on-site review and follow-up procedures for each clinic. After obtaining a sampling of the clinic's record, the team examines these for evidence of specific problems according to criteria stipulated by the state. Following the on-site review, the team's responsibilities are related to follow-up and reporting functions. Reporting requirements include providing a fully documented report to the DMA describing the clinic visted, the records examined and the problems discovered. Reviews are conducted by personnell knowledgeable in applicable program regulations to discern any problems in quality of care of compliance with policy, The GMTs are prepared to undertake any one or all the following actions:

Inform the clinic of the results of review.

Determine the appropriate corrective measures.

Conduct follow-up visits to determine the acceptability of improvement.

Prepare for the DMA a final report of EDSF's and the clinic's role in the review and follow-up procedures.

Submit to the DMA recommendations of the action to be taken in the event that problems still exists.

EDUCATIONAL PACKAGE ON
SOUTHWESTERN PENNSYLVANIA PSRO

SUBMITTED BY: DONALD C. BROWN, MD
CHAIRMAN OF THE BOARD

GEOGRAPHIC AREA:	Five Southwestern Pennsylvania PSRO (SWPPSRO) counties: Beaver, Fayette, Greene, Washington, and Westmoreland, covering approximately 3,700 square miles.
HOSPITALS AND BEDS:	17 acute care hospitals with 4,014 beds.
FEDERAL DISCHARGES:	Approximately 62,000 annual federal discharges. About 73% are Medicare; 27% Medical Assistance.
PRACTICING PHYSICIANS:	Approximately 1,000 physicians practice in this area.
PHYSICIAN MEMBERSHIP:	The SWPPSRO has always had more than 50% physician membership.
PLANNING CONTRACT:	Granted June, 1974.
CONDITIONAL DESIGNATION:	Designated CONDITIONAL June 1975.
OPERATIONAL STATUS:	Designated FULLY OPERATIONAL January 1981.

APPROACH

The SWPPSRO was organized by physicians representing this 5-County area on a voluntary basis in June 1974. Local physicians have always been actively involved in the SWPPSRO and currently about 30 percent of the SWPPSRO physician membership are actively involved. This physician involvement and commitment is largely responsible for the SWPPSRO's effectiveness and is the foundation upon which the SWPPSRO success is built.

The SWPPSRO's primary strategy for improving medical care is through promoting physician awareness of local practice patterns. As a result of the SWPPSRO's routine, on-going interaction with area hospitals, and the support, involvement and efforts of many SWPPSRO physicians within their own hospitals, the SWPPSRO has been successful in influencing favorable changes in physician practice patterns and effectuating improvement in the local medical care delivered.

THE SWPPSRO IS A CATALYST FOR CHANGE

A MEASURE OF OVERALL CHANGE

One overall measure of inpatient hospital utilization is Average Length of Stay (ALOS). ALOS is probably the simplest measure of a PSRO's ability to influence practice patterns. A declining Medicare ALOS is evident since the SWPPSRO joined the local health-care community:

PAYSOURCE	CALENDAR YEAR					
	1975	1976	1977	1978	1979	1980
Medicare ALOS	11.7	11.7	11.3	10.9	11.1	10.9
Medicaid ALOS	5.9	5.9	6.1	5.9	6.1	6.0
Prior to PSRO Implementation		PSRO Implementation Period	PSRO Fully Implemented			

Other common measures of hospital use are the number of admissions and the number of patient days. The problem with these measures is that they are difficult to evaluate since they are dependent upon many factors; the most relevant factor being the size of the population base from which they are generated. Other relevant factors include the age distribution of the population base and patient migration patterns, that is, the occurrence of patients receiving their hospital care in a geographic area other than where they reside.

The number of Medicare beneficiaries in the SWPPSRO area has been steadily increasing and the national trend is toward an older population. As a result of these factors, increased admissions and days should be expected. Also, the SWPPSRO's close proximity to the Pittsburgh area makes migration patterns a potentially relevant factor. With these caveats in mind, information on admissions and patient days for the SWPPSRO area is presented below:

All Federal Discharges	CALENDAR YEAR					
	1975	1976	1977	1978	1979	1980
Number of Discharges	49,247	52,434	56,644	59,285	60,322	63,016
Number of Patient Days	491,615	526,909	550,850	558,176	588,724	609,991

On the following page is strong evidence of the SWPPSRO's ability to influence favorable change and to reduce hospital utilization despite generally rising admissions and patient days. These favorable changes occur as a result of the establishment of SWPPSRO priorities and the concentration of efforts and resources on these priorities.

THE SWPPSRO IS A CATALYST FOR CHANGE (CONT.)

CHANGE THRU FOCUSED EFFORTS

The SWPPSRO collects data on all federal patients in its area. Profiles are constructed from these data and are used to identify and document local practice patterns. Most often, a profile is constructed from the data collected on patients with the same or a similar primary diagnosis or principal procedure. The profile category may be limited to either Medicare or Medicaid patient data.

Since 1977, the SWPPSRO has directed its attention to 14 profile categories which are among those that include the greatest number of patients in the SWPPSRO area. Profiles have been constructed and attention has been focused on unusual practice patterns. Medical review committees at area hospitals have been pressed to investigate and respond to these patterns. Objectives have been established for five of these profile categories. Areawide medical care evaluation studies have been conducted in nine of these profile categories.

The SWPPSRO's effectiveness in influencing and improving areawide patterns of practice can most appropriately and accurately be measured by its accomplishments with these 14 profile categories as demonstrated in the following Summary and Specific Example:

SUMMARY OF AREAWIDE ACCOMPLISHMENTS IN 14 PROFILE CATEGORIES RECEIVING CONCENTRATED ATTENTION SINCE 1977	
NET REDUCTION IN ALOS:	Of the 14 profile categories; 9 had a lower ALOS in 1979 than 1977. 2 had no change in ALOS; 3 had a higher ALOS.
NET REDUCTION IN ADMISSIONS:	Of the 14 profile categories; 10 had fewer admissions in 1979 than 1977; 4 had more admissions. For the 14 profile categories overall, there was a net reduction of 631 fewer admissions in 1979 than 1977.
NET REDUCTION IN PATIENT DAYS:	For the 14 profile categories overall, there was a net reduction of 8,270 fewer patient days in 1979 than 1977.

Following is a specific example of how the SWPPSRO has been successful in influencing favorable change.

THE SWPPSRO IS A CATALYST FOR CHANGE (CON'T.)

CATARACT SURGERY: AN EXAMPLE OF INFLUENCING AREAWIDE CHANGE

Cataract surgery is among the procedures most frequently reimbursed by Medicare and it is one of the 14 profile categories which have received concentrated attention by the SWPPSRO. The following synopsis shows how the SWPPSRO has been successful in influencing change in the local treatment of cataract surgery:

STEP 1 THE SWPPSRO IDENTIFIED DIVERGENT PRACTICE PATTERNS
In CY 1977, the SWPPSRO constructed a profile on cataract surgery. Significant differences were identified among hospitals with respect to both preoperative (preop) and postoperative (postop) ALOS.

STEP 2 HOSPITALS WERE REQUESTED TO EVALUATE THESE PATTERNS
The data was distributed to all area hospitals.

STEP 3 AN AREAWIDE CATARACT SURGERY ALOS OBJECTIVE WAS ESTABLISHED
To reduce the areawide cataract surgery ALOS from the 1977 level of 4.3 days to 3.9 days.

STEP 4 SWPPSRO MONITORING DEMONSTRATED ACCOMPLISHMENTS
By CY 1978, the ALOS for cataract surgery had been reduced to 4.0 days.

STEP 5 A NEW OBJECTIVE WAS ESTABLISHED
To reduce the cataract surgery ALOS from the 1978 level of 4.0 days to 3.7 days.

STEP 6 SWPPSRO MONITORING INDICATED PROGRESS HAD SLOWED
By CY 1979 the cataract surgery ALOS had been reduced to only 3.9 days. Some hospitals continued to have longer preop stays.

STEP 7 THE INVOLVEMENT OF AREAWIDE OPHTHALMOLOGISTS WAS SOUGHT
All area Ophthalmologists were asked to provide input to the SWPPSRO regarding an appropriate preop LOS for elective, uncomplicated cataract surgery.

STEP 8 A LOCAL STANDARD OF ONE PREOP DAY WAS ESTABLISHED
Standard adopted in April 1980 based upon areawide input from Opthalmologists. Additional preop days would have to be justified on a case-by-case basis.

STEP 9 MONITORING SHOWED SUBSTANTIAL IMPROVEMENTS
By the first half CY 1980, the areawide ALOS for cataract surgery had been reduced to 3.7 days. The areawide preop ALOS which had consistently been 1.4 to 1.5 days since 1977 dropped to 1.2 days during the first five months after the standard was established.

STEP 10 SWPPSRO INVOLVEMENT CONTINUES
Although substantial areawide accomplishments have been made, the SWPPSRO recently identified five hospitals in which additional improvement is expected, and PSRO objectives have been established for these hospitals.

THE SWPPSRO TAKES ACTION ON SERIOUS PROBLEMS

In the preceding pages, we have illustrated the success of the SWPPSRO's general approach to influencing areawide changes in local practice patterns and in local medical care.

Occasionally, the SWPPSRO comes face to face with a serious problem that is compounded by the inability or unwillingness of an individual practitioner or provider to cooperate with the PSRO to correct the problem(s).

In these situations, the SWPPSRO is committed to employing any means that it has available to resolve the problem; including the use of penalties and sanctions provided under the law, and, it has done so with complete regard for the serious nature of the problem and the real or potential injury to the federal beneficiaries.

Following are three examples of the SWPPSRO's actions in face of unusual and potentially serious problems.

THE SWPPSRO TAKES ACTION ON SERIOUS PROBLEMS (CONT.)

PROBLEM: FINANCIAL HARM TO FEDERAL PATIENTS

One Hospital did not discharge federal patients in a timely manner when hospital care was no longer medically necessary and Medicare and Medicaid benefits were appropriately terminated by the SWPPSRO. This resulted in patients being financially liable to the hospital for the cost of medically unnecessary days.

SWPPSRO ACTION

Initially, the SWPPSRO's efforts were geared towards fostering the cooperation of the hospital administration and medical staff to correct this problem; but these efforts were unsuccessful. Therefore, the SWPPSRO submitted a sanction report and recommendation against the hospital.

The Regional Office of Program Integrity became involved and the hospital was given a 6-month correction period. The SWPPSRO assisted the hospital in developing a plan to correct the problem. Continued SWPPSRO monitoring demonstrated that significant improvement occurred. This allowed the SWPPSRO to rescind the sanction recommendation.

IMPACT

The substantial reduction in medically unnecessary days at this one hospital as a result of the SWPPSRO's efforts and willingness to use the sanction when necessary is highlighted in the following table:

REDUCTION IN MEDICALLY UNNECESSARY FEDERAL PATIENT DAYS AT ONE HOSPITAL ACHIEVED BY SWPPSRO INTERVENTION

	TIME PERIOD (Discharges)	# OF MED. UNNEC. DAYS	% OF DAYS MED. UNNEC.
3-MONTH PERIOD PRIOR TO CORRECTION	4/1/79-6/30/79	714	5.1%
3-MONTH PERIOD AFTER CORRECTION	4/1/80-6/30/80	98	0.7%

ESTIMATED ANNUAL REDUCTION IN MEDICALLY UNNECESSARY DAYS:
2,000 to 2,500 bed days saved.

THE SWPPSRO TAKES ACTION ON SERIOUS PROBLEMS (CON'T.)

PROBLEM: UNACCEPTABLE QUALITY OF CARE

Through the review program, the SWPPSRO identified a physician who was providing inappropriate and unacceptable quality of care to federal patients. This problem was confirmed through in-depth peer review of more than 50 of this practitioner's cases. This practitioner treats a large number of federal patients; about 500 discharges annually, with over 6,000 patient days.

SWPPSRO ACTION

A meeting was held between this practitioner and SWPPSRO physicians to discuss the identified deficiencies. As a result of this meeting, the SWPPSRO Board of Directors requested this practitioner to limit his practice to only those federal cases which they determined he could handle satisfactorily and, the practitioner agreed. However, continued monitoring showed that he is not abiding by this agreement.

Because of the severity of the problem, the SWPPSRO Board of Directors prepared a sanction report recommending that this practitioner be excluded from participation in the Medicare and Medicaid Programs for a substantial period of time. The practitioner has been notified of the official violation. The sanction recommendation will be held until the practitioner has the required opportunity to present additional information.

THE SWPPSRO TAKES ACTION ON SERIOUS PROBLEMS (CONT.)

PROBLEM: COOPERATION WITH OFFICE OF PROGRAM INTEGRITY IN INVESTIGATIONS OF FRAUD AND ABUSE

The SWPPSRO's sanction recommendation against an area hospital led the Office of Program Integrity (OPI) of the Health Care Finance Administration into an evaluation of physician billing to Medicare for hospital visits conducted during medically unnecessary stays.

SWPPSRO ACTION

At the request of OPI, the SWPPSRO reviewed 50 cases with medically unnecessary stays and rendered determinations on the medical necessity of the physician visits billed to Medicare and on the appropriateness of the visit code (i.e., was it a comprehensive visit, brief visit, etc. that was conducted) since various codes mandate different levels of payment. An in-depth report of the findings was submitted to the OPI.

POTENTIAL IMPACT

In the 50 cases, the SWPPSRO identified and reported to the OPI 379 physician visits billed to Medicare during the medically unnecessary portions of the hospital stays which were either medically unnecessary or billed at an inappropriate visit code.

SUMMARY AND CONCLUSIONS

The SWPPSRO's significant past accomplishments are briefly highlighted in this report. These are the accomplishments of a PSRO that is built upon a broad and strong foundation of physician commitment, cooperation and involvement. In this environment the SWPPSRO has been able to inspire improvement in the local medical care in a positive way, primarily through our ability to enhance the physicians awareness of the appropriate need for change. But, in the occasional situation where the SWPPSRO is unable to foster the external commitment and cooperation necessary to effectuate appropriate change, we have taken any available recourse to achieve our goals including the use of sanctions, as appropriate.

The SWPPSRO continues to build upon its past experiences and develop more sophisticated and effective programs as we mature. Recently, for example, more stringent requirements for area hospitals to maintain the privilege of operating an in-house PSRO delegated review program were adopted.

One hospital recently had this privilege revoked by the SWPPSRO because the hospital program did not meet the SWPPSRO requirements to effectively reduce medically unnecessary days and; PSRO physicians and employees now conduct a non-delegated review program at this hospital.

Another hospital, one in which the review program is being conducted in a non-delegated fashion, recently had their request to be granted delegated privileges denied because they were unable to prove their ability to operate an effective program.

In this report the SWPPSRO demonstrated its ability and commitment to reduce hospital utilization. Thus far, the SWPPSRO has concentrated on 14 common profile categories which account for a large number of federal patients. Through our efforts, we have been successful in reducing both ALOS and the number of admissions for these patients resulting in a net reduction of 8,270 patient days.

Reduced admissions have been achieved despite an increasing Medicare population and other factors which may legitimately explain general rises in admissions and patient days which the nation, overall, is experiencing. These significant accomplishments have been achieved in an educational as opposed to a punitive fashion, that is, by making physicians who may have tended to admit patients more readily or to keep their patients in the hospital longer aware of their colleagues who were more inclined to treat their patients as outpatients or in fewer hospital days, and just as effectively. Thus, we believe we have truly changed physician practice patterns and that these changes, for the most part, can be maintained with minimal continued PSRO monitoring. As these 14 profile categories are de-emphasized to routine monitoring, the SWPPSRO can concentrate its efforts on new profile categories and bring about change there as well.

The SWPPSRO recently initiated the evaluation of 10 new profile categories. By establishing our priorities and focusing our efforts to accomplish long-lasting change and then establishing new priorities, we believe our PSRO promises significant future benefits.

Other recent initiatives of the SWPPSRO include the review of ancillary services and the review of special care units, including the intensive care unit (ICU) and cardiac care unit (CCU).

In conclusion, we believe that our past accomplishments are significant but that we have just begun to realize the full benefits that our PSRO program can bring to our local medical care community.