REVIEW OF PROFESSIONAL STANDARDS REVIEW PROGRAM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

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REVIEW OF PROFESSIONAL STANDARDS REVIEW PROGRAM

TUESDAY, SEPTEMBER 18, 1979

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

The subcommittee met at 2 p.m., pursuant to notice, in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge and Durenberger.

[The press release announcing these hearings follows:]

Press Release # H-53

PRESS RELEASE

FOR IMMEDIATE RELEASE
August 13, 1979

UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
2227 Dirksen Senate Office Bldg.

SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON
PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs)

The Honorable Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold hearings on Tuesday and Wednesday afternoons, September 18 and 19, 1979 to review the administration and operation of the professional standards review program.

The hearings will begin each day at 2:00 P.M. in Room 2221 Dirksen Senate Office Building.

Senator Talmadge said: "Properly functioning PSROs are the key to assuring that Medicare and Medicaid patients are in the right place at the right time getting the right care. Allowing for reasonable medical discretion, these Federally-sponsored and Federally-funded organizations of practicing physicians are the principal mechanism by which over-utilization or inappropriate utilization of costly health services may be significantly reduced. At the same time, PSROs have the responsibility of assuring that necessary care is provided and that the care is of a quality meeting professional standards."

"It is clear," said Senator Talmadge, "that a substantial number of PSROs are making measurable progress toward achieving the objectives of the program. It is equally clear that other PSROs have not performed effectively. The purpose of these hearings is to hear from the Administration and the PSROs themselves concerning: (1) administrative and other problems in implementing the program; (2) the criteria and results of successful PSRO activity and how they might be enhanced and expanded; and (3) the criteria by which inadequate PSRO performance is measured and the specific steps taken or proposed to remedy poor performance."

"We are rapidly running out of time in terms of getting a handle on the costs of Medicare and Medicaid," stated Talmadge. "We must beef up and fully support those PSROs which demonstrate that they can do a responsible and professional job. At the same time, we cannot tolerate indifferent or pro forma performance by those PSROs which cannot carry out their responsibilities. Those organizations must be replaced as rapidly as possible."

"In sum," Talmadge said, "we need to sort out those PSROs doing a good job from those which are not. It is our hope that these hearings will expedite that necessary sorting."

It is anticipated that public witnesses asked to testify will include representatives of Federal and State agencies as well as the PSROs themselves.

Written statements.--Those organizations and individuals who desire to present a statement to the Committee, are urged to prepare a written position of their views for submission and inclusion in the record of the hearings. Statements submitted for inclusion in the record should be typewritten, not more than 25 double-spaced pages in length and mailed with five (5) copies by October 1, 1979 to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D. C. 20510.

P.R. # H-53

Senator TALMADGE. The hearing will be in order. Today we begin the first of 2 days of hearings intended to assist in evaluating the operations and effectiveness of the PSRO program. That program, while considerably less controversial now than during the period preceding its enactment in the first 2 or 3 years of operation, still is the subject of discussion and question.

These hearings hopefully will serve to raise the level of discussion and answer some of the questions. There is not much question that the congressional appropriations for the PSRO program have been less than adequate for PSRO's to meet their responsibilities.

However, the dilemma confronting the Congress has been an inability up until now to reasonably and effectively sort out those PSRO's doing a good job from those doing an indifferent or poor job. We in the Congress are not in the business of establishing annuity programs for PSRO's which operate in token and in different fashion.

On the other hand, there are many thousands of conscientious physicians working actively and professionally through PSRO's to improve both the cost effectiveness and the quality of medical care provided to millions of medicare and medicaid patients.

We want to support the efforts of those conscientious people as fully as we can. The testimony at these hearings may well provide the justification for beefing up Federal financial and administrative assistance to the good guys. The problem with PSRO evaluation has in large part been one of averaging. That is, all of the PSRO's are lumped together in determining the effects of their work.

The result of that is that the performance of the good PSRO's is diluted and the performance of the bad PSRO's is made to look better than it is. Again, we need an effective sorting out process to distinguish and recognize excellent and improving PSRO's.

So far evaluations of the cost effectiveness of PSRO's have been done on a rather simple and inadequate basis. That is each day saved in hospital care, the PSRO is credited with saving the difference between the cost of an occupied hospital bed and the standby cost of an unoccupied hospital bed.

There are several other factors which, while difficult to measure, nonetheless need to be considered. First, the direct and indirect PSRO review on ancillary hospital costs such as X-ray, laboratory, and pharmacy costs. To what extent does significant reduction in the utilization of hospital beds result in the closing down, conversion or nonconstruction of new hospital beds? To what extent are health costs moderated by the increasing emphasis of PSRO's to require preadmission testing, their approval to approve elective admissions on weekends unless the hospital is geared to caring for the patient on weekends; and requirements that physicians specify the tests to be performed on their patients, rather than letting the hospital proceed with a shopping list of tests unrelated to diagnosis?

And of great importance as we shall hear from the witnesses is the unmeasured effect of improvements in the quality and economy of care for Federal patients on non-Federal patients. It is my understanding that these dollar effects are quite substantial.

In other words, where PSRO changes practice patterns using shorter stays, less tests and so forth, those improvements spill over into the non-Federal area as the physicians supply similar standards to their nonmedicare and nonmedicaid patients.

I supported Senator Bennett in his long and lonely fight to make the PSRO's a reality. Years of work by this committee before the enactment of PSRO had indicated the need for change. Most utilization review in medicare and medicaid we found was nominal or ineffective. We needed to do something about it.

It seemed to Senator Bennett as it seemed to me and ultimately the majority of the House and Senate, that it would be far preferable to have practicing physicians, organized in publicly accountable fashions, undertake continuing review rather than leave it to the insurance company clerks and the bureaucrats.

I think our faith in the professionalism and conscientiousness of the large majority of physicians practicing in this country has been justified. We have a long way to go but we have come a long way and the direction is clear.

We will hear from an extensive group of witnesses these next 2 days representing all areas of the country. Most of the PSRO's we will hear from are relatively young. We did not schedule the Utah, Colorado, and New Mexico PSRO's since they have testified here in years past and their performance is well known.

We will also hear from representatives of the States of New York and California who, in significantly different ways, have questions about the effectiveness of the PSRO program in relation to medicaid.

Finally, it seems to me that unless the critics of the PSRO program have an approach to review which is better, believable and workable, we have no choice but to work in partnership with many thousands of practicing physicians who have come forward to help us and help their profession and to help their patients.

Now, it is a pleasure to welcome our first witness, Dr. Helen Smits. Doctor, we are delighted to have you and we would be delighted to have you insert your full statement in the record and summarize it.

As you know, the Senate is in session. We will be interrupted by votes. You may proceed as you see fit, Dr. Smits.

STATEMENT OF DR. HELEN L. SMITS, DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU, HEALTH CARE FINANCING ADMINISTRATION OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DENNIS SIEBERT, DIRECTOR OF THE OFFICE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Dr. SMITS. Thank you, Mr. Chairman. First of all, I would like to bring to you the regrets of Mr. Leonard Schaeffer, the Administrator of the Health Care Financing Administration. His schedule was very difficult and he is very sorry that he is unable to be with us today.

I would also like to introduce Mr. Dennis Siebert on my right. Mr. Siebert is the Director of the Office of Professional Standards Review Organizations. I will try to be fairly brief in summarizing my testimony.

I am obviously very pleased to be here before the subcommittee today.

I would like to start out by pointing out how very impressed I am with many of the individual performances by PSRO's and how very pleased I am that these hearings provide an opportunity for a number of PSRO's that have undertaken unusual or special local initiatives to come here and speak to you about them.

I think that these organizations can speak best for themselves. I am sure this will make for a very interesting set of hearings.

I agree with you completely that one of the grave problems we face in evaluating the program is the fact that most observers and critics of the program tend to review its aggregate results when in fact its greatest achievements are probably local accomplishments which cannot be identified in aggregate findings.

In addition to recognizing good PSRO's, one of the major initiatives we have undertaken in the last year is to also recognize poor PSRO's. As you probably know by now, four individual organizations have been notified that their funding will not be renewed. In reconsidering the cases as requested by these organizations, we have determined that three of those would not be renewed, and they were in fact terminated.

The reasons for nonrenewal have ranged from mismanagement of funds to inadequate performance of PSRO activities. In one instance the PSRO was most active in correcting the problems which had prompted the recommendation for nonrenewal and it has, therefore, remained in the program.

I hope you will understand, however, that I do not think the number of PSRO's that are defunded is a good measure of how effectively we are running the program. Now that we have begun to get tough with them, PSRO's which have been notified of our intent to defund have been considerably more willing to work with us to improve specific problems that we have pointed out to them.

One of the major tasks that we have undertaken over the last few years has been to try to determine exactly how PSRO's should be evaluated. As you know, our major evaluation rests on whether or not PSRO's reduce the days of care which medicare beneficiaries use in hospitals compared to the days of care which medicare beneficiaries use in hospitals in non-PSRO areas.

This is obviously in itself a fairly simple measure and does not in any sense reflect the full spectrum of PSRO activities.

There are a number of things that PSRO's are doing that we think show signs that the program is working very well. For example, fully one quarter of all PSRO's now have contracts to perform private review for nonfederal patients. These are contracts written with the insurance companies. Those same insurance companies were very skeptical about the program when it began. I think any PSRO which can convince its local Blue Cross plan or other local insurance agency that it is doing a good job probably is.

Next we have urged PSRO's to enter into very active actions with planning agencies and are pleased to see the number of memoranda of agreements with HSA's is increasing rapidly.

I agree with you, though, that as we look at the PSRO program we must look not just at the program itself, but at the program to which we are comparing it—that is, utilization review.

We have now reached a rather unusual position in that utilization review, which was originally touted as a very economical program compared to PSRO's, to the best that we can determine has begun to cost more than the PSRO program itself.

If you take the figures that were widely circulated in 1977 in the OPEL evaluation and inflate them for the number of discharges today and adjust for dollar inflation into 1979, you will find that a fully implemented utilization review program costs slightly more than a fully implemented PSRO program.

We suspect that it may cost a good deal more. And one of the things we will be doing in the next year is looking as carefully as we can at exactly what utilization review does cost us. We would like to supplement the anecdotal evidence about its expense with results from a more thorough analysis.

For example, when a large PSRO was defunded in Tennessee, the hospitals were under the impression they had to do utilization review at PSRO prices. They came to us and appealed because they felt they wouldn't be able to do it.

The problem for us, of course, and for you is that utilization review is hidden in the general hospital budgets. It appears in HCFA's general funds. It does not appear as a specific line in the budget. And, therefore, although we know that where there is no PSRO there is utilization review, it appears on the budget lines as though the PSRO program adds to the total cost of medicare and medicaid in a way that is not exactly correct.

We have been working within HCFA to correct this situation—that is, to produce a line in the budget which shows the number of cases under utilization review so that when cases are moved from one program to the other, you can see what really happens to costs. We expect that the 1981 budget will be presented in that form.

As you know, one of the major things that PSRO's have done to control costs is to undertake focused review. One of the most important things that PSRO's have is an effective areawide data system. Instead of knowing just what is going on as a physician in his own hospital, through the PSRO physicians and hospitals now know what is going on in all the other hospitals in the area. This has allowed PSRO's to focus their efforts on those particular cases where problems are suspected: Where lengths of stay are long, where the admission takes place on the weekend, where a particular hospital, a particular service or even a particular physician has had a great many denials of whole cases or of individual days.

This effort to focus review more carefully and to target it on problems is part of an entire effort we have undertaken to see that we and the PSRO's agree as to what they should be emphasizing.

As we negotiate each PSRO's annual budget we now negotiate a series of specific, measurable objectives which the PSRO is expected to accomplish within the coming fiscal year for the budget it is given. We feel that over time these objectives will, first of all, give you a sense of what we and the PSRO's think they ought to do and then give all of us a sense as to whether or not the PSRO's have accomplished what they want to do.

Finally, I would like to mention the fact that the most current PSRO budget has been reduced slightly over the amount that the administration requested. That will have a number of effects on us.

Partly it will limit our ability to move cases out of utilization review into PSRO review even though we know that the net cost of doing so would be either nothing or perhaps there would be some net savings from doing so.

In addition, funding constraints have limited our ability to move into certain areas such as long-term care as was originally planned, and have also limited our ability to undertake the kind of new initiatives in which we are very interested and in which you have expressed a great deal of interest, specifically in areas such as the use of unnecessary ancillary services, long preoperative stays, weekend admissions, and particularly the general battery of testing ordered on admission to the hospital.

Despite the limits though, there are some PSRO's that have been very active in these areas. I think you will be hearing from some of them today.

As I said at the beginning, I am delighted with the performance of many individual PSRO's. I think they have done very well with limited funds and with a great deal of skepticism in the community surrounding them. That concludes my prepared remarks. I will be glad to answer any questions you may have.

Senator TALMADGE. Thank you very much.

If it is agreeable with you, Senator, I would suggest 5 minutes of questioning from each member.

We have heard complaints from PSRO's that medicare intermediaries and medicaid agencies have continued to pay for services which have been denied by PSRO's. What action has the Department taken to correct this problem?

Dr. SMITS. Our regional offices have a program known as CIEP, contractor inspection and evaluation program. This is a formal analysis of the performance of a medicare intermediary. How well the bills are processed is a part of that program.

Now, we do attempt to look in that evaluation at whether or not PSRO denials are being honored. We will be converting that system to a more specific set of functional standards shortly. I believe that even more emphasis will at that time be placed on performance in this area. Obviously we have many medicare intermediaries as well as many PSRO's. Some are better than others. We would be pleased, however, to receive any complaints from any individual PSRO's and to investigate those in detail.

Senator TALMADGE. What happens if PSRO says "Don't pay it?" Do you not pay it?

Dr. SMITS. We believe we are not paying it. But, as I said, there are a large number of intermediaries. If there is an error rate in some intermediaries, it should be a major factor in considering their performance as a contractor with the Federal Government.

Senator TALMADGE. How long does it take to make a decision?

Dr. SMITS. About whether or not a contractor is performing properly?

Senator TALMADGE. Yes.

Dr. SMITS. That area of the health care financing administration is not my direct responsibility. I am not clear on the time frame. I believe their contracts are 3 years. But if there was serious lack of performance, it could be evaluated and presumably corrected during a contract period.

Senator TALMADGE. How long does it take?

Dr. SMITS. To decide not to——

Senator TALMADGE. Yes; to make a decision one way or another, either pro or con?

Dr. SMITS. In terms of the general contract with HCFA?

Senator TALMADGE. Yes.

Dr. SMITS. I would have to submit that for the record.

Senator TALMADGE. If you would submit it.

[The information follows:]

I. Subject: Complaints From PSROs that Medicare Intermediaries Have Continued to Pay for Services Which Have Been Denied By PSRO's

Specific question: How long does it take to make a decision about whether a Medicare Intermediary is performing properly?

Onsite reviews and other evaluative techniques for assessing intermediary performance are conducted on an ongoing basis throughout each year under the Contractor Inspection and Evaluation Program. If any significant problems are detected during these reviews, HCFA initiates actions immediately to lead to correction of the problems by the intermediary. These reviews by HCFA regional office personnel include monitoring of the intermediary's compliance with PSRO determinations as well as compliance with the Medicare law, regulations, and general instructions in major operating areas such as bill processing and provider reimbursement. These reviews culminate in an Annual Contractor Evaluation Report (ACER) for each intermediary, which discusses its performance in major functional areas during the evaluation period.

Several times during the past few years, PSROs have thought that intermediaries paid for services which the PSRO denied. In each case, the intermediary was determined to be properly carrying out HCFA instructions even though it paid for services denied by the PSRO.

ACFA guidelines state that providers under PSRO review must be granted presumptive waiver status. This means that the intermediary must pay for services rendered up until the time the provider is notified that services are no longer covered. (If the beneficiary is still an inpatient when the notification is given, an additional 1 to 3 days may be paid, if additional time is needed to arrange for the necessary post discharge care.) In cases where the PSRO denies services retrospectively or does not provide timely notice, the intermediary is obligated to pay for the services rendered prior to notice of noncoverage.

HCFA is reviewing its policy to determine if a greater role should be given to PSRO's in the review of presumptive waiver status of providers.

We will, of course, look into any specific situations that are brought to our attention.

Senator TALMADGE. Focused review, as opposed to general review of cases, is now the PSRO approach. But until the PSRO undertakes an overall review to identify problem areas, how does it know where to focus?

Dr. SMITS. If available data systems are good, it probably does not need to do the review first in order to know. There are parts of the country where we have a good deal of evidence before the PSRO goes in on comparative lengths of stay, comparative use by various beneficiaries in different institutions, costs in different institutions and so on. In those instances I think the PSRO's can focus quite well even without having done review across the board.

Clearly, however, focusing is partly a response to the budget constraints and we really essentially have no choice but to focus. The PSRO's have to do the best they can with the dollars available to them. At the present funding level, that is $8.70 per discharge; in 1979 PSRO's are able to review in specific detail about half of the cases and to focus out about half of the cases.

Senator TALMADGE. Medical care evaluation studies have shown numerous areas of poor medical practice. What is HEW doing to

assure that corrective action is being taken by PSRO's where deficiencies have been identified?

Dr. SMITS. The PSRO's take the first steps, and I think those are very important ones. When I was a member of the UR Committee and of a PSRO I felt the most important actions took place on the stairways of the hospital with people arguing with each other about what they should or should not have done.

When that kind of informal peer pressure, which is what the program is all about, doesn't work well, PSRO's move next to a more formal process of requesting that an individual physician receive additional training, get additional medical education.

They often ask for the additional training in a specific area: learn more about antibiotics or the management of a particular kind of case. If he or she will not respond to that, will not obtain the education and the behavior doesn't change, the final option open to the PSRO is a sanction. The PSRO could ask us to fine the individual if they felt it appropriate or could ask us to remove that individual from the program.

Senator TALMADGE. It appears that my time has expired. I have a three-part question and it won't take long. What are you planning to do to respond to the budget cuts in 1980?

Dr. SMITS. The best we can. We are looking into it. We have told all PSRO's they cannot move into any new hospitals. We are having to look very closely since, as you know, we do not really have control over how many discharges are reviewed. We can control the unit costs but if a lot of cases come into a hospital we are covering, they come in.

We will be exploring a variety of options which may involve asking PSRO's to pull out of hospitals and may involve some increased terminations purely on a budgetary basis.

Senator TALMADGE. Could unit review costs be reduced below $8.70?

Dr. SMITS. We do not think so at the present time. I think 50 percent of the cases focused out is a little bit risky already. We are beginning to get some evidence of really startling, quite quick rises in length of stay as soon as an entire hospital is focused out. That would mean the PSRO cannot afford to stay out of that hospital. They will have to go back in.

Senator TALMADGE. On a performance basis, is it not possible that a given PSRO could justifiably spend $25 in reviewing an admission while another PSRO, based on its work, could be overpaid at $5 per review?

Dr. SMITS. Not only on its work but on the local practical patterns. It is clear there are parts of this country where hospital beds are used much more generously than other parts. I would agree that large variations in costs are not inappropriate for the program.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Thank you. Let me just pick up at that budget point and the matter of priorities, and let me go back to a portion of your written statement and relate that to the following quotation:

Also underway is an objective to strengthen the objective setting process to assure that PSRO's address problems of national significance, national goals currently

under development. In the national goal, each PSRO will be required to address these goals through its objective.

Would you define that for me, and then relate it to the last page, on what you can and cannot do within your rent budget?

Dr. SMITS. The first part is easy, the national goals, will be general directions and will deal with issues such as the tremendous variation in the use of hospital beds by medicare beneficiaries. We know what the national average is; we know, correcting for in and out migration, how beneficiaries use beds in each PSRO area. So we can ask a PSRO to compare itself to that national average, to even its regional average.

We will also be addressing some specific issues in surgery where very great variations in rates of elective surgery suggest that there may be overuse of surgery, particularly of certain procedures.

It is more difficult at this point, I think, to specifically relate that to the budget cuts. Certainly, many PSRO's have indicated to us that at the current budget levels they are not able to set the kind of objectives they would like to, or sometimes to accomplish the kind of objectives our regional offices would like them to accomplish.

Senator DURENBERGER. So that the information to achieve the national objectives comes from the PSRO as part of setting their own objective-setting process?

Dr. SMITS. One of the very important products of the program which few people appreciate is the national data system. The PSRO's have data on all the discharges; which they review. They submit this data to us, and it is aggregated. Some very interesting facts come out of that data system, such as the information about variations in length of preoperative stays.

We really hadn't had that information before and it has been very useful to us. What we would do then is feed back to the individual PSRO the aggregated national and regional data, so they have something to compare themselves against.

Senator DURENBERGER. Skip the regional and just address yourself to an example of national data, and explain to me the significance to a community of a PSRO using national data in its own process of review.

Dr. SMITS. Rates for cataract surgery in this country vary from five cases per 1,000, among the elderly per year, to 16 per 1,000 per year. That may be partly related to differences in the populations. Some people are more prone to cataracts than others.

It probably is also related to some changes in the standards for performance of cataract surgery. In a community where physicians have somewhat uncritically accepted the practice of early cataract removal, we are now asking that physician group to deal with the fact that they are doing three times as many cataract procedures per 1,000 individuals as the national average. That doesn't in and of itself prove that that is wrong or that those cases were handled wrong, but we are asking them to go back and examine the cases in detail.

In the instance of cataract surgery, that usually means a review system in which some kind of evaluation of visual acuity takes place before surgery.

So what we have really done, I think, is put in the hands of the physician groups some information which they have to deal with and interpret in light of the clinical context.

Senator DURENBERGER. Is that a costly process—that is the first part of the question—gathering this information nationally?

The second part of the question is, where is this information presently available, perhaps not in the same perfected state that it would be if it came through your process? For example, insurers and so on.

Dr. SMITS. The process of collecting the PSRO data? Not by Federal standards. Until not terribly long ago, we had a 75 cents per discharge cost limit on it. We would have to, I think, submit for the record what the aggregate cost of the data system is now; and we would be glad to do that.

[The following was subsequently supplied for the record:]

II. SUBJECT: USE OF NATIONAL DATA SYSTEM BY PSRO'S

Specific question: What is the aggregate cost of the national data system?

In 1978, the total cost of operating the data system was about $6 million. This includes both PSRO costs and costs incurred at the national level. Annual costs for the national level in 1978 were slightly less than $1 million, while PSRO costs were slightly greater than $5 million. PSRO costs were calculated based on costs incurred in collecting and processing data on approximately 7 million discharges and do not represent full program implementation.

Dr. SMITS. Yes, we do have other data, particularly on medicare; better data on medicare patients than on medicaid patients. Even the available medicare data, however, does not provide all the information needed by PSRO's, such as data on patients having long stays.

The greatest problem with the medicare data that comes through the bill payers is that it isn't available to you for over 1 year in the case of broad utilization indicators and approximately 2 years in the case of more specific aggregate displays, so it is very hard to track current trends.

Senator TALMADGE. Thank you very much for your contribution.

[The prepared statement of Dr. Smits follows:]

STATEMENT OF DR. HELEN L. SMITS, DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU, HEALTH CARE FINANCING ADMINISTRATION

I am pleased to appear before the Subcommittee today to discuss my perceptions of the areas of greatest PSRO program success and the areas which have presented particular problems for us.

I am particularly encouraged by the progress we have made to improve the management of the program and the performance of many individual PSRO's. We hope to see continued positive results in the future. Today I would like to focus on the progress we have made, appropriate criteria for evaluating the program, and the ways in which Congressional cuts decreasing our budget request have created problems for the program.

SPECIFIC PERFORMANCE EVALUATION

I would like to begin by pointing out how very impressed I am by the successful performance of the best PSRO's. National recognition of the performance of individual PSRO's, even the outstanding ones, is often overshadowed by trends revealed in overall statistics. The program, however, was designed to foster local initiative and no thorough evaluation should overlook the impact of the efforts many PSRO's have made to deal with local problems. This year, PSRO's that have demonstrated the ability to perform have received additional funds to conduct special initiatives in areas such as ancillary services review. We feel this encourages good performance

and simultaneously fosters new review techniques which are badly needed to control wasteful spending. We plan to continue funding PSRO's to conduct special initiatives, based on demonstrated positive impact.

PSRO's which have performed poorly, on the other hand, face loss of Federal funds if their problems are not corrected. Within the past year we have discontinued support of four PSRO contracts. The reason for these actions, in some cases, has been mismanagement of Federal funds, and in others, inadequate performance of PSRO functions. These defundings demonstrate our commitment to positive performance by PSRO's as a criterion for continued funding.

Although the extreme action of defunding must be taken in some cases, improvement, rather than punishment, must remain our major goal. Now that PSRO's understand that non-renewal of their grants is a serious possibility, we are finding those in trouble more willing to work with us to resolve their problems. This allows us to retain the positive aspects of the organization, while working to improve the weaker aspects. For example, one organization which had been notified of our intent to discontinue funding was most cooperative in moving to correct the problems which had prompted our notification. Because the PSRO took decisive corrective actions, including a change in personnel and strengthening of financial operations, we were able to avoid termination, thereby retaining the physician support which had led to satisfactory review performance.

PERFORMANCE INDICATORS

In assessing the quality of PSRO performance and making funding decisions based on this assessment, we use a variety of performance indicators. Aggregate utilization findings, as reflected in last year's HCFA evaluation and the recent Congressional budget office reanalysis, represent only one type of outcome to consider and are of limited value when it comes to assessing individual performance. There are many other areas in which PSRO's can, and have, demonstrated positive performance. For example, through the medical care evaluation process, PSRO's are documenting positive impact on quality, such as reductions in overprescribing of drugs. PSRO's are identifying poor quality hospitals and preparing sanction reports on these facilities. Decertification actions were initiated in two cases based on PSRO findings. PSRO's are also identifying poor physician practices and, where appropriate, providing valuable data to licensing boards.

PSRO actions have contributed to the closing of expensive and unnecessary hospital beds in parts of the country which have particularly high utilization rates. You may have noticed news reports indicating that our local PSRO is now requiring that many minor surgical procedures be done on an outpatient basis.

PSRO's are cooperating with Health Systems Agencies (HSA's) to collect data for planning purposes. PSRO's which are conducting both hospital and long term care review have provided HSA's with documentation of the need for additional long term care beds. PSRO's have also documented improvements in quality of care in long term care facilities by monitoring and recommending changes in physician practice patterns.

A further measure of success is the fact that fully one quarter of all PSRO's have contracts with private insurers to conduct review of non-Federal patients. The fact that skeptical insurance companies find that a PSRO contract is a good way to get the job done seems to be excellent evidence that we are succeeding.

While we recognize the importance of taking into account factors such as these in determining the success or failure of individual PSRO's, we have yet to devise an evaluation system which reflects such variable aspects of performance. The temptation, therefore, may be to look only at the major evaluation studies to determine program impact.

Even by this standard, however, the program has shown striking improvements, even though the data for the most recent studies was gathered before the impact of our management initiatives could be fully felt. The HCFA evaluation study showed a 1.5 percent aggregate reduction in utilization and a cost-benefit ratio of 1.1. The reanalysis conducted by the Congressional Budget Office (CBO) using the same data, however, showed a net reduction in utilization of 2 percent and a cost-benefit ratio of 0.7. The difference in the ratios resulted primarily because CBO assumed that empty beds would be filled, thereby transferring costs to the private sector and decreasing PSRO benefits.

While we do not support this as a valid assumption and recognize that this study has been touted as a negative one, its data can be used equally well to suggest that the program would be quite successful if it covered all hospitalized patients rather than only those funded by the Federal government.

Beyond evaluating PSRO's on a stand-alone basis, PSRO's should be compared to other alternatives. The main alternative, Utilization Review (UR), is not nearly as satisfactory.

The cost of UR is included in each hospital's general administrative expenses. The only applicable limits are general limitations on reasonable costs. The costs of State review are part of the administrative costs of the Medicaid program. To finance PSRO review, on the other hand, regional offices negotiate PSRO budgets for both overhead costs and the actual costs of review. PSRO's, in turn, negotiate costs with individual hospitals performing delegated review. New regulations will make these hospital negotiations binding, thus avoiding the problem of hospitals receiving excess reimbursement by declaring high costs to be "reasonable and necessary". PSRO costs are therefore controllable while UR costs are not.

When we defunded the PSRO in Tennessee, many hospitals expressed concern that they could not conduct UR within the same cost constraints as had been imposed on the PSRO. In actuality, cost controls will not be in effect for the UR programs established to replace PSRO review.

Interestingly, when one extrapolates the cost figures for UR contained in the 1977 evaluation to fiscal year 1980 and compares them with the present estimates for the cost of a fully implemented PSRO program, UR is slightly more costly. Our actuaries felt the 1976 data was too soft to generate a precise comparison and recommended a more conservative estimate based on the assumption that there is little difference in PSRO and UR costs. For budgetary purposes, therefore, the cost of UR and focused PSRO hospital review are roughly the same. To obtain better and more current information we will be undertaking a more comprehensive study of UR costs in the next year.

OBJECTIVE SETTING

A key measure for assessing individual PSRO performance, and representative of one of our major management initiatives, are the objectives each PSRO negotiates with HEW and, as a consequence, is held accountable for meeting during the course of its grant year. The initiation of this process represented a major redirection in the program and we feel progress to date has been very good. Regional office staffs now work with each PSRO to identify and negotiate realistic and quantifiable objectives based on the particular nature of the utilization and quality problems in the PSRO area. The objectives set by PSRO's have ranged from reduction of long preoperative stays for specific procedures to improvement in inappropriate use of the emergency room and increases in the usage of outpatient settings for surgery. As of now, all PSRO's have negotiated their objectives; a small number of PSRO's, whose objectives were not acceptable, have had restrictions placed on their grants until acceptable revised objectives are submitted.

In the next year we will monitor closely PSRO progress in achieving their objectives. Also underway is an effort to strengthen the objective setting process to assure that PSRO's address problems of national significance. National goals are currently under development and each PSRO will be required to address these goals through its objectives or to justify why the National priority is not relevant to its area. Through this process we expect to be able to continue to assess PSRO's on an individual basis and also to be able to report to Congress on general PSRO performance in areas of special concern or importance.

BUDGET CONTROL

We think the objective setting process contributes to other elements of improved program management as well. We believe that with better management of the review process, PSRO's can continue to be effective at lower costs. For this reason, another of our major management initiatives has been better budget control. As PSRO's were funded throughout the past year, their review budgets were reduced by an average of 30 percent. For 1979, all PSRO budgets have been negotiated at lower rates. By the end of this year that review cost will average approximately $8.70 as opposed to the average of about $13 in 1977.

Because of this limitation, all PSROs will have highly focused review systems by the end of this year. Through focusing, PSRO's place greater emphasis on the particular diagnoses, procedures, hospitals, or physicians where problems have been identified. Those cases which do not represent problem areas are still abstracted and reviewed on a statistical basis.

Since these initiatives should result in better program management and in lower unit costs, the cost-benefit ratio of the PSRO program should show very significant improvement in our next evaluation.

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CONGRESSIONAL BUDGET REDUCTIONS

Recent Congressional budget cuts have restricted our movement into areas of review other than hospital review. Our mandate requires the conduct of review in the long term care and ambulatory care settings, as well as hospital emergency rooms, outpatient departments, and ancillary services. To move into these areas in a more timely way, it is important that funds be made available to carry out adequate developmental work.

Funding contraints have resulted in support for only 48 long term care review projects, in spite of considerable PSRO interest and documentation of the importance of linking the hospital and long term care review systems. Funding our budget requests would have provided some expansion of this effort.

Our efforts in ambulatory care review have been oriented toward methodology development. Five PSRO's have been funded to conduct projects designed to illustrate the limitations and opportunities given various approaches to review in the ambulatory setting.

Other experimental areas have also been curtailed. While approximately 70 PSRO's have received limited funds for ancillary services review and other new aspects of hospital review to date, these represent "one-time" funds to conduct special projects and will often not be renewed.

Congressional failure to fund our full request level has restricted our ability to devote sufficient attention to several areas of particular concern to this committee, such as review of long preoperative stays, elective weekend admissions, and certain admission services.

We are attempting to fund these relatively new types of review and emphasize priority areas for hospital review to produce maximum results in terms of actual impact on utilization and quality and to expand our knowledge of what works and what does not work in each review setting. We have tried to balance our desire to expand into these areas with our desire to fund PSRO's to initiate hospital review in all areas of the country. We are particularly interested in your ideas on how we may best carry out your intent to conduct the various types of review within our funding limits.

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

Senator TALMADGE. The next witness is Dr. Robert A. Morton, medical director, Colonial Virginia Foundation for Medical Care, Virginia Beach, Va., accompanied by William S. Grant, the executive director.

We are delighted to have you. You may insert your full statement in the record and, due to time constraints, I will ask you to limit your testimony to not over 10 minutes.

STATEMENT OF ROBERT A. MORTON, M.D., MEDICAL DIRECTOR, COLONIAL VIRGINIA FOUNDATION FOR MEDICAL CARE, VIRGINIA BEACH, VA.; ACCOMPANIED BY WILLIAM S. GRANT, EXECUTIVE DIRECTOR

Dr. MORTON. Thank you, Senator.

The purpose of our appearance today is to share with you our experiences as a PSRO, some of which were expected of us by the Government, some of which were innovative and unexpected, and all of which are in keeping with the intent and spirit of Public Law 92-603 which established the PSRO system. No other organization has the inherent ability that PSRO's do to examine and influence the practice of medicine across the country.

We have submitted a more detailed statement. I would like to use this brief time to mention a few of the high spots of that statement in the areas of physician involvement, impact of utilization review, impact of medical care evaluation studies, findings in the long-term care review program, and a couple of remarks rela-

tive to the assessment of our activities and our feelings about the future.

In the area of physican involvement, we feel that one reason, and perhaps the main reason, for our success as a PSRO is that the physicians of our area are committed to peer review, not just as a minimal response to Federal requirement but as an obligation of the medical profession to assure quality of care to all patients.

Of a membership of about 800 physicians, 122 are actively involved in committee and board of directors activities of the foundation. Close to 5,000 physician man-hours annually are devoted to peer review. Most of these hours are not reimbursed by Federal or any other dollars.

Our PSRO is physician directed; the board establishes policies, and a very competent staff operates only within those policies. The board is very knowledgeable of Federal requirements and Federal concerns and keeps itself informed of these issues.

In the area of utilization review, we feel we have had definite and beneficial impact. In the acute care hospital program, 30,000 days of care were saved in 1973 for medicare patients only. This results, by our estimate, in about three times the amount of money saved that the entire review program cost.

The reduction in the average length of stay was areawide, but, more importantly, there was a more significant reduction in those hospitals that had a poor utilization pattern originally.

I will digress a moment here.

You were talking a minute earlier about good PSRO's and average PSRO's being lumped together. We run into that problem at the hospital level too, of lumping things together, and try to look at individual hospital problems; and where more impact is needed we feel we are making that.

The foundation developed a psychiatric review program in cooperation with the National Institute of Mental Health. As a result of this activity, the review of psychiatric patients for DHEW has resulted in a 22-percent decrease in the average length of stay.

The foundation has also contracted with the Department of Defense to review CHAMPUS patients with psychiatric diagnoses. In 5 months' time, the admission rate for these patients dropped to less than one-third of the 1978 level, and the length of stay dropped 60 percent. The cost of this review to the Defense Department was $5,187 and the net savings were over $1.5 million.

Review in a State psychiatric facility, which had 220 beds designated in active treatment units, was started in 1978. After a 60-percent denial rate and in working closely with the medical staff, there occurred a reduction to only 78 active treatment beds.

An increase in staff physicians assigned to an acute care medical/surgical unit within the State institution occurred when PSRO consultants questioned the adequacy of patient care.

In conjunction with the health systems agency, we assisted in the creation of 14 skilled nursing beds in the State hospital to care for patients with both organic and psychiatric diagnoses who did not need acute hospital care.

The foundation instituted a problem-oriented system of focused review in 1979 due to the funding cut to $8.70 per patient for review activities. We are now reviewing only 35 percent of medi-

care and medicaid patients, but the number of instances of misutilization identified continues at the 1978 level when we were reviewing 100 percent of patients. Therefore, our focusing must be in the right direction.

The Colonial Virginia Foundation has developed one of the most aggressive medical care evaluation study programs in the country. We have been accomplishing the conduct of four acute care multihospital MCE's, two multihospital psychiatric MCE's and one long-term care facility MCE annually, plus the equivalent number of restudies.

Not only are we conducting the traditional audit of specific diagnoses and procedures but also have studied the care rendered to ambulatory patients and ancillary services' utilization.

We have identified that the preoperative length of stay is a distinct problem in a number of hospitals. A restudy showed some improvement but not sufficient to satisfy our committees. As a result, more intensive concurrent review on patients admitted for elective surgery has been started in those hospitals where it was needed.

Poor medical records on patients treated in hospital emergency departments was identified as a problem. The restudy shows significant and satisfactory improvements. We have only recently identified the misuse of intermittent positive pressure breathing treatments as a problem.

Over half of the patients receiving this service have no valid clinical indication for it. Corrective action is being devised and a restudy will be conducted in 1980. We are currently instituting a study on the use of computerized axial tomography, otherwise known as CAT scans.

The foundation originated and spearheaded the first nationwide medical care evaluation study, in which nine PSRO's from around the country cooperated. The topic was cesarean section. The final results are not available yet, but in our own area we demonstrated a significant deficiency in prenatal care and an excessively high infant mortality rate. This study has suggested further MCE topics for 1980.

Psychiatric MCE studies have clearly shown that patients subject to concurrent review meet standards of care more frequently and had shorter lengths of stay than those patients not under concurrent review.

As far as review of long-term care patients is concerned, the foundation identified in our area that 6,401 days of care were wasted in acute care hospitals in the first 6 months of 1979 by patients awaiting nonavailable skilled care beds. Using simple cost projections, it appears to us that about $1 million is wasted annually on medicare and medicaid patients because of the shortage of skilled care beds. The health systems agency was appreciative of our findings and is more vigorously addressing this problem.

Finally, we have been scrutinized by several agencies, and no significant problems have been found.

The medicare fiscal intermediaries have disagreed with less than one-half of 1 percent of the PSRO medical necessity determinations. A DHEW financial audit found no problems; a GAO study also found no problem. A health standards and quality bureau

assessment found no significant problem except the lack of long-range planning, which is difficult to do when we are dependent on annual funding grants, but which we are attempting to address.

The Colonial Virginia Foundation believes in the old principle that legislation should be a minimal response to needs. Our needs are a stable and predictable financial base and a clear and unequivocal statement of support and confidence in the PSRO program by both the Congress and the administration.

With these two needs met, we foresee a continuation and expansion of what appears to us to be an extremely effective joint venture between Government and the medical profession to provide appropriate and high-quality medical care to the citizens of the United States.

Thank you.

Senator TALMADGE. Thank you very much, Doctor. We appreciate having your excellent testimony.

I am impressed by your statement that peer review is not just a Federal requirement but an obligation of the medical profession to assure quality of care to all patients. Your testimony contains ample proof that a PSRO can achieve real savings, while at the same time improving the quality of patient care.

You are to be congratulated. Dr. Morton, I have felt that in the areas that you are focusing on—preoperative stays, respiratory therapy, weekend admissions, long-term care in hospitals and others—are areas of great waste. Would you agree that the cost of reviewing these areas would be far outweighed by the savings to be realized?

Dr. MORTON. Yes, sir; I would agree with that.

Senator TALMADGE. You have had a good deal of experience in reviewing psychiatric care in hospitals. Do you believe there would be any special problems in reviewing the services in mental health centers that psychologists and psychiatrists perform outside the hospitals?

Dr. MORTON. We have no experience in this. Yes, I think there might be some benefit in reviewing those areas. Certainly in the hospital we have found numerous areas of concern and have had, as shown, quite a bit of impact on that.

Senator TALMADGE. Do you find your efforts resulting in positive changes in medical practice?

Dr. MORTON. Yes, sir.

Senator TALMADGE. For example, have you found that more than half of the inhalation therapy given in hospitals was not clinically indicated, has there been a reduction in ordering the use of inhalation therapy as the result of your work?

Dr. MORTON. We don't know yet. We just recently came up with this finding. Our corrective action program is reporting back to the hospital and asking them to conduct their own educational programs relative to this.

One of the things we noticed in this is that the teaching hospitals that are medical school affiliated had much less use of IPPB, which is the abbreviation for this treatment, had much less use of that than the smaller community hospitals. In other words, there is a growing knowledge that this particular treatment is not all that it

used to be thought to be, and that the indications for its use have considerably narrowed in recent years.

This information has not really filtered through to all hospitals yet. By showing the smaller community hospital—and I don't mean to be beating on them because they are small—but by showing them that the university affiliated hospital is able to get just as good results without using the types of treatments, by using other less expensive and probably more effective forms of treatment, we will see a change in their practice pattern.

Not seeing that change, then we would have to go to some method of denial of payment for those services; but that would be a last resort.

Senator TALMADGE. Our staff has reported that we are spending about $1 billion a year more in that therapy alone; and if half is unnecessary, that means we are wasting one-half billion dollars a year in that one area alone.

Dr. MORTON. Well, half is not necessary in eastern Virginia. I don't know about the rest of the country.

Senator TALMADGE. Senator Durenberger?

Senator DURENBERGER. Thank you.

So I can expand my understanding of your role and your function and your accomplishments—let me go back to the chairman's second question as it relates primarily to psychiatry. There is a statistical record of great accomplishment in your statement. Your project with the National Institute of Mental Health shows a 22-percent decrease in average length of stay; in your project CHAMPUS with the Department of Defense the length of stay dropped 60 percent; the project with the State psychiatric facilities showed a 60-percent denial rate and a substantial reduction, apparently, in active treatment beds.

My question basically then is, what happened to the persons with mental health problems in the community that you served after the accomplishment of some of these objectives?

Dr. MORTON. Yes, sir. I don't think that we have done away with mental illness in eastern Virginia. What has happened, I believe, is that there are alternative forms to hospitalization for treatment of mental illness and that the psychiatric community is turning to those areas.

Within the State facility, the 220-bed reduction, the reduction from 220 to 78 active treatment beds did not result in the discharge of any patients; they were merely reclassified at an intermediate level, rather than an active treatment level. This makes no difference to the taxpayers in Virginia because they are still supporting the patients. It does make a difference to the medicare program, which was paying for them in an active treatment bed and does not in an intermediate care bed.

So there is a different flow of dollars, but I am not sure of the taxpayer benefit from this.

More importantly though than the money involved, is that the hospital has to put itself in the position of defining exactly what they are doing from the quality standpoint; of what patient was deserving of active treatment, and were they really getting it, although classified as it; and by their own initiative, as we began to make these findings, decided they were not really active. They are

the ones who changed the bed figures; the PSRO did not. We merely pointed out the problem.

So I believe the patients benefit by having a better definition of what the expectation is, the outcome of that patient.

In the same institution, the medical/surgical unit which is classified as an acute care hospital had very definite problems with lack of physician care. That was corrected; and they also had problems with moving patients out, because the average skilled nursing facility simply did not want to accept a patient who happens to have a psychiatric diagnosis, along with what other organic problem they had.

So, working with the health systems agency—and, incidentally, getting around the State law in Virginia, which prevents their institutions from having skilled beds—we were able to get skilled beds created in that institution, again placing the patient at the appropriate level of care so the funding could be appropriate to the care.

Senator DURENBERGER. What role does the source of funding play in some of those decisions, whether it is medicare, State funding, private funding, and so forth? In your whole analysis you have just gone through—and it looks like a thoughtful approach—what role does source of funding play in some of the decisions you make regarding appropriate care?

Dr. MORTON. I don't think the source of funding plays any role in our determination of what is appropriate care for patients, or an appropriate level of care.

Senator DURENBERGER. The comment you made earlier about skilled nursing care versus intermediate, that is not a commentary?

Dr. MORTON. Well, those are the effects; that is what happens after you make the decisions; but that is not, in my mind, the reason the decisions are made.

Senator TALMADGE. Thank you.

[The prepared statement of Dr. Morton follows:]

STATEMENT TO THE SUBCOMMITTEE ON HEALTH, U.S. SENATE COMMITTEE ON FINANCE

SEPTEMBER 16, 1979.

The Colonial Virginia Foundation for Medical Care, which is the Professional Standards Review Organization for Eastern Virginia, like many of our counterparts, has been reluctant to share statements of our activities with others. Primarily, this reluctance has come from the number of studies and restudies that have been conducted to validate or invalidate the claims made by PSRO's as to their activities. We feel that the time has come for us to take the basket off of our light and share with you some of our accomplishments. As a kindness to you and anyone else who may read this report, we have omitted the various graphs, statistical tables and reports which document our activities; but be assured that upon request we will be happy to provide whatever additional information you may need.

In 1978, the 13 component medical societies in Eastern Virginia came together and decided that a physician-controlled Professional Standards Review Organization was preferred to one controlled by some outside group of non-physicians. To this end, they incorporated and received a planning grant from DHEW to become the PSRO in this area. After a voting process in Virginia that clearly indicated that the physicians preferred local PSRO's as to a single state PSRO, we were then granted conditional status and in a period of six months implemented all acute general hospitals in our area. Subsequent to that, we have implemented five psychiatric hospitals, a chronic diseases hospital, and a U.S. Public Health Service Hospital, as well.

In January of 1979, we implemented Long Term Care Review for skilled patients in eight skilled nursing facilities in our area.

The Board of Directors early on, discussed what the role of the PSRO would be in Eastern Virginia and decided that this was an opportunity the Federal government had given physicians to conduct peer review, and our intention was not merely to meet the minimum requirements of the PSRO Program, but to use this as an opportunity to deal with peer review in all areas. As a result of that decision, this Foundation has conducted a project with the National Institute of Mental Health on establishing a peer review mechanism for psychiatry, which was extremely successful in reducing by some 22 percent, the average length of stay for hospitalized schizophrenics in our area. As a result of this, we implemented a pilot project which continues for a special psychiatric review in the area hospitals and state facility. This has resulted in a reduction in the number of active treatment beds in the State psychiatric hospital and a reduction in length of stay for psychiatric patients in the area overall.

CHAMPUS has recognized our activities in the psychiatric area and has funded this Foundation to do PSRO-type review for CHAMPUS beneficiaries who have psychiatric diagnoses.

We hope you can see in this brief introduction that the Foundation has taken the resources that Congress has provided us and attempted to use them effectively in the PSRO Program, as well as extend them into other types of review.

PHYSICIAN INVOLVEMENT

Our strongest asset as a PSRO is the physician support and participation that we enjoy. Over 800 physicians are members of the Foundation, out of approximately 1,300. While this figure is in line with most PSRO's membership across the country, we feel that most especially the activities of those who are involved in the actual working activities of the PSRO represent that physician support mentioned above.

The Board of Directors of the Foundation is composed of 15 physicians, who have met regularly, month after month, from the inception of the Foundation in July of 1975 until the present. We have developed seven standing committees, whose collective physician membership stands at 122 members. Our average attendance at our meetings is approximately 65 percent, and we estimate that areawide 1,800 physician manhours annually are devoted to the PSRO Program and in the delegated hospitals, over 4,000 manhours annually are given to this program. Most of these hours are not, in fact, reimbursed by the PSRO. The physician activities that have been associated with these manhours are complete review and revision of the AMA Criteria Set; the conduct annually of 7 areawide medical care evaluation studies and restudies; the concurrent review system in acute, psychiatric and long term care settings.

Finally, in the area of physician support, we think a significant sequence of events occurred. In 1977, the Medical Society of Virginia opposed the PSRO Program, but when through our efforts and the other PSRO's efforts in the State, we have shown physicians that this is an effective working relationship with government. To this end, in 1978 the Medical Society's President in its publication of Virginia Medical Monthly strongly praised PSRO as being a reasonable partnership between physicians and government and encouraged all physicians to support it. We feel this represents a shift in attitude on the part of physicians in Virginia and shows our support for the program.

The PSRO is physician directed, and while we have a very competent staff they only act within the policy framework that is established by the Board of Directors. Physicians in this area are involved in the PSRO Program and supportive of the PSRO Program, and I think this is reflected in the 122 committee members and certainly the 4,000 manhours that are given in the delegated hospitals to committee work, as well as Physician Advisor activity.

UTILIZATION REVIEW

The CVFMC operates a primarily delegated system of concurrent utilization review. Only one of the acute care hospitals is non-delegated for this function. Data from the Medicare Fiscal Intermediaries show that the average length of stay (ALOS) for the calendar year 1976 (pre-PSRO review) for Area 5 of Virginia was 11.7 days. In 1977 the CVFMC was designated a Conditional PSRO and all acute care hospitals in the area were phased in under the PSRO review system and 100 percent of federally-funded patients were under concurrent review for the calendar year 1978. In those two years the ALOS for the area dropped to 11.0 days or a 6 percent reduction. If the Medicare patients admitted in 1978 stayed an average of

11.7 days as in 1976, an additional 30,000 patient days of care would have been utilized. It is difficult to translate saved days of care into dollars but by any reasonable cost factor applied to a patient day in an acute care hospital, the savings in the Medicare program alone considerably more than offsets both PSRO and delegated hospital cost review for both the Medicare and Medicaid programs. Comparative data for the Medicaid program is not available since the Virginia State Medicaid Agency has only recently (1979) developed a reliable information system.

Perhaps more importantly, a breakdown of the change in ALOS figures by individual hospital shows a measurable impact in those hospitals who had a significantly longer ALOS to start with. Seven hospitals exceeded the areawide ALOS in 1976. Taken as a group the ALOS in these hospitals dropped over 10 percent by 1978 and the two hospitals with the longest ALOS figures (17.0 and 14.5 days respectively) dropped over 15 percent each. Only 4 of the hospitals showed an increase in ALOS during this time, all of these had lower ALOS figures than average in 1976. Only one of these hospitals had a statistically significant increase in ALOS and as a result, that hospital instituted a review system in 1979 focusing on problem physicians identified by the PSRO data system.

It is difficult, at best, to judge the quality of decisions made by physician reviewers at the hospital level relative to the necessity of hospitalization. Second guessing, by a retrospective review of a sample of patient records, does indicate that some disagreement does occur between the PSRO Physician Consultants and the hospital Physician Advisor. The CVFMC does measure the rate of denial of benefit determinations by hospital, which is one objective measure of physician review activity. In the entire area, approximately 1 percent of Medicare and Medicaid patients had their benefits terminated by the PSRO review system in 1978. Interestingly, there was a stright line correlation between this measurement and the reduction in ALOS. In those hospitals with a denial rate in excess of 1 percent, the ALOS dropped 10.9 percent from the 1976 figures. The group of hospitals with a denial rate of between 0.5 percent and 1 percent showed a decrease ALOS of 6.9 percent and those four hospitals with a denial rate of less than 0.5 percent showed an increase in the ALOS. This information has been fed back to the hospitals in 1979 with the result that the numerical quantity of denials for that area is almost identical with the 1978 figures even though the intensity of concurrent review has been dropped to include only 35 percent of federally-funded patients versus the 100 percent review in 1978.

Due to the funding cut to $8.70 per patient for review activties in 1979, the CVFMC developed a problem-oriented review system rather than continuing concurrent review on all patients. Though our data base was really not sufficiently large enough to allow any comfort in identifying problem areas, the 35 percent review level does seem to be focused in approximately the right directions since identification of misutilization continues at the 1978 level.

The CVFMC implemented PSRO review in our first year of conditional status at the State Psychiatric Facility's Medical-Surgical Unit. Surveys were conducted by Foundation Physician Committee members and it was felt that there was not an adequate amount of physician involvement in patient care. Subsequently, the facility employed additional physicians which has resulted in improved quality of care rendered. The facility has had difficulty in transferring patients who require skilled level of care to facilities that provide these services due to the reluctance of accepting patients with psychiatric problems.

The Foundation supplied information supporting the need for such beds to the HSA, and, as a result, fourteen (14) medical-surgical beds have been converted to skilled nursing beds through the certificate of need process. The State of Virginia's legislation does not allow for skilled level of care beds to be located within state facilities, but the CVFMC, in cooperation with the facility and the HSA, is attempting to modify this law.

As a result of the NIMH Project, the Foundation submitted a proposal to CHAMPUS for the review of all CHAMPUS beneficiaries in the Tidewater area. It was determined that to get a more accurate picture of the quality and appropriateness of services rendered to CHAMPUS beneficiaries that this contract be for all diagnoses. In March of 1979, the CVFMC was awarded a contract by CHAMPUS for review of psychiatric diagnoses in all acute care hospitals and psychiatric facilities throughout Area V of Virginia. Concurrent review was implemented on April 9, 1979 in twenty-two acute care hospitals, five private psychiatric hospitals and one state psychiatric facility.

During the first five (5) months of the project, there occurred a 60 percent decrease in the average length of stay, from 44.9 days to 26.9 days, as determined from supplementary data compiled by participating facilities for 1978 and 1979.

Furthermore, CHAMPUS and Fiscal Intermediary data showed that there were approximately three hundred (300) CHAMPUS psychiatric patients admitted monthly in 1978; since the implementation of the CVFMC's Psychiatric Review Program there has been less than one hundred (100) admissions per month. The program cost was $5,187, which saved approximately $1,513,000 during those 5 months!

Further, upon implementation of the Psychiatric Review Program in the State Psychiatric Facility, it became apparent that the majority of patients being treated in that facility were not receiving acute psychiatric treatment but an intermediate level of care. To date there has been a sixty (60) percent denial rate of the patients treated at this facility. The Foundation has worked closely to define acute psychiatric care versus a lower level of care which has resulted in a redefining of the types of beds and the services rendered to the patients. When review was implemented, there was a total of two hundred and twenty (220) licensed acute psychiatric beds; this number has now been reduced to seventy-eight (78). The cooperative effort between the facility and the CVFMC Multi-Disciplinary Psychiatric Committee has resulted in a more cost effective treatment and has allowed for an increase in resources to provide quality of care rendered.

The CVFMC plan to continue problem-oriented review in the future. The data base is building, data quality is improving and problem identification is becoming more exact. In addition, the CVFMC will change the system of review in 1980 from the traditional assignment of a certified number of days based on diagnosis and age group to a more efficient and intensive cyclic review system designed to identify specifically the point in time at which necessity for hospitalization ceases. This type of review has been shown to clearly have more impact on misutilization and to be more efficient, thus increasing the cost-effectiveness of PSRO review.

Utilization review has rapidly progressed from the primitive one-on-one physician review of a few years ago to the sophisticated problem-oriented system mentioned above. PSRO's and physicians must have sufficient time and resources to continue development of effective means of changing patterns in the delivery of health care. Physicians who make up the PSRO's, are through their own efforts learning how to better utilize hospital facilities. PSRO's do improve with age.

MEDICAL CARE EVALUATION STUDIES

In 1977 and 1978, respectively, the Foundation, as part of its unique psychiatric review program, conducted an areawide (11 facilities/units) study of "Schizophrenia in Adults" (age 19 and above). Individual psychiatric hospitals/units not only received, for the first time, valuable feedback on their own patterns of psychiatric care, but were able to compare patterns of care with other psychiatric hospitals/units. In addition, these facilities were stimulated to increase resources in the form of staff MCE Committees and Committee Assistants. Whereas audit had previously maintained a low priority in these facilities, it gained much credibility as a tool for assessment of the quality of delivery and organization of psychiatric care services as a result of data and patterns of practice identified in the two studies.

Several significant pieces of data emerged from analysis, the most significant being length of stay and a positive change of criteria compliance across studies. The average length of stay reflected a 21.93 percent decrease for the area. Average compliance rates for criteria (diagnosis, treatment processes, complications) showed a significant increase. More specifically, the compliance rates increased for Federal beneficiaries, after implementation of concurrent review but decreased for those patients not subject to the concurrent review process.

During the first quarter of 1978, eighteen hospitals participated in a study of "Abdominal Hysterectomy". Study analysis revealed an average preoperative length of stay of 44.17 hours (range of 102.3 to 24.9) that in almost all instances was due to (1) delays in obtaining specialist consultation and (2) laboratory and X-ray studies conducted on an inpatient basis that could well have been performed on an ambulatory basis. Recommendations for corrective action addressed this issue quite specifically.

A restudy conducted in 1979 revealed a 2.4 hour reduction in pre-operative length of stay with four hospitals (longest LOS in original study) continuing to have an excessive length of stay despite some reduction. Consequently, these hospitals were required to institute the Foundation's policy and procedure for review of elective surgery patients which requires Physician Advisor (peer review for all cases in which the pre-operative length of stay exceeds twenty-four (24) hours unless there is a documented unstable medical condition requiring extensive evaluation and/or stabilization; or essential preliminary studies and procedures performable only on an inpatient basis are required. Data regarding effectiveness of this action is to be provided to the Foundation by November of this year.

During the fourth quarter of 1978, seventeen (17) acute care facilities participated in an areawide study of "Spontaneous Epistaxis or Nosebleed in the Emergency Room". This study is one of a very few attempts on the part of PSRO's to evaluate care rendered to outpatients. Assessment of data revealed a significant deficiency in ambulatory patient management in the areas of documentation of vital signs and patient follow-up care instructions. Feedback to the hospitals resulted in widespread institution of policies designed to correct these deficiencies as well as concurrent monitors designed to ensure corrective actions. Preliminary results of the restudy (which looked only at these two areas) indicate an increase in compliance rates despite a relatively short period of time since institution of corrective actions.

The Foundation, just this month, completed a Medical Care Evaluation Study of the utilization of IPPB (Intermittant Positive Pressure Breathing) in acute care hospitals in Area V of Virginia. The use and misuse of IPPB has been of significant concern to third party payors to the extent of overt threats to no longer pay for this service. Results of the study demonstrated that less than half of the patients receiving the treatment had valid clinical indications for the use of IPPB. Even in institutions with the better practice patterns, one of every five patients did not meet the justification criteria. It should be noted that despite these findings, informational data collected indicate a significant trend toward utilization of other less expensive therapies. It was determined that all hospitals should conduct educational programs relative to the indication and value of the alternative forms of respiratory therapy currently available. A restudy will be conducted in 1980 to measure impact of the findings and the educational programs.

Consistent with its mandate as a PSRO to review the quality and appropriateness of ancillary services, such as diagnostic imaging techniques, to assure their appropriateness and quality the CVFMC has recently developed criteria for the review of Head Computerized Axial Tomography (CAT) Scans.

Computerized Axial Tomography has been accepted by the medical profession as a useful, accurate and safe diagnostic procedure. This technological advance has contributed greatly to the quality of patient care, even though it is an expensive service. Because of the expense, CAT scans have received unfavorable publicity by both the press and government agencies. Health Systems Agencies operating under HEW "guidelines" have the capability and responsibility of limiting patient access to the service. In addition, the CVFMC perceives that there may be unnecessary days of hospitalization in which patients are awaiting CAT scans.

A concurrent Medical Care Evaluation study will be conducted beginning October 1, 1979 for a sixty (60) day period on Federally-funded patients receiving CAT scans of the head. Data collected (for up to 2 scans per patient) will include compliance to physician developed justification criteria (reason performed); date ordered; date performed; reason for delay (over 24 hours) if any; date results posted on medical record; results of the scan (if correspond with reason ordered; if finding differs from original reason; if negative) and total number of scans performed per patient during hospitalization.

It is anticipated that the study will encompass 1,000 to 1,500 cases, an adequate sample of the utilization of this service. Data will be collected using the current PSRO data abstract to allow for minimal cost and staff time.

In 1978 the Foundation spearheaded a project with nine PSROs from across the country to conduct the first nationwide Medical Care Evaluation Study (MCE). The project, designed to compare how physicians in one region of the country perform in relation to physicians in other regions, seemed a logical step, given the previously demonstrated value of comparing medical staff performance across hospitals. In addition, it was felt that PSRO's could work together effectively in analyzing medical care without being asked to do so by HEW. Certainly no other organization(s) has this inherent ability to examine the practice of medicine, across payment sources, in this country.

The topic, Primary Ceasaren Section, was selected because of its controversial nature, indications for the procedure have undergone drastic revision in the past few years; and the number of Cesarean births has increased dramatically. As a result of these factors, considerable interest and concern was expressed on the part of physicians in the CVFMC's area, by physicians active in the Foundation's MCE program and, finally, on the part of physicians involved in the other PSRO's that participated in the study. Objectives of the study were to:

—Determine representative national patterns of practice for Primary C-Section

—Evaluate regional variations in indications, length of stay or other parameters

—Evaluate maternal operative and post-operative complications and document regional variations

—Evaluate immediate neonatal outcomes

Preliminary data reveals wide variation in age and indications as well as length of stay. Final results and recommendations are pending collection of additional demographic data. Within the CVFMC area, the study revealed a high percentage of patients with absence of documented prenatal care. Also, of the 618 patients delivered by Primary Ceasarean Section, 2.1 percent of the infants expired (highest mortality rate shown in the multi-PSRO data).

The concerns of physicians regarding these findings were further heightened by review of the Health Systems Plan for Area V of Virginia, which reveals a prenatal mortality rate of 7 percent (1976) above the nation. It is further noted by the HSA that the magnitude of this problem is illustrated by the fact that the risk of dying in this period of life is higher than at any other time of life until age 65 (numerous studies) and that there is much evidence indicating that a significant portion of infant death is preventable.

Consequently, the CVFMC has elected to perform a study of the problem involving all area hospitals providing obstetrical services and has invited military hospitals (3) in the area to participate. It is anticipated that concomitant studies will be conducted in hospitals with neonatal intensive care units.

OTHER

Since January of 1979, CVFMC has been active in the review of skilled nursing patients in a long term care setting. As part of that, we instituted a level of care determination survey among area hospitals, which has pointed out what we have always felt was a problem in the area—a lack of skilled nursing beds in Eastern Virginia. The statistics from the survey show that during the first six months of 1979, 592 patients waited a total of 6,401 days in acute general hospitals awaiting placement in a skilled nursing bed. This averaged out to about 10.8 days per patient. Further, using some simple cost projections, we feel that if these beds were available, Medicare and Medicaid in our area would save over $1,000,000 annually in the difference between the acute general hospital cost versus skilled nursing home cost. We have brought this to the attention of our area Health Systems Agency, and for the first time they have begun to recognize and project long term care bed needs at the skilled and the ICF level. They are beginning to approve applications for skilled beds in the area.

The Foundation, from its inception, has established a strong stand for physician documentation. As a result, in our non-delegated hospital and eventually extending into our delegated hospitals, we have reviewed physician documentation to determine if there are physicians who have difficulty in keeping timely progress notes and history and physicals in the charts. On at least six occasions we have identified physicians who stand head and shoulders above their peers in this problem area and have placed them on special requirements to certify the necessity of hospitalization. As a result, their documentation has improved and after a period of, three to six months, we were able to relieve the physicians of the requirements. Further, in at least one instance, the delegated hospital, in an effort to reinforce the need for documentation, has suspended admitting privileges for a physician who failed to document in the prescribed fashion.

Finally, CVFMC has tried to look at itself not only from its activities to determine whether we feel that our activities have justified the funds that have been entrusted to us, but we also have tried to look at the various assessments that we have been subject to determine what outside groups may feel about us.

Our Medicare intermediary has been monitoring us since the beginning of our binding review, and the sum result is that they disagreed with less than ½ of 1 percent of our decisions as a PSRO, well below the 5 percent level that would indicate a problem with this PSRO's decision making process. Unfortunately, our State Medicaid Agency, has not developed a monitoring plan, although we have gone to them time and time again asking if there are problems with the PSRO review program. There appear to be none from their correspondence with us concerning our decisions that are being made for Medicaid in Virginia.

The CVFMC has undergone a DHEW financial audit which discovered no problems and our accounting system was found to be both reasonable and adequate. The General Accounting Office in conjunction with a study, reviewed our activities and had no major criticisms, other than noting that our funding level was different from the fund levels for other PSRO's. We have gone through an assessment by the Region III Office, which was conducted by the Health, Standards and Quality Bureau, and there were no substantial criticisms about the review system. There

were some suggestions concerning long-range planning, which is very difficult to do in a program that is subject to annual funding grants, but which we have attempted to remedy. Our feeling is that the outside agencies who reviewed us have basically found us to be operating a PSRO Program that is both reasonable and technically acceptable to them.

We hope we have shown that this Foundation has taken aggressive stands with the PSRO Program. In some ways we have been very successful at identifying problems, both in utilization and in quality. However, we are by no means completely happy with our own progress as a PSRO, and feel that there are still areas we can both improve quality and utilization. If our progress has not been as rapid as desirable, it is not due to lack of enthusiasm, but results from our lack of sophistication and knowledge of how the delivery system works and what the most effective methods are to bring about change and lasting change in the health care system. We hope our experience as a PSRO, as well as the other experiences of our peers, will convince you and others that this is, in fact, a worthwhile endeavor. Never before has government provided the resources to physicians to take a leadership role in evaluating how the delivery system works. We think we are making important findings about hospital operations and problems.

Once again, if we can provide you any more information concerning activities or our findings, we would be happy to do so. We will try in the future to be more sensitive to your needs for information about the PSRO Program and our activity.

Respectfully submitted.

J. SHERMER GARRISON, M.D.,
President, Board of Directors.

ROBERT A. MORTON, M.D.,
Medical Director.

WILLIAM S. GRANT,
Executive Director.

Senator TALMADGE. The next witness is Mr. Richard F. Galbraith, M.D., chairman of the board, Foundation for Health Care Evaluation, Minneapolis, Minn.; accompanied by Mr. Carl Gustafson, executive vice president.

Doctor, we are happy to have you here. Please insert your statement in full in the record and summarize in 10 minutes.

STATEMENT OF RICHARD GALBRAITH, M.D., CHAIRMAN OF THE BOARD, FOUNDATION FOR HEALTH CARE EVALUATION, MINNEAPOLIS, MINN.

Dr. GALBRAITH. Mr. Chairman and members of the subcommittee, thank you for inviting us here today to discuss our views on the role of professional standards review at the local level.

I am Dr. Richard Galbraith. I am chairman of the board of the Foundation for Health Care Evaluation in Minnesota. Unfortunately, Mr. Carl Gustafson, our executive vice president and director of administration, was called home on a medical emergency last evening and cannot be here today.

The foundation is a private, nonprofit corporation, formed by area physicians in 1969 and incorporated in Minnesota in 1971. Our primary goal since the beginning has been to assure that quality health care is delivered at reasonable cost.

When Congress passed Public Law 92-603 in 1972, we believed the congressional intent was to guide health care providers. The law gave the physicians a significant degree of flexibility insetting standards through which performance is judged.

From the inception, many of our peers have interpreted this law as an inflexible regulatory arm, restricting their ability to practice high quality medicine. The foundation leadership, however, agreed with what we believe was the congressional intent in providing for considerable local authority to manage the peer review program.

In 1974 the foundation was designated as one of the first 12 PSRO's in the Nation. In 1977 we extended the geographic scope of our responsibility beyond the Minneapolis-St. Paul area to encompass the two-thirds of Minnesota which falls north and west of the Twin Cities. Our PSRO area includes 110 hospitals, 4,000 physicians and nearly 300 long-term care facilities.

At the present time the foundation manages a hospital review system for both private and Federal patients. In 1978 the foundation completed a pilot long-term care review project which has been assessed by the Rand Corp. as one of the country's most innovative approaches. In 1979-80 the foundation will implement this program.

We also have a pilot program in ancillary services review. We continue to engage in such activities as consulting, research, and private review which are not supported by PSRO funds.

As a physician organization, we are concerned with public accountability. Though most PSRO boards of directors are 90 percent doctors, our board officers have always sought representation from consumers, industry, third-party payers, and public agencies, as well as providers. As a result, only 55 percent of our board members are physicians; however, the work of the board is further enhanced by those who voluntarily serve on various standing committees and task forces. In 1978 our physicians donated over 1,600 hours of their time to the foundation.

As members of this subcommittee, you have no doubt heard of the many debates over the performance of professional standards review organizations. We cannot provide any simple answers to this question. We can only show some indications of what we have done through PSRO:

From 1974 to 1977, national medicare data reflected a more appropriate use of hospitals in our area. Data from this source are not yet available for 1978.

Medicare-days declined nearly 600 days per 1,000 enrollees, a decrease of 13 percent.

The average length of stay dropped from 11.7 days to 10.8 days, almost 1 full day. This brought us very close to the national average.

From 1976 to 1977 our PSRO showed the second highest rate of decline in total medicare-days in the Nation, minus 10.7 percent.

The health systems agency in our metropolitan region reports that the total days of hospital care—Federal and private—declined 2.3 percent between 1976 and 1977. That is about 62,000 patient-days saved at nearly $200 per day, or over $1 million.

In 1978 we were at or below the national average for preoperative stays in 9 out of 11 procedures. In 4 of the 11 procedures our preoperative stays declined to at least 20 percent below the national average since 1977.

We have no intention of resting on these gains. We are still a half a day above the national average for medicaid length of stay, for example. We are confident that far more patients with psychiatric or chemical dependency problems could be treated outside the hospital, saving large numbers of hospital-days. Addressing these problem areas is a corporate priority for 1979-80.

As significant as these facts and figures are, we would like to illustrate gains made in other important areas of performance:

We are promoting physician awareness of the need for quality assurance, helping the health care community work in unison to make improvements and maturing with the increasing challenges of PSRO management.

We believe that our strong commitment to working directly with providers can bring more personal awareness of public accountability for quality and appropriate utilization. Since our inception we have chosen to delegate review to all hospitals. This assumes that responsibility for providing the highest quality of care and appropriate utilization lies with the medical staff and the facility. Because this nurtures self-improvement, there is no more effective means of heightening awareness of the need for quality control.

In a second major area of impact, the foundation is viewed as a major factor among the forces that constitute the health system in our region. For example, the foundation is now invited to participate in health policy discussions on such issues as alternative uses of excess hospital beds, decisions on the need and location of new hospitals, and levels of reimbursement.

Meetings and work groups formed around these issues have become a regular feature at the foundation. Besides staff and physician expertise, the community often calls upon the foundation because of its all-patient data base. Hospitals use our all-patient data base to support their own institutional planning. Diagnostic groups from our data will be used by the State's rate review system to establish budget guidelines for hospitals.

Hospital utilization statistics are used by the local health systems agency to project regional bed needs. Several HEW-sponsored research efforts rely primarily on foundation data. Data from our long-term care review program will similarly benefit the community.

Because the foundation is a focal point for quality control, we have been approached by health maintenance organizations, private insurers and Blue Cross/Blue Shield of Minnesota to conduct their private review. We currently have a contract with Blue Cross and expect to broaden the scope of private review still further. This benefits Federal patients directly by increasing the data base upon which decisions are made and by increasing the peer review pressure on providers.

Another area of accomplishment has been the foundation's willingness to adapt to changing expectations. Stringent calls for PSRO accountability, beginning with the first Office of Policy Evaluation and Legislation—OPEL—report, caught the foundation and other PSRO's napping.

Despite the claims of premature and incomplete assessment, the fact remained that a highly visible evaluation questioned the effectiveness of what we were doing. In 1977 the foundation was reviewed by the Health Standards and Quality Bureau—HSQB—via an indepth site visit.

We also have had some failures. One is that we have not been able to get back to our physicians the fact that PSRO is a primary ally and not an enemy; and if we can get this message across, we

will eventually accomplish a great deal more than at the present time.

Thank you, sir.

Senator TALMADGE. Doctor, in your testimony you mentioned the case where you worked with a delegated hospital that was covering up the fact that some of its physicians were providing inappropriate care. How did you identify this hospital?

Dr. GALBRAITH. Well, our present data base, Senator, allows us, through what we call focused review, to bring problems within hospitals right into our data base. Whereas before when we did all-bed review we did not have that data available. We can now focus in on any real problem that is going on within an institution.

And, whereas we delegate all of our review to a hospital, when they are not giving us data back, the first we do is go looking and asking why. We found out some answers. We found out they weren't doing anything on quality assurance.

But rather than give up on them and say, "OK, we have the mandate from the Government to go in and say you will be defunded, or potentially that," we went back and we started working 1 on 1 with them in an educational process, and within a few months we turned that loss entirely around. They not only do good quality care and utilization, but they are now one of our best backers in terms of helping us educate others.

Senator TALMADGE. Is it possible you may be overlooking less flagrant cases?

Dr. GALBRAITH. I think the flagrant cases, those cases where a doctor could practice bad medicine in one institution and go to another institution down the road and not be known for what he had done before, seldom occurs. We have what we call a physician identifier code now in the State of Minnesota, where all physicians have a common code in every hospital to which they go. The identity of the physician is unknown to the foundation by name but all data from that physician's patients come into the foundation by his code number. If there is a problem with that physician in more than one hospital, that data goes directly back to the hospital, to the medical staff, for them to handle.

Senator TALMADGE. I was reading your full text here, and I noticed some of the problems that you found in your studies of many of the hospitals, and I quote: "A multihospital audit of transurethra resection of the prostate led the Minnesota Society of Urology to a penetrating examination of the indications for this procedure."

Does that mean that procedure was sometimes performed when it should not have been, or is that procedure within itself inappropriate?

Dr. GALBRAITH. Well, I am looking for specifically that——

Senator TALMADGE. That is on page 4.

Dr. GALBRAITH. No, I mean, in my footnotes here. I have the audit itself where the society took the audit because there were a number of problems with bleeding, postoperatively, in some of these patients, and there was also disagreement on how much tissue should be removed from the prostate, a minimum amount that should be removed and a maximum amount that should be removed.

Well, when we got the data back, it was rather shocking to some of the urologists as to the discrepancy in various hospitals. So they took it upon themselves, when they got the data, to do an indepth review of this themselves, and they came up with some—I don't have those facts with me, but they came up with some startling facts that changed the approach to the TUR significantly. And there again our data base is helping them and the hospitals use us as a focus for finding problems and solving those problems.

Senator TALMADGE. Thank you.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

Doctor, what percentage of your budget every year is financed out of Federal funds for PSRO purposes?

Dr. GALBRAITH. Senator, I guess I would have to leave that to Mr. Gustafson, who is not here; but I will tell you this much: We have a budget in the neighborhood of about $4 million now, and our budget has gradually changed over the years from what the Federal Government has allowed us, that is, the decrease per patient and our expansion out into the various communities and private industries where we are taking on more and more of their review, so that it is not 50-50, but we are hoping to approach that number.

And I think eventually in our particular PSRO, if the Federal Government said, "Tomorrow you are all through and we are not going to give you anything," I think we would still survive.

Senator DURENBERGER. How do you determine the contract rate? I take it it is negotiated, but when you are serving an HMO, a Blue Cross, the private insurer, is there a standard fee around the country for this that is strictly negotiated on the basis of what you can produce? And is there some room to improve that rate?

Dr. GALBRAITH. I don't know what that is, Senator. I would have to ask Mr. Gustafson if he were here. He could tell you the figure, but right now I can't.

Senator DURENBERGER. OK. On the basis of your experience, and I think the foundation has been at this now for about 10 years——

Dr. GALBRAITH. As a foundation we are 10 years old; yes.

Senator DURENBERGER. Is there a primary emphasis or focus shifting from utilization control for strictly cost purposes to quality control?

Dr. GALBRAITH. Well, I have always felt that utilization for quality control is a very important factor in medicine. I think medicine in 1972 had the first opportunity to join with the Federal Government in an experiment. I never thought that medicine ever needed control; I think they needed change; and I think that change has evolved because the concept of the PSRO from its beginning was a good one. And I think from the concept alone we have attempted to expand on that concept, to the point where we have always felt that we needed peer review among ourselves; we always needed people, at least my own peers, to tell me whether I am doing the right or wrong thing; and if I am out of the norm, I want to know when and how much and how do I get back there.

All right, by the same token, by starting a PSRO and by expanding, in the Twin City area, for instance, we probably have the largest number of HMO's. That has probably been a favorable thing in one factor for helping the doctors look at themselves a

little closer and saying, "Hey, can you actually do something to reduce those costs?"

HMO has shown them a little bit, but on the same track PSRO has shown the same thing, and the foundation continues to expand on its educational value to the individual physician. We never thought we should be a regulatory arm. We have always felt we should be an educational arm.

Senator DURENBERGER. Do you find in those areas of the State, particularly the metropolitan areas where there are alternative forms of health care providers, fee-for-services providers, that your job is made easier than those parts of the State where you have only one system?

Dr. GALBRAITH. I think that our particular area of the country has such a strong medical community they want to do what is best for the entire State.

I think the best example is in eastern Minnesota, where we just started our new program with PSRO. We are now allowing those people to set their goals, and then if they set their goals and have problems, we are there to help them. We are not there to come down with a right arm, like most people think we are.

They solve those problems by choosing what they think is the best method, going to us for educational and technical purposes, and solving their own problems. I think that is what it is all about.

Senator TALMADGE. Thank you very much.

I want to commend you and your associates for the fine job you are doing.

[The prepared statement of Dr. Galbraith follows:]

Testimony Presented by Richard Galbraith, M.D., and Carl Gustafson of the Foundation for Health Care Evaluation

SUMMARY

A. The Foundation for Health Care Evaluation is a private nonprofit corporation formed in 1969 to assure quality care at reasonable cost.

1. The Foundation assumed responsibilities as a PSRO in 1974 after determining that the intent of Congress was to guide providers but to allow them a significant degree of flexibility in managing peer review. Many of the physicians in our area still view PSRO as restrictive regulation rather than their ally.
2. The Foundation has PSRO sponsored programs in acute and long term care review and engages in consulting, education and private review which are not PSRO funded.
3. Foundation physicians believe in public acceptability and extend representation to public agencies, consumers, and others. Only 55% of the Foundation's Board members are physicians.

B. We can provide no simple answers to the overall performance of PSRO's nationally. We can provide some indications of what we have done:

1. Improved hospital utilization (Medicare) from 1974 to 1977.
   a. Days of care down 600/1000 enrollees.
   b. Average length of stay down nearly a day.
   c. Highest rate of decline (10.7%) in days of care 1976-1977.
2. Average length of stay for selected diagnoses down in four groups and up in only two.
3. Average preoperative length of stay at or below the national average for 9 out of 11 procedures.
4. Medical care evaluation studies link problem-identifying with problem-solving. We ranked eighth among PSRO's in using this tool. Through this we have done such things as: reduce length of stay for deliveries, and ensure that informed patient consent for a procedure is obtained.
5. We are not content to rest on these gains. Medicaid ALOS is a half day over the national average. In certain psychiatric and chemical dependency diagnoses we are well above average in use of the hospital. These are corporate priorities in 1979-80.

C. Facts and figures do not tell the complete story. We have also made gains in:

1. Promoting community awareness of quality issues by, for example, working one-to-one with a hospital to get them to make self improvements.
2. Helping the community work in unison on issues related to quality, through data sharing and direct collaboration.
3. Adapting to change by evaluating ourselves and by improving our internal management enough to remain productive after a 20-30% budget cut.

D. We have not accomplished all we set out to do:

1. A successful fee review program was terminated because of the Federal Trade Commission. We not only lost the benefits of the program, we lost the commitment of many of the physicians in our area.
2. We have failed to devise a program able to provide the right kind, amount and timeliness of feedback.
3. We have fallen into using standard methods because they are required rather than trying new approaches.
4. We have failed to convince Congress of the need for financial incentives to push PSRO beyond problem-finding to problem-solving.

E. We are optimistic about the future because public opinion polls show quality to be a high priority. We have the tools and the approach needed to improve quality.

Mr. Chairman and Members of the Subcommittee, thank you for inviting us here today to discuss our views on the role of professional standards review at the local level. I am Dr. Richard Galbraith, Chairman of the Board of the Foundation for Health Care Evaluation in Minnesota. I am accompanied today by Mr. Carl Gustafson, Executive Vice-President of the Foundation. The Foundation is a private non-profit corporation formed by area physicians in 1969 and incorporated in Minnesota in 1971. Our primary goal since the beginning has been to assure that quality health care is delivered at reasonable cost.

When Congress passed PL92-603 we believed the congressional intent was to guide health care providers. The law gave the physicians a significant degree of flexibility in setting standards through which performance is judged. From the inception many of our peers have interpreted this law as an inflexible, regulatory arm, restricting their ability to practice high quality medicine. The Foundation leadership however, agreed with what we believed was the congressional intent in providing for considerable local authority to manage the peer review program.

In 1974, the Foundation was designated as one of the first 12 PSROs in the nation. In 1977 we extended the geographic scope of our responsibility beyond the Minneapolis-St. Paul area to encompass the two-thirds of Minnesota which fall north and west of the Twin Cities. Our PSRO area includes 110 hospitals, 4,000 physicians and nearly 300 long term care facilities.

At the present time, the Foundation manages a hospital review system for both private and federal patients. In 1978 the Foundation completed a pilot long term care review project which has been assessed by the Rand Corporation as one of the country's most innovative approaches. In 1979-80 the Foundation

will implement this program. We also have a pilot program in ancillary services review. We continue to engage in such activities as consulting, research and private review which are not supported by PSRO funds.

As a physician organization we are concerned with public accountability. Though most PSRO boards of directors are 90% doctors, our board officers have always sought representation from consumers, industry, third party payers and public agencies as well as providers. Only 55% of our board members are physicians. The work of the board is further enhanced by those who voluntarily serve on various standing committees and task forces. In 1978, our physicians donated over 1600 hours of their time to the Foundation.

As members of this subcommittee you have no doubt heard of the many debates over the performance of Professional Standards Review Organizations. We cannot provide any simple answers to this question. We can only show some indications of what we have done through PSRO.

From 1974 to 1977, national Medicare data reflected a more appropriate use of hospitals in our area. (Data from this source are not yet available for 1978.)

- Medicare days declined nearly 600 days per 1000 enrollees, a decrease of 13% .
- The average length of stay dropped from 11.7 days to 10.8 days, almost 1 full day. This brought us very close to the national average.
- From 1976 to 1977 our PSRO showed the highest rate of decline in total Medicare days in the nation (-10.7%).

- The Health Systems Agency in our metropolitan region reports that the total days of hospital care (federal and private) declined 2.3% between 1976 and 1977. That is about 62,000 patient days saved at nearly $200 per day.

Data on all federal patients from HEW shows that from 1977 to 1978 the Foundation showed average length of stay decreases in four of eighteen groups of diagnoses with increases in only two groups.

In 1978 we were at or below the national average for preoperative stays in 9 out of 11 procedures. In four of the 11 procedures our preoperative stays declined to at least 20% below the national average since 1977.

We have no intention of resting on these gains. We are still a half a day above the national average for Medicaid length of stay, for example. We are confident that far more patients with psychiatric or chemical dependency problems could be treated outside the hospital, saving large numbers of hospital days. Addressing these problem areas is a corporate priority for 1979-80.

Through our medical care evaluation studies we have the capacity to improve the performance of health care practitioners. Medical care evaluation studies link problem-finding and problem-solving in one strategy. We have used this strategy vigorously. An HEW report showed us to be eighth among PSROs in the number of studies performed since the inception of PSRO. Most of the hundreds of studies were done in individual institutions.

In addressing area wide problems, multi-hospital studies are used for comparisons and regional problem-solving. Seven of these have been completed. Some results are:

- A high length of stay for normal deliveries was found and was significantly reduced.
- A study of myocardial infarction emphasized the need for further research on pacemaker insertion and the use of intensive care units.
- Hysterectomies showed high rates of bladder injury and hemorrhage. This problem is being closely monitored in the hospitals involved.
- In the electroconvulsive therapy audit, informed consent was lacking in 20% of the patients. This has been totally corrected.
- A multi-hospital audit of transurethral resection of the prostate led the Minnesota Society of Urology to a penetrating examination of the indications for this procedure.
- In the tonsillectomy and adenoidectomy audit, more than 50% of the medical records lacked sufficient documentation of the medical conditions warranting surgery. This is presently being corrected.

Medical care evaluation studies have identified problems in the quality of care that otherwise would have gone unnoticed. In some cases, direct action has brought improvements. In others, results have lead to education or further research.

As significant as these facts and figures are, we would like to illustrate gains made in other important areas of performance.

- Promoting physician awareness of the need for quality assurance.
- Helping the health care community work in unison to make improvements.
- Maturing with the increasing challenges of PSRO management.

We believe that our strong commitment to working directly with providers can bring more personal awareness of public accountability for quality and appropriate utilization. Since our inception we have chosen to delegate review to all hospitals. This assumes that responsibility for providing the highest quality of care and appropriate utilization lies with the medical staff and the facility. Because this nurtures self improvement, there is no more effective means of heightening awareness of the need for quality control. For example, we found the situation at one hospital to be so severe that virtually no quality assurance activities were taking place. We were sure that what amounted to a cover-up was occurring. The PSRO mandate provides us with the authority to take away the rights delegated to a hospital and do the job ourselves. We rejected that course and chose instead to work on a one-to-one basis with physicians and administrators at that hospital. After many months the corner was turned and the hospital today not only conducts a solid program but now knows the meaning of self-responsibility for quality assurance.

In a second major area of impact, the Foundation is viewed as a major factor among the forces that constitute the health system in our region. For example, the Foundation is now invited to participate in health policy discussions on such issues as alternative uses of excess hospital beds,

decisions on the need and location of hospitals, and levels of reimbursement. Meetings and work groups formed around these issues have become a regular feature at the Foundation. Besides staff and physician expertise, the community often calls upon the Foundation because of its all-patient data base. Hospitals use our all-patient data base to support their own institutional planning. Diagnostic groupings from our data will be used by the state's rate review system to establish budget guidelines for hospitals. Hospital utilization statistics are used by the local Health Systems Agency to project regional bed needs. Several HEW-sponsored research efforts rely primarily on Foundation data. Data from our long term care review program will similarly benefit the community.

These examples illustrate a point. The resources made possible by our PSRO are unique in the community and help others to do a better job. This sharing, though still in its infancy, ultimately will lead to better care at more reasonable cost. In a recent example, the existence of all-patient data (private as well as federal) enabled us to identify two physicians whose patterns of practice for treating whiplash injuries indicated the possibility of fraud. The Foundation convened third party payers and the drug enforcement agency. The matter is now under investigation.

Because the Foundation is a focal point for quality control, we have been approached by health maintenance organizations, private insurers and Blue Cross/Blue Shield of Minnesota to conduct review. We currently have a contract with Blue Cross and expect to broaden the scope of private review still further. This benefits federal patients directly by increasing the data base upon which decisions are made and by increasing the peer review pressure on providers.

Another area of accomplishment has been the Foundation's willingness to adapt to changing expectations. Stringent calls for PSRO accountability beginning with the first Office of Policy Evaluation and Legislation (OPEL) report caught the Foundation and other PSROs napping. Despite claims of premature and incomplete assessment, the fact remained that a highly visible evaluation questioned the effectiveness of what we were doing. In 1977 the Foundation was reviewed by the Health Standards and Quality Bureau (HSQB) via an in-depth site visit.

Our results on the measures used by OPEL were adequate. The site visit indicated generally favorable performance as well. Nevertheless, we were not comforted by the knowledge that we were doing an adequate or good job.

In 1977-78 we started an experimental evaluation of our own impact by using our expanded geographic area as a test site. This study is still in progress. It represents a unique example of an individual PSRO undertaking an evaluation that matches the scope and scientific rigor of national assessments. We expect this evaluation will allow us to strengthen our review program by pointing out its weaknesses. After the HSQB site visit assessment, we translated specific performance problems into corporate objectives. Many of the problems dealt with internal management and organization. Nearly 85% of these objectives were met during the fiscal year now concluding. Others have been brought forward to be tackled in 1979-80. Meeting these objectives means that we can remain productive despite a 20-30% budget cut in unit costs per review.

Not all that we set out to accomplish has been achieved. We also would like to share a few of our failures with you today.

Prior to the inception of PSRO the Foundation's primary role was fee review. This tremendously successful program was well received by physicians, insurance companies, and consumers as a means of maintaining quality while limiting the costs. Not only was it successful from an economic standpoint but it acted as a catalyst for increasing physician participation. We were advised in 1976 that the Federal Trade Comission might bring suit. Rather than face the expense of such action we dropped the program. As a result, fee review and all of its important benefits were lost. The most important loss was the level of active physician involvement. Physicians interpreted the termination of this program as an inappropriate regulatory encroachment on peer review in medicine. We believe that one way of regenerating physician enthusiasm is to reimplement this successful activity.

A major failure has been our inability to rekindle that kind of physician commitment in other Foundation programs. A major reason for this failure is a misinterpretation of the PSRO law by peers. We have failed to get across the message thatPSRO is an ally not an enemy of both the patient and the physician. We need providers to be an integral part of every aspect of review.

We have failed to devise programs that yield clinically relevant performance feedback in the right amount and timeliness. Peer review data ultimately will have to be as useful to practitioners as lab and X-ray tests are today, if providers are to value and use evaluation in their own practice. This will require a better match between information technology, which is available, and new quality assurance techniques, which still need to be refined.

We have failed to be as flexible in our approaches to quality assurance as we might have been. We have been locked in certain methods by administrative requirements.

Finally, we have failed to emphasize to Congress or the administration the importance of creating appropriate incentives. There are disincentives for poor performance through defunding or administrative pressure. There are few positive rewards to assume new challenges. This is an opportunity for Congress and the Administration to be creative. Financial incentives should be used to move PSROs from problem-identifying to problem-solving. We should be encouraged to become a fully accredited continuing medical education center, for example, so that we can solve more of the problems which we identify.

Despite our failures, we are optimistic about the future. National and state public opinion polls consistently note the importance the public places on health care quality. We know a lot about this concern. We have or can create the tools needed to assure the public that it will receive value for new health expenditures. We believe that local peer review rather than regulation is the best approach. In our area, the Foundation is the agency to which the community turns for issues of quality and appropriate utilization. We in turn collaborate with other groups that control reimbursement and the supply of services. Together we can do something about both the quality and the costs of health care.

Thank you for your attention. Mr. Gustafson and I are now prepared to answer any questions you may have.

Senator TALMADGE. The next witness is John M. Wasserman, M.D., executive medical director, California PSRO Area 23, Torrance, Calif. Doctor, if you will insert your full statement in the record and summarize it, we would be grateful, sir.

STATEMENT OF JOHN M. WASSERMAN, M.D., EXECUTIVE MEDICAL DIRECTOR, CALIFORNIA PSRO AREA 23, TORRANCE, CALIF.

Dr. WASSERMAN. I thank you for inviting me to attend. I hesitate to go over the same ground some of the other witnesses have gone over. However, I will tell you a little about the area I represent.

We have seven PSRO's in Los Angeles County. We had eight, but now have seven. In the brief I have submitted, there is a map of the county. It shows that area 19 has been defunded. So, now we have a hiatus. We have an area of the county which has no PSRO.

Similarly, we are in juxtaposition to Orange County which is a very early conditional PSRO, and where, I believe, only six out of its very numerous hospitals are implemented and because of the recent funding freeze has been advised it is to implement no more.

So on two of our sides we have no PSRO. We have been advised by the State, which is confirmed by my own observation, that we have had a migration—a migration of physicians to institutions where they encounter substantially less quality assurance monitoring than they had encountered in area 23. As a matter of fact, we closed a hospital through the sanction mechanism and the physicians have gone to both Long Beach and Orange County. We put them on preadmission certification in our area. Nobody seems to have taken any action against them in the contiguous areas where there is no PSRO.

While it makes us look good, it is not good for the program. And, when the statistics come up next year, we are going to look great because these physicians and their highly questionable practices are gone. It is not really good for the program.

The delay in implementation is based on funding. It is counterproductive for the well-being of the taxpayers and individual patients of this country.

The interesting perception that various groups have of the PSRO in our area, I suppose, is qualitatively no different than it is in the rest of the country. The very ultraconservative physicians say that we are the Federal Government. The very consumer-oriented people consider that we are the fox guarding the chicken house.

As a matter of fact, we had a purely spontaneous public discussion with Mr. Nader at Newport Beach in May and he made some remarks which suggested to me that he should very profitably increase his knowledge of the PSRO program. And, when I suggested this to him, he rather bitterly stated that we sounded like a well-functioning PSRO and that to him was a complaint.

However, I would like to comment, if I may, and I am going to let the written record speak for itself. I would like to comment on two or three things I have heard before me. And that is the ability of the PSRO to operate on the basis of statistics. Well, I am not at all convinced of this. First of all, statistics are by their very nature greatly delayed. When you look at statistics in 1979, what are you looking at? You are looking at something long gone by.

The PSRO and the hospitals reflect a dynamic process and they change not only from day to day but they change from week to week and month to month. And when you delegate a hospital and if you do not monitor it, or if you waive review, you do not know what is going to happen next week.

In spite of the fact that the program was oriented to delegation at its early stages, we developed the philosophy that we would only delegate on the basis of very specific and objective criteria. And, out of the original 33 hospitals we have delegated only 14, and perhaps we made a mistake in one, perhaps we were too generous.

In any event, we think that focusing could be a very useful tool in the majority of our delegated hospitals. We think that focusing would be both useless and contraindicated in our nondelegated hospitals. We have had nondelegated hospitals with a denial rate of approximately 16 per 100 admissions, either total admission denials or length of stay.

We have recently been funded for and we are about to begin binding ancillary service review on October 1, 1979.

Out of the first three hospitals we looked at in preparation for this assumption of review, to our horror we found that in one hospital there was a 12-percent problem with ancillary orders and billings, and in another we found a 23-percent deviation from acceptable practices. These represent either utilization problems or fraud problems or a combination of the two.

In any event, we extrapolated this to some of the other similarly behaving hospitals in our area and we came to the conclusion that in seven hospitals which have a total of 8,400 federally funded admissions per year, we could postulate a minimum of a $200 loss per admission to the taxpayers of this country. Besides the cost, many patients are being exposed to the risk of unnecessary diagnostic procedures to which they should never have been exposed.

I think a basic problem is that we have gone through the fiscal intermediary reports relating to rankings and gradings, but we have been using 1960 technology when we should be using 1980 technology in the billing process in the hospitals. Even the grocery stores do a better job. They have automatic checkers now where every individual item shows. Hospitals submit a bill that says "Diagnostic services: $7,000." And so here you have the system. What do you call it? They call it the honor system. The payer has the honor and the payee has the system. And until this is rectified, until we get down to some kind of modern approach to the billing process, we are going to be swamped by the sheer volume. And this volume will kill the program unless we do something about it. I would like to make a comment regarding the excellent relationship and the mutual assistance we have enjoyed with Blue Cross of Southern California, the fiscal intermediary who greatly assisted us with this ancillary service monitoring.

I would say to you again that I do not have as much confidence as others in the data system. First of all, data systems change. And all the people that work for us and all the people that work for you and all the people that work for the administration have to learn about the new data system. Just about the time they begin to understand a little bit about a particular system, they have to go on to another data system and then you have to try to compare the

statistics generated from this data system with the last. I am not at all certain that a data system can be the total basis for legislation nor the total basis for funding of an important program. It would seem to me that a more rational approach to evaluating this program would be for the development of the use of some very imaginative physicians who have been chiefs of staff and chairmen of utilization committees and presidents of foundations. One of these physicians should be installed in each one of the regions and they should be sent out to each PSRO and say: "What are you here for? What behavior changes do you expect to make in your particular PSRO, in physicians, in institutions? And, show me how you have done it."

I think that will be far more profitable than relying on a data system which comes 1 year later, 2 years later.

For similar reasons, I am not as entranced with medical care evaluation studies as many. The medical care evaluations study is a retrospective operation. The concurrent audit in combination with concurrent review is a very useful mechanism. It protects patients while they are hospitalized. The retrospective study protects the future patient. It does not really address the quality of care being given to the patient concurrently. And, I think there should be room for both types of systems.

Even the joint commission has removed the rigid application of the criteria of the retrospective audit. And hopefully, we are approaching it as well. We have priorities because of limited funding. And I am not certain that our priorities are in the right place. And I would be pleased to discuss the priorities if anyone would care to ask me.

Thank you.

Senator TALMADGE. Thank you very much, Doctor, for your fine statement. Would you describe some of the specific abuses that you found in the Los Angeles area?

Dr. WASSERMAN. Well, let us go to title 19 for the moment. We found that the State has been issuing certifications of medical necessity for certain procedures as an inpatient because there was an approved treatment authorization request to the State.

When we took over binding review, we found that the hospital was, in fact, treating these people as outpatients but billing the State for inpatients. We found 19 of these in 1 month in one hospital. We notified the State and suggested to them that if they wanted to do something retrospectively, they had a fertile field in which to do it, that we were doing it concurrently. We suggested it was fraud and we suggested, too, to the State that the ball was in their court. They should do something about it.

It is interesting if I may take a moment to tell you how we developed the relationship with the State. We went to see the representatives of the State Department of Health, and said we were a conditional PSRO and were ready to work for them and ready to help. They did not want to talk with us. So we went and pounded the halls of Sacramento and saw the legislative committees and we offered them a low-risk/high-yield proposition where we would review three hospitals, one good one, one poor, and one intermediate by the methods of our choice. And they could review and evaluate us in any way they wanted to at the end of 3 months.

If they thought we were good, we would continue with medicaid review, and if not, we would stop. We have been working well with them ever since.

We now utilize preadmission certification for all elective admissions in nondelegated hospitals for title 19. We started off with agreement with the State that we were going to do this for only 17 diagnoses. There are certain procedures like umbilical hernias in babies under the age of 5 which normally do not need surgery because the child will heal spontaneously and we suspected this was a procedure subject to abuse.

We do preadmission certification on all elective surgery in title 19 patients in the nondelegated hospitals because there is a presumption that if the hospital is nondelegated, it does not have a commitment nor a process to effective quality assurance.

We have recently found that one physician is performing many hysterectomies and is doing them on the basis of a diagnosis know as carcinoma in situ. Carcinoma in situ is in the eye of the beholder and the beholder is the pathologist. It was suggested to us from the frequency that the disease might possibly be in the eye of the beholder and not in the uterus. And, so we are getting second opinions from the tumor pathology registry.

We utilize preadmission certification for certain diagnoses and for certain physicians. First of all, if we find that the physician or the surgeon has a history of inappropriate activity, we will subject all of his surgery to second opinions. There are some surgeons who are constantly required to get second opinions from a PSRO approved consultant until they have demonstrated to us over a period of time that they have some reliability. These are primarily in the nondelegated hospitals. They are not in the delegated. It is interesting to note that 40 percent of these patients never have the second opinion and do not have the surgery.

We perform a function in monitoring the delegated hospitals. We monitor them every month and we look at the appropriateness of the activities of the physicians. We have a coordinator that performs this monthly monitoring. She brings reports back, and they go to the appropriate physicians. We look at them and we send them a letter. Every hospital gets a letter every month. And we give them a summary of our perspective of how they are performing, and we require a meaningful response.

That is pretty much it, Mr. Chairman.

Senator TALMADGE. I was impressed by your finding that two out of the three hospitals you reviewed had from 12 percent to 23 percent inappropriate use of ancillary services. Would you say that focusing review efforts on hospitals or physicians with relatively high ancillary service rates would be significantly cost effective?

Dr. WASSERMAN. Focusing them out I think would be cost ineffective with the present level of problems in metropolitan areas in this country. Focusing out is fraught with danger. We tried focusing out, Mr. Chairman. We focused out a simple thing like normal deliveries. We focused them out today and we thought isn't that wonderful? Now we were saving time and money. The next thing we know we turned around and found out that one particular hospital admitted 16 false labors that month and was going to

collect inpatient reimbursement for 15 inappropriate admissions. We went back and denied them retrospectively.

All I am saying is that focusing at an early stage of the life of a PSRO is full of great economic and quality risks.

Senator TALMADGE. You testified that 40 percent of the prospective surgery patients do not appear for mandatory consultations and do not have surgery in your area. Could the physicians for some of those patients simply admit the patient to a hospital in another PSRO area?

Dr. WASSERMAN. Not through a PSRO in another area because we are the only one doing title 19 in Los Angeles. But they could get permission from the State and do it in any other area. Incidentally, I erred on the side of conservatism. It is 60 percent who are not getting a second opinion and 60 percent are not having the surgery.

Senator TALMADGE. Doctor, you have made a great contribution to our deliberations here. I commend and compliment you and your associates for the outstanding job you are doing. Thank you very much.

The next witness is Dr. G. W. Eklund, associate medical director, Multnomah Foundation for Medical Care, Portland, Oreg., accompanied by Philip C. Walker II, executive director.

Doctor, you may insert your statement in full and summarize.

[The prepared statement of Dr. Wasserman follows:]

STATEMENT TO UNITED STATES SEN

COMMITTEE ON FINANCE

SUBCOMMITTEE ON HEALTH

JOHN M. WASSERMAN, M.D., MEDICAL DIRECTOR
PSRO AREA 23 - 23840 HAWTHORNE BOULEVARD
TORRANCE, CALIFORNIA 90505

(See attached map for Area boundaries)

The successes and failures of the PSROs since the passage of Public Law 92-603 in 1972 are both extrinsic and intrinsic by cause.

The prerequisite concurrence of all agencies involved, including the Social Security Administration and State Medicaid Bureaus has been absent. In addition, timely and adequate performance was damaged by the overt adversary positions held by a significant segment of the medical community, manifested by the exhibition of anxiety and hostility by both physicians and hospitals to any perceived form of governmental intervention. This resistance to any change or variation has directly contributed to the delay of program implementation.

DHEW has been remiss in its obligation to promulgate program regulations. Dozens of lawyers have been standing in the wings objecting to requirements as specified in 'Transmittals' and, in fact, have challenged the legality of these letters of transmittal which have been used in lieu of published regulations.

I personally have been the recipient of an $11 million lawsuit subsequent to the attempted de-delegation of a non-performing hospital. It is interesting to note that requested assistance was not given from any segment of DHEW during this litigation which centered around the lack of specific regulations.

Those of us who have been involved in the PSRO for some time now retrospectively see how naive we were in attempting to fulfill the requirements of the law with our limited knowledge of how one does business in a governmental environment. We think we are now, however, less naive and are learning how to live with the apparent conflicting pressures.

We are still unhappy with the lack of a relationship between Part A and the Part B carrier. We now deny hospital services but are unable to do much about the payment to the physician who has ordered the inappropriate services. Physicians are frequently simplistic, and in order to keep their enthusiasm, there has to be some relationship in time between cause and effect.

You might imagine the frustration of this PSRO when we attempted to process a sanction report against a hospital because of the daily inappropriate activities of its medical staff and administration and the imminent threat to the lives of the patients. The sanction process takes approximately 3 months to produce any visible effects. By the time such effects had been produced, we found it necessary to prevail upon the Office of the Attorney General of the State of California and the County of Los Angeles Health Facilities Division to do something regarding the threat to the patients.

In the matter of evaluating a PSRO, how much is the closing of this type of hospital worth? What is it worth to put a hospital out of business which normally has 18 to 20 Titled patients, 90% of them either being mistreated or should not have been admitted at all? It is extremely difficult to translate these type of actions into dollars in order that a PSRO may be evaluated on the basis of cost-saving.

For nearly seven years the PSRO program has emphasized hospital delegation as a matter of right. Thankfully, this has recently been amended. The entire program is now paying for that delegation emphasis and many PSROs are struggling in an attempt to determine how to de-delegate some of the hospitals which they delegated. Our personal experience has been fortunate in that we developed very specific criteria for delegation and have delegated only 15 out of the 32 hospitals in our area.

In the recent regulation which proposes funding in the non-delegated hospitals, a pass through funding system was proposed. It places the PSRO in a

position of being beholden and dependant upon non-delegated hospitals for funding.

I have previously alluded to the extrinsic factors which have delayed the appropriate implementation of this program. I must honestly admit that there are intrinsic factors which have had a bearing upon implementation such as a lack of commitment of the people involved in an individual PSRO, and lack of emphasis upon physician participation. There have indeed been a few PSROs in which the physician involvement was specifically designed to maintain the status quo. While it is always dangerous to generalize, it might be safe to say that a PSRO which almost totally delegates its hospitals and which finds very few activities that it wishes to challenge, very few patterns of behavior that it attempts to change, would in my eyes be suspect until proven otherwise.

I have often heard the argument that occasionally a unique PSRO does not utilize denials because certain educational activities are so excellent and profound that the behavior change sought occurs spontaneously. It would appear to me that this defies the laws of probability and human behavior, but may occur rarely.

Turning to the assessment and hopeful improvement of the PSROs, what techniques should be employed? Fundamental to fulfillment of the PSRO mission is physician involvement and planning, criteria development, peer review, medical evaluation studies, and the medical determination of problems in utilization and quality. The PSROs must attempt to use the educational approach to correct problems which have been unearthed as a result of both audits and concurrent review. However, when it is determined that the physician or the hospital is uneducable, sanctions must be utilized to correct or eliminate the problem. These type activities must be done by physicians and cannot be done without physicians. Without active physician participation, there is only pro forma activity which is superficial at best. It is therefore the responsibility of those who are assessing a PSRO to see that these necessary activities by the physicians are actually being performed.

Secondarily, it would appear that the approach by the individual PSRO toward hospital delegation is an extremely important reflection of the commitment of the policy making people in the PSRO. It has been my experience that mass delegation of authority without adequate criteria and appropriate monitoring is an indication of a non-performing PSRO.

The concurrent denial rate which a PSRO has generated during its review process may be significant in the evaluation of the PSRO, although it should not be used as the single index by which a PSRO is evaluated. Assessors must also become extremely familiar with the evaluation of the PSRO by outside agencies such as the fiscal intermediary, the County Health Department, and the State Department of Health. Assessors must evaluate the ability of the PSRO to produce documented improvement in such areas as inappropriate admissions, weekend admissions, admissions from emergency rooms that are inappropriate, reduced inappropriate surgery, and the waiver status of the hospitals. If a PSRO has allowed all of its hospitals to enjoy a favorable waiver status, this would also tend to fly in the face of experience.

DHEW has provided technical assistance to the PSROs in the areas of data collection and management, the financial management of PSROs, and the appropriate management of documents. The great area of defect, however, has been in stimulating the improved performance in both utilization review and quality assurance. This activity cannot be performed by non-physicians nor even by physicians who have had little or no experience in a hospital or clinical setting.

It is my view that HEW should recruit a cadre of physicians who have been in the position of chief of staff and/or have served on various committees of hospitals and have an ample amount of clinical experience. These physicians would periodically visit each PSRO and attempt to evaluate its commitment to the aims and goals of the legislation as well as the process that the PSRO utilizes to achieve those goals. These physicians could also assist with motivating techniques.

The physicians who are presently employed by DHEW in the PSRO program have largely administrative duties. Admittedly, there would be some cost in the recruitment and employment of these physicians. However, the PSRO program itself has a significant cost, and certainly the costs of Titles XVIII, XIX, and V programs are astronomic. I believe that the present evaluation of the PSROs is frequently inherently defective because of the employment of paper indices to evaluate a complex program, thus producing acceptance of pro forma behavior.

The calculation of average length of stay is important, but there are many qualifiers to this index. The percentage of disagreement figures between the PSRO and the fiscal intermediary used alone is excessively simplistic since the variation in the performance of the fiscal intermediaries is apparent to all who are familiar with such activities. For example, in our own PSRO we have had disagreement with one fiscal intermediary and little or no disagreement at all with the two other fiscal intermediaries.

Someone is going to have to make some very difficult decisions. Does the individual PSRO have a commitment? Does it have a goal oriented process? How long can a PSRO non-perform before DHEW will defund?

The inherent problems in operating under a grant or contract with the federal government are nowhere more apparent than they are in this program. At one moment in time the PSROs might be urged to accelerate their implementation for the benefit of the program, and the following month they are advised that due to impending funding crises the implementation is to cease. We were advised on the one hand to develop a plan for long-term care review. But before the ink was dry, we were advised that there was no money to be allocated for doing such review. We were advised to develop a memorandum of understanding with the Health Systems Agency which we did. The Agency promptly went defunct. The PSROs continue to operate under the cloud of the Freedom of Information Act while attempting to investigate cases for possible action against an institution or physician. We

are occasionally harassed for premature information before the case has fully been developed at the Office of Program Integrity. We are occasionally held responsible for activities outside our mission as a PSRO.

If the PSRO program is going to be successful, it will only be successful as a long term program, without the annual swings of appropriations, without the consequences of the delays in promulgating regulations, and without the possible inactivity which has been brought about by a question as to the application of the Freedom of Information Act.

It was difficult to sanction hospitals when the sanction regulations had not as yet been published. In spite of this, sanctions occurred. It is difficult to apply fiscal restraints to a hospital when in spite of denying medical necessity, the hospital is either directly or indirectly reimbursed through various types of annual or monthly programs.

In spite of all the problems enumerated above, the majority of the PSROs are improving. Improvement in both process and commitment is contagious. Many PSROs are seeking improvement in contiguous areas. Many PSROs have improved to the extent that private industry is asking us to do reviews for their own insured. This particular PSRO is about to start binding review for private patients covered under Blue Cross of Southern California, and we are also currently discussing the possibility of similar review with the Health Insurance Association of America. The initiative for the latter discussions came from HIAA.

Improvement is required in the billing and payment processes for services rendered by hospitals particularly in the area of ancillary services. Both billing and payment mechanisms are based on obsolete technology. It would appear that a 1980 computer technology should be implemented in order to obviate mass billing for ancillary services. Hundreds of items are included which totally overwhelm the monitoring system. Monitoring can only be done on norms and profiles and rankings, a method which permits substantial abuse. We had not been funded

until this time to review ancillary services, but we have never worn blinders and where in fact we do see abuses in this area, we refer them to the fiscal intermediary for appropriate action. See attached sample case.

Our PSRO has 8 physicians on total pre-admission certification for all Titled patients. We have often mandated consultations, and have refused to permit poorly performing physicians to serve as consultants. As a matter of fact, we have recently referred one such poorly performing physician through the appropriate sanction processes and the matter is awaiting action by the program administrator. Hopefully, this physician will no longer be allowed to treat Titled patients. We are now receiving frequent inquiries from other PSROs throughout the nation who are seeking assistance in formulating sanction reports.

We require Treatment Authorization Requests for all elective hospital admissions to non-delegated hospitals for Title 19 patients. We also require consultations and we pick the consultants. The surgical procedures are selected by 1) random sampling and 2) the utilization and quality experience. The interesting result is that 40% of patients do not appear for the consultations and do not have the surgery in our Area.

We have removed favorable waiver status from 8 hospitals. Other PSROs are learning to use the waiver removal techniques.

How does a PSRO place physicians on pre-admission certification, how do you mandate consultations? We have learned from the techniques of other PSROs to improve our performance, and many PSROs are now learning from us. There is a learning process involved, and I am confident that continual improvements will occur with the existence of adequate funding. I am also confident that the proposed funding for 1980 is at such a level that the performance of PSROs employing random sampling or based on focusing will produce a reaction to our performance by the Congress which will probably result in the termination of the program by 1981.

I have just been informed that the Central Office has advised the Regional Office to delay any further implementation of review in hospitals not now under review. This seems to produce a rather paradoxical situation. There will undoubtedly be a migration of poor and marginal physicians who are now being adequately controlled by a local PSRO to hospitals which are not under PSRO review and as well from PSROs that are doing total review to the PSROs who are not able to conduct total review because of the funding crisis. Unfortunately for the country, the people who have been traditionally opposed to the Title XVIII and XIX programs are now claiming the power of prophecy since they alleged prior to the passage of the Bennett Amendment in 1972 that the PSRO law would be self-destructive. It appears as though this present level of funding would serve to corroborate the prophecy.

In conclusion, the overall potential of the PSROs in this country will not be determined by taking a mean of the performance of all the PSROs now in existence. The potential of the program will be more adequately determined by looking at the individual performing PSROs and demanding that the non-performing PSROs come up to the performance required by the legislation. This requires time, commitment and money. The present level of funding of the program precludes the possibility of its success. The newer conditional PSROs have been advised that they must do focusing from day 1 of their existence, which is an impossibility. They require time to learn, time to be motivated, assistance from other PSROs, and an opportunity to do total review in order to develop a data base so that they may intelligently focus out the areas which would not be cost effective to review.

We have had outstanding assistance from one of our fiscal intermediaries. Their assistance, however, has been limited by the resources available and their screens are similarly limited by funding.

It is my view that the screening activities of the fiscal intermediary are about 20% effective, particularly in the area of ancillary services.

We have recently been funded with a one time $35,000 grant to do binding ancillary services review. Of the first three hospitals that we selected, two of the three were found to have a 12% to 23% inappropriate use of ancillary services. I have been advised that the ancillary services costs to government programs is approximately 120% to 130% of the daily board and room rate. This is an enormous waste. I am attaching herewith sample cases of some of these distressing overutilization cases which are wasting millions of dollars of the taxpayers' money (Attachment II).

If we were suspect last year, you are not going to like us any better next year because the level of funding presently proposed for 1980 will make us have some very difficult decisions. How much is acceptable fraud? How much is acceptable overutilization? We are confident that our process is cost effective in the ratio amount 15 to 20 to 1 and has an educational return factor which will multiply this proceeding factor by at least 3 or 4 over a period of time.

The choice appears quite clear. Congress can either mandate a permanent medical police force or attempt through such organizations as the PSROs to permanently change the behavior of the health providers whose behavior requires to be changed in the interests of our society.

ATTACHMENT I

California PSRO Area 23

a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

TO: John M. Wasserman, M.D., Medical Director

FROM: Marie Ryan Petro, Special Projects Coordinator

DATE: 22 February 1979

SUBJECT: Abstract of Psychiatric Patient Admission at

This 54-year-old female was admitted on 30 December 1978 with a diagnosis of severe reactive depression, rule out hypothyroidism. The patient has no previous psychiatric history.

The patient had been caring for her mother, who died of terminal cancer on 12/5/78. She apparently displayed symptoms of anxiety, confusion, and helplessness from that time. At the time of admission, the patient (according to her son, with whom she lives) is unable to care for herself.

Throughout the hospital stay, the patient appeared depressed. Even at the time of discharge, the patient was verbalizing her own needs to be cared for by others. She was discharged on 4 February 1979.

On 14 February 1979, the patient was readmitted with the same diagnosis of severe depression. (According to the medical record, a relative of the patient made an initial call to the hospital social worker, requesting hospital coverage information; the relative intimated the patient would need long term care. The caller was referred to the patient's physician, and the patient was readmitted.) The history states the patient began to regress quickly after discharge. There was deterioration in self care, with infantile demands upon the family for total care including feeding and bathing. The family members became alienated and were either unable or unwilling to continue caring for the patient.

(more)

Abstract of Psychiatric Patient 22 February 1979
Page 2 of 3

Comparison of Medical Workups

Certain procedures and consultations were done during the first admission and repeated during the second admission. These will be indicated by superscript numbers, matching up each of the repeated procedures.

First Admission (12/30/78 through 2/4/79)

(1) Internal medicine consult, to work up for possible hypothyroidism.

ENT consult, to work up headaches.

Surgical consult; impression: probable leiomyomata of uterus; recommends: endometrial biopsy. (Biopsy done, findings negative)

Pelvic ultrasound shows small fibroids.

Pap smear findings were negative; no vaginitis.

(2) EKG: normal.

Treadmill (and 1 repeat): inconclusive due to patient's poor exercise tolerance; however, no ST segment displacement, probably OK.

(3) EEG: normal.

(4) Chest x-ray: normal.

Brain scan and cerebral blood flow (and 1 repeat): normal.

Skull series shows defect in petrous bone (post surgical defect).

(5) CAT scan: post surgical artifact; remainder of scan normal.

Thyroid scan: normal.

Bilateral mammograms: normal.

UGI: normal.

Mastoid series: normal.

Second Admission (2/14/79 to present)

(1) Internal medicine consult notes Hgb improved from 9.0 to 11.8; impression: hypothyroidism under replacement treatment.

Neurological consult; recommends: repeat neurological workup.

Cervical, thoracic, and lumbar spine x-rays show degenerative osteoarthritic changes.

Nerve conduction: normal conduction of all nerves.

(2) EKG: normal.

(3) EEG: normal.

(4) Chest x-ray: normal.

(5) CAT Scan: normal.

(6) Electrolytes: normal.

(7) Hgb: 11.3 grams.

(8) T_4RIA: 2/14: 9.8 / T_3RIA: 2/14: 27

Myelogram: negative.

(continued)

22 February 1979

Barium enema: normal.

6 Electrolytes: normal.

Stool for occult blood (and 1 repeat): normal.

7 Hgb: 9.0 grams.

8 T_4RIA: 1/2:<1.0, 1/10: 6.1, 1/16: 11.9, 1/26: 10.8, 1/30: 8.1
T_3RIA: 1/2:<20, 1/10: 90, 1/16: 140.
T_3: 28.4 on replacement.

Comparison of Medications Ordered

First Admission	Second Admission
$FeSO_4$	$FeSO_4$
Dalmane	Dalmane
Sinequan	Sinequan
Stress Tabs	Stress Tabs
Synthroid	Synthroid 0/1 mgm.
	Multivitamins
	Elavil

SUMMARY OF ATTACHED CASE

The attached case failed the routine screening by the fiscal intermediary.

As a result of PSRO review and involvement, an indepth study was undertaken. The resultant savings to the program is $2125.80 for this one case.

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

23 February 1979

Dear Doctor

Enclosed please find copies of the face sheets for the admissions of and summaries of the ancillary services performed during the hospitalizations. We would appreciate the appropriate committee of your medical staff reviewing the ancillary services performed for this patient and giving us their comments on the appropriateness, or lack of appropriateness, of the services performed.

Please note that the services which were duplicated in the second admission are circled.

We are obligated to draw to the attention of the Fiscal Intermediary inappropriate ancillary services and would like your comments prior to taking any action.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW:jj

cc:

3857

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

March 28, 1979

Charlotte Smith, R.N.
Assistant Manager
Blue Cross of Southern California
Medical Dept. - 8th Floor
P.O. Box 70000
Van Nuys, California 91470

Dear Charlie:

Enclosed is the letter written to , Chief of Staff at , dated February 23, 1979, regarding the appropriateness of the ancillary services for both admissions of . Attached to the letter are two face sheets, the abstracts of these admissions, and comparisons of medical workups and of medications ordered.

Also, for your information, concurrent review of Medi-Cal patients at has shown that all patients admitted for laparoscopic tubal ligations have routine orders which include EKG, Chest X-ray (P.A. and lateral), SMA_{12}, VDRL, and CBC. The patients are admitted and discharged on the same day the procedure is done. Usually, the EKG with a preliminary report is on the chart on the date of the procedure. The SMA_{12} and VDRL reports are received in Medical Records at a later time.

We hope that you will be able to deny the specific ancillary services which were done at and review the trends which have apparently developed at

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW:DB:pb

MEDI-CAL
INTERMEDIARY OPERATIONS

1979 APR 10 PM 1:25

PSRO
AREA 23

April 5, 1979

Dr. John M. Wasserman, Medical Director
Area 23 PSRO
23840 Hawthorne Boulevard, Suite 100
Torrance, California 90505

Dear Dr. Wasserman:

The information you forwarded on Medi-Cal recipient at has been forwarded to our Medi-Cal Review unit for investigation.

With respect to we reviewed their HUHP Reports for Ancillary Services for quarterly period ending December 31, 1978, after your phone call to Betty Montgomery. With respect to Laboratory Services they do not fall outside the area averages.

Once again, thanks for the information and we will pursue your findings to see if we should take any direct action.

Sincerely,

Charlotte Smith (CS)

Charlotte Smith
Assistant Manager, PSRO/UR

CS/lec/IIIa5

cc: Betty Montgomery

MEDI-CAL
INTERMEDIARY OPERATIONS

1979 JUN -8 PM 12:49

June 1, 1979

PSRO
AREA 23

Dr. John Wasserman, Medical Director
Area XXIII PSRO
23840 Hawthorne Boulevard, Suite 100
Torrance, California 90505

Dear Dr. Wasserman:

As you requested we have completed medical review on the case of
at . Attached are copies of the Discharge Summary and other documents that we had available for our review. Other portions of the medical record are not currently available for our M.D. Reveiwer.

The following situations are questionable in terms of Medical Necessity on the First Admission:

A. Treadmill

There was a normal EKG and no significant dyspnea on exertion.

B. Repeat Brain Scan and Flow

Not indicated since first studies were normal.

C. Thyroid Scan

No masses felt and hypothyroid by laboratory studies.

D. Upper G.I.

No significant abdominal symptoms or findings.

E. Thyroid Studies

No necessity for T4, T3 except the first and those on 1/30.

The following situations are questionable in terms of Medical Necessity on the Second Admission:

A. Spinal X-rays

No record of any back problems seen.

B. EKG, EEG, Chest X-ray, CAT Scan

All these tests were normal during the first admission.

C. Electrolytes

No indication of abnormalities documenting the need for this study.

D. Myelogram

No indication seen in documentation of a back problem.

These findings are being submitted to the Medi-Cal Department for their handling.

Sincerely,

Charlotte Smith
Assistant Manager, PSRO/UR

CS/pmb/wb6(2)

cc: Betty Montgomery
Medi-Cal MARS

California PSRO Area 23
a professional standards review organization

April 12, 1979

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

Mr. Bud Lee
Chief of PSRO Monitoring Unit
California Department of Health
714 "P" Street
Sacramento, CA 95814

Dear Bud:

Enclosed please find some self explanatory material regarding unusual ancillary service utilization at two of our hospitals. I believe this shows the tremendous potential for loss by both Titles 18 and 19 programs.

I believe a few extra dollars spent of intervening ancillary services review would be probably the most cost-effective activity Titles 18 and 19 could be involved in.

PSRO Area 23 looks forward to adequate funding so that we might limit the ancillary service overutilization which is grossly apparent in the case. has changed its behavior substantially since we have drawn to their attention that their past behavior patterns with regard to abortions have bordered on fraud and if you care to follow their statistics, you will see that their Title 19 in-patient population since April 1 has dramatically diminished, and hopefully the routine use of excessive ancillary services with the reduction in admissions. You might be interested in knowing that our demand for consultants in Title 19 surgical patients on a random basis has had a rather unique effect.

The patients have failed to make or keep their second opinion visits and the procedures are not being performed at least in PSRO Area 23. It would be interesting to know if these patients were getting state approval outside of our area.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW: pb

Enclosure

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

14 June 1979

Mr. Tom Heerhartz
Chief, Field Services Section
California Department of Health
714 "P" Street
Sacramento, CA 95814

Dear Mr. Heerhartz:

Enclosed please find a copy of the information being sent to the M.I.O.

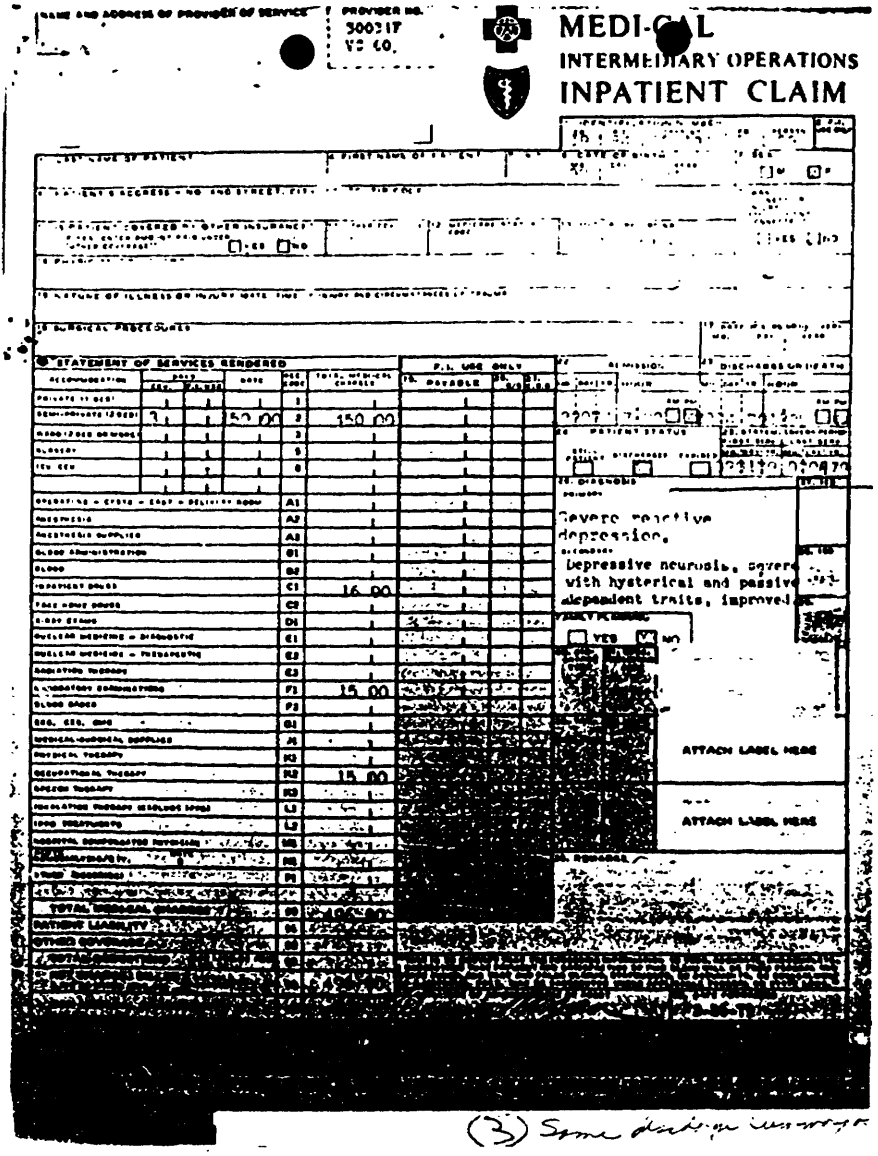
We want to be certain we are not "spinning our wheels" and would appreciate being informed as to whatever action is being taken by your department.

Very truly yours,

John M. Wasserman, M.D.
Medical Director

JMW:MRP:jj

Enclosures



MEDI-CAL
INTERMEDIARY OPERATIONS
INPATIENT CLAIM

PROVIDER NO.
300317
VS 60.

STATEMENT OF SERVICES RENDERED

	DAYS	UNITS	DATE	CODE	TOTAL CHARGES	P.H. USE ONLY			
						PROVIDER	DR.		
				1					
	3		50 00	2	150 00				
				3					
				5					
				6					
				A1					
				A2					
				A3					
				B1					
				B2					
				C1	16 00				
				C2					
				D1					
				E1					
				E2					
				F1	15 00				
				F2					
				G1					
				J1					
				K1					
				L1	15 00				
				L2					
				L3					
				L4					
				M1					
				P1					
				S1					
				S2					
				S3					
				S4					
				S5					
				S6					
				S7					
				S8					
				S9					

Severe reactive depression.
Depressive neurosis, severe with hysterical and passive dependent traits, improved

YES NO

ATTACH LABEL HERE

ATTACH LABEL HERE

(3) Some [illegible]

Patient Name _____ Doctor _____ Hosp No _____

Address _____ Phone Number _____

Admission Date 3/14/74 Discharge Date 3/4/74 Birthdate _____

IT IS SUGGESTED THAT THE DISCHARGE SUMMARY CONTAIN THE FOLLOWING

1) Reason for admission

2) Pertinent findings from lab, X-ray & etc.

3) Treatment and/or operation

4) Course of care and complications if any

5) Final diagnosis

6) Condition on discharge

7) Medication R'x'd and disposition

DISCHARGE DIAGNOSES:

1. Depressive neurosis, severe with hysterical and passive dependent character traits, improved.
2. Adult onset hypothyroidism, severe, improved on replacement therapy - Synthroid 0.1 mg. Last T4 at 7.8 micrograms/dl.
3. Gait instability secondary to #1 (cerebellar ataxia secondary to chronic hypothyroidism) with component of functional regression. No demonstrable central nervous system lesion at this time and normal cerebrospinal fluid examination.
4. Uterine fibroids/polycystic breast disease.

RECOMMENDATIONS:

1. Transfer to Camarillo State Hospital. Admission arranged by L.A. County Harbor General Hospital with admissions officer, Mr. Stevens (Camarillo).
2. Patient is in need of continued intervention to alleviate depression and restore independent living skills.
3. Recommend neurological follow-up on continued thyroid replacement to reassess degree of improvement in ataxia.
4. GYN follow-up also in two months.
5. Medications-Elavil 150 mg. daily in divided doses 50 mg. tid; Synthroid 0.1 mg. daily; Ferrous Sulfate 5 grs. 1 tab. po tid; Stress tabs 1 po bid; Dyazide one tab. po every day for ankle edema.

[illegible] is a 33 year old

DISCHARGE SUMMARY

CONTINUED------P 2

first residing with her son in the Bellflower, California area, who is readmitted following a lengthy hospitalization from to at this facility in which she was extensively evaluated for severe hypothyroidism, depression, and multiple somatic complaints. Following discharge the patient quickly began to regress and the family refused further support because of the patient's level of demands and felt they were unable to provide further care. Marked presenting symptoms at this time continues to be that of depressed mood, affect, verbalizations about feelings of hopelessness, somatic preoccupation and intermittent instability of gait and balance.

The patient presents an extremely complex history which includes the information that for the past several months prior to her hospitalization in December that she had been regressing with deteriorating self care, epidoses of confusion, feelings of depression and having an extremely difficult time caring for her aged mother who died on December 5, 1978. Following the death of the mother the patient became even more regressed, expressed the feelings of hopelessness and then began to show marked intellectual deterioration. Of significance, the patient also had failed to continue to take thyroid medication which she had been taking for longstanding thyroid disorder first diagnosed by her General Practitioner some years previously and had stopped taking Valium 5 mg. po bid for her "Nerves". The patient was seen by her General Practitioner and felt to be severely depressed and referred to this facility. At that time the initial presentation was one of marked organicity, the patient being confused demonstrating memory loss, headache, gait instability, lethargy, slowing of speech and general behavioral and psychological regression. Her concentration was poor. She had no overt psychotic symptoms and additionally had complaints of weakness, showed symptoms of vaginal bleeding and gave a history of menometrorrhagia. She also complained of left breast pain, suprapubic discomfort along with her previously mentioned complaints of headache, backache, leg pain and inability to ambulate without assistance.

PROBLEMS (HOSPITAL COURSE AND APPROPRIATE LABORATORY DATA): 1. **Confusion and depression:** The patient's deteriorated mental status appeared to be a combination of characterological problems with a lifelong history of masochistic endurance, passive dependent and somewhat hysterical character traits along with having had a highly conflicted relationship with her dying mother who died

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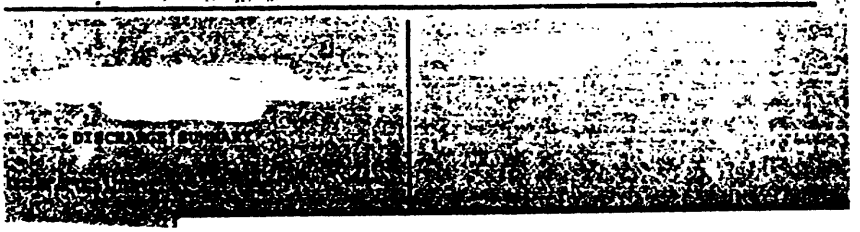

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abruptly before her hospitalization. Additionally, this appeared to be largely secondary to her marked hypothyroidism with admission T3 less than 20 nannograms per dl and T4 less than 1.0 mcg/dl. TSH was 45.6 with an upper limit of normal of 10.3 mcg.%. Gradually during the course of her hospitalization, the patient showed marked improvement and clearing of sensorium; improvement of memory, concentration and ability to attend to individual, group and milieu psychotherapy. In the course of her evaluation for her organicity, skull x-rays were performed and however evidenced a density in the left petrous area which was later felt to represent a giant air - cell and not an invasive lesion. The patient was also treated with antidepressant medications and showed marked improvement in terms of improved affect and improved mood. She also was much more independent at the time of discharge and with only marginal support, able to attend all ward activities.

PROBLEM #2: Ataxia: The patient was seen in neurologic and neurosurgical consultation by Dr. Katakia and Dr. George Locke respectively. Initial impression along with that of the initial skull films gave us significant concern for possible destructive cerebellar lesion, however, on continued evaluation, CAT scan of the brain showed no involvement of the brain proper but confirmed again this left petrous density. Tomograms of the area again were consistent with that of a giant air cell, no evidence of fluid or of invasive tissue. Brain scan and flow study were normal. EEG was normal. Posterior fossa and spinal myelogram were normal and CSF examination was completely within normal limits revealing a clear sample, no RBC's, one WBC. Total protein was 20 mg., normal 15-45; glucose 66, normal 40-80 mg.%. CSF culture was also negative. X-rays of the cervical spine revealed marked degenerative osteoarthritic changes with narrowing at C6, 7 intervertebral space. The spine is otherwise normal. Thoracic spine showed mild degenerative changes, otherwise within normal limits. The lumbar spine showed advanced degenerative osteoarthritic changes with narrowing at the L5 -S1 intervertebral disc space, lumbar spine was otherwise normal.

PROBLEM #3: Vaginal bleeding: At the time of admission the patient had evidence of intermittent vaginal bleeding which was felt secondary to her hypothyroidism and menometrorrhagia. Upon thyroid replacement, the symptoms has abated although GYN consultation by Dr. Monroe noted approximately an 8 weeks size uterus with subsequent follow-up of pelvic ultrasound

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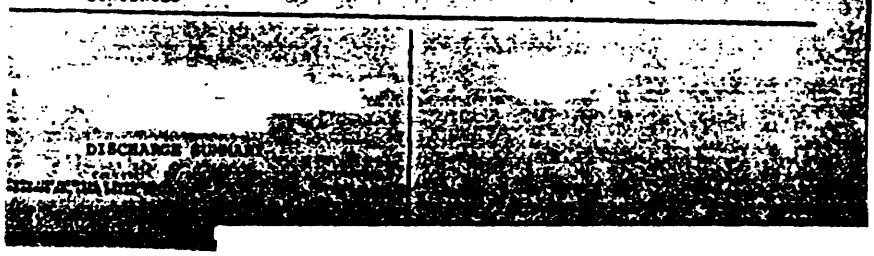

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revealing multiple small fibroids.

PROBLEM #4: Anemia: The patient at the time of admission following longstanding menometrorrhagia was found to have a marked iron deficiency. Shortly after admission her lowest hematocrit was 27.9 and hemoglobin of 9.1 with a differential of 63 segs, 1 band, 1 eos., 34 lymphs., 1 mono. with red cell morphology showing slight anisocytosis. Serum iron level was markedly deficient, 22, lower range of normal being 65-175 mcg.%, total iron binding capacity was 105, low normal 215-475 mcg.%. The patient was begun on Ferrous Sulfate 5 grs. tid and responded with improvement in her anemia. At the time of discharge the patient's last CBC reveals a white count of 6.2, RBC of 4.09, hemoglobin 11.3, hematocrit 34.6 with a normal differential, normal red cell morphology, normal platelet count and a reticulocyte count of 0.9%. Serum B-12 and folate levels were also within normal range prior to institution of additional supplemental vitamins.

PROBLEM #5: Multiple pain complaints referable to chest, abdomen and legs: The patient at the time of admission had marked complaints referable to every somatic group. Gradually during her hospitalization routine EKG and subsequent Holter monitor revealed no abnormalities and the patient on physical examination was felt to have no specific acute problem. As the patient's depression and general physical status was improved, the degree of her somatization decreased markedly and at the time of discharge the patient only complains of mild left breast pain and indeed on bilateral mammograms reveals polycystic breast disease.

LABORATORY DATA: As follows: EKG - nonspecific ST-T wave abnormalities on 12/31/78. Repeat on 2/16/79, normal. Holter monitor within normal limits. Chest x-ray normal. Skull x-rays as mentioned above - defect in the left petrous bone considered surgical defect or possible cholesteatoma or other invasive lesion, ruled out. Brain scan normal. EEG with repeat 2/16/79, within normal limits. CAT scan with supplemental views of the left petrous bone on 1/4/79 showed osseous defect in the left petrous bone, however, the remainder of the scan was normal. Repeat study on this admission 2/16/79 - within normal limits. Thyroid scan normal. Pelvic ultrasound suggestive of small fibroids. Bilateral mammograms consistent with fibrocystic disease. Upper GI and barium enema normal. Endometrial biopsy revealed

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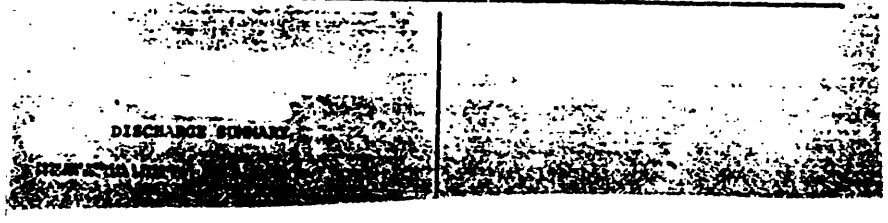


polypoid cystic endometrial hyperplasia. Urinalysis normal. VDRL nonreactive. SMA-12 panel unremarkable and completely within normal limits. On admission 2/14/79 AM cortisol 21.8, normal 6-21 mcg.%. P.M. Cortisol 13.7, normal 3-18 mcg.%. Pro time normal. Complete myelogram performed on 2/21/79 by Dr. Badel revealed no gross abnormalities in the lumbar, thoracic, cervical or foramen magnum, posterior fossa or in the cerebellar pontine angles. The patient tolerated the procedure well. Nerve conduction study of both legs completely within normal limits. Repeat CAT scan and EEG at the time of this admission 2/16/79 were both within normal limits.

The patient is currently quite alert, cooperative and verbalizes increasingly hurt feelings of depression, recent loss of her mother and highly conflicted relationship with her children who are currently unable to provide further support for her. We are currently in a crisis regarding the placement of this patient in light of no family support, resources, no funding aid at this time due to prior difficulties with the patient and her family applying for appropriate funds and being refused admission at both Metropolitan State Hospital and for a shortage of beds at Harbor General Hospital. We are unable to find any board and care facility at this time. The patient is understandably quite distraught over her placement difficulties, however, because of significant pressures to discharge the patient in light of her currently non-acute status by the PSRO Review, will be discharged at this time. It is however recommended in light of the residual gait instability that the patient be followed neurologically and in terms of her general medical status over next couple of months.

The patient although much improved, regresses frequently and would benefit from longer term hospitalization to promote independent living skills, assertion and to alleviate her depression.

OKT/eg
D: 2/25/79
T: 2/26/79

DISCHARGE SUMMARY

1/23/79 - 1/31/79 (re-submitted all 211 → 214)

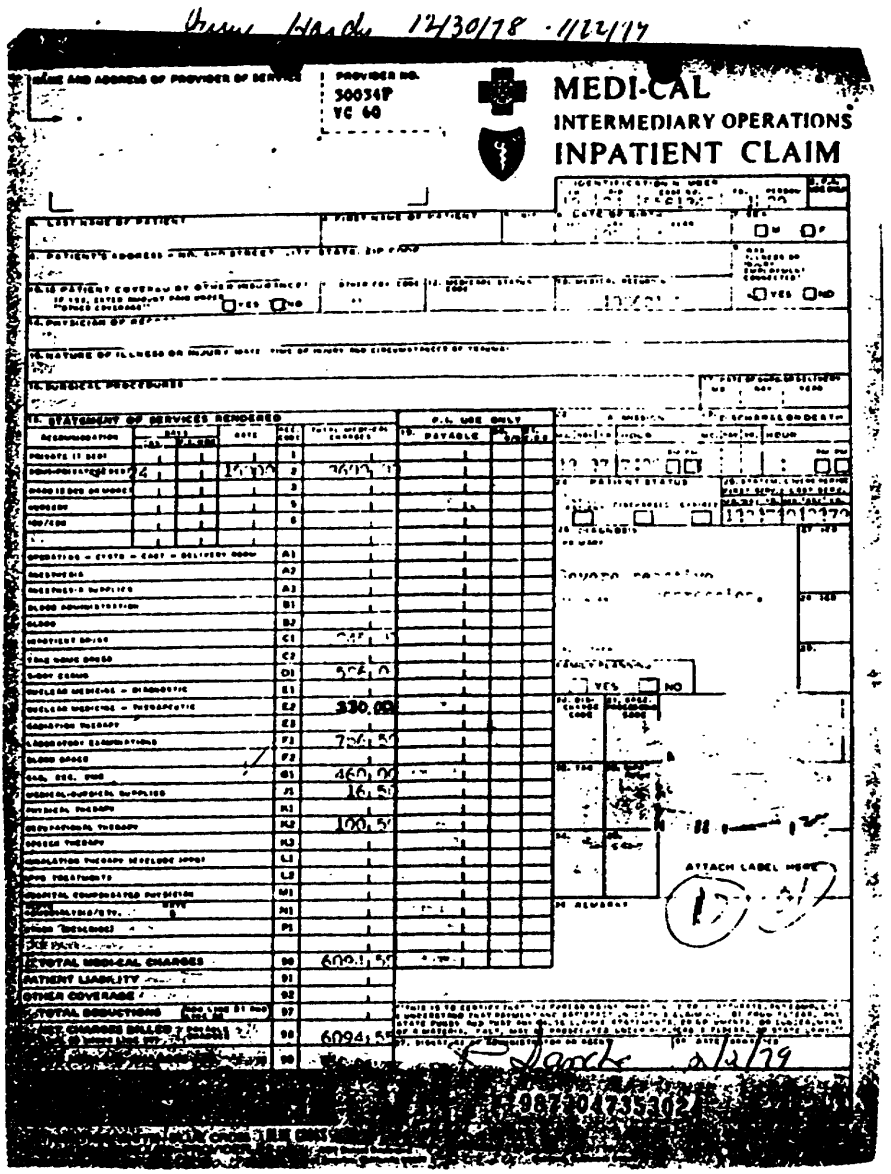
PROVIDER NO.
300217
YC 60

MEDI-CAL
INTERMEDIARY OPERATIONS
INPATIENT CLAIM

1		1500	00
2			
3			
4			
5			
A1			
A2			
A3			
B1			
B2		75	00
C1			
C2			
D1			
E1			
E2			
E3			
F1		151	50
F2			
G1		150	00
J1		15	75
K1			
K2		80	00
L1			
L2			
M1			
N1			
P1			
50		1926	15
51			
52			
57			
58		1926	15
59			

11 PATIENT COVERED BY OTHER INSURANCE? ☐ YES ☐ NO
11. OTHER COV. CODE: 11
13. MEDICAL RECORD NO.: 1776126
14. DATE OF BIRTH
15. SEX ☐ M ☐ F
17. DATE ILLNESS OR INJURY OCCURRED ☐ YES ☐ NO
23. STATEMENT OF SERVICES RENDERED
P.S. USE ONLY
25. PAYABLE
27. ADMISSION
28. DISCHARGE HOUR
29. PATIENT STATUS
1/23/79 1/31/79
31. PRIOR AUTH. NO.
32. DIAG. CODE
33. OPER. CODE
34. DIAG. CODE
35. OPER. CODE
36. TAR
37. MAJOR DIAG.
ATTACH LABEL HERE
ATTACH LABEL HERE
39. REMARKS
for Chronic Medical Treatment
for hospitalization
2/01/79 - 2/11/79
40. I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.
SIGNATURE OF ADMITTING PHYSICIAN OR SURGEON
David Monroe M.D.
41. DATE PROCESSED
2-13-79
V 1976534 001

BLUE CROSS | BLUE CROSS OF SOUTHERN CALIFORNIA | BLUE CROSS OF NORTHERN CALIFORNIA | BLUE SHIELD OF CALIFORNIA



Trans Hawks 12/30/78 - 1/22/79

PROVIDER NO.
300349
VC 60

MEDI-CAL
INTERMEDIARY OPERATIONS
INPATIENT CLAIM

STATEMENT OF SERVICES RENDERED

FOR MEDICAL CARE

ATTACH LABEL HERE

MEDI-CAL
INTERMEDIARY OPERATIONS

DEAR PROVIDER:

2/82

REFERENCE CLAIM NO. WE ARE UNABLE TO PROCESS THE ATTACHED MEDI-CAL CLAIM.

THE RETURN REASON(S) AND/OR INSTRUCTION(S) TO FOLLOW ARE STATED BELOW:

622 C (AUTHORIZATION) PLEASE SUBMIT EMERGENCY CERTIFICATION OR APPROVED AUTHORIZATIONS.

614 C (AUTHORIZATION) FORM MC 180 IS REQUIRED FOR ALL HOSPITAL EMERGENCY ADMISSIONS AFTER THREE DAYS AND NON-EMERGENCY ADMISSIONS ON OR BEFORE THE LAST DAY STATED ON THE PREVIOUS APPROVAL.

BLUE CROSS OF SOUTHERN CALIFORNIA / BLUE CROSS OF NORTHERN CALIFORNIA / BLUE SHIELD OF CALIFORNIA

PSRO – CERTIFICATION

PSRO:	PATIENT'S NAME:	PATIENT'S H.I. NO.:
0023 22		

ACUTE HOSPITALIZATION

THIS HOSPITALIZATION HAS BEEN CERTIFIED

(MEDICARE ONLY)
FOR 36 ACUTE DAYS BEGINNING 2 AND ENDING _____ DATE NOTICE GIVEN _____

FOR _____ SNF DAYS BEGINNING _____ AND ENDING _____ ☐ NO SNF BEDS AVAILABLE

(MEDICARE ONLY)
GRACE DAYS APPROVED BEYOND THE FIRST AUTOMATIC DAY ☐ NONE ☐ ONE ☐ TWO

LONG TERM CARE

THIS SNF STAY HAS BEEN CERTIFIED

FOR _____ SNF DAYS BEGINNING _____ AND ENDING _____ DATE NOTICE GIVEN _____

(MEDICARE ONLY)
GRACE DAYS APPROVED BEYOND THE FIRST AUTOMATIC DAY ☐ NONE ☐ ONE ☐ TWO

PRIMARY DISCHARGE DIAGNOSIS

ICDA [ ][ ][ ][ ] OR HICDA – 2 CODE _____

ANCILLARY SERVICES

☐ ALL ANCILLARY SERVICES APPROVED

☐ ANCILLARY SERVICES NOT APPROVED – IDENTIFY

WAIVER

☐ NOT PAYABLE UNDER WAIVER – EXPLAIN

REVIEWER SIGNATURE:	DATE SIGNED
Jeanne Gilbert	2/5/79

MEDICAL ONLY ☐ EMERGENCY ADMISSION ☐ ELECTIVE ADMISSION MEDICAL I.D. NO. _____

MEDI-CAL

INTERMEDIARY OPERATIONS

79 AUG 28 PM 1:06

August 24, 1979

PSRO
AREA 23

Administrator

RE:
I.D. #:
Admission Date:
Discharge Date:
Total Charges: $3,516.70

Date of Admission:
Discharge Date:
Total Charges: $2,931.70

COPY

Dear Administrator:

It has been brought to our attention, thru an ongoing quality control audit of paid claims, that there appears to have been overutilization of the following diagnostic procedures during the above captioned hospitalization:

Dates of Service: thru

A. 2-Treadmills $300.00

There was a normal EKG and no significant dysnea or chest pain on exertion.

B. Thyroid Scan (nuclear Meds) $330.00

No masses felt and the patient was hypothyroid by laboratory studies.

C. UGI X-ray $54.00

No significant abdominal symptoms or findings.

D. Thyroid Studies $97.50

No medical necessity for the T3, T3 except 12-31-78 and 1-31-79

Dates of Service: 02-14-79 thru 02-22-79

A. Spinal X-rays $107.50

The medical necessity is not documented, there is no record of any back or neurological problem noted.

Page 2

B. Chest X-ray, EKG, EEG and CAT Scan $431.50

All of these tests were normal during the first admission.

C. Echoencephalogram, Echocardiogram, and MCV (nuclear medications) $492.15

The medical necessity for these tests are not documented.

D. Electrolytes $50.00

There was no indication of any abnormalities documenting the need for this study.

E. Myelogram (supplies, pharmacy and lab) $203.15

There was no indication noted in the documentation of a back or neurological problem.

Therefore, charges for the above mentioned items will be deleted. An adjustment will appear on a future remittance advice reflecting the withdrawal of these charges.

Any request for re-evaluation must be submitted in writing and must include medical information not originally submitted. (Do not submit another claim). We will then be pleased to reconsider the matter. Please send this information to:

MIO Medical Review
Blue Cross of Southern California
P.O. Box 70000
Van Nuys, California 91470

Sincerely,

Bernard Townsley, M.D.
Medical Advisor

BT/vr

cc:

Utilization Review Coordinator
Charlotte Smith
Betty Montgomery
John Wasserman, M.D.
Medical Director
Insurance Desk, Hospital

ATTACHMENT II

The California PSRO Area 23 noted discrepancies in X-ray charges and orders in hospital #028. Communication with the fiscal intermediary revealed that neither the procedures nor charges had failed the routine screens. In December, 1978, the PSRO requested that a study be conducted by Blue Cross of Southern California based on our findings.

The validation study did not substantiate the suspected problem with radiology, however, after a cursory review of laboratory usage and in-depth study was implemented. The results of this study revealed the over charge error rate to be approximately 23% of the total lab charges on those cases which were reviewed.

California PSRO Area 23 started its own preliminary study in August of 1979. This study has confirmed the findings of the above mentioned study. An additional in-depth study will be instituted with recommendations for correction included.

ADDENDUM

Support Statements from:

1) Letter from State Department of Health

2) Letter from Blue Cross of Southern California

3) Letter from Office of Program Integrity

4) Letter discussing Lack of Linkage between Hospital and Physician Payments

5) Summarization of 2nd Opinion Consultations

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-9166

September 5, 1979

John Wasserman, M.D.
Executive Medical Director
23840 Hawthorne Blvd., Suite 100
Torrance, CA 90505

Dear Doctor Wasserman:

This is in regard to the recent federal attempts to force PSROs to focus their review systems in order to reduce administrative costs.

As we have stated previously, we do not quarrel with the concept and intent of focusing. The difficulty is in defining the problem areas because of a general lack of adequate baseline data to justify focusing.

When the systematic evaluation of empirical data supports the focusing of review, we will support PSRO efforts to reduce their administrative costs in this manner. In the interim, we cannot agree with a PSRO's focusing of review unless we concur with their focusing methodology and monitoring plans.

It is obvious that your PSRO's success to date has been influenced to a large degree by your board's commitment to promote effective, efficient and economical delivery of health care services. We support and appreciate Area 23 PSRO's continuing efforts in mitigating the problem of unnecessary hospital admissions and surgeries.

Sincerely,

Beverlee A. Myers
Director

Blue Cross
of Southern California

Mailing Address:
P.O. Box 70000
Van Nuys, California 91

1979 AUG 31 PM 2:08
PSRO
AREA 23

August 30, 1979

Dr. John Wasserman, Medical Director
California Area 23 PSRO
23840 Hawthorne Boulevard, Suite 100
Torrance, California 90505

Dear Jack:

I'd like to thank you for taking time out of your busy schedule to discuss the medical review of our Private Business. The review mechanisms currently used by your PSRO are applicable to our situation. I would not wish to impose another review system on the hospitals, but rather utilize an existing review program that has demonstrated effective performance.

The track record of your PSRO has demonstrated an understanding and application of the principles of utilization control and appropriateness of medical care. I look forward to our continuing discussions at your earliest convenience.

Sincerely,

Earle J. Haile

Earle J. Haile, M.D.
Vice President and Medical Director

nw

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
100 VAN NESS AVENUE
SAN FRANCISCO, CALIFORNIA 94102

REFER TO:
OPI:BMS

1978 SEP 6 PM 2:23

August 31, 1978

PSRO
AREA 23

John M. Wasserman, M.D.
Executive Medical Director
PSRO 23
23840 Hawthorne Blvd.
Suite 100
Torrance, California 90505

Dear Dr. Wasserman:

We in the Office of Program Integrity thank you and your staff for the exemplary manner in which you have been performing your review functions in the area of our responsibility. Not only have you been pleasant to deal with, but also, in my opinion, the "end product" has been one which could be well emulated by all PSROs. Such efforts, encouraging better patient care by deterring inappropriate or harmful medical services will certainly go a long way in achieving our common goals.

My personal best wishes for your continuing success and satisfaction in this work.

Sincerely,

Boyd M. Swartz
Acting Regional Director
Office of Program Integrity, HCFA

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

September 6, 1979

Mr. Tom Heerhartz, Chief
Field Services Section
California Department of Health
714 "P" Street
Sacramento, California 95814

Dear Tom:

You may recall I expressed some concern about the possible lack of linkage between denied hospital stays and payment to physicians by Blue Shield.

Our further investigation suggests that in those cases where there has been a denial of a length of stay, Blue Cross South has appropriately notified Blue Shield.

Admission denials, however, are a different matter, and there has been no apparent method of notifying Blue Shield. As a result, it is entirely possible that physician payments by Blue Shield have been made.

I phoned Alberta Elder at Blue Shield and expressed my concern. She attempted to reassure me but was unsuccessful, and on my advice called Blue Cross, which I believe the information she received tended to confirm our suspicions.

We are now developing a mechanism so that Blue Shield will be notified as well as Blue Cross South in order that appropriate action may be taken. We intent to dig out all of the admission denials in Medi-Cal since July of 1978 and send the information to Blue Shield for their action.

Sincerely,

John M. Wasserman, M.D.
Executive Medical Director

JMW: pb

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

TO: John M. Wasserman, M.D.

FROM: Karen Gibbs, A.R.T.

DATE: 6 September 1979

SUBJECT: Second Opinion TAR Consults Requested From 1 May 1979 through 31 August 1979

Total Consults Requested:	36
Total Consults Received:	13 (36% of requested)
Total Denied:	4 (30% of received)
Total Approved:	9 (70% of received)
Total Consults Not Received:	23 (64% of requested)

Cases Denied:

1. Right incisional ventral hernia; hemorrhoidectomy.
2. Total abdominal hysterectomy.
3. Ligation of short saphenous veins - right and left legs; ligation of long saphenous vein - left leg.
4. Debridement of ulcer with IV antibiotic treatment.

KG:jj

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II-A,B,C	Sample PSRO Monitoring Report for Delegated Hospital Not Performing Optimal Review
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XVII	Cover Letter of Sanction Recommendation on an Individual Hospital
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California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

May 17, 1979

Dear Dr.

The Board of Directors of PSRO Area 23 has determined the following for elective female sterilization:

Outpatient procedure for sterilization is the procedure of choice. This requires no TAR.

LAPAROSCOPY:

LAPAROSCOPY is generally the procedure of choice as an outpatient sterilization procedure.

ABDOMINAL (MINI) LAP and VAGINAL TUBAL LIGATION:

These procedures may also be done as outpatient procedures. If hospital admission is required for abdominal laparotomy and vaginal tubal ligation, a TAR is required. The procedure planned should be identified. With morning of surgery admission, a one day stay would be expected in most cases.

If a classical laparotomy and longer hospital stay is planned, a medical reason must be stated in the TAR.

Acquiring the TAR and meeting the MC 128 informed consent requirements remain the responsibility of the physician performing the surgery.

Sincerely,

John M. Wasserman, M.D.
Executive Medical Director

JMW/RU/by

cc: U. R. Chairman
Administrator

II-A

JMW

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

MONITORING VISIT

DATE: April 4, 10, 18, 25, 1979

CHARTS REVIEWED: RETROSPECTIVE 60 CONCURRENT 24

HOSPITAL PERSONNEL: _____

_____

_____

REVIEW COORDINATOR: _____

_____

TOTAL CHARTS REVIEWED: 84

SUMMARY: A total of 84 charts were reviewed either concurrently or retrospectively. These included both Medicare and Medi-Cal cases for our monitoring for the month of April.

At the time of our review, the following cases lacked an H & P; # 166063, 181953; 181955 and 182543 lacked H & P's, but there were consults. On case # 182614, H & P done after patient was discharged, and 182233 patient admitted 4/6/79 and not completed until 4/17/79.

Coordinator and Physician Advisor's reviews were done in a timely manner.

Several cases were reviewed by our Physician Advisors and our Medical Director. Their comments are attached.

Thank you for your continued cooperation.

MF/by
5/8/79

II-B

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

May 8, 1979

, M.D., U.R. Chairman

Dear Drs.

Our routine monitoring visits of April 4, 10, 18, 25, 1979 involved review of 84 Medicare and Medi-Cal charts. The cases which failed our coordinator screen were referred to several of our Physician Advisors and myself, who, following review of these cases, made the following comments:

Case # 168214

The medical record shows no reason given for delaying a dirty wound debridement and repair until day after admission. This appears to have been an emergency problem. The length of stay for wound dressings, P. O. meds and afebrile patients seems lengthy.

Case # 182455

From review of the medical record, the need for admission is questioned. Pre-admission outpatient x-rays and EMG could have been done, as well as being seen by a consultant. There was a delay in consultation request and response and his report does not imply patient needs acute care. The P. A. response seems to allow for delay of service and lack reasons for acute hospital care.

Case # 181953

This case lacks an H & P and there are only two progress notes for the stay. The medical record shows the admitting note as being admitted for evaluation of two episodes of near syncope. There were no investigative studies done except for a monitor. Quality of care is questioned on basis of information reviewed and also for necessity of admission due to lack of documentation.

Case # 177290

Review of the medical record shows that the attending physician doesn't address problem for which patient was admitted i.e. drug O. D. From the coordinator records, there were no progress notes by the attending and some of these may have been back dated. A second OB - GYN consult was called after the first one had already seen and evaluated patient. If patient did take an overdose, why was Demerol 75 mg. IM ordered day of admission?

Drs.

The consultant states in the history "denies drug use" yet adds drug abuse in final impression, with no signs on physical examination to back up impression.

Question, where is result of drug screen? The quality of care is a grave question in this case.

Case # 182509

In review of this case, if the patient had not been admitted over the weekend, the workup could have been completed in two days, rather than four. This appears to have been a scheduling problem.

Case # 182695

The record shows that neither the History nor Physical even suggests a TIA. The physician advisor rationale lacks rationale. All the studies that were done could have and should have been done as an outpatient.

Case # 182669

The documentation in the medical record shows that the patient could have been discharged on 4/19/79, after the completion of the CT Scan. Patient was asymptomatic per chart and progress notes.

Case # 167712

The medical record shows the patient to be ambulating ad lib on 4/16/79. The Physician Advisor rationale for approval is not substantiated by documentation in the chart.

We regret out of 84 cases sampled, a substantial number will be difficult to defend to the Fiscal Intermediary. It is not the performance a PSRO expects from a delegated hospital. These cases will be referred to our Hospital Care Evaluation Committee, and we request your appropriate committee review them for quality of care and utilization questions. We will expect a response from your committee for the HCEC Meeting. I hope your committee will be able to defend these Medicare and Medi-Cal cases from your institution when they are questioned by the Fiscal Intermediary and the State.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW/by

III

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

13 July 1979

M.D.

Dear Doctor

In view of the frequency of admissions of acute hypertensive crises through your emergency room, the PSRO will require in the future that the resting blood pressure be taken, recorded, and signed first by the physician and second by the nurse prior to treatment.

The above procedure will be a prerequisite for certification of medical necessity by PSRO Area 23.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW:jj --

cc: Administrator

AREA 23 DELEGATED HOSPITALS

DISCHARGES AND DENIALS - JUNE, 1979

DATA SOURCE: HOSPITAL CENSUS AND PSRO DATA

HOSPITAL NUMBER	MEDICARE			MEDI-CAL		
	Approx. # Discharges	# Adm. Denials	# C.S. Denials	Approx. # Discharges	# Adm. Denials	# C.S. Denials
005	15	0	4	0	0	0
006	274	0	37	Not under PSRO Review		
007	128	0	0	8	0	0
012	352	0	20	177	1	3
013	4	0	0	0	0	0
016	168	0	0	6	0	1
024	185	0	1	20	0	0
025	197	0	2	85	0	0
027	161	0	20	168	0	0
030	50	0	0	39	0	0
031	144	4	3	383	11	7
032	136	0	1	158	0	1
034	153	0	3	32	0	0
036	407	3	11	461	0	3
037	219	0	0	151	0	0

SUMMARY

MEDICARE

2593 Discharges
7 (0.27% Admission Denials
102 (3.93% Continued Stay Denials

MEDI-CAL

1688 Discharges
12 (0.71%) Admission Denials
15 (0.88%) Continued Stay Denials

ME/by
7/12/79

MEDICARE/MEDI-CAL STATISTICS

AREA 23 HOSPITALS NOT DELEGATED FOR CONCURRENT REVIEW

DISCHARGES, REFERRALS, DENIALS - JUNE, 1979

DATA SOURCE: HOSPITAL CENSUS AND PSRO DATA

HOSPITAL #	MEDICARE				MEDI-CAL			
	Approx. # Discharges	# Referred	# Adm. Denials	# C.S. Denials	Approx. # Discharges	# Referred	# Adm. Denials	# C.S. Denials
002	13	1	0	1	0	2	0	0
003	40	5	4	0	28	3	1	0
004	48	9	2	6	40	9	1	0
008	35	1	0	0	4	0	0	0
009	73	2	0	0	72	7	0	1
015	122	10	0	3	279	39	11	4
017	48	4	1	1	99	23	5	1
018	119	32	10	6	452	148	23	52
019	117	15	1	5	51	30	1	10
021	47	1	1	0	40	3	1	0
022	1	0	0	0	21	2	0	0
026	70	6	1	1	50	15	3	1
028	72	9	0	2	111	6	0	1
029	104	7	0	4	147	8	2	1
033	16	1	1	0	33	3	1	0
038	61	14	2	4	17	1	0	0

SUMMARY:

MEDICARE
986 TOTAL DISCHARGES
117 (11.87%) Referrals
23 (2.33%) Admission Denials
33 (3.35%) Continued Stay Denials

MEDI-CAL
1444 TOTAL DISCHARGES
299 (20.71%) Referrals
49 (3.39%) Admission Denials
71 (4.92%) Continued Stay Denials

MEDI-CAL STATISTICS

PSRO AREA 23 HOSPITALS NOT DELEGATED FOR CONCURRENT REVIEW

JUNE, 1979

DATA SOURCE: HOSPITAL CENSUS & PSRO DATA

HOSPITAL NUMBER	CONCURRENT REVIEW				TARs		
	Approx. # Discharges	# Referred *	# Adm. Denials	# Continued Stay Denials	# Approved	# Deferred	# Denied
002	0	2	0	0	0	1	0
003	28	3	1	0	4	1	2
004	40	9	1	0	4	3	0
008	4	0	0	0	1	1	0
009	72	7	0	1	27	4	3
015	279	39	11	4	51	6	1
017	99	23	5	1	2	3	0
018	452	148	23	52	0	0	0
019	51	30	1	10	4	0	0
021	40	3	1	0	15	2	2
022	21	2	0	0	7	1	1
026	50	15	3	1	28	6	3
028	111	6	0	1	11	0	1
029	147	8	2	1	26	9	5
033	33	3	1	0	4	0	0
038	17	1	0	0	7	1	0

SUMMARY: Concurrent Review

1444 Total Discharges (20.71% referred to Physicians)
49 (3.39%) Admission Denials
71 (4.92%) Continued Stay Denials

TAR Processing

287 Total TARs processed (191 approved, 18 denied)
3 Consultations requested (3 completed)

* By Coordinator to physician for failure to meet screening criteria.

ME/by
7/12/79

VI

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

TO: Administrator
Chief of Staff
U.R. Chairman
All Partially Delegated Hospitals

FROM: John M. Wasserman, M.D., Executive Medical Director

DATE: April 30, 1979

SUBJECT: TAR Procedure

Enclosed please find a memo dated March 13, 1979 which states that a Treatment Authorization Request (TAR) must be submitted to the PSRO by the physician performing the elective surgical procedure.

We have had inquiries regarding this procedure and it appears some of the PSRO Area 23 attending physicians are not aware of this policy. We have sent you this memo as a reminder and hope you will make all your physicians aware of this policy.

JMW:CMG:pb

VII

California PSRO Area 23

a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

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 several 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.#	Dates of Stay
05-0212			4/23 - 4/25/79
05-0212			4/16 - 4/17/79
05-0376			4/23 - 4/24/79
05-0376			4/20 - 4/26/79

Sincerely,

Vicki

Vicki M. Nishioka, R.N.B.S.
Review Manager

VMN: pb

VIII-A

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

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.

HH 876715 - 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.

HH 875173 - 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.

HH 842186 - 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.

HH 864351 - Admitted 5/22/79 for repair of Medial Meniscus Tear. Surgery cancelled 5/23/79 due to lack of operating room time.

HH 593478 - Admitted 5/4/79 with foreign body in hand. Surgery cancelled due to schedule overload until 5/7/79.

Each of these cases resulted 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 unpredictability 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

JMW: pb

cc:

IX

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

June 21, 1979

M. D.
H. R. Chairman
Hospital

Dear Dr.

The PSRO Hospital Care Evaluation Committee reviewed your hospital's monitoring reports for the past six months at their June 20, 1979 meeting. The report included 180 cases monitored by the PSRO Review Coordinator and 20 cases reviewed by a Physician Advisor.

The Committee noted that an effective utilization review system continues at Hospital. No major problems or trends are evident. The PSRO staff was directed to continue monitoring, and the next physician site visit will occur in about six (6) months.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW/CMG/by

cc: M.D. - Chief of Staff
Administrator

X-A

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

June 22, 1979

[M.D.

Dear Dr.

Section 1160 of Title XI of the Social Security Act obligates each physician who provides services or other items for which payment may be made by the Medicare, Medicaid, or Maternal and Child Health or Crippled Children Service programs to ensure that such services or items ordered, authorized, directed or arranged for will be:

1) Provided only when and to the extent, medically necessary; and

2) Of a quality which meets professionally recognized standards of health including those standards utilized by the PSRO; and

3) Supported by evidence of medical necessity and quality in the form and fashion and at such times as the PSRO requires in the exercise of his duties and obligations.,

Because of the high incidence of referrals of your Medicare cases to the PSRO Physician Advisors from January, 1978 to June, 1979, a number of your cases were reviewed at the June 20, 1979, meeting of the PSRO Hospital Care Evaluation Committee. The PSRO data indicates that of your 120 Medicare admissions in this time period, 100 of the cases were referred with only 50 cases receiving certification of medical necessity. PSRO Area 23 shall continue reviewing your patterns of care.

The possible findings of such a review could include the following:

1) Over-utilization of services or items;

2) Excessive utilization of inpatient facilities at an inappropriate level of care when other facilities at an appropriate level are available;

3) Inadequate documentation of the necessity and quality of care;

4) Inferior quality of services or items being provided.

X-B

Page 2

If no significant improvement is noted, PSRO Area 23 has the authority to remove the Waiver of Liability status from the facility (ies) utilized and/or to impose 100% Pre-Admission Certification on any provider, facility, diagnosis (es) or procedure (s) that appear to establish a pattern of a failure to meet established local standards of quality of care. Beyond this point, the PSRO is obligated to recommend to the Secretary of DHEW appropriate sanctions. The current PSRO and DHEW Sanction policy is available for inspection at the PSRO office. Additionally, under the terms of the recently enacted PL 95-142, the Medicare-Medicaid Fraud and Abuse Amendments, the PSRO is also under the obligation of reporting suspected cases of fraud or abuse of the Medicaid program or beneficiaries to the State of California Board of Medical Quality Assurance.

We want you to be aware of these procedures and your due process rights under PL 92-603. Please contact this office if you wish any available information.

Sincerely,

John M. Wasserman, M.D.
Executive Medical Director

JMW: CMG: pb

XI

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

June 21, 1979

Chief of Staff
Hospital

Dear Dr.

The PSRO Hospital Care Evaluation Committee reviewed your hospital's Waiver of Liability Status at their June 20, 1979 meeting. The report included the pattern of care statistics from Hospital from March through May, 1979.

The committee was pleased to note your obvious efforts to lower your denial rate. Improvement was noticed particularly in May, 1979. Unfortunately, admission denials during this same period have increased and are still considered at an unacceptable level. Based on this information the Hospital Care Evaluation Committee has determined to continue your off waiver status with the next review scheduled for September, 1979.

Sincerely,

John M. Wasserman, M.D.
Executive Medical Director

JMW: CMG: pb

cc: Mr. Administrator
Utilization Review Chairman

XIV

XII

California PSRO Area 23

a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

Dear

The following information was developed as a result of our experience with your hospital during the month of , 1979, for Medicare and Medi-Cal admissions.

cases were denied certificates of medical necessity due to a lack of documentation which would substantiate admission and/or continued stay in the acute hospital setting. Of these, resulted in the issuance of Termination of Benefits notices, while denied further stay but discharged prior to receiving notification. Please refer to the reverse side of this letter for detailed information of the statistics.

We would hope that medical staff activity could influence these physicians, particularly the ones involved in numbers of cases, to improve their chart documentation in order to assist your hospital towards future delegation.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW:jj

cc: Chief of Staff
Administrator

APPROX. # ADMISSIONS	ADMISSION DENIALS	LENGTH OF STAY DENIALS	DENIALS-PT. D/C'd PRIOR TO NOTIFICATION
MEDI-CAL			
TOTAL:	TOTAL:	TOTAL:	TOTAL:
MEDICARE			
TOTAL:	TOTAL:	TOTAL:	TOTAL:

XIII

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

Dear Doctor

We have advised
that his patient
will require a second opinion consultation regarding

Further action by PSRO Area 23 on this Treatment Authorization Request will await receipt of a copy of your consultation at the PSRO office.

We are permitted to authorize a consultation fee of up to
for this service. Any services rendered should be billed to Medi-Cal with the appropriate RVS codes and proof of eligibility. The Uniform Claim Form (C-4359) should be used for this billing.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW:dp

Enc:1

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

Dear

Your Treatment Authorization Request for
has been received in this office.

The agreement between PSRO Area 23 and the State is such that we are obliged to sample by consultation the cases submitted with Treatment Authorization Requests.

This case has been selected for random consultation, and the consultation fee will be paid by the State of California by request of PSRO Area 23.

We therefore request the above patient be advised that before a Treatment Authorization Request is approved, a consultation with:

be performed. Following receipt of a report from the consulting physician, the Treatment Authorization Request will be acted upon.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JMW:jj

CERTIFIED MAIL
Return Receipt Requested

November 28, 1977

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

M.D.

Dear Doctor

Please be advised that, pursuant to your explicit request not to be notified by reviewing physicians from the PSRO, as expressed in our telephone conversation on November 22, 1977 concerning your patient the PSRO will no longer be contacting you in reference to any of your cases under PSRO review.

I wish you to know that by refusing to allow our Physician Advisors to contact you to discuss cases that are being reviewed under the authority of PL 92-603, you have waived your initial due process rights. In so doing, you have relinquished your participation in the initial determination process in the review of cases under your care.

Nevertheless, I want you to be officially notified of your remaining due process rights. In cases where an initial negative determination has been made with which you disagree, you may request a formal reconsideration from the PSRO Peer Review Committee. If you remain dissatisfied with their decision, you may appeal it to the California Statewide Council, the Secretary of DHEW, and the Courts, in that order. Specific time frame and dollar amount requirements are available at the PSRO Area 23 office.

I might also advise you that PSRO Area 23 has the authority to impose 100% pre-admission certification on any provider, facility, diagnosis(es), or procedure(s) that appear to establish a pattern of a failure to meet established local standards of quality of care. Beyond this point, the PSRO is obligated to recommend to the Secretary of DHEW appropriate sanctions. The current PSRO and DHEW sanction policy is also available for inspection at the PSRO office. Additionally, under the terms of the recently enacted PL 95-142, the Medicare-Medicaid Fraud and Abuse Amendments, the PSRO is also under the obligation of reporting suspected cases of fraud or abuse of the Medicare program or beneficiaries to the State of California Board of Medical Quality Assurance.

We want you to be aware of these procedures and your due process rights under PL 92-603.

If this letter does not accurately reflect your request to this office, or if you wish to cooperate with the Physician Advisor at the initial determination level, please contact me at your earliest convenience.

Sincerely,

John M. Wasserman, M.D.
Medical Director

JW:pls

cc: U.R. Chairman,
Administrator,

XVI-A

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

June 21, 1979

M.D.

Re: Patient

Dear Dr.

Your letter regarding the above patient was referred to our Hospital Care Evaluation Committee at its meeting June 20th, and I have been directed by the committee to comment on your letter.

The above patient was discharged from Hospital on April 25, 1979 and admitted to the following day, April 26. It was noted that you were the physician of record for both admissions. It was also noted that in the History and Physical written for the April 26 admission by you there was a reference, "due to not having any of the patient's recent medical records available, we are not able to know the extent of previous workups."

The committee directed me to draw to your attention the duplication of services performed on the 2 admissions and found it rather remarkable that as the physician of record on both admissions, you did not have available the rather extensive diagnostic workup performed at the first admission. The committee concluded that a cardiac consult performed on April 18 followed by another cardiac consult on April 27; that a Vectocardiogram performed on April 21 which was interpreted to be normal following an April 22 EKG with an echo cardiogram on April 27; with an EKG on April 26 -- were duplicative with nothing in the record to indicate the necessity for this duplication. It was also noted that the brain scan done on April 20 was duplicated on April 27; that the normal X-rays of chest done on April 20 were repeated on April 29; that the VDRL and FTA's which were positive produced no further comment.

I have been directed to inform you that these duplications are contrary to the Medicare regulations and the committee requests a comment from you within 15 days.

The PSRO is obligated to refer such cases to appropriate agencies, and has instructed our staff to review patterns of care for patients in Titles 18 and 19 programs in which you are the physician of record.

XVI-B

Page 2

The attendant denial of hospital days unfortunately produces a fiscal loss to the hospital through no fault of its own, and we would think it should be a matter of some concern to the hospital to see that it is not repeated. In the event that you have some explanation to mitigate the conclusions which the committee has reached as a result of reviewing these 2 admissions, these comments should be in this office no later than July 10, 1979.

Very truly yours,

John M. Wasserman, M.D.
Executive Medical Director

JMW: pb

*Referred to Program Integrity and State SUR Team.

California PSRO Area 23
a professional standards review organization

XVII

CONFIDENTIAL

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

October 5, 1978

PSRO — [redacted]

Hugh McWilliams
Executive Secretary
PSR Statewide Council
One California Street, #2810
San Francisco, California 94111

Dear Mr. McWilliams:

Attached is a report of Hospital violations of obligations, under Section 1160, Title XI of the Social Security Act (42 USC 1320 C-9), which have been determined by PSRO Area 23 and a sanction recommendation that the Hospital be excluded/terminated from the Medicare, Medicaid (Medi-Cal), and Maternal and Child Health or Crippled Children Service programs.

Please advise this office if additional information or clarification has been requested.

Sincerely,

Christopher P. Robson
Executive Director

CPR:dcw
Enclosure

XVIII

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-9166

1979 MAY 14 AM 11: 5

PSRO
AREA 23

May 4, 1979

John Wasserman, M.D.
Medical Director
California PSRO Area 23
23840 Hawthorne Boulevard, Suite 100
Torrance, CA 90505

Dear Doctor Wasserman:

We have seen so much paper flowing to us from your organization recently that we thought it would be appropriate for us to acknowledge the positive influences you are having on the delivery of health care in your area and to express our appreciation for the innovative activities you have engaged in. We think it is obvious that your organization is dedicated to improving the health care delivery system and is not satisfied with merely perpetuating the status quo.

We would appreciate any advice you can give us on loopholes in our current system and, if possible, recommendations on how they might be corrected.

Thank you for your past cooperation. We are looking forward to good things from you in the future.

Sincerely,

Tom Heerhartz, Chief
Field Services Section

(Hay in) XIX

"45"

California PSRO Area 23
a professional standards review organization

23840 HAWTHORNE BOULEVARD
SUITE 100
TORRANCE, CALIFORNIA 90505
(213) 378-2248

July 11, 1979

Mr. Hugh McWilliams
Executive Secretary
PSR Statewide Council
One California Street, #2810
San Francisco, California 94111

Dear Mr. McWilliams:

Attached is a report of practitioner violations of obligations under Section 1160, Title XI, of the Social Security Act (42 USC 1320 C-9) which have been determined by PSRO Area 23 and a sanction recommendation that the practitioner be excluded/terminated from the Medicare, Medicaid (Medi-Cal), and Maternal and Child Health or Crippled Children Service programs.

Please advise this office if additional information or clarification has been requested.

Sincerely,

Donald P. Balzano
Donald P. Balzano
Administrative Director

DPB: pb

Attachments

STATEMENT OF G. W. EKLUND, M.D., ASSOCIATE MEDICAL DIRECTOR, MULTNOMAH FOUNDATION FOR MEDICAL CARE, PORTLAND, OREG.; ACCOMPANIED BY PHILIP C. WALKER II, EXECUTIVE DIRECTOR

Dr. EKLUND. Thank you for the opportunity to testify here on the continued and adequate funding of PSRO. I am Dr. Eklund. I am a practicing radiologist and associate medical director of the foundation. Mr. Walker is our executive director. The Multnomah Foundation for Medical Care Services as the PSRO in Multnomah County encompassing the greater Portland area.

You have had submitted a complete report of the foundation's program, structures, performance records, and supporting statistics. And I will not bore you with this. I would like to make a few comments that I hope will provide a framework to put some of that into perspective.

The Multnomah Foundation for Medical Care has participated in the full spectrum of activities which the original PSRO concept perceived as potential areas which we would impact. We have identified those areas which are cost effective and we have also identified some areas which are not cost effective. We have proof or ability to impact both on cost containment and quality assurance. We have identified innovative mechanisms for improving the effectiveness of the PSRO effort together with cost-saving techniques that have resulted in a highly efficient and cost-effective operation proving that PSRO can be responsible in the management of its international affairs as well as meeting its objectives.

The Multnomah Foundation for Medical Care was on the threshold of expanding into new areas where a significant impact on cost containment was anticipated. The major decrease in Federal funding has compromised this.

I would like to tell you a few things about what I think PSRO is and what PSRO is not. First, to the Federal Government and the third-party payers, the PSRO is the most efficient means for identifying and dealing with matters of cost containment and quality assurance. PSRO is the best means to maintain the highly technical monitoring process that is being required for a very rapidly expanding science. And finally, to the Government, PSRO, I believe the record will show, is a proven product.

To the patient PSRO is the greatest advocate he has ever had to address matters of quality care. PSRO is the best insurance he has ever had against either willful or coincidental disinterest in spending of his health care dollar.

And, to the physician, PSRO is the most effective mechanism to certify his accountability in matters of quality care and cost control.

PSRO is an accepted and respected device capable of meeting his needs to evaluate the efficiency of practice patterns and to impact on efforts to modify suboptimal patterns of patient care.

Testimony has already been offered to support this from some of the other speakers.

And to the physician, PSRO is also the most palatable method of accountability.

To the hospital, PSRO is a credible and an efficient means of meeting its responsibilities to show accountability in delivery of

cost-effective quality medical care. And PSRO is something else to the hospital. It is a very welcome mechanism to identify and to deal with problem areas in medical care delivery that up to now have been very inefficiently dealt with.

PSRO is not a few things. Among them PSRO is not as inherently vulnerable to political influence as the HSA and it is not impotent to affect responsible utilization of new facilities and new equipment. Once that equipment is installed, whether with the certificate of need or without a certificate of need. It is not a regulatory body responsible to make complex, highly technical decisions without the essential professional expertise required to understand these issues let alone their long-term impact of effect. And that is frequently the case with the HSA.

It is inherently not an adversary to the physician, to the patient, or to the hospital. In short, there is no mechanism today better accepted by all parties concerned with medical care cost and quality than PSRO. It has worked, it will continue to work, but it needs your support if it is going to realize its full potential.

PSRO is inherently designed to reward all who support it and all who survived by it. And, Senator, that is worth a lot. Thank you very much.

Senator TALMADGE. Thank you very much, Doctor, for a very fine statement. Senator Packwood, your distinguished Senator from Oregon who is a member of the Finance Committee, would like you to answer two questions, Dr. Eklund. The first question is—do you believe that PSRO's can be effective in long-term care review?

Dr. EKLUND. Yes, sir, I believe they can. I think we have already demonstrated the potential effect. I do not think we have realized all of the possibilities that may come from long-term care review but we are already impacting in that area at the present time.

Senator TALMADGE. The second question is—have you found roadblocks in attempting to achieve this goal?

Dr. EKLUND. In long-term care?

Senator TALMADGE. In peer review.

Dr. EKLUND. In peer review, yes. Of course, it is funding support. I think we have had some difficulty defining exactly what our responsibilities are or what our authority is to take action against certain individuals or hospitals where there has been an identified deficiency. This is becoming more clear as PSRO's around the country are coming to gripes with it.

I think one of the problems we still have today is the fact that we can retrospectively deny payment to a hospital for the services performed by an inappropriate admission or inappropriate use of the hospital. But that does not impact on the physician, it only impacts on the patient in the hospital.

Senator TALMADGE. To what extent have you had the support of the physicians and the hospital administrators?

Dr. EKLUND. We have had exceptional support in Multnomah County. Of the 1,600 physicians, we have, I think, 1,200 or 1,300 of them that are actually members of the Multnomah Foundation for Medical Care. We have had excellent support from all but two hospitals. Those hospitals have chosen to be nondelegated. One of the hospitals has recently had its waiver liability lifted in and effort to deal with some problems that we were unable to solve or

to get the hospital to solve. They are now in a position to request reconsideration of that position.

At the other hospital, we are seeing significant changes by finding new physicians on the staff with whom we can deal and bring about some of the changes that we have attempted.

Senator TALMADGE. Thank you, Doctor.

[The prepared statement of Dr. Eklund follows:]

TESTIMONY SUBMITTED

to the

SENATE COMMITTEE ON FINANCE

by

MULTNOMAH FOUNDATION FOR MEDICAL CARE

IN SUPPORT OF

CONTINUED PSRO BUDGET APPROPRIATIONS

Introduction

The representatives of Multnomah Foundation for Medical Care (MFMC) are pleased to be offered the opportunity to present the following written testimony to the Senate Finance Committee as part of their deliberations on the subject of Professional Standards Review Organizations (PSRO). Multnomah Foundation for Medical Care, representing 1300 physicians in Multnomah County, presents this testimony in support of continued and adequate funding of the PSRO program. The review of medical care has been taking place in Portland, Oregon since 1972, prior to the implementation of the federally mandated PSRO program. The Foundation is pleased to be among the first organizations to receive PSRO financial support in 1974.

Under the auspices of the PSRO contract, the Foundation has been involved in the following activities: (1) implementation of acute care review on a concurrent basis in all of the area's hospitals; (2) implementation of concurrent review in all of the skilled nursing facilities located within the county; and (3) demonstration projects including the testing of more efficient and economical data systems, the evaluation of skilled nursing facility review, and an ambulatory demonstration project, all in conjunction with the Department of Health, Education, and Welfare.

As part of PSRO review, Multnomah Foundation for Medical Care, for a period of five years, performed concurrent review of each Medicare/Medicaid patient admitted to the hospitals and skilled facilities within the county. The results of this activity will be discussed later in this report.

In carrying out the charges of PSRO review, the Foundation has also implemented a sophisticated, low-cost, effective method of performing profile analysis of health care indicators in order to provide guidance to the review system operations. Along with concurrent review, the Foundation and the community of hospitals have achieved 100% implementation of valid, efficient medical care evaluation studies. These studies are topic specific and are done either by individual hospitals or on an area-wide basis addressing specific known problems in health care delivery

within the county. After five years of operating the above system, the Foundation for Medical Care has recently achieved a less costly system than that initially implemented in 1974 under PSRO review. By applying the resources in a manner which identifies specific problems within the community's health care delivery system, it has been determined that concurrent review of each patient's medical record is no longer economically justifiable and that the resulting benefit of this 100% review is less than the cost of operating this system. In the place of a concurrent review system, the hospitals of Multnomah County are currently addressing only topics which have shown variances through profile analysis or have been identified as variant from other resources outside the county. This system is currently operating in a very economical manner, expending resources only on the investigation of topics when there is some indication of a continued opportunity for impact.

The Results of MFMC Review to Date

The effects of utilization control and the resulting cost containment of PSRO review in Multnomah County were evident almost immediately after implementation of the review process. The Department of Health, Education, and Welfare's project assessment, published by the Health Care Financing Administration, August 1, 1978, under the title of "PSRO Performance Assessment Report -- Multnomah Foundation for Medical Care," shows that in 1974 the average length of stay for the Medicare population in Multnomah County was 11 days compared to a U.S. average of 11.6 days. A short two years after implementation of PSRO in Multnomah County, the length of stay was 9.6 compared to a U.S. average of 11.1. Multnomah Foundation for Medical Care recognizes that it cannot take credit for all the decrease in length of stay. However, two additional studies performed by outside agencies appeared to validate that a major portion of this decrease was attributable to PSRO review. The first of the validation studies was done by your own General Accounting Office (GAO) in its 1977 analysis resulting in the publication by the Comptroller General of the United States entitled, Problems with Evaluation of the Cost Effectiveness of Professional Standards Review Organization, published July 19, 1979. In this study, the GAO validated a study report published by the Multnomah Foundation for Medical Care which looked at the initial effects of PSRO review in Multnomah County. While there were some adjustments in the figures used in the study, the trend in decrease seen in the Medicare and Medicaid populations was significant and tended to validate that decreases were significant in Multnomah County. The result of the General Accounting Office study showed an adjusted estimate of savings of approximately $5,400,000.

The second study, which tended to validate the significant decreases in length of stay since the initial implemention period of PSRO in Multnomah County, was the PSRO 1978 Program Evaluation, published by the Department of Health, Education, and Welfare in January, 1979. The results of their utilization review study showed Multnomah County area's days of care to have decreased 11.36% with 5.1% directly attributable to the PSRO. This impact placed Multnomah Foundation for Medical Care 11th in the national ranking of PSROs in terms of its effect on

utilization. With this, we are pleased to note that the top ten included only one western area (traditionally low utilization rate). The rest of the top ten principally were high utilization areas including New York, Connecticut, Maryland, and populous areas of California. Another portion of the same study by DHEW on the 1978 program evaluation concerned itself with the benefit-cost indices of PSRO review and its effect on length of stay. Multnomah County ranked 13th nationally in the number of total days saved and 7th in terms of the cost-benefit ratio with a 2.56 figure assigned to Multnomah County.

Results such as these clearly indicate promising effectiveness of the PSRO program when implemented in an efficient manner. The above results are only a small portion of the impact a community-based peer review system can have in a community. Results of the effectiveness of review in the future, however, will be on a smaller scale than affecting utilization rates for total populations. These smaller focused studies, however, not only continue to demonstrate the effects of utilization control but also the results of studies performed in assessing and improving the quality of medical care being delivered to the federally financed patient. Currently, many studies such as this are being performed in the metropolitan Portland area under the auspices of PSRO through the Multnomah Foundation for Medical Care. Many of the studies are specific to individual hospitals, other studies are performed on an area-wide basis in attempts either to validate a specific cause of a problem or in other cases to address problems which are community-wide and not specific to any individual hospital.

The PSRO program has also provided the opportunity for the development of true community based professional review of the health care profession. It is our opinion that without the guidance and the charge given to organizations receiving PSRO designation, the concepts of an integrated and acceptable review nucleus would not have developed. The Multnomah Foundation for Medical Care can today be considered a mature organization identified by the community and looked to by the practitioners of health care in the community as the focus of peer review within Multnomah County. The organization is effectively serving as liaison between medicine and other health care practitioners in developing methods of assessing health care as well as defining responsibility of each of the professions. We have become the focal point for peer review activity between the health care providers and the insurance industry. We have become the third party interested in patient care and the acceptability and cost of patient care, playing a major role as patient advocate as opposed to representing either the insurance industry or the health care industry.

A Look Back to the Obstacles and Difficulties of Developing into an Effective Review Organization

The challenges of developing a community-based peer review system have been great. Obstacles faced have ranged from local apathy of the medical profession

to difficulties and problems experienced with any federal program. Initially most of the obstacles faced in developing an organization such as Multnomah Foundation were local. There was disinterest by physicians, hospitals, and by patients. All of these contributed to making a review organization a friend of no one and required us to sell the concepts and philosophies to all populations which would be involved in peer review. After nearly six years, many of these obstacles have been overcome. Recently hospitals have looked to the Foundation for guidance and education in methods of performing and developing quality assurance programs. The physician support of peer review has grown significantly in the recent past. While there will be continuation of apathy in the medical and health care professions concerning the need for peer review, each year additional members enroll as participating physicians in the peer review program. It is our opinion that the slowest sell has been that of the public. It is their recognition that is so necessary to assure support of the PSRO. However, it appears that this population sees the least need for peer review to take place. Much of this feeling, we feel, comes from the fact that their health care is paid for either by the federal government or by private insurance; consequently, it is usually not an out-of-pocket expense, compounded by the fact that very rarely is the medical care so poor that it is life-threatening to the individual. Many of our activities in the past year have been directed toward educating the public as to what peer review does and how it can and does benefit the individual. Most of our educational efforts have been through the use of radio, television, and the printed media. We feel that this is an essential step in the selling of peer review to the public.

The selling of peer review to the community has been compounded in difficulty by the fact that to be an efficient and effective peer review mechanism, certain confidences of practitioners must be respected until the desired results have been achieved. Attempting to balance confidentiality and the public's need to know makes it very difficult to meet the charges of the organization as well as public education.

Most of our difficulties (classifying these as different from obstacles) have been with the administration of the PSRO program by DHEW. The standard boilerplate difficulty is that which the reader has heard many times--that of the red tape involved in participating and receiving federal dollars to perform an activity. Today, the major difficulty we face is that of inadequate funding for the first time since Multnomah Foundation has been contracting with the department. We recognize that when Congress limited the amount of dollars to be spent on the PSRO program, that it was time to take such action. Multnomah Foundation for Medical Care was prepared at that time and has achieved modifications of the review system to make it more efficient and economical. However, the drastic cut in the dollars available to perform PSRO has curtailed and slowed down the activities leading to results which the organization is capable of achieveing. The curtailment of the federal dollars available to Multnomah Foundation has also limited the ability to expand peer review into settings which are necessary and beneficial to the federally-financed patient and to the federal paying agency. After negotiating with the State of Oregon for three years in attempting to expand into

intermediate care review, we are being prevented from expanding into this area by lack of federal dollars. In the acute care setting itself, our major focus, the lack of federal support dictates that we study a few problems annually and solve a few problems in health care delivery annually rather than addressing the majority of the problems which do exist in the delivery of health care. This action slows down the effects and the impact that Congress will be able to see on an annual basis. At the same time, we are pleased to see the Department begin to take steps that Multnomah Foundation for Medical Care feels imperative in this time of limited funds to do a very large job. We feel it imperative that the Department continue to evaluate stringently those PSROs that are not performing in a competent manner, closing down or withdrawing financial support from those which are doing a substandard job. At the same time, we strongly support the concept of PSRO area integration, combining two, three, and four small PSROs into a larger area which may decrease the administrative costs involved in the peer review program.

One of the major difficulties that we have had with the administration over the past five years has been the inability of the federal program to define how a PSRO moves from conditional status to fully operational status. Annually, the Multnomah Foundation for Medical Care has requested full designation. This was at least considered during 1978. However, within the Health Care Financing Administration there was not agreement among the staff as to what full designation involves, whether it means the criteria to determine designation should be minimal criteria or optimal criteria. This is an important difference and to be applied from a national level, we, being experienced in criteria application, can see no other choice but for it to be a minimal standard. The criterial elements which are contained in the law ask the questions, is the PSRO doing PSRO acute care review, is it in long term care review, does it have a policy to review ancillary services, does the Board structure meet with the federal guidelines, etc., etc. We feel it a strong detriment to the PSRO program that organizations serving as PSROs have not been designated as fully operational when the new, fledgling organizations in many parts of the country called Health Systems Agencies are moving rapidly from planning to conditional to fully designated organizations.

Another difficulty that the PSRO program nationally has experienced is that of decentralization of control of the program. In the early years of PSRO when it was managed from the central Bureau of Quality Assurance, answers to questions were uniform regardless of which PSRO was calling and asking a question. We have a significant change in this since the time the decentralization of the program has taken place, with one organization calling its region for guidance and getting onw answer and another organization calling its different region and getting a totally different answer. This makes it very hard for the almost 200 organizations attempting to operate nationally to operate in an effective, uniform manner. The decision to move the Health Care Financing Administration from Rockville to Baltimore, Maryland also set the program back probably 12-24 months caused by the loss of trained, educated and experienced federal employees who were involved in the program at the Rockville, Maryland location. We are faced today with new staff at the federal level who in many cases have had little or no experience in the PSRO program.

Areas Where Future Impacts May Still be Expected From the PSRO Program

Earlier in this testimony, Multnomah Foundation for Medical Care spoke of its achievements which have been accomplished in the past. Now we would like to turn to the future for both Multnomah Foundation for Medical Care and our perceptions of the PSRO program as a whole. We feel that Congress can expect to see decreased gross utilization patterns in ceratin parts of the country. Currently we are beginning to work with the Baltimore City PSRO in comparing utilization figures between two metropolitan areas, one on the west coast and one on the east coast. This is being done as an attempt to start addressing the questions as to why utilization rates vary so much from coast to coast in this nation. We hope that this activity will lead to similar activity in different sites of the country.

Locally we see continued impact being made which will affect the quality and the cost of medical care to the federal beneficiary. On an area-wide basis, we are evaluating and reviewing the surgical rate evident in Multnomah County since this area has a significantly higher surgical rate per 1000 insured than the nation as a whole. Many of the studies we are currently performing address ancillary services and the need for admission testing by hospitals which may in some cases be duplicative (this includes the need for routine laboratory work). We are looking at the need for admission to the hospital for certain procedures; the concept of surgi-centers and outpatient day surgery centers become more and more appealing as the cost of health care continues to escalate. There is still significant work to be done in the discharge planning process in Multnomah County--assisting in the early identification of patients for whom discharge planning is going to be necessary, and assuring that this is begun in such a manner that the patient does not stay in the hospital an extra day or two waiting for placement decisions to be made.

The PSRO program cannot be looked at as the total solution for the costs and quality of health care. Federal, State, and local regulation must provide the guidance necessary to assure that all organizations involved in health do not work against the other. At a time when the technological advances in medicine are accelerating at phenominal rates, we should be making every effort to assure cost effectiveness and quality assurance methods. The illogical and frequently political application of restraints imposed by the certificate of need process is in many cases inflationary. It has resulted in enormous added cost to the process of building and equipment acquisition, replacement or upgrading. Once granted, the certificate of need does nothing to assure the appropriateness of utilization or cost containment measures or identification of abuses.

The PSRO concept has proven to be highly effective in certain areas where leadership and administration have accepted their responsibility and diligently pursued the challenge to impact on both cost containment and quality assurance. Multnomah Foundation for Medical Care is exemplary.

The proliferation of Computerized Axial Tomography (CT) units throughout the country has generated an enormous amount of attention. The use of the certificate of need process to control its use and abuses has been perceived as the consumers'

guardian angel, protecting him -- or her -- from the unholy union of modern technology and modern day medicine men united to divest the helpless sick from their life savings under the guise of providing "the best possible medical care." Reality, however, is slowly and painfully revealing to all of us that Computerized Tomography is to diagnostic imaging of medical practice today what Conrad Roentgen's discovery of x-ray was a few decades ago. Assurance of responsibility in the use of such new modalities should be the cause deserving of of our time, effort and means. The PSRO concept was created to provide such assurances. After several years of growing pains and literally millions of man hours and dollars, this concept has begun to emerge from its pubertal naivety into the full blossom of a mature body with proven integrity and responsibility.

At a time when it has proven its potency in accomplishing its objectives and when the need for guidelines in the use of a plethora of new diagnostic and therapeutic modalities which are being paraded before physicians responsible for their use, and at a time when an ever increasing degree of sophistication is needed to recognize abuses of these modalities, and when initial costs must be carefully weighed against the long term cost of less expensive, more familiar or traditional services, we must not weaken, let alone destroy the one and only mechanism that has credibility, and all the inherent potential to be ally and advocate for the patient, the physician, and the third party payor.

The full potential for PSRO is yet a long way from reality. Properly supported and appropriately empowered, the PSRO system will continue to prove its cost effectiveness to unqualified gratification of Congress and its impact on quality assurance to the medical profession. Success in both of these objectives will bring to all concerned an understanding and appreciation for the mutual benefits inherent in such a cooperative effort.

Senator TALMADGE. The next witness is Harry S. Weeks, Jr., M.D., president of the West Virginia Medical Institute, Charleston, W. Va.

Dr. Weeks, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF HARRY S. WEEKS, JR., M.D., PRESIDENT OF THE AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Dr. WEEKS. Thank you, Mr. Chairman.

My name is Harry Weeks and I am president of the West Virginia Medical Institute. I am a practicing physician in West Virginia. We consider it a privilege to appear before this committee today and we thank you for the opportunity to testify. The institute is the statewide PSRO for West Virginia. It was incorporated in 1973 and in July of 1975 was awarded a contract to become the conditional statewide PSRO. Since West Virginia is perceived to be a highly rural State, it is erroneously assumed that the State is highly agrarian. It is more correct to characterize West Virginia as a rural blue-collar State since almost half of personal income for employed persons over the age of 16 are derived from industrial or related occupations.

Five major industries account for approximately 30 percent of the States' employment.

The high degree of unionization in West Virginia has influenced the medical utilization pattern within the State, as has been recognized from the UMWA program over the past 25 years. West Virginia is also experiencing a growing percentage of older people in the population, which reflects the continuing need to monitor the quality and efficient utilization of medical services in the State.

The institute has implemented concurrent review in 66 acute care hospitals, and has statistically demonstrated a decreased length of stay in hospitalized medicare and medicaid patients. Initially there were 78 acute care facilities in the State, three of which had no Federal admissions.

After completion of the initial phase of our program implementation, the number was reduced to 66. Whether the PSRO program influenced the reduction in the number of hospitals is problematic. That it has impacted on already unstable or deteriorating situations is highly probable. There is no evidence that this change has lessened the availability or quality of medical care. And without accurate information one is only surmising that an element of cost effectiveness has occurred in the reduction in the number of hospitals.

The institute has endeavored to assess the factors related to medicare discharges per 1,000 enrollees in order to provide a perspective on high utilization rates and the development of methodology for corrective action. Already national figures reflect that discharges per 1,000 enrollees decreased 2.5 percent from 1976 to 1977 in West Virginia while the same statistical tables show an increase of 1.6 in region 3 and an increase of 1.4 percent in the United States.

There has also been a significant decrease in the average length of stay since implementation of the program. Using the same re-

ports the average length of stay decreased 2.8 percent in West Virginia while decreasing only 1.6 percent in region 3 and 2.7 percent in the United States; in days of care West Virginia decreased 5.2 percent while the region remained the same and the Nation decreased 1.3 percent.

Another study shows that West Virginia's average preoperative length of stay was equal to or less than the U.S. Northeast, southern or north-central regions in 6 of the 11 procedures studied.

The most obvious effect on the proper utilization of health care services is reflected in the observations of all parties working within the program. A watchdog presence has been established which is recognized by all providers. The physicians recognize that the utilization of hospital services and quality of care rendered to their patients is indeed being monitored by physicians. The largest hospital in the State reported no waiting list only 3 months after delegation for the first time in its history. Other hospitals have developed exemplary quality assurance programs and are reporting increased chart documentation and improved recordkeeping.

Our impact in rural areas has been hampered by problems inherent to Appalachia: isolated communities, small hospital staffs, and a lack of local expertise to implement satisfactory PSRO goals. We expect to overcome this problem by implementing a telecommunication system by which review in many of these nondelegated hospitals can be accomplished in the Charleston office. We feel confident that this will improve both utilization and quality of care as well as provide a more cost effective review.

The PSRO implementation effect on non-Federal programs in the utilization services has been attested to by the fiscal intermediaries. A representative of a major Blue Cross plan in the State reported there was a 46-percent drop in the number of diagnostic admissions on private patients during the last 6 months of 1977. This was largely attributed to the initiation of PSRO review in the hospitals covered by the plan. Another intermediary reported similar impact and cited one hospital with an average length of stay of 16 days during 1976–77 dropping to 12.5 days after implementation in 1978.

It was reported that another hospital had a 3.5-day decrease following PSRP implementation. A side effect was also reported on non-Federal admissions through an example of one hospital's total planwide average length of stay of 12.0 in 1976 dropping to 10.9 simultaneous with the PSRO review of Federal admissions in 1978.

According to information contained in transmittal 83, the average length of stay for medicare patients in West Virginia in 1974, 1 year prior to implementation, was 11.5. The average certified length of stay for medicare patients during the last 6 months of 1978 was 10.3.

Early in the program we were pressured into delegating hospitals as rapidly as possible. This created some situations which hampered the effectiveness of our program. One such hospital was delegated during the first quarter of 1976. And for the first year the medicare average length of stay was 11.5 days, increasing to 11.6 days the following year. During this period numerous problems arose which necessitated a decision by the institute's board of trustees to revoke the hospital's delegated status. In the year fol-

lowing the change in status to nondelegated, the average length of stay dropped to 9.5 days and the total number of medicare admissions dropped by 37 percent.

The data used to calculate average length of stay includes both certified and noncertified days. A greater impact of PSRO effectiveness could be demonstrated if the noncertified days were not calculated into the average length of stay. In the second quarter of 1978 a breakdown of information on the HSQB 121 form revealed that one hospital had 1,197 noncertified days which gave an average length of stay of 10.1 as compared to the average length of stay of 7.0 for those days certified.

While comparable data is not available for medicaid, our impression, developed from trend analysis of the institutes; concurrent review activity outcome summary, indicates a reduction of seven-tenths of 1 day in medicaid length of stay since implementation. We dropped from 6.4 in the third quarter of 1977 to 5.7 by the fourth quarter of 1978. The most recent information we have on specific diagnoses for medicare patients shows a decrease in 14 of the 15 diagnoses studied; 7 of the 14 decreased in excess of 1 day.

Incidentally, Mr. Chairman, I am also president of the American Association of PSRO's. I would like just to briefly read the summary statement.

While the early days of the program were filled with problems such as intra-HEW struggles over funds, antagonism toward the program on the part of the medical profession and vice versa, lack of sophistication to review methodology, and concern on the part of many segments about the effect of the program on their own operations, the PSRO program can now be counted a success.

In enacting the PSRO program, the Government has moved from a passive role of insurer to one of a prudent purchaser of health care on behalf of its beneficiaries.

As a professional association we have tried to cooperate continuously with HSQB to improve all aspects of the program.

We agree with your opening statement on funding. We feel there is simply a level below which this program cannot function. We feel we are pretty close to that level right now.

Thank you very much. This concludes my remarks.

Senator TALMADGE. Thank you, Doctor. As you know, there is considerable controversy over the confidentiality of certain PSRO information. Proponents of disclosure say that PSRO evaluations serve to inform the public as to which physicians or hospitals are performing poorly and this information should be a matter of public record. Others argue that the disclosure of information that identifies an individual patient, practitioner, or provider would serve to undermine the participation and candor in this program. What are your views on this matter?

Dr. WEEKS. Well, I think that the confidentiality issue is a critical one. This is the guts of our operation. And while it is not our intention to hide anything from the public or a public body that ought to have this information, we do feel that those with the knowledge of how to interpret the information we have is absolutely necessary. On the other hand I feel that much of this fear is because the PSRO's and bodies like the HSA's are not familiar enough with the interchange of handling data to really be comfort-

able with it yet. And we attempted in our State, for instance, to contact public bodies that need this information, let us say, for planning purposes or health purposes or what have you and we are trying to get them to agree to an annual report format where we would give them as much of this information that they need for their purposes without getting into the confidentiality areas. And so far our efforts have met with favorable response of the parties involved.

In other words, we can help them. We are not afraid to do it. But we do see times in which we need to look very crisply at this information. To give you a for instance, we recently looked at our data and found one group of hospitals serviced by one group of ophthalmologists whose average length of stay on cataracts was almost twice that of the rest of the State. Of and by itself it would be damning to release that information without a "look-see." So we asked for a medical audit. What we found surprised even me. We found about 80 percent of these patients were being retained in the hospital for a bilateral extraction: do one, wait 3 days, do the other. And actually they were probably doing a better job for less money than some of the other doctors in the State.

Senator TALMADGE. Thank you very much.

[The prepared statement of Dr. Weeks follows:]

STATEMENT OF HARRY S. WEEKS, JR., M.D., PRESIDENT, AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. Chairman,

My name is Harry Weeks. I am a practicting physician in West Virginia and current president of the American Association of Professional Standards Review Organizations, as well as medical director of the West Virginia Medical Institute. I very much appreciate your invitation to appear and discuss the PSRO program.

Mr. Chairman, I believe the PSRO program is a success. It has shown that it can accomplish the original objectives of the legislation, even though it is not yet in successful operation in every area of the country or in every area of medical care review.

What I would like to do today is first review briefly some of the significant developments during the start-up stages of the program, then move to where I see the program today, and finally present some thoughts on changes which we believe will improve the program.

THE EARLY STAGES

Since peer review was not entirely new to physicians, there was a solid group of physicians ready to work with HEW in getting the program into operation. But there was, of course, in the beginning a goodly amount of skepticism on the part of many physicians on working with the government on matters so close to personal medical care. At the start, the lack of understanding on the part of HEW, and on the part of many physicians, of what medical care review involves has meant that creation of the administrative framework, both at the local PSRO and the Federal level, has taken more time and coordination than many of us envisioned.

This early period was characterized by low rates of physician involvement, false starts, short-sighted policies, rapid changes in some policy areas, and no policy at all in others, and high turnover of HEW employees working directly with PSROs -- all resulting in confusion, frustration, and delays for local PSROs.

While the rate of issuance of policy documents was slow in the beginning, by 1977 the flow had reached the point where it was difficult for us to digest or comment intelligently on all the material. It meant, too, that PSROs moved from an atmosphere of considerable administrative flexibility to a severely restrictive set of detailed instructions under which the local PSRO had to labor. It is not surprising then that some observers viewed PSROs as "laboring".

In the beginning, and to some extent still, the program labored under such handicaps as (1) intra-HEW struggles over funds, (2) concern of State medicaid agencies, (3) concern of medicare fiscal intermediaries over how they were to relate to the program, (4) external pressure from data processors, (5) a reluctant, skeptical hospital industry concerned with the effects of utilization review on their operations, (6) outright antagonism toward the medical profession by some Federal pesonnel charged with working for the success of the program, and (7) outright antagonism toward the program by certain strong segments of the profession itself.

I believe that few people understood or appreciated what a unique concept PSRO embodied when this committee first developed it. The thought that the medical profession could be charged with the responsibility of entering into a partnership with the Federal government to regulate itself brought on

reactions ranging from disbelief to derision to sarcasm. But the basic idea underlying the PSRO program was sound, and time has validated the original judgement of this committee.

In fact, enactment of the PSRO program was one of the major signs that the government -- led by your committee -- was moving from a passive role of insurer to one of a prudent purchaser of health care on behalf of its beneficiaries.

PRESENT SITUATION

Now let me move to discuss what we see as the present situation in the program -- much of which has been determined by forces at work during the earlier stages.

One of the current features of the program is the existence of the American Association of Professional Standards Review Organizations. Formed out of two major needs -- one to act as clearinghouse, representative, and consensus builder for PSROs in their daily dealings with the government, and the other to act to assist its membership to achieve success under the program -- AAPSRO has continously and consistently worked for the success of the program. We have stimulated physician support, worked with other organizations to develop understanding of the objectives of the program, and supplied a wide variety of technical services to fledgling PSROs.

Out of this activity, we have come to know, quite well we believe, the strengths and weaknesses in the local programs. Most of our time and money is spent on these efforts, and we have been supported strongly by HSQB in these efforts. The work continues.

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The recent Congressional cutbacks in funding of the program seem to have been essentially responses to the demand that the program demonstrate its cost-effectiveness at the earliest moment. One of the current results of this attitude has been the demand for elimination of poorly performing PSROs. The thinking seems to be that the funds now going to the poorly performing PSROs can go to those which are performing well, and thus increase the cost-effectiveness of the total program. While AAPSRO is on record as strongly in favor of weeding out those PSROs which cannot or will not improve their performance, there is a trap here which we all need to avoid. Let me explain. If the funds which would otherwise go to a poorly performing PSRO are merely transferred to another PSRO area, two undesirable results will occur. First, there will be increased hospital expenditures -- and, therefore, program expenditures -- when hospitals must reinstate the discredited utilization review committee system with no likelihood that they will be effective. Second, program savings derived from the activities of an effective PSRO review system are foregone. To avoid this pitfall, what we must do in an area where a poor PSRO has been terminated is to establish another PSRO in the area or have a nearby effective PSRO take it over. The total funds required will be the same, but there will be more assurance that the funds will go for cost-effective review.

The PSRO assessment process established by HEW, designed initially to identify PSRO weaknesses and to furnish assistance to correct weaknesses, is now used to identify and eliminate poorly performing PSROs. Weaknesses in the assessment system itself need to be eliminated if this process is to be fair and effective. Lack of uniform application of the criteria, widely varying interpretation of similar situations from region to region, and lack of pertinent data have

plagued the system. However, in recent weeks, we have seen some progress in correcting the situation, and hopefully, current efforts will continue to make improvements.

Under the leadership of Dr. Helen Smits, great improvements have been made in decreasing program rigidities and in challenging PSROs to identify and correct problems in their own localities. The level of complaints in these areas coming to me are now approaching a minimum.

Despite the emphasis on cost reductions, a goal with which we agree, the interest of physicians generally, as should be expected, continues to be concerned with improving the quality and appropriateness of care furnished to their patients. It is extremely important to remember that much of the change for better derived from the PSRO program cannot be measured by numbers. Let me illustrate with an example or two. Changes in physician attitudes immediately comes to mind. Physicians are becoming much more conscious of the cost of services they provide to patients and of the need to better document the provision of these services. They are becoming more attuned to the need to work more closely with and monitor the performance of other health care practitioners who participate in the delivery of services to patients. These contributions of the PSRO program to the delivery of economical, efficient and high quality care cannot be measured in terms of dollars but are invaluable products of the PSRO program and must be recognized as such.

Nonetheless, recognizing that support for the program rests largely on results which can be quantified, we have established a Task Force on Impact to document the results of the activities of individual PSROs. While the final report is not quite ready, I have attached some preliminary information to my testimony which I ask be made part of the record of these hearings. I hope you and your excellent staff will be able to review this material.

However, those of us who are heavily involved in review activities continue to point out that much more can and should be done. Some of these activities are:

1. Ancillary services review;
2. Focused long-term-care review;
3. Strict adherence to the PSRO's certification by state agencies and fiscal intermediaries;
4. More concentrated action by HEW in instances where fraud or abuse of the program is known or suspected by the local PSRO;
5. Education of administrative law judges hearing appeals as to the significance of PSRO review;
6. Ambulatory care review, particularly E.R. and out patient visits and hospital controlled outpatient clinics;
7. Review of all patients in all medical settings.

The PSRO program is likely to be a part of any national health insurance program since just about all those who are currently sponsoring a national health insurance plan include PSROs. Senator Long's bill, the Kennedy-

Waxman bill supported by labor, and the Administration bill all would provide a role for PSROs. This fact illustrates that PSROs are coming into general acceptance and their effective results are being recognized. Moreover, our activities in the review of private pay patients is rapidly increasing and with good results. For example, Duane Heintz of the Caterpillar Corporation recent said, " We're becoming increasingly satisfied with the PSRO performance -- the reduction in patient days seems to be accelerating the longer the process is in force."

It is, therefore, with some real pain, Mr. Chairman, that we have concluded, and must report to you, that recent low funding levels have placed the program in real jeopardy. There simply is a level below which the program cannot function adequately as a national program. Many of us have concluded that the fiscal 1980 funding may very well have dipped below that level.

Mr. Chairman, in your search for ways to improve the Medicare and Medicaid programs, I urge that you examine some of the effects of current law which tend toward increasing unnecessary costs. While each item may be minor the sum of them could be significant. We know that the committee has already acted in this area, for example the proposal to provide for swing beds in rural hospitals. Let me give an example of the sort of thing I have in mind.

Although the current Medicare law has no manner in which to consider socio-economic situations, we do see instances where monies could be spent in a different manner with greater consideration for these patients. Specifically, we have encountered a group of patients undergoing radiation and chemotherapy for cancer. These patients do not need an acute level

of care, yet the treatment can only be given at larger medical centers. Frequently, these patients are discharged from the hospital and are required to travel great distances. One case I have in mind lived 130 miles from the closest center and, being treated on an outpatient basis, traveled 260 miles daily on secondary state roads. These patients are quite ill. Some require the use of an ambulance. If they stay in the hospital, payment is denied, and either the patient pays or the hospital absorbs the loss. It would seem appropriate to create, under special circumstances, consideration for a domiciliary level of reimbursement to the hospitals to allow these patients to be treated in a less costly and more humane manner.

It is my hope, Mr. Chairman, that the information gathered at these hearings will form the basis for a sound, fair appraisal of the program and its potential. It is my strong belief that if you accomplish that goal, those who can influence the funding levels will conclude that this is a cost-effective program, and, perhaps more importantly, think of it as a program which is substantially improving the quality of care and the quality of life of the tens of million of patients covered under Medicare and Medicaid.

Mr. Chairman, that concludes my testimony. I will be glad to respond to any questions you or other members of the Subcommittee may have.

ATTACHMENT

TESTIMONY OF HARRY S. WEEKS, JR., M.D.

PRESIDENT

AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The American Association of Professional Standards Review Organizations conducted a survey of PSROs to determine the impact local PSROs are having on the delivery of health services within their communities. While the final report of this survey is not yet completed, the following are some of the responses received:

1. The Montana Foundation for Medical Care reported several examples of their impact.
   - A practitioner with an extremely high rate of cataract extraction and intraocular lens implantation reduced the incidence of performing these procedures and performs them only on patients who are willing to pay the entire bill themselves rather than submit to a second opinion consultation program.
   - A practitioner who was abusing the Medicaid Program through excessive services provided to nursing home patients completely changed this pattern and now provides only necessary care.
   - A facility responsible for a significant number of T & As performed has reduced the number to almost none since the PSRO imposed a pre-admission, second-opinion surgical consultation program.

- A practitioner with many questionable practice patterns resigned his license and is no longer in practice. A group of practitioners who were performing a particular procedure in an inappropriate manner have completely discontinued the practice.
- Throughout 1978-1979, the PSRO has had 26 individual practitioners, facilities or procedures under special review activity. Four of these have resulted in a formal recommendation to the Secretary of HEW to exclude the practitioner from the Medicare/Medicaid program.

2. The New York County Health Services Review Organization recommended to HEW that a hospital be permanently excluded from eligibility to provide Title V, XVIII, and XIX services on a reimbursable basis because of serious problems in the quality of medical care. The hospital was closed in 1979.
3. The PSRO in Ann Arbor, Michigan, discovered that an unnecessary surgical procedure was being performed. The chief of service of the hospital was informed; he notified the physicians involved, and the procedure is no longer performed.
4. In June, 1977, the Dade-Monroe PSRO conducted a medical care evaluation study at four non-delegated hospitals to evaluate the management of low back pain. One hospital had a high incidence of surgical intervention and, compared to other hospitals, a lower performance in meeting criteria. The results were presented to the hospital with specific recommendations for corrective action. A concurrent monitoring procedure was implemented which required physician review of all

scheduled laminectomies prior to surgery. A review of surgical acitivity showed a decrease from 21 cases in 1976 to 14 cases in 1977 and a decrease to 3 cases in 1978.

5. The Delmarva Foundation for Medical Care in Easton, Maryland, is believed to have had influence on the revocation of hospital admission privileges of a physician who was found to have practiced irregular procedures.
6. The Genesee Region PSRO in Rochester, New York, identified two physicians whose repeated poor performance led to limitation of staff privileges.
7. The North Central Medical Peer Review Foundation in Greensboro, North Carolina, reported that, as a consequence of review, one physician lost his admitting privileges and must use a consultant in order to admit.
8. The PSRO in Maine has documented its impact in several instances:
   - Physicians at a small rural hospital suspected inappropriate admissions for one particular diagnostic category for one particular physician. An audit confirmed the suspicion, the physician was subsequently required to obtain consultation, and anecdotal reports suggest the inappropriate admission rate was corrected;
   - A hospital voted to perform pre-admission certification for a Canadian physician which resulted in the prevention of several unnecessary admissions, and the physician eventually confined his practice to Canada;
   - The PSRO was asked to address certain issues about the use of Swan Ganz catheters. Since that time, the physician whose actions prompted such inquiry has ceased performing the procedure.

9. The PSRO in Monrovia, California, was instrumental in a hospital closing one whole wing. There was a drop in days billed from 35,541 days in 1977 (pre-PSRO review) to 32,815 days in 1978 (under PSRO review). The change in days was considered to be influenced by the PSRO since there was no evidence of significant migration into or out of the area or marked increase in occupancy of neighboring small hospitals.

10. As a result of hospital profiles developed by the PSRO in Madison, Wisconsin, which indentified questionable physician practices, there were several examples of impact:

    - Two physicians terminated their practice (one retired under pressure and the other left the state);
    - One physician responded to a LOS of 29.3 days in 1977 by reducing it to 12.9 in 1978;
    - After PSRO intervention, a physician with a LOS of 14 days for cholecystitis in 1977, reduced it to 10.3 in 1978

Senator TALMADGE. Our next witness is Dr. George Fisher, secretary, board of directors, Philadelphia PSRO, Philadelphia, Pa., accompanied by Thomas DiVicenzo, executive director.

Doctor, if you would summarize your statement for the record.

STATEMENT OF DR. GEORGE FISHER, SECRETARY, BOARD OF DIRECTORS, PHILADELPHIA PSRO, PHILADELPHIA, PA.; ACCOMPANIED BY THOMAS DIVICENZO, EXECUTIVE DIRECTOR

Dr. FISHER. Thank you very much.

Your introductory remarks and of the previous speakers allow me to summarize the first nine pages. Let me simply summarize the status report.

Philadelphia has experienced a 3½-percent reduction in the number of days of care and a 4.8-percent reduction in the average length of stay per admission during 1 year of the program implementation for which we have comparable statistics.

These changes occurred both in patients under the Federal programs and in other patients. Without correction for age and diagnostic mixtures we do not feel such statistics are completely dependable and we are unable to provide you with such corrections.

No. 2, the program was initially regarded with reluctance locally but is now widely accepted and even met with some enthusiasm in the medical community. Friction and hostility have been minimal. Coming down in the Metroliner, Mr. DiVicenzo and I were chuckling over a letter we received from the hospitals in which the administrators were complaining they didn't know they were going to be able to conduct a good review program with the reduced funding through focusing.

No. 3, careful selection of six hospitals for direct external review, nondelegated review, has resulted in a dramatic improvement in patients statistics which we do claim is a direct result of our program. We do not feel that similar improvement would result from imposing direct, external, nondelegated review on other hospitals. The resulting loss of credibility would be highly counterproductive at this stage in the program. It would amount to unscrambling an egg.

We call your attention to the fact that although the 12,000 days of hospitalization apparently saved in those six hospitals are spectacular, there were actually apparently 40,000 days saved in the remaining delegated hospitals.

So that the major impact of the program aside from sensationalism is actually in the more or less invisible process of education.

No. 4, other parts of the program which are more difficult to measure have also improved. No. 5, we feel that funding should be improved and a concrete suggestion for an incentive system of augmented payments is suggested. If you are following my prepared remarks, I am now going to page 9. We offer the suggestion that the three goals of (1) increasing communication between the physicians of various PSRO's, (2) creating a basis for incentive PSRO reimbursement and (3) providing public accountability for the review program can all be furthered by: Establishment of an inter-PSRO peer review system. It would be our concept that gross statistical performance benchmarks on the hundred most common diagnoses, plus cost benchmarks for program elements, might be

used as a basis for a challenge ranking system. The PSRO's would be asked to defend any low scores before their peers, who would advise the Secretary as to their appraisal.

Out of such a process you can be sure would emerge all arguments, weak and strong, as to the imaginativeness and energy which the PSRO had employed to correct the apparently low score, as well as defensive criticism about the meaningfulness of the particular benchmark. Although it is obvious that the Secretary would make the final determinations, it is inevitable that the advice of the peer reviews would mostly be followed because in this as in other fields of life, it takes one to know one.

No. 6, we propose a data task force be constituted and data developmental awards should be made. In this connection, I might pause and say that we have an excellent mechanism in the social security system to determine the length of time when the patient received treatment and the time when he died since social security has to cut off payments when he dies. That is really all we can hope to influence. Nobody lives forever. And so if you compared what a patient had in the way of treatment with the interval between that treatment and the time he died, you would establish, it would seem to me, a fairly simple system for providing material for data examination.

Considerable experience has now accumulated with advantages and disadvantages of various data approaches. This experience needs to be consolidated and debated. Competition by other agencies for the same data needs to be subjected to an informed adversary process and the cost-benefit issues need to be balanced against the PSRO need for confidentiality and speed. The issue of invasion of hospital prerogatives needs to be debated out in the open instead of surreptitiously as at present.

The issue of data consortia with other agencies, which we presently disapprove, should be explored in its political as well as its data processing ramifications.

Since the money available for the PSRO data has been so limited, vendors have been discouraged from investing seed capital to develop new systems. It may well be possible that a task force on data would recommend that grants be made to fund the developmental costs of new systems which are perceived to be necessary, whether main computers, off-line batch processing or telecommunicated shared processing.

The task force should attempt to determine whether it might be in the public interest to free vendors of their present inhibitions that the products they develop might fall in the public domain for competitors to use.

We propose another task force on the effect of retrospective cost reimbursement on the true costs of overutilization. Numerous voices have suggested that physicians should receive copies of the itemized patient bills in order to sharpen their attention to costs. This has actually taken place in very few hospitals and one must suspect there is hidden resistance to the idea.

One very strong argument against focusing attention on patient charges is that they bear so little relationship to the average cost of the service. Even the average cost is not what we are interested in. The true saving of doing one less test or saving 1 day of

hospitalization is the incremental or marginal cost of doing one more, in an era of heavy fixed costs: A test which appears to cost $30 may only cost a few pennies. Its true cost-benefit ratio may be quite different from the apparent cost-benefit ratio of posted charges.

The PSRO's need expert advice on this subject since without it they are led to inappropriate responses and quality care may uselessly suffer.

Finally the coalescence of physician opinions about techniques and technology. There are areas of medical practice where the public decides and the medical profession follows. Abortion on demand is an example of an essentially moral issue with minor technical complexity. There are at the other extreme issues like cancer chemotherapy which are so technically complex that the public has no choice but to follow the evolved consensus of the profession.

The issue of hypochondriacs and terrified, demanding patients is a third example. Some physicians exclude such patients from their practice and others have a more understanding considerate sympathy with them. Unfortunately it is difficult to distinguish kindly sympathy, which we endorse, from program abuse, which we deplore. No one has proposed a better way than physician peer review to work out an appropriate set of public attitudes on the matter.

Thank you.

Senator TALMADGE. Doctor, to what extent does medical and nursing staff loyalty and dependence on a given hospital influence their ability to deny care and services in that hospital on a significant scale?

Dr. FISHER. Well, sir, I think when the program was developed we misunderstood the activities that take place in metropolitan areas. The general reaction in a large metropolitan area when they discover behavior they disapprove is to attempt to exclude that person from the staff. He goes elsewhere and he tends to aggregate with others of his kind.

That is not typical of small towns where perhaps there is only one hospital and he has to stay there. Consequently most of the attitude of the nurses and fellow staff members are not directed to the degree that I would like toward education and improvement but tend to polarize themselves into trying to make it so uncomfortable for the person on the staff that he will leave.

Senator TALMADGE. Thank you very much for your contribution to our deliberations. We appreciate it, sir.

[The prepared statement of Dr. Fisher follows:]

TESTIMONY BY THE PHILADELPHIA PROFESSIONAL STANDARDS REVIEW ORGANIZATION

SUMMARY

1. Philadelphia has experienced a shortening of the number of admissions, the number of days of care, and the average length of stay for admission during the period of program implementation. These changes have occurred both in patients under the federal programs and in other patients. Without correction for age and diagnostic mixtures, we do not feel such statistics are completely dependable, and we are unable to provide such corrections.
2. The program was initially regarded with reluctance, but is now widely accepted and even met with some enthusiasm in the medical community. Friction and hostility have been minimal.
3. Careful selection of six hospitals for direct external review has resulted in a dramatic improvement in patient statistics which we do claim is a direct result of our program. We do not feel that a similar improvement would result from imposing direct external ("non-delegated") review on the other hospitals, and the resulting loss of credibility would be highly counter productive.
4. Other parts of the program which are more difficult to measure have also improved.
5. We feel that funding should be improved, and a concrete suggestion for an incentive system of augmented payments is suggested.
6. We propose that a data task force be constituted and that data developmental awards should be made.
7. We propose that a task force be constituted to examine the complex relationship between the program and true incremental cost savings.
8. We make a number of other suggestions, foremost among which is a reassertion of the central role of physician peer discussions in providing advice to the public about the legitimate latitude of professional discretion.

The Philadelphia PSRO welcomes the invitation of the Senate Committee on Finance to submit testimony on the PSRO system, with particular reference to experience at the Philadelphia PSRO. My presentation will be divided into three parts; achievements, problems, and suggestions for future improvements.

ACHIEVEMENTS

1. Statistical Experience: It has become traditional in the evaluation of the PSRO program to look at individual hospitals and individual PSRO areas with regard to the number of patients discharged, the number of days of care rendered, the average length of patient's stay (which is the first divided by the second), and the number of days of hospitalization per thousand eligible in the area. We now present our experience with these statistical indicators, and it is favorable to the program. However, we wish to register our strong objection to the use of such indicators because patients may switch allegiance to various hospitals and they may elect to be hospitalized either inside or in the suburban counties surrounding our metropolitan area. Furthermore, the age mixture may change and indeed in Philadelphia we present evidence from the 1970 census compared with the 1978 statistics produced by the HCFA (table No. 2) showing that there has been a significant decrease in the number of patients aged 65-75 in our area and a significant increase in the number of patients aged 75 and above. Table 1 illustrates that there is a progressive national increase in the discharge rate related to the age of the patient over the age of 65, and Table 5 shows that there is an even steeper increase in the rate of days of care rendered by age 65 progressively to age 85. We have attempted to introduce a correction factor for this age change, but we have no way of knowing whether there have been shifts of

our population through allegiance in other counties or from other countjes into our area; we furthermore do not know whether elderly patients have followed the general trend. We have been told that 23% of the patients hospitalized in Philadelphia come from neighboring counties, and the 12% of Philadelphia residents elect to be hospitalized outside of the county. Considering (Table 3) note the 24 fully delegated and 6 fully non-delegated hospitals in our area, through raw statistics indicate that there has been a 0.8% increase in the number of cases admitted and the correct figure would be 0.5% The number of days of hospitalization rendered to Medicare patients has decreased 3.0% in raw figures and 3.5% corrected for the age change.The average length of stay in raw figures has decreased 3.8% and the corrected figure for age is 4.8%.Although these figures are favorable to evaluatation of our program, we repeat our protest that such figures are not useful until they have been corrected for the diagnosis of the patients, and the degree of difficulty which that diagnoses presented to the treating institution. When speaking of the Medical Assistance program the total inponderability of the population base must be mentioned. Patients ordinarily do not present themselves to the Medical Assistance Program until they become sick and are admitted to the institution. Employment in the Philadelphia area has been steadily decreasing in recent years, and the general downturn in the economy has undoubtedly also had an impact on the number of Medical Assistance eligibles. We are completely unable to cope with this complexity. We hope that it is fair to allude to the experience of the Blue Cross subscribers in our area (Table 7) who are hospitalized by the same doctors in the same hospitals although their review is not under our direct supervision. In the Blue Cross subscribers, there has been a 30% reduction in the number of days of stay per thousand subscribers in the past eight years. In view of the uncertainty of determining the population base for the Medicare and Medical Assistance Programs, and particularly the number of

eligible Medical Assistance patients, we feel that this achievement is creditable and must be attributed to the impact of PSRO program to some degree.

Experience In The Non-Delegated Hospital

The Philadelphia PSRO spent a great deal of time and exercised great care in designating a few hospitals for review to be conducted directly by the staff of the PSRO itself, rather than through the delegation process to individual hospital committees. This process of direct external review is commonly referred to as non-delegated review. We believe that our evaluation process was extremely thorough and fair and stands examination by anyone as to our inpartiality. The limited number of hospitals which received non-delegated status reflects both the limitation of our budget, and the consensus of the PSRO Board that these are the only hospitals in which appreciable improvement could be expected by intensive somewhat punitive review. Hospitals are generally selected on the basis of woefully inadequate record documentation, or the failure to produce sufficient qualified physician volunteers to run an effective program. The statistics (Table 6) show a shortening of the average length of stay and a decrease of the days of stay in these hospitals which is so dramatic that it is difficult to attribute these changes to any factor other than the impact of the PSRO review program, and it can be calculated that the costs of the entire program are more than repaid by the experience in these few hospitals. We wish to emphasize at this point that we do not believe that the same experience could have been obtained by non-delegated review, however intensive, in the remainder of the hospitals in our area. While it has been said by others in retrospect that it would have been better to start all hospitals in a non-delegated manner, conferring delegation only after the demonstration of excellent performance, it is too late for this approach. The friction which would result from such a change would be quite destructive to

successful continuation of the program as a whole, because to reverse our stance would totally destroy our credibility in the physician community.

Improved Experience in Delegated Hospitals

There is no doubt that we underestimated, as Congress also probably underestimated the difficulty of organizing and monitoring a delegated system for a process that was completely unknown to all of the participants, was largely misunderstood by hospital administrations, and which was severely under funded from the start. In support of the contention that the delegated hospitals have improved their performance, I can only offer the scores and monitoring experience coming to us from our Monitoring Committee. The data does not permit an analysis or a judgement about changes in the case mixture, necessity of admission, or average length of stay by diagnosis in these delegated hospitals. Nevertheless an extremely diligent and concerned Monitoring Committee has repeatedly reported to the Board that we have evolved from early stages of only minimally satisfactory performance in most of the delegated hospitals, to the present state where most of the delegated hospitals are performing a creditable job. We have every reason to believe that continued improvement in the delegated system will lead to nearly complete satifaction with this process in another year or perhaps another two years.

Medical Care Evaluation Studies

Everyone who has participated in the Medical Audit System has made the awesome discovery that this process is much more complicated and much more difficult to perform satisfactorily than anyone anticipated. The problem is made more difficult by the fact that every physician is trained to evaluate statistical evidence and is unwilling to accept shabby or inadequate evidence as proof. On the other hand, extensive experience with evaluating such studies seems to confer very little ability to perform them. Inspite of this disappointment however, we have noticed a remarkable improvement in the performance of these studies and a remarkable spread of understanding of how

to perform the process among our hospitals. Congress will have to content itself with the fact that it will be at least two more years before Medical Care Evaluation Studies can be said to be a truly effective instrument for medical care evaluation, but on the otherhand it is clear that we will in time reach that point. This unfortunate situation is apparently the fault of no one, but is the fault of everyone for underestimating the magnitude of the learning process.

5. Friction and Due Process

The Philadelphia PSRO is very proud of the fact that our process and achievements have been associated with very little friction between ourselves and the hospitals in our area, and with very little friction with the Medical Profession in general. Probably the principle feature of our program which explains this lack of friction in a punitive process is the heavy emphasis on due process. Due process is a system which is quite familiar to lawyers and administrators, but is extremely unnatural to the medical profession and quite foreign to its training and experience. This is one more part of the program whose difficulty was underestimated at the start, but where significant achievement and progress has taken place.

PROBLEMS

Underfunding

The instant response which every member of our Board of Directors and every member of our staff would make to any criticism whatever of our program, would be the severe degree of underfunding of the program. While I happen to be a personal advocate of the healthful effect of periodic cycles of fiscal stringency, the PSRO program has passed the point of diminishing returns in such an approach. While

ordinary businesses respond to downturns in the business cycle by taking the opportunity to prune their least effective employees, our experience has been different. The repeated threat that the PSRO program is in jeopardy has resulted in our best employees taking fright and seeking employement elsewhere. Local PSRO's have not been in the position to afford the advice and services of consulting firms, and they have not been in a position to afford the recruiting of adequate numbers of highly trained and experienced management talent. Among the physician members in the organization, considerable resentment has developed from the fact that there simply has been no money to pay adequate numbers of hours of physician time for a project which cannot hope to be succesful without significant physician input. Lack of money has forced entirely too much delegation of the review process to physician extenders. This process has not been good for quality of the program and it probably has not been cost effective. We hope Senators will not object to introducing the example of the candy bar manufacturer. The chocolate manufacturer finds that he has difficulty raising prices because vending machines will only accept dimes and quarters. Therefore, when the price of sugar and cocoa rises, his response is to reduce the size of the candy bar. We feel that the candy bar principle has clearly been at work in the fiscal restraints on the PSRO program, just as it would be present in the event of imposed cost containment on hospitals. Philadelphia has been particularly fortunate to a degree greater than most PSROs in preserving physician involvement, but this has only been possible through the contribution of significant amounts of unpaid volunteered time by physicians, particularly on the Board of Directors.

The Novelty of The Program

The Bennett Amendment precipitated the medical professional and its new managerial assistants into a program which they often did not understand, for which no model

were available, and which forced a great deal of reinvention of the wheel. It was naive of us all to suppose that such a massive new ambitious program could have been accomplished quickly with so little experience and so few patterns to follow.

Unexpectantly Large Organizational Problems.

The PSRO program imposed the requirements of adjusting a basically judicial system onto a green and inexperienced organization, against the problems of accustoming itself to the complexities and their ambiguities of the bureaucratic system. We attempted to impose a quasi - judicial program of the bureaucrats and we attempted to impose a system of due process on a medical profession which is trained to operate in an environment of trust. We all imagined this to be an easy problem, and it is a hard problem.

Neither Autonomy nor Firm Directon

The PSRO program could have undoubtedly moved more rapidly if authoritarian directives of an unambiguous sort had been laid down at the beginning, and enforced with firmness. In retrospect, this would have been a mistake, but at the time the concerns of an inexperienced bureaucracy and the inherent sluggishness of government also prevented the PSRO's from having sufficent autonomy to find their own way. The process that resulted was a continual one of testing. Proposals were made, answered ambiguously only after long delays, and ofter answered in the negative. The PSRO program should have been permitted the latitude of making some mistakes, and the principal concern which the PSRO's felt imposed on them was that it was acceptable to make few successes, but it was utterly unacceptable to make any mistakes. Those of us who have carefully read the Bennett Amendment find it to be one of the most precise and carefully worded, carefully throughout documents in the history of recent law. Fiscal stringency and a change in focus of the program from its original intent of quality maintenance to one which

is primarily that of cost containment, has lead to the development of a program which is clearly inferior to the obvious intent of the language of the law.

SUGGESTIONS FOR IMPROVEMENT

1 More Generous Funding.

2. An Incentive System For Funding

The PSRO's experienced the imposed rationing system of the Washington headquarters which was in turn responding to fiscal stringency imposed on it by the Congress. We do not propose that our fiscal difficulties should be solved by pouring money into the program as was done in Cancer Research or the Space Sattelite Program. Rather, it is our suggestion that a system be developed wherein a program which meets certain specified benchmarks of improvement is rewarded in a parallel manner by increased funding for subsequent years. Such a system would concentrate more money in those areas where more improvement in obviously needed because of the demonstration of prior improvement. It would have the additional advantage of reducing funding and possibly even eventually phasing out the system when it had reached the point of diminishing or zero return.

3. Greater Interchange of Experience, Particularly on The Physician Level

The American Association of PSROs has done its best with limited funding against the problems of the heavy expense of transcontinental travel. A few local attempts have been made spontaneously such as the New England Consortium of PSROs and the Mid-Atlantic Conference of PSROs. In addition to increasing the funding and support of such information interchanges, more imagination should be applied to mechanisms for permitting the PSROs to share their experiences with each other. It is noticeable that interchange of information is much further advanced among the professional staff

of the PSROs than it is among the physicians. Because of the higher renumeration rate for physicians, it was inevitable that fiscal stringency should fall hardest upon this level, but this is certain diaster for a program which is fundamentally concerned with the medical field. Journals for the interchange of experience, conferences, workshops, and particulary site visits interchanged between the PSRO organizations might be examples of more imaginative approaches to the information interchange problem. From my own point of view, the most helpful experience which I derived from other PSROs was obtained from participating in a site visit with another PSRO, and having our own organization receive a site visit. Augmentation of this site visit process would probably serve to educate HSQB, and improve the opinion of the Bureaucracy as to actual performance of the PSROs.

PEER REVIEW BENCHMARKS THROUGH ORGANIZATION PEER REVIEW

At this point we wish to pause and make a concrete suggestion. We offer the suggestion that the three goals of: 1) increasing communcation between the physician of various PSRO's 2) creating a basis for incentive PSRO reimbursement and 3) providing public accountability for the review program can all be furthered by:

Establishment of an inter-PSRO peer review system. It would be our concept that gross statistical performance benchmarks on the hundred most common diagnoses, plus cost benchmarks for program elements, might be used as a basis for a challenge ranking system. The PSRO's would be asked to defend any low scores before their peers, who would advise the Secretary as to their appraisal.

Out of such a process you can be sure would emerge all arguments, weak and strong, as to the imaginativeness and energy which the PSRO had employed to correct the apparently low score, as well as defensive criticism about the meaningfulness of the particular benchmark. Although it is obvious that the Secretary would make

the final determinations, it is inevitable that the advice of the peer-reviews would mostly be followed because in this as in other fields of life, it takes one to know one.

We continue with other suggestions.

3. More Autonomy

Since it is obvious that no one knows exactly what should be done in these programs, the PSRO's must be given the latitude to make some mistakes, and the forgiveness to be able to recover and learn from those mistakes. We recognize that increased autonomy probably implies that failure to perform would meet with greater sanction.

Rotation and Internal Denial

We believe that the program is in some danger at this point in developing an elitist coloration, with resulting isolation of the reviewers. We allude to Section 1155 of the PSRO law regarding rotation of reviewers. While we have had experience which indicates that excessive rotation of physicians through the review process can be disruptive to the program, there is still little doubt that expansion of the number of reviewers would simultaneously expand the conscienceness and participation of the physician community. We believe that the program is now ready to face more attention on internal delays, particularly delays imposed by the hospital systems, as contrasted with review of admission necessity and prolonged length of stay. Since a certain amount of slippage and delay is inevitable in a tailor-made individualized medical care system, a great deal of tolerance must be displayed while the system developes experience with coping with the problems of system handicaps imposed by hospital organization. It is clear that internal delays will never be completely eliminated, but it is not clear where the point of diminishing returns would develop.

Reassurance About Data Security

The Hippocratic Oath states, among other things, "what soever things

I shall learn about the affairs of men in the course of my profession I shall hold forever secret". The history of the warfare about medical data between PSRO and other agencies has been very disturbing to the medical professiona. We believe that the American public is similarly unwilling to have its personal information become the subject of newspaper articles and non-professional scrutiny. THere is no doubt that the medical profession would rather that no one know about this information at all, if that is the only choice between restricting this information strictly to the professional circle. This assertion may seem self serving, and perhaps to a certain extent it is self serving. Nevertheless, the system depends upon the confidence of physicians that peer review is truly taking place, and not merely cost containment. In the larger sense, the medical profession is completely confident that the American public supports our reluctance to have medical data breeched in confidentiality and used for unintended purposes.

At this point, we make another concrete suggestion:

A TASKS FORCE TO DEVELOP MORE APPROPRIATE DATA SYSTEMS

Considerable experiences has now accumulated with the advantages and disadvantages of various data approaches. This experience needs to be consolidated and debated. The competition by other agencies for the same data needs to be subjected to informed adversary process, and the cost/benefit issues need to be balanced against the PSRO need for confidentality and speed. The issue of invasion of hospital perogatives needs to be debated in the open instead of surreptitiously as at present. The issue of data consortia with other agencies, which we presently disapprove, should be explored in its political as well as its data processing ramifications.

Since the money available for PSRO data has been so limited, the vendors have been discouraged from investing seed capital to develop new systems. It may well be possible that a task force on data would recommend that grants be made to fund the development costs of new systems which are perceived to be

necessary, whether mini-computers, off-line batch processing, or telecommunicated shared processing. The task force should attempt to determine whether it might be in the public interest to free vendors of the present inhibition that their products would fall into the public domain, for competitors to use.

We have three other concrete suggestions which time does not permit me to discuss. They may be found in the appendix, relating to a task force on the effect of retrospective costs reimbursement on the true cost of overutilization; the pooling of expert talent; and the coalescence of physician opinions about techniques and technology. I would be happy to discuss these three proposals if you feel that time permits.

In conclusion, on behalf of the Philadelphia Professional Standards Review Organization I wish to thank the Health Subcommittee of the United States Senate Finance Committee for its patience and attention in listening to these remarks. We hope that at least to some degree they will be found to be have been helpful.

APPENDIX

1. A Task Force on the Effect of Retrospective Cost-Reimbursement on the True Costs of Overutilization.

Numerous voices have suggested that physicians should receive copies of itemized patient bills in order to sharpen their attention to costs. This has actually taken place in very few hospitals, and we must suspect there is hidden resistance to the idea. One very strong argument against focussing attention on patient charges is that they bear so little relationship to the average cost of the service. Even the average cost is not what we are interested in. The true saving of doing one less test or saving one day of hospitalization is the incremental (i.e. marginal) cost of doing one more in an era of heavy fixed costs. A test which appears to cost thirty dollars may actually only cost a few pennies; its true cost/benefit ratio may be quite different from the apparent cost/benefit ratio of the posted charges. The PSRO's need expert advice on this subject, since without it they are led to inappropriate responses, and quality care may uselessly suffer.

2. The Pooling of Expert Talent

As a large PSRO, Philadelphia has been able to afford a statistician and a trained accountant. We may now have to relinquish such talent, and the small PSRO's never could afford it. On the other hand, we would be delighted to share specialized talent of this sort with other PSRO's, providing a mechanisms for

cost-sharing were established. This is the sort of organizational cost-reduction which might actually enhance the program rather than cripple it.

3. The Coalescence of Physician Opinion About Techniques and Technology

There are areas of medical practice where the public decides and the medical profession follows. Abortion on demand is an example of a basically moral issue with minor technical complexity. There are, at the other extreme, issues like cancer chemotherapy which are so technically complex that the public has no choice but to follow the evolved consensus of the profession.

Most issues fall somewhere in between the extremes, with a component of public choice, and a component of technical complexity. Let me give you three examples. In the case of drug and alcohol addiction, the public has some pretty firm beliefs which may not be in keeping with the best judgement of doctors. There are a number of complications and crises in these disorders which can be described to nurse coordinators and approved when present. But there remains the ambiguous bulk of cases where institutional care has some short-term benefits, but which are subject to abuse by some institutions, the larger picture is one of general failure to cure the addiction as a metter of practical experience. The Philadelphia PSRO is currently in the process of arguing this out. We have no clear answers, but we expect to chip away at it, and the public will ultimately benefit by our internal struggles. Ultimately, the physician peer review system promises to have its greatest unique achievement in the useful impact of professional debate on public opinion.

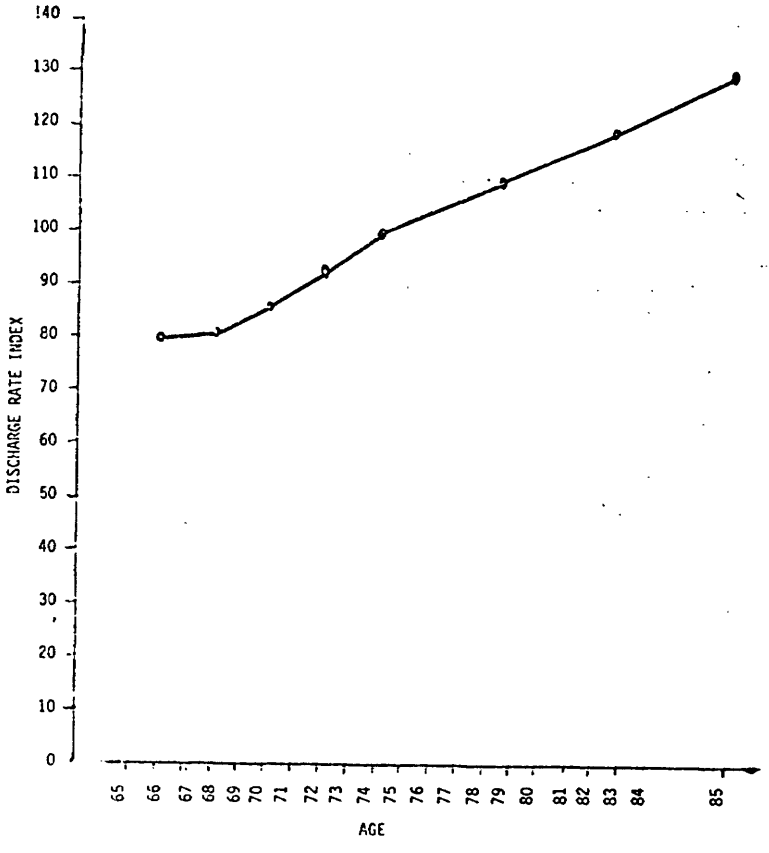
The issue of hypochondriacs and terrified demanding patients is the third example. Some physicians exclude such patients from their practice, but others have a more understanding considerate sympathy for them. Unfortunately, it

is difficult to distinquish kindly sympathy, which we endorse, from abuse of program integrity, which we deplore. No one has proposed a better way than physician peer review to work out a set of appropriate public attitudes on this matter.

The PSRO program must find ways to encourage such internal debate of the limits of professional latitude, and coalesce the attitudes of 200 PSROs into something approaching national public consensus.

TABLE 1

DISCHARGE RATE INDEX BY AGE



Source: Research and Statistics Note, No.3, June 1973;DHEW, Health Care Financing Administration, Office of Policy, Planning and Research.

Table II

1970 Phila. Population by age and
1978 Medicare Enrollees by age

1970 Population 65 and over= 228,148
1978 Medicare Enrollees= 231,154

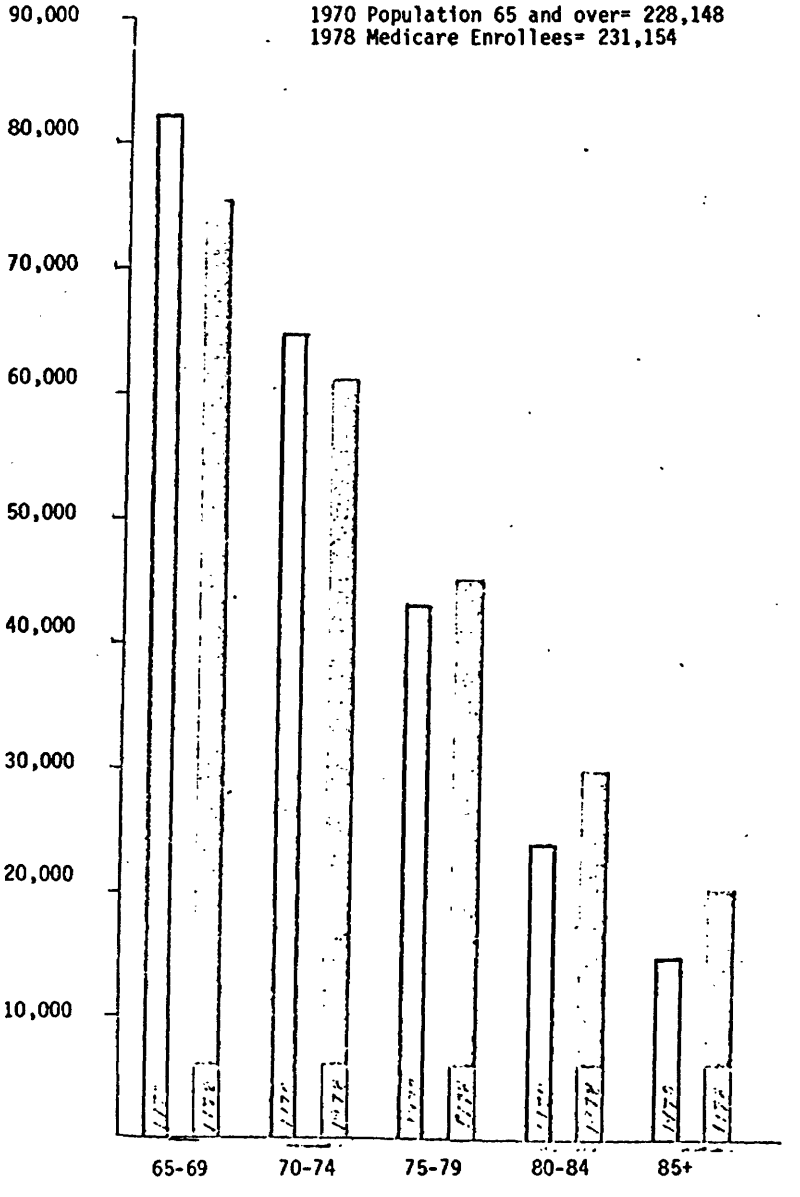


TABLE III

24 fully implemented hospitals by 7/1/77

	Medicare			Medicaid		
	7/77 6/78	7/78 7/79		7/77 7/78	7/78 7/79	
Cases	54,775	58,663	+7.1%	71,376	68,448	- 4.1%
Days	771,688	782,955	+1.5%	547,572	497,297	-9.2%
ALOS	14.1	13.3	-5.7%	7.7	7.3	-5.2%

Combined Medicare and Medicaid

	7/77-6/78	7/78-6/79	
Cases	126,151	127,111	+0.8%
Days	1,319,260	1,280,252	-3.0%
ALOS	10.5	10.1	-3.8%

Source: Utilization Review Activity Summary

HSA of Southeastern Pennsylvania
Medical-Surgical Admission Rates--Southeastern Pennsylvania, 1977

Location of Hospital	1977 Admissions		Patient Origins Per 1974 Study					
			Bucks	Chester	Delaware	Montgomery	Philadelphia	Other
Bucks	41,126	#	33,764	-	-	4,483	1,357	1,439
		%	82.1	-	-	10.9	3.3	3.5
Chester	24,770	#	-	21,129	793	1,759	1,362	916
		%	-	85.3	3.2	7.1	5.5	3.7
Delaware	51,928	#	104	727	43,620	727	4,258	2,441
		%	.2	1.4	84.0	1.4	8.2	4.7
Montgomery	87,674	#	8,241	3,156	8,767	44,012	18,762	4,734
		%	9.4	3.6	10.0	50.2	21.4	5.4
Philadelphia	237,700	#	6,180	1,426	7,844	12,123	184,693	25,434
		%	2.6	.6	3.3	5.1	77.7	10.7
Total Admissions			48,289	26,438	61,024	63,104	210,432	34,964
1977 Est. Population			339,786	226,742	462,345	498,943	1,444,873	N/A
1977 Est. Adm. Rate (per 1,000 population)			142.12	116.60	131.99	126.48	145.64	137.68

*Adjusted for Patient Origin per 1974 Survey

Source: HSA/SP.

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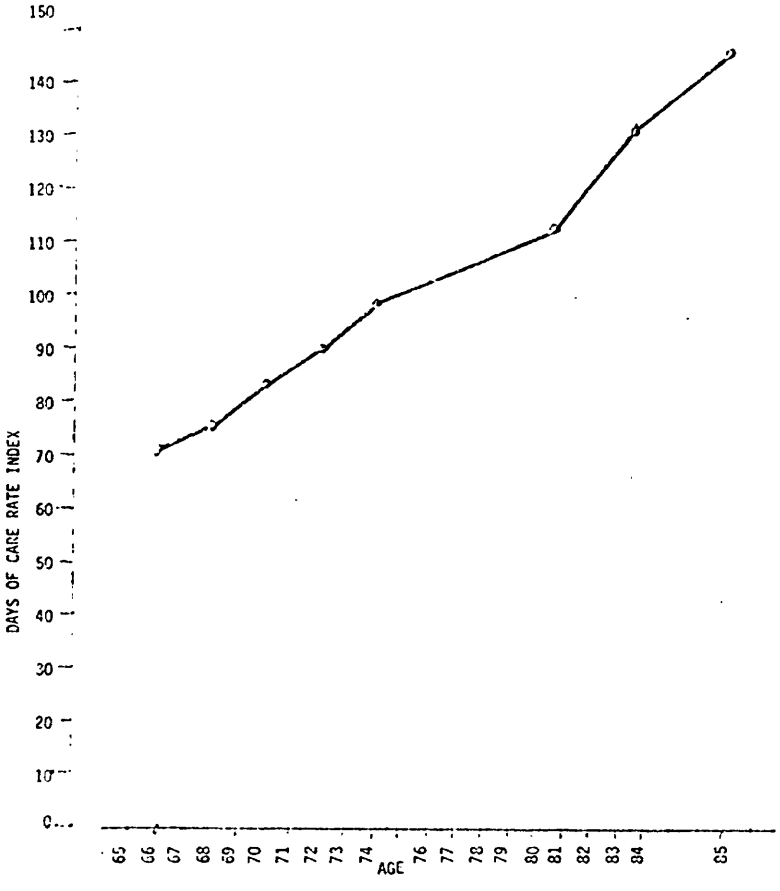
TABLE V

Days of Care Index by Age



Source: same as Discharge rate index

TABLE VI

6 Non-delegated hospitals

7/78-7/79

	Medicare			Medicaid		
	Pre-PSRO	PSRO Review		Pre-PSRO	PSRO Review	
Cases	4171	4247	+1.8%	8581	10,181	+18.6%
Days	58,622	47,725	-18.6%	48,720	48,045	-1.4%
ALOS	14.1	11.2	-20.6%	5.7	4.7	-17.5%

6 Non-delegated Hospitals Medicare and Medicaid

	Pre-PSRO	PSRO Review	
Cases	12,752	14,420	+13.1
Days	107,342	95,770	-10.8
ALOS	8.4	6.6	-21.4

Source: Utilization Review Activity Summary

TABLE VII

Report of [illegible] Blue Cross of [illegible]

Average Length of Hospital Stay (Days)

'78	7.22
'73	7.79
'68	8.34
'63	9.26 *

* [illegible]

Inpatient Days Decline in 1978

Reflecting in part the effectiveness of current cost-containment programs for the development of short preadmission tests and utilization review, the average number of days spent in the hospital by our subscribers continued to decline in many ways demonstrative of previous contractual provisions at work during 1978.

On the average, each 1,000 of our subscribers spent 760 days in the hospital during 1978. In 1970, such Blue Cross subscribers spent 1,087 days in the hospital. Had this decline not occurred, the added cost in 1978 alone would have been more than $142.5 million. Most importantly, it means that in only eight years time, our subscribers are now spending 30 per cent less time in the hospital, away from their jobs, homes and families.

Another key indicator is the average length of stay (ALOS) for Blue Cross inpatients. During 1978 the ALOS likewise declined to 7.22 days. Had this moderation not taken place, the unnecessary cost would have been $56 million during 1978 alone as compared to 1970 when the average length of stay was 8.37 days.

Senator TALMADGE. The next and final witness for today is Dr. Robert J. Brennan, president, Bay State PSRO, Boston, Mass., accompanied by Gary M. Janko, executive director.

Mr. Brennan, we are delighted to have you, sir. If you would insert your statement in the record and summarize, we would be grateful.

STATEMENT OF DR. ROBERT J. BRENNAN, PRESIDENT, BAY STATE PSRO, BOSTON, MASS.; ACCOMPANIED BY GARY M. JANKO, EXECUTIVE DIRECTOR

Dr. BRENNAN. We are very pleased to respond to the invitation of the Subcommittee on Health of the Committee of Finance to discuss the operating aspects of the PSRO program from our perspective. At the outset, it should be noted that our interest in the successful and meaningful implementation of Public Law 92-603 is motivated by manifold and diverse reasons. As citizens of this Nation, we are vitally concerned that the eligible population receive, when medically necessary, what is their due. This is well stated in the preamble to the pertinent section of the law. We are still cognizant of the deep deliberations and the mountains of evidence weighed by this very committee relative to the spiraling costs of titles 18, 19, and 5, which led to this legislation in 1972.

As members of the medical profession which is so intimately involved in these programs, we have an added and inherent responsibility to insure that the care that this population receives is rendered in as judicious a manner as possible. We are well aware that the legislation passed in 1965 contained the necessary powers to guarantee the last statement and we are quite conscious of the fact that it would not augur well for the profession if it were to fumble the opportunity which has been offered to them by this legislation.

Further, we consider it to be of paramount importance to remember that the United States is the first country in the Western World to put such a program in place. In summary, it would be our judgment that commonsense and pride in our profession would dictate that we make every effort to make the program successful.

From a national standpoint, as a result of PSRO activity, a tremendous amount of data has been generated, analyzed, the results interpreted and varying conclusions have been drawn. The net result has been that there are those who feel that the program at last has turned a corner and is proven to be an effective tool in the controlling to some degree, the cost of these programs. On the other hand, there are those who do not believe that the results achieved to date have justified the expectations placed upon them, given the program costs.

Our main purpose in being here today is to offer you firsthand evidence of how the program is working from the viewpoint of us who are in the field. Some of the points we will cover are in and of themselves of such a nature that they do not fit the precise machinations of a computer. We shall confine our observations to the year 1978 and following.

In this brief presentation we have not made any attempt to even estimate the degree of dollar impact of our review activities for a variety of reasons, one of them being the relatively short notice

given to appear before the subcommittee; others are factors beyond PSRO control; that is, administratively necessary days, shortage of nursing home beds, to name but a few. These negate to some degree the effects of concurrent review and lastly it would be presumptuous of us to present to the committee figures which could not stand the strongest scrutiny to which they would undoubtedly be subjected.

However, while we consider financial impact to be a legitimate concern and indeed a very important one, nevertheless, there are other criteria by which effectiveness may be measured and it is to these that we address our remarks.

In the area of hospital concurrent review, a total of 953 admissions were denied and a total of 24,547 days of care were denied for the year 1978. During this period there were a total of 35,700 administratively necessary days. One hospital underwent sanction proceedings and a recommendation for sanction was submitted by us to the Secretary of HEW through the prescribed channels.

Another hospital has just closed its inpatient facilities, an event which can be attributable to the effectiveness of the review process. A third hospital in a major city announced to the news media that the workweek had been cut 20 percent and the employees were given a 20-percent reduction in wages. It was stated that this action was the direct result of PSRO utilization review. We feel that the closing of a hospital or hospitals is a major event certainly as far as the community is concerned, but not a happy one.

Nonetheless, we conclude quite justifiably that in these closings that the PSRO has had a positive impact both on the quality and cost containment mandates of the law, both implicitly and explicitly.

The large number of administratively necessary days mentioned above aroused our curiosity as to why the number was so large, and therefore, on it's own initiative, the PSRO did an in-depth study to determine what the reasons were for this situation. It was determined that the major factor in this problem was a lack of appropriate level of care beds and that these patients were merely awaiting placement.

The Commonwealth of Massachusetts could have saved an additional $2,747,559, had such beds been available. This information, at the State's request, has been made available to them as an aid to them in solving this problem.

Social service departments in the hospitals in the Bay State area have become involved in discharge planning within 48 to 72 hours of a patient's admission to a hospital. This has resulted in much improved planning and is a direct result of physician education. As a result of our utilization review process, the physician has gradually learned that he can no longer wait until the last minute while a search for placement in a lower level of care is initiated. It should be noted that this information comes from the social workers themselves who are only too glad to be involved at a much earlier time in the patient's hospital stay. It also reflects the interchange that has taken place between the various services of hospitals and the PSRO.

Such a situation did not exist to such a degree prior to 1974. Interestingly enough, lack of discharge planning is cited in the CBO report as a significant factor in increasing medicare costs.

To comply with the national PSRO budget and to increase the efficiency of the PSRO review, in August of 1978 the Bay State organization commenced a study to make adjustments in the review process to render it more cost effective. The system confines review to those admission diagnoses where past data show that admission denial is most likely, and to admission by symptom.

After field testing in four hospitals, this system became effective in the Bay State area hospitals on August 1, 1979. This system of review bears the title of focussed review. In closing we would like to make the observation that the Bay State organization has always been concerned with performance.

In September of 1978, under the leadership of Dr. Paul Gertman of the Boston University Health Policy Institute, using the appropriateness evaluation protocols developed by Dr. Gertman, the Bay State PSRO underwent an evaluation. A draft report indicates that the PSRO has had a statistically valid impact on utilization.

We also note that in the 1978 OPEL report, that the Massachusetts PSRO's ranked sixth in the Nation in cost effectiveness. Another study done by Dikewood Industries, under an HEW grant, revealed that Bay State ranked second among the 12 PSRO's studied.

Mr. Chairman, this concludes my prepared statement. Again, we would like to express our appreciation at being allowed to bring these matters to the attention of the subcommittee. I or Mr. Janko, the executive director, will be glad to answer any questions which you may have.

Senator TALMADGE. Thank you very much, Doctor. The bill this committee recently approved calls for reduced payments to hospitals that keep nursing home patients in their acute beds. This would apply where there are nursing home beds available or where there are excess hospital beds that could be converted to long-term care. Federal funds would be provided to help these conversions. Do you believe that these provisions would make a substantial contribution to PSRO's efforts?

Dr. BRENNAN. They certainly would.

Senator TALMADGE. That was the thinking of the committee also, Doctor. We thought we would save money there in the long run. I appreciate what you have had to say here. This has been an interesting 2 hours for me. We have heard from eight witnesses representing eight different PSRO's. And every one of them testified that it was cost effective, that it saved the Government money and provided better care for the patients.

And they were from throughout the country: North, South, East, and West.

Thank you very much. This completes the hearing for this afternoon. The committee will stand in recess until 2 p.m. tomorrow.

[Whereupon, at 4:05 p.m. the subcommittee hearing adjourned, to reconvene at 2 p.m., Wednesday, September 19, 1979.]

REVIEW OF PROFESSIONAL STANDARDS REVIEW PROGRAM

WEDNESDAY, SEPTEMBER 19, 1979

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

The subcommittee met, pursuant to notice, at 2 p.m., in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge and Baucus.

Senator TALMADGE. The subcommittee will be in order.

The first witness for today is Dr. Richard N. Pierson, Jr., chairman, board of directors, New York County Health Services Review Organization, accompanied by Eleanore Rothenberg, Ph. D., executive director.

Doctor, we are happy to have you with us. You may insert your full statement in the record and summarize it, sir.

STATEMENT OF RICHARD N. PIERSON, JR., M.D., CHAIRMAN, BOARD OF DIRECTORS, NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION, ACCOMPANIED BY ELEANORE ROTHENBERG, PH. D., EXECUTIVE DIRECTOR

Dr. PIERSON. Thank you, Mr. Chairman. I am Dr. Pierson, a professor of medicine at Columbia University and chairman of the New York County Health Services Review Organization.

I would like to make three points:

Peer review in New York County is effective; two, peer review in New York County is faced with serious problems of two kinds, we might say, both from the left and from the right, or, to be more specific, we might say from the North and from the South. Three, changes are needed, and I will suggest what these changes might be: First, effectiveness; Reductions in length of stay. These have occurred and are documented in the materials which are available.

New York City in many respects has the longest length of stay in the Nation. I would submit to you, however, that these are fragile and only partially useful statistics. The reasoning for that statement may come out in the course of questioning. Second, another statistic is the closing of hospitals and the important question to ask is which ones.

When PSRO went into effect, there were 40 hospitals in New York County. There are now 28; 12 hospitals have been closed. Many of these have closed for reasons which are related to the existence of PSRO. We do not claim credit for individually closing

those hospitals, many of which were in the first year that we were active.

Let's look at the hospitals which were closed. They tended to be small; they tended to be proprietary; they were nowhere near representative of the hospitals in New York City. Consider the spectrum, consider that they were at the lowest end of the spectrum of quality. They did not necessarily show the longest length of stay. In some instances they may have had shorter lengths of stay; but these stays were in general the least appropriate and necessary.

At first, these closings occurred, if I may say so, because the Senate, because "Wallace Bennett turned on the lights" and people began to look around and worry about what was going on. Now, closings are by a different mechanism, and I would call your attention to this mechanism. This mechanism is known as sanctions a part of the PSRO law.

Consider a specific hospital which was closed a little less than 1 year ago. New York City, New York State and the Bankruptcy Court were unable to close the hospital; they were unable to do so because of something which I, as a naive amateur, would suggest is political paralysis.

PSRO provided the hard data, objective data, on the basis of which it was possible to bypass political paralysis. We are now considering sanctions in three other hospitals, and these hospitals follow my previous comments about being at the lowest end of the quality spectrum.

Next, let me address the problems which we now have. Our energies are being wastefully expended. First from the North, the pressures of struggling with a demonstration project which is faulty in concept, flawed in design and so stacked against the principle of peer review that had it been carried out, the PSRO would very likely have lost the battle. Why? Because a team of examiners whose prime motivation is to reduce quantity is pitted against a team whose motivations are to reduce inappropriate quantity, to increase quality, and to educate.

In D'Alembert's rule of calculus, it is possible to optimize only for a single variable. We are forced to optimize for three variables, and this is a much more complex problem.

The second reason has to do with the Panzer Division strategy, which is, it is always possible in a war to take any position, no matter how strongly defended, by concentrating one's best forces, by striking at only one point, by using crack troops and by bringing maximum support, air strikes, et cetera, in a saturation effort. It is the type of effort which a politically motivated process may carry out and may make us look foolish.

Our forces must, by law, be spread over the whole range of hospitals of all varieties. We cannot win a Panzer war when we depend on largely volunteer forces, which I will describe in a moment; and when these are pitted against the full resources of a State health department, we have problems.

Consider, if you will, how did it come about that we are at war with our fellow physicians and health officers who work for the State Health Department. We, in fact, need their help; we will depend on the help, the partnership, of the State Health Depart-

ment. We have many things to learn from them; we have many resources which they can use. We would look much better if we could expend our energies and your money by making common war against bad hospitals, bad physicians and even against the diseases which affect our patients.

Can you, as legislators who structure these strategic encounters, protect us from such diversionary and wasteful encounters?

Second, our problems come from the east and west and these are problems with our hospitals, the problem of compliance. We have come into an arena in which many, indeed most, physicians did not want us; they did not feel they needed us; and in the case of the hospitals, many are quite frightened both of our methods and our effects.

How could we, the PSRO, invade this turf and persuade physicians to be monitors of each other? The answer is key. Senator Wallace Bennett was ingenious in his response, which was to give us the responsibility to organized medicine and then hold us responsible for using it. I hope you will remember back to this point as you hear subsequent testimony from members of State health departments, professional regulators.

The answer in New York is that we, as board members in New York County, are the turf; we are the physicians; we are the hospitals. I am the immediate past president of the New York County Medical Society, a physicians' organizations Ivan Bennett, the founding chairman, is the president of the University Hospital and dean of the New York University Medical School. Theodore Cooper, formerly director of the National Institutes of Health, currently is the dean of the New York Hospital. Twenty-four other board members represent the leadership of hospitals, medical societies and city health departments. Consider our powers to influence our colleagues. We are their elected leaders. Do they all love us? Do all of your constituents love you?

For both of us, we have to get 51 percent of the vote every few years. Like you, we are responsible for our results. Could anyone else do it better? We are the turf. The State Health Department does not face election; their tools are punitive; ours are internal to the system and they are positive.

I submit that we are your best bet, and we need your help.

Finally, what changes are needed? I would start out by saying not necessarily more funds but funding better directed at the real problems. First, never give us the task of competing with the State or wasting scarce funds fighting against another government agency.

Another example: We have 16 delegated, 12 nondelegated, hospitals in New York County. We now know that we must dedelegate three hospitals. How can we afford the much higher expenses? Give us available emergency supplemental budget support so that we can afford the flexibility of taking away delegation, a flexibility that at the moment we would be sorely pressed to be able to fund.

We have had two successive 20 percent budget cuts in 3 years, yet this year we have three new hospitals to take on, 50,000 additional discharges. This is not logical; this is not possible. We will fail in some area of our responsibility if we try to take on this additional load.

Finally, and related to funding, we need a restricted menu of what we will tackle, a scorecard against which to be judged, where the tasks are commensurate with the resources. We are doing inhospital review; we should do long-term care review; we should do ambulatory care review. Twenty-five percent of expenditures in medicaid, but only 1 percent of PSRO budgets are directed at ambulatory care review. We should monitor office practice and ancillary services in hospitals.

Consider a single example, the problems of a psychiatrist doing office practice. What records does he keep? How would one monitor the efficiency of his practice from the point of view of privacy, from the point of view of confidentiality?

We have very recently referred to the Office of Program Integrity a sequence of billing senile patients for daily intensive psychotherapy. If we were asked to carry out the same study next year, we could not, for lack of funding.

I would finish by reminding you of a World War II cartoon in which two soldiers are seen sitting in a foxhole, with the shells bursting overhead, and one says to the other, "Willie, if you knows a better hole, go to it." If you don't know a better hole, give us the tools and time; we know what the job requires. We have delivered and we can deliver. We thank you.

[Prepared statement of Dr. Pierson follows:]

STATEMENT BY RICHARD N. PIERSON, JR., M.D., CHAIRMAN, BOARD OF DIRECTORS, NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION

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 Associate 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 decades and have been active in such professional organizations as the New York County Medical Society, of which I am immediate past President, the New York Academy of Sciences, the American Heart Association, and the American Physiological Society.

I am one of the founders of the 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 report on some significant achievements of the New York County PSRO, some of the objectives yet to be reached, and some of the major problems the PSRO continues to face. 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 has had a clearly measurable positive effect both on the quality and quantity of hospital medicine in New York County.

ABOUT NYCHSRO

The 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 academic medical centers, 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 1000 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 (See Attachment I). As of July 1979, there were an estimated 5,466 doctors of medicine and osteopathy (approximately 45 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 pecent 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 County enjoys a national, and in many cases, an international reputation for major achievements in the medical sciences, some most scandalous medical practices have also been documented, including, among others, the "ping-ponging" and overutilization in ghetto-area shared health facilities (the so-called "Medicaid mills") reported to this Committee in 1976 by former Senator Moss, which report brought prompt legislative action. Moreover, questionable utilization patterns have been identified by HEW in terms of long in-patient lengths of stay in New York County.

Specific NYCHSRO programs designed to address these problems and their positive end results will be reported by me and by NYCHSRO's Executive Director in the next segments of this presentation.

NYCHSRO'S IMPACT ON QUALITY OF CARE

The most striking result of the PSRO program, to date, has been NYCHSRO'S impact on the quality of care provided to Federal beneficiaries served in Manhattan hospitals.

During the past year, for example, NYCHSRO has succeeded in developing a concurrent quality review program and, through its application, played a major role in removing a substandard hospital from the health care delivery system in New York County. The latter is an example of this PSRO's willingness to use objective review to determine whatever action was or is necessary to assure that the quality of care provided meets professionally recognized quality standards.

I think the members of this Subcommittee would be interested in the following description of NYCHSRO's sanction proceedings against Hospital X for violating its obligations under Section 1160 of the Social Security Act.

CASE HISTORY OF SANCTION PROCEEDING AGAINST SUBSTANDARD HOSPITAL

The hospital in question was a voluntary, 214-bed institution located in the Harlem section of Manhattan's upper west side which serviced a low-income population primarily composed of blacks and Hispanics. The medical services offered were surgery, medicine, and pediatrics. In addition, there was an alcohol detoxification treatment unit to deal with the high incidence of alcoholism in the population served.

In September, 1976, New York County Health Services Review Organization (NYCHSRO) granted the hospital delegated status to perform the review process under the PSRO mandate. In September, 1977, NYCHSRO withdrew delegation of the concurrent review process from the hospital based upon the determination that the hospital no longer displayed the capabilities necessary to perform delegated review functions effectively.

Upon assumption of the review process, NYCHSRO staff observed, among other things, the following:

1. An unusually high percentage of physician advisor referrals (60 percent of cases reviewed compared with 10 percent average in other area hospitals) of which more than half resulted in adverse determinations. These figures were the highest of any hospital under NYCHSRO's purview.

2. Serious delays were found in the medical records with respect to:

(*a*) Obtaining medically necessary consultations,

(*b*) Reporting laboratory tests and X-ray findings,

(*c*) Performing diagnostic studies,

(*d*) Scheduling indicated operative procedures, and

(*e*) Identifying social service and/or discharge planning problems.

3. Treatment plans and progress notes were characteristically either vague or non-existent.

The following examples illustrate some quality of care problems which were found:

CASE NUMBER AND REMARKS

101 Admitted April 4, 1978 with head trauma. Neurology consultation was requested April 4, 1978 but not done as of April 15, 1978. Patient discharged April 16, 1978, with consultation not answered. Orthopedic consultation ordered April 6, 1978, answered April 10, 1978.

102 Admitted with head trauma on August 21, 1977. In a state of semi-coma for several days. Progress notes of September 14, 1977 stated patient to be transferred to another hospital since full work-up could not be done at Hospital X. Patient was never transferred for this work-up, no reason documented; however, this patient had a C.A.T. scan at Hospital Y on November 20, 1977.

103 Alternate care date October 19, 1977. No social service documentation from January 1, 1978 through February 16, 1978. No documented attempts to place patient.

104 Admitted January 19, 1978. Diagnosis: fractured neck right femur. Suprapubic mass noted March 5. March 26 consultation is not yet answered.

105 Admitted on February 21, 1978 with a diagnosis of cerebral concussion. Neurological consultation ordered February 21, 1978. No response as of February 31, 1978.

Detailed documentation of these and other related deficiencies were compiled by NYCHSRO staff between January and March, 1978. In addition, a special quality of care review of thirty-three (33) selected hospital episodes was conducted by NYCHSRO Physician Advisors, resulting in a finding that nearly forty percent (40 percent) did not meet professionally recognized standards of quality.

NYCHSRO thus determined that there were potential violations of the obligations imposed upon the hosital under Section 1160 of the Social Security Act. On April 3, 1978, NYCHSRO informed the hospital of its decision and invited representatives of the hospital's governing body, administration, and medical staff to a meeting to discuss NYCHSRO's findings.

Between May and August of 1978, NYCHSRO met with the hospitals' representatives on several occasions and gave the hospital repeated opportunities to fulfill its own plan of action to correct the severe problems identified by NYCHSRO. NYCHSRO's staff and physicians found, however, that no substantial improvements occurred with regard to deficiencies in the quality of care provided. On August 23, 1978, the PSRO Board of Directors finally determined that the hospital was endangering the lives of its patients and therefore had violated Section 1160 of the Social Security Act. Pursuant to Section 1157 of the Act, NYCHSRO submitted a sanction report to the Secretary of DHEW through the New York Statewide Professional Standards Review (PSR) Council. NYCHSRO's Board recommendedd that the hospital be permanently excluded from eligibility to provide titles V, XVIII, and XIX services on a reimbursable basis, knowing that such an action would compel the closing of the hospital which was already in the throes of a financial crisis, being saved solely by State subsidies.

At the request of the Statewide PSR Council, NYCHSRO provided additional updates on the problems in the hospital between August 23, 1978 and September 30,

1978. On October 5, 1978, the Council conveyed NYCHSRO's sanction report to DHEW documenting its own concurrence with NYCHSRO's recommendation.

After reviewing NYCHSRO's sanction report and other pertinent information, DHEW's Office of Program Integrity (OPI) recommended to the Secretary of DHEW that the hospital be excluded as an eligible provider under the Medicare and Medicaid programs.

On December 6, 1978, a pre-termination notice of ninety days was sent to the hospital by the Director, Region II, Health Standards and Quality Bureau (HSQB), recommending the removal of the hospital's eligibility for participation in the Title V, XVIII and XIX programs.

NYCHSRO's concurrent review staff remained at the hospital performing concurrent review activities despite the absence of any improvement in the problems originally identified. In fact, conditions deteriorated to such an extent that the review system was seriously compromised. Confusion had increased, particularly in the medical records and billing departments, and tensions had heightened as reimbursement from State agencies decreased.

On January 10, 1979, NYCHSRO's Executive Director notified DHEW of her intention to remove the NYCHSRO staff from the hospital and to discontinue review activities there, effective January 11, 1979.

From January 11, 1979, until the January 22, 1979 meeting of the NYCHSRO Executive Committee, NYCHSRO staff continued to certify the days of the care, reviewing the hospital charts at NYCHSRO's offices.

At the meeting of the Executive Committee, however, the staff was directed to cease all review activities and to no longer certify hospital days of care for reimbursement under the federal health care financing program.

On February 3, 1979, the hospital was closed.

Aside from the sanctioned hospital, three other hospitals have been brought in for potential violations of obligations under Section 1160 of the Social Security Act. Repeat monitoring is planned. If problems of substandard care are not resolved, these hospitals could be sanctioned as was Hospital X.

In Hospital A, the following quality problems were identified:

1. An unusually high incidence of one surgical procedure (reanastamosis of fallopian tubes) was noted as being performed on patients without sufficient consideration of the medical indications for such procedures.

2. Inadequate alcohol detoxification protocols were identified for patients treated at the hospital resulting in the discharge of these patients before they were "drug free."

3. The hospital was found to have poorly formulated or non-existent after care plans, especially with respect to patients treated on the detoxification unit, resulting in a pattern of readmission for detoxification.

An in-depth review of fifty-three (53) medical records was conducted by NYCHSRO physicians confirming these deficiencies in the quality of care. After communicating its findings to the responsible hospital representatives, the hospital submitted a corrective action plan to NYCHSRO.

This was followed by a second study to evaluate the impact of the corrective action plan on the care provided. An abrupt and significant decrease in the number of tubal reanastamosis procedures has been observed. In addition, there has been an upgrading of the detoxification protocol as well as the development of viable after care plans for these patients. Specifically,

1. Patients treated for alcohol detoxification are drug free 48 hours prior to discharge and receive appropriate counselling as well as discharge planning.

2. A new Medical Director of the Alcohol Detoxification unit has been appointed.

3. All admissons to the detoxification unit receive comprehensive testing and physical examinations.

4. A pre-admission program for patients to be admitted for tuboplasities has been implemented.

In Hospital B, based on two (2) MCE studies of the care provided in its detoxification unit, the following improvements were noted:

1. The average LOS for patients studied was reduced from 19.8 days to 6.4 days after PSRO-required corrective action was instituted.

2. The hospital showed a substantial reduction in the use of sedative-hypnotic drugs with 92 percent of the patients studied being discharged drug free as opposed to 42 percent before NYCHSRO's intervention.

3. After care plans were documented in 66 percent of the cases studied before the PSRO corrective action and in 100 percent of the cases afterward.

In Hospital C, concurrent review activity revealed the following problems:

1. Diagnostic tests, therapies, and consultations were indicated but were not ordered.
2. Medical problems were not identified or were managed improperly.
3. Diagnostic tests, therapies, and consultations were ordered but were delayed or not carried out at all.
4. Progress notes, diagnostic reports, and consultants' reports were incomplete or absent.

Forty medical records of patients then hospitalized were reviewed by NYCHSRO physicians. Of these, 28 (70 percent) were judged by the physician advisors as not meeting professionally recognized standards. Four (10 percent) were judged as no longer requiring acute hospital care, and eight (20 percent) were judged as meeting professionally recognized standards. Fifteen separate physicians were recorded as the attending physicians in the 28 cases judged as not meeting professionally recognized standards. The hospital was notified of potential violations of Section 1160 of the Social Security Act and was directed to submit a corrective action plan which it did.

At Hospital D, the following patterns of questionable medical care were identified through the concurrent review process:

1. Questionable delays in scheduling and performing appropriate diagnostic and therapeutic procedures were documented.
2. There were inadequate histories and physical examination (e.g., an almost total absence of medically indicated rectal, pelvic, and neorologic examinations).
3. A large number of colonoscopies were performed without the antecedent rectal examinations, guaiac studies, sigmoidoscopy or barium enema studies.

A sample of sixty (60) of the hospital's medical records was analyzed by NYCHSRO physicians. Deficiencies observed were communicated to the appropriate hospital representatives. Further action will depend on submission of a corrective action plan by the hospital, and monitoring of that corrective action.

Based on NYCHSRO's early experience in establishing a peer reveiw mechanism for its area, it is no surprise that hospitals in New York have responded to PSRO along a spectrum ranging from excellent to "going through the motions" to disinterest and annoyance. The net results have been a function both of physicians' response, and of administration/trustee reception.

Despite the elements of pressure, underfinancing, and professionally well institutionalized resistance, we have some very notable successes, as described above.

My colleagues and I wish to thank this Committee and its staff for the opportunity to describe how NYCHSRO has progressed in its efforts to achieve the objectives of the PSRO program. With the support of the administration and the Congress, we believe that physicians, given the necessary authority and resources, can do the job intended, namely assuring that the care provided and paid for under the Medicare, Medicaid and Maternal and Child Health Programs are medical necessary, are provided at the least costly level of care consistent with the medical needs of the patient and meet professionally recognized quality standards.

Mr. Chairman, that concludes my portion of the presentation on behalf of NYCHSRO. Following the remarks of NYCHSRO's Executive Director, we will will be pleased to answer any questions you or other members of the Committee may have.

ATTACHMENT I.—NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION—BOARD OF DIRECTORS

Name, address, date elected, and expiration of term

Lowell E. Bellin, M.D.[1], Columbia University, School of Public Health, 600 West 168th St., New York, N.Y. 10032: November 1977–October 1980.

John T. Brennan, M.D., 30 West 60th St., New York, N.Y. 10023: November 1978–October 191981.

Herbert Cave, M.D., Box 1147, Mount Vernon, N.Y. 10551: November 1978–October 1981

June Jackson Christmas, M.D., Commissioner, Department of Mental Health and Mental Retardation Services, 93 Worth St., New York, N.Y. 10013: November 1976–October 1979.

Irwin J. Cohen, M.D.[1], 50 East 72nd St., New York, N.Y. 10021: November 1978–October 1981.

Theodore Cooper, M.D., Dean, Cornell University, Medical College, 1300 York Ave., New York, N.Y. 10021: November 1977–October 1980.

Charles H. Debrovner, M.D., 338 East 30th St., New York, N.Y. 10016: November 1977–October 1980.
Lawrence Essenson, M.D.[1], 2 East 77th St., New York, N.Y. 10021: November 1978–October 1981.
Reinaldo Ferrer, M.D., Commissioner of Health, New York City Department of Health, 125 Worth St., room 336, New York, N.Y. 10013: November 1978–October 1980.
John A. Finkbeiner, M.D., 34 East 67th St., New York, N.Y. 10021: November 1977–October 1980.
Philip F. Fleisher, D.O., 40 East 61st St., New York, N.Y. 10021: November 1978–October 1979.
Alta T. Goalwin, M.D.[1], Director, Quality Assurance, Metropolitan Hospital Center, 1901 First Ave., New York, N.Y. 10029: November 1977–October 1980.
Robert G. Hicks, M.D., 145 West 11th St., New York, N.Y. 10011: November 1976–October 1979.
John L. S. Holloman, M.D., 27–40 Ericsson St., East Elmhurst, N.Y. 11369: November 1976–October 1979.
Albert F. Keegan, M.D., Director of Radiology, Bellevue Hospital, 27th St. and 5th Ave., New York, N.Y. 10016: November 1976–October 1979.
Edward Leifer, M.D., 161 Fort Washington Ave., New York, N.Y. 10021: November 1978–October 1981.
Norman Medow, M.D., 146 East 71st St., New York, N.Y. 10021: November 1978–October 1980.
George W. Melcher, Jr., M.D.[1], President, Group Health Inc., 326 West 42nd St., New York, N.Y. 10036: November 1976–October 1979.
Virginia C. Mitty, M.D., 130 East 18th St., New York, N.Y. 10003: November 1978–October 1981.
Richard B. Nolan, M.D.[1], Director, Department of Surgery, Beekman-Downtown Hospital, 170 William St., New York, N.Y. 10038: November 1977–October 1980.
Andrew H. Patterson, M.D., 343 West 58th St., New York, N.Y. 10019: November 1977–October 1980.
Richard N. Pierson, Jr., M.D.[1], Director, Nuclear Medicine, St. Luke's Hospital Center, 114th St. and Amsterdam Ave., New York, N.Y. 10025: November 1977–October 1980.
Wilfred Reguero, M.D., 151 East 83rd St., New York, N.Y. 10028: November 1978–October 1979.
D. Jeanne Richardson, M.D., 180 East End Ave., New York, N.Y. 10028: November 1976–October 1979.
Albert M. Schwartz, M.D.[1], 1148 Fifth Ave., New York, N.Y. 10028: November 1978–October 1981.
Roger W. Steinhardt, M.D.[1], 990 Fifth Ave., New York, N.Y. 10021: November 1978–October 1981.
Eugene Streim, M.D., 118 East 60th St., New York, N.Y. 10019: November 1976–October 1979.

[1] Member, executive committee.

OFFICERS

Richard N. Pierson, Jr., M.D., chairman: November 1979–Present
Richard Nolan, M.D., vice-chairman: December 1978–Present
George W. Melcher, Jr., M.D., treasurer: December 1978–Present.
Lawrence Essenson, M.D., secretary: December 1978–Present.

Senator TALMADGE. Thank you very much. I want to commend you and the New York County PSRO for its conscientious and magnificent work. As a result of your efforts, a number of amendments have been approved by the Finance Committee which are designed to meet some of the costly overutilization problems that you have identified.

I understand that well over half the hospitals in the country have been delegated review authority by their own PSRO's. Do you believe that this amount of delegation is appropriate, given the historical problems with internal hospital review programs?

Dr. PIERSON. I would like to refer that question to Dr. Rothenberg, who has led a large staff and has a quantitative answer which, I think, is of the kind you want.

Senator TALMADGE. Doctor, we would be happy to hear from you.

Dr. ROTHENBERG. Thank you very much.

As an attachment to the materials in my statement, there are tables which specifically give information about our experience with respect to delegated and nondelegated hospitals. Very clearly, the nondelegated hospitals, where staff nurses and physicians have conducted review directly shows a remarkably clear indication that nondelegated review works better than does delegated review in most instances.

My answer to your question is this: Initially, PSRO's were encouraged to delegate review functions to hospitals which were willing and able to perform the functions. In fact, most PSRO's were encouraged to delegate period. In New York County we took a different approach. We only delegated those which met our criteria. Over time we have not found that the hospitals have performed in every instance; and in four hospitals we have withdrawn delegation when the facts led us to that decision.

We have now before us an additional six hospitals which are suspected of not being able to perform these functions effectively; so the answer is that on a case-by-case basis one would have to approach this delegation very cautiously and do it on an exception basis.

Generally, if we had our chance to do it all over again, we would be even more cautious than we were at the beginning.

[Prepared statement of Dr. Rothenberg follows:]

STATEMENT BY ELEANORE ROTHENBERG, PH. D., EXECUTIVE DIRECTOR, NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION

Mr. Chairman and members of the subcommittee, my name is Eleanore Rothenberg. I am the Executive Director of New York County Health Services Review Organization (NYCHSRO), the PSRO for Area XI of New York State, which is located in the heart of New York City. I have been with the PSRO since 1974, when I was asked, by the interim governing body, to help prepare a plan for the establishment of a conditional PSRO for the area. Previously, I served as staff researcher and policy analyst to the chief operating officer of New York University Medical Center.

I hold a doctorate in health administration and have served as a consultant to the New York Governor's Panel on Medical Malpractice, and for HEW, as a consultant on alcoholism and alcohol abuse. In addition, since 1976, I have been adjunct assistant professor at the Columbia University School of Public Health and Administrative Medicine. I have published and presented a number of papers on quality assurance, health planning, and medical malpractice and am currently the chairman of the AAPSRO Task Force on Impact as well as a member of the governing body of the Alliance for Continuing Medical Education (ACME).

I am here to describe the progress and problems of the PSRO in New York County, the achievements made to date and challenges still to be faced, as well as some frustrations and obstacles which may adversely affect NYCHSRO's performance.

NYCHSRO'S SPECIAL INITIATIVES

First, I want to describe some of the special initiatives undertaken by NYCHSRO to address and resolve quality and utilization problems which persist in the PSRO area.

CONCURRENT QUALITY REVIEW

NYCHSRO has submitted and been approved for special funding by the Department of Health, Education, and Welfare (DHEW) to carry out a vigorous concurrent quality review program building upon its experience, to date, in sanctioning substandard providers.

"CARVE-OUT" POLICY FOR UNNECESSARY, AVOIDABLE, AND COSTLY DAYS OF CARE

In order to reduce medically unnecessary pre-operative days of stay due to delays in diagnostic work-ups, consultations, and scheduling of surgical procedures, NYCHSRO instituted a "carve-out" procedure with fiscal impact on hospitals showing unnecessary, avoidable, and costly delays. (See Policy on Medically Unnecessary Avoidable Days of Hospitalization, Phase I & II attached.)

SPECIAL PEER REVIEW PROJECT; VALIDATION OF PSYCHIATRIC SERVICES FOR THE OFFICE OF PROGRAM INTEGRITY

At the request of the regional Office of Program Integrity (OPI), NYCHSRO participated in a validation study on psychiatric services provided to Medicare beneficiaries. The purpose of the study was to correlate services billed to the Medicare program with information available in the medical records. Of the 150 cases reviewed by NYCHSRO, 130 cases (involving 14 physicians) were questioned by nurse review coordinators and referred to NYCHSRO physician advisors.

Our physicians were unable to verify part or all of the claims in 110 of the 130 cases questioned because the medical records did not substantiate the number of visits or types of therapy sessions claimed. Moreover, the necessity of the admission was questioned in 2 cases and the appropriateness of psychotherapy was questioned in 19 others. Examples included:

Questionable psychotherapy for a deaf patient who reportedly refused to talk. Thirty-three (33) 15 minute sessions had been billed for under Medicare.

Of 46 psychotherapy sessions (of 15–44 minutes each) only 24 had been documented in the medical record. Moreover, the doctor had billed for 10 electroshock therapy treatments actually done by another physician.

Eight 45 minute psychotherapy sessions had been billed for despite the fact that the patient spoke no English and there had been no indication that an interpreter was used.

Fifty-five psychotherapy sessions were billed for involving a patient admitted for "CVA" evaluation There were no psychiatric symptoms on admission according to the medical record.

PERFORMING PSRO REVIEW AT REDUCED COSTS

NYCHSRO has reduced its total costs for the performance of PSRO review in acute care hospitals by 25 percent through a focusing mechanism which seeks to maintain the integrity of the review system while allowing for problem diagnoses, physicians, and hospitals to be targeted for intensive review.

PSRO REVIEW OF SHARED HEALTH FACILITIES (THE SO-CALLED MEDICAL MILLS)

NYCHSRO has successfully implemented a shared health facility review program (pursuant to Pub. L. 95–142) with positive end results, including a potential sanction proceeding against one such facility and correction of identified deficiencies in all others. (See Attachment II for key chronology of Shared Health Facility Program.)

INAPPROPRIATE LONG STAYS IN ACUTE CARE HOSPITALS FOR PATIENTS AWAITING ALTERNATE LEVELS OF CARE

NYCHSRO has documented, through special studies of patients awaiting alternate level of care placement, that approximately 500 federal beneficiaries are backlogged in acute care hospitals on any one day in New York County because of an apparent shortage (or misutilization) of available long-term care beds in the area. According to our study, the average waiting time for Medicare patients is approximately 29 days while for Medicaid it is 70 days. What is unknown, however, is how many patients are inappropriately placed at the Skilled Nursing Facility (SNF) and health Related Facility (HRF) level. Despite the fact that NYCHSRO has submitted an approvable Long Term Care review plan to DHEW, funds will not be available for this important component of the PSRO review system undil fiscal year 1981.

PREADMISSION CERTIFICATION FOR ELECTIVE PROCEDURES

An experimental pre-admission certificatopni program has been tested in several area hospitals with good results. The program is being extended to all hospitals in New York County. It is anticipated that the impelementation of this program will reduce unnecessary admissions for questionable elective surgical procedures.

CHANGES IN HOSPITAL UTILIZATION SINCE PSRO IMPLEMENTATION

This presentation would be incomplete if it did not include reference to changes in hospital utilization since the initiation of PSRO review in area hospitals. However, due to the absence of complete and reliable baseline data, the analysis of utilization trends must be circumspect. Furthermore, it is to be recognized that other factors may have accounted for some of the changes observed in New York County since July, 1975.

Nothwithstanding these limitations and qualifications, it is apparent that improvements have occurred. While it is not our intent to attribute all of them to PSRO review, it can be noted that the PSRO's presence marked the beginning of, and has been directly correlated with, the reversal of certain trends in hospital utilization and facility expansion.

For example, since NYCHSRO's designation as the PSRO for Manhattan (New York County)

The rate of Medicare discharges per 1,000 enrollees has increased, as has the national rate, but has remained substantially below the national average (see figure 1)

The average length of stay has declined markedly for Medicare beneficiaries from 17.7 days in 1976, when the NYCHSRO program implementation reached 15 percent to 16.2 days in 1977 when it reached 50 percent (figure 2)

Medicare days of care per 1,000 population (adjusted for patient migration) has declined, falling below the 1974 rate and reversing the annual upward trend before PSRO implementation reached the 50 percent mark (see figure 3)

Twelve of New York County's 40 hospitals (or 30 percent) closed, removing over 1,500 beds from an area judged by most planning groups to be overbedded.

The actual number of days of care paid for under Medicare program in 1977 (in non-municipal hospitals) was more than 70,000 days less than in 1976, representing a decline of almost 4.5 percent and a reversal of the steady upward trend for the previous five years. (See table 1)

One of the problems NYCHSRO has identified in implementing the PSRO program, has been the disparity between delegated and non-delegated hospitals. For example, of the 15,600 days denied through adverse determinations made in 1978, the year for which these data are most complets, three quarters of the denials were rendered in non-delegated hospitals where NYCHSRO staff conducted all concurrent review functions directly.

As a consequence, the utilization impact of PSRO review has been markedly greater in non-delegated hospitals under review than in delegated hospitals.

Specifically, for the 10 non-delegated hospitals (excluding municipals) there was a decline in 1978 of approximately 40,000 days of care (representing 11.6 percent), while for the delegated hospitals there was actually an increase of approximately 7,794 days of care or 0. 7 percent (See tables 2 and 3).

It is important to note here that NYCHSRO has called two of the delegeted hospitals to task on their poor performance (requiring implementaion of corrective actions) and has suspended delegation in the case of a third.

NYCHSRO AND THE NEW YORK STATE MEDICAID PROGRAM

Regarding the relationship between NYCHSRO and the Title XIX (Medicaid) Agency in New York, the State's posture historically has varied from hostility at the beginning to reluctant accommodation more recently.

As PSROs in New York State began implementing their review programs, the State, citing major financial difficulties, promulgated legislation (chapter 76 and Chapter 77) which authorized a conflicting review system requiring technical utilization controls aimed mainly at reducing Medicaid patient days. Sometimes these controls were without any regard to prudent medical management or to the medical needs of the patients.

Ironically, in a special New York City Comptroller's audit (requested by NYCHSRO) is was found that PSRO review decisions appearing on Medicaid hospital bills were being ignored by the Medicaid claims payment agency. As a result, an estimated $11 million in reimbursement to hospitals had been made for patient days denied by PSROs as medically unnecessary.

The confusion this conflict generated among institutions, physicians and patients was so great that it took an Act of Congress (Public Law 95-142, originating in this Committee) to induce the State Medicaid Agency to negotiate a Memorandum of Understanding (MOU) with the PSROs wherein the State would (a) accept PSRO determinations as binding for payment purposes and (b) limit its activity to monitoring the PSROs' performance.

However, the New York State Medicaid Agency, after protracted negotiations, insisted that the MOU would not be signed unless the PSROs also agreed to participate in a special Demonstration Project. This Project called for the State's review system to continue in over 50 hospitals located in five PSRO areas (four of which were located in New York City) for a two-year period. During this time a comparison would be made between the State's on-site system and the federal PSRO review system, based on review in a "matched" set of hospitals.

The PSRO's, eager to resolve the conflict, and pressured by DHEW not-withstanding its own general counsel's opinion that the legality of such a demonstration project was in doubt, agree to withdraw its reviewers from the State-assigned hospitals and to participate in this contest which began in February, 1979. Last week, in response to a lawsuit brought by the Greater New York Hospital Association (GNYHA), a federal district court enjoined the demonstration project on the grounds that it violated the provisions of the Social Security Act with respect to PSRO review activities.

Today, confusion reigns, once again, as the hospitals and the PSROs unexpectedly find themselves responsible for Medicaid reviews. Neither the hospitals nor the PSROs have staff immediately available for this purpose. More importantly, DHEW has not set aside funds for such review functions since it was assumed that the State would incur all the costs associated with the review of Medicaid admissions to these demonstration hospitals.

To illustrate, on Monday an urgent call was received from the Adminstrator of Bellevue Hospital (a 1,248 bed municipal hospital with 18,691 annual federal discharges) advising us that the 6 member on-site State review staff would be removed within twenty-four (24) hours. Therefore, the Hospital would have to assume review functions in order to certify the Medicaid bills and not impede the cash flow needed for the continued operation of the Hospital.

Finally, the State has been monitoring the PSRO's performance in area hospitals not included in the Project. The preliminary results indicate that the State apparently expects the PSRO to promptly resolve longstanding quality issues which the State itself has been attempting to resolve (unsuccessfully) since 1965, when Article 28 of the Laws of New York State was enacted to address such problems. This approach by the State should be abandoned because it will only impede improvement in the State-PSRO relationship without providing any benefit to anyone (patients, hospitals, the State agencies or the PSRO's).

OBJECTIVES YET TO BE REACHED AND OBSTACLES FACED BY THE PSRO

Despite NYCHSRO's achievements in controlling utilization and improving the quality of care in New York County, there remain formidable problems to be resolved and obstacles which may impede NYCHSRO's ability to continue to perform effectively.

The following utilization problems still require vigorous PSRO review in acute care hospitals:

NYCHSRO ranks fourth among all PSROs with an average length of stay (ALOS) for Medicare patients of 16.2 days.

NYCHSRO ranks high among reporting PSRO's with a Medicaid ALOS of 9.7 days.

In eight out of eighteen selected diagnoses, NYCHSRO shows an ALOS 20 percent above the nation.

Clearly, these are urgent problems which must be addressed. However, the negotiated budget for NYCHSRO for the upcoming fiscal year has been reduced substantially, raising serious doubts as to whether NYCHSRO will be able to control and reduce identified inappropriate utilization patterns.

To illustrate this point, the last three hospitals to be brought under the PSRO review system in New York County are municipals which, based on the NYCHSRO assessment, will most likely need more attention than can be provided under current budgeting constraints.

Moreover, despite the substantial difference between delegated and non-delegated hospitals in terms of utilization impact, NYCHSRO will be required to reduce its monitoring efforts. It is anticipated that NYCHSRO will no longer be in a position to promptly suspend or remove delegation, when indicated (as it has done in the past) because of the caps imposed on concurrent review costs.

In addition to utilization problems to be addressed, there is a great desire to undertake review in long term care facilities and in hospital outpatient departments and emergency rooms. However, as mentioned earlier, there are no funds available for these important programs to be undertaken in New York County at this time.

Despite these limits, NYCHSRO remains a substantial organization with a strong commitment from the physician community to assure that necessary care is provided to patients served in New York County and that the care provided in our area meets professionally recognized quality standards.

Mr. Chairman, that concludes NYCHSRO's prepared testimony before this Subcommittee. We thank you for this opportunity and will be pleased to answer any questions you or the members of your Subcommittee may have.

ATTACHMENT I.—NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION

POLICY MEDICALLY UNNECESSARY AVOIDABLE DAYS OF HOSPITALIZATION—PHASE I, SEPTEMBER 1, 1979

Background

Public Law 92-603 clearly mandates local physicians, through their PSRO review system, to make determinations as to whether hospital days of stay are or were medically necessary and appropriate before certification can be made for payment purposes under the Medicare/Medicaid programs. Medically unnecessary hospital days may occur at any point during an otherwise necessary hospitalization. Although a PSRO certifies the necessity for admission to a hospital, such admission (and continued stay) certifications assume that the period of the stay assigned by the PSRO will only cover days of stay which are medically necessary and appropriate at the acute level of care. PSROs, therefore, may *not* certify one or more days of stay during an otherwise certified period, if the(se) day(s) were not medically necessary and could reasonably have been avoided.

During the summer of 1977, New York County Health Services Review Organization (NYCHSRO) identified problems in various hospitals relating to medically unnecessary avoidable days which were being certified during the concurrent review process. The extent of this problem has been confirmed by the Medicare Fiscal Intermediary (FI) in its monitoring of PSRO performance during the past year and New York County hospitals have been informed regarding these findings.

In November, 1977, a Department of Health, Education, and Welfare (DHEW) PSRO Project Assessment Team conducted an intensive evaluation of NYCHSRO's performance. Among other things, the DHEW Project Assessment Team advised NYCHSRO to proceed with a mechanism to deny PSRO certification of medically unnecessary and avoidable days of hospital stay by a "carve out" method.

Both the DHEW Project Assessment Team's recommendation, and NYCHSRO's experience with an educational carve-out procedure in non-delegated hospitals, prompted NYCHSRO's Board of Directors, early in 1978, to review the approach of utilizing a carve-out mechanism with fiscal impact. The NYCHSRO Board of Directors decided to solicit the area hospitals' opinions on the matter, and on March 6, 1978, a letter was sent to the Chief Executive Officer (CEO) of each Manhattan hospital inviting comments. NYCHSRO received ten letters of response from area hospitals. Most indicated that their policies were in consonance with the objectives of the carve-out mechanism. A few indicated a preference for an educational approach to one with fiscal impact.

Based upon these responses, the NYCHSRO Board of Directors, at its June 19, 1978 meeting, established an ad-hoc Physician Advisor Subcommittee to develop guidelines for the implementation of a carve-out mechanism to deny federal payment for medically unnecessary and avoidable hospital days. The Physician Advisor Subcommittee presented its proposed guidelines to NYCHSRO's Hospital Review Committee on August 2, 1978. The Hospital Review Committee accepted those guidelines and recommended that they be circulated to the Manhattan hospitals for their comments and recommendations.

On August 4, 1978, NYCHSRO sent these guidelines to all Manhattan hospitals as well as to the Greater New York Hospital Association (GNYHA) requesting comments. The written responses received from GNYHA and individual hospitals were unanimous in acknowledging the existence of medically unnecessary and avoidable days and supporting the concept of correction through a carve-out mechanism.

Many of the hospitals' observations contributed to the refinement of the NYCHSRO carve-out guidelines and significantly influenced the approach to their implementation which was approved by NYCHSRO's Board of Directors on August 21, 1978.

Implementation

NYCHSRO's carve-out program will be implemented in a phase-in approach, beginning on October 1, 1978, based on well known problems documented by the

PSRO review system. Phase I will include the following carve-out review with fiscal impact:

1. All hospitals will be expected to review and carve-out days of pre-operative stay for patients admitted on a Friday or Saturday for elective surgery scheduled for the following week when it is determined that the pre-operative (diagnostic) services could have been rendered in fewer days.

2. All hospitals must review and deny "pass days" for which no medical justification can be documented.

3. Those hospitals for which NYCHSRO profiles for the calendar year 1977 indicate an average pre-operative stay greater than the NYCHSRO areawide norm will be required to implement carve-out review for all elective pre-operative days of stay.

These hospitals will receive computer-generated reports shortly which will assist them in reviewing their high pre-operative lengths of stay.

All hospitals in New York County will be expected to perform the remaining carve-out reviews (see guidelines below) without fiscal penalty (except as noted above) for the purpose of educating the hospital's administrative and medical staffs regarding this matter. Several hospitals have already been conducting such educational reviews, and some have reported progress in the amelioration of this problem. Through these means, each hospital will be able to identify specific problem patterns within the institution.

The next phase(s) of NYCHSRO's carve-out program will be described in subsequent communications to the hospitals. It should be noted that NYCHSRO intends to refine these policies through the analysis of specific patterns, by hospital, to identify problems needing solutions.

In conjunction with the above, NYCHSRO is also developing a mechanism for pre-admission certification for selected elective surgical procedures. A confirmed operating room date will be part of the criteria for admission.

Carve-out review procedure

In the course of the concurrent review process, a nurse review coordinator may identify a specific day or group of days within a previously assigned length of stay period which appears to have been medically unnecessary and avoidable. The nurse review coordinator must refer this case to a Physician Advisor (PA). If the PA determines, based upon a review of the clinical record, that the day(s) in question were medically unecessary and the avoidance of the(se) day(s) could reasonably be expected to have been within the control of the responsible physician of record and/or the hospital, an adverse determination should be rendered. In essence, the specific day(s) are "carved-out" from the patient's hospital stay. Such a denial should not be construed as affecting the entire hospitalization nor as a disapproval of an extension of the current stay.

Notification of an adverse determination rendered for medically unnecessary and avoidable days must be sent to the patient, physician, hospital, and fiscal agent or intermediary. Since medically unnecessary and avoidable days fall within the responsibility of the physician or the hospital, the patient cannot be held financially liable for these days, and must be so informed in the notification sent to him/her. (However, if a patient refuses treatment, and such refusal is clearly documented in the medical record, and the patient is informed that his/her refusal may lead to fiscal liability, then the patient may be held liable.) Carve-out denials must be documented on the appropriate Medicare billing sticker or Medicaid billing form. A copy of the adverse determination letter should also be attached to the billing form(s).

Guidelines for identifying potential medically unnecessary avoidable days

The following guidelines address some of those situations that would constitute medically unnecessary avoidable days.

1. A prolonged pre-operative stay has occurred without sufficient reason documenting the cause for delay prior to surgery. Particular attention should be directed to patients who are admitted on Friday or Saturday for elective procedures.

2. Any pass situation where the patient leaves the acute care facility for non-medical reasons.

3. An unnecessary delay has been noted in scheduling diagnostic and/or therapeutic procedures, or booking operating room time.

4. An unnecessary delay has been identified in the performance of diagnostic and/or therapeutic procedures.

5. An unnecessary delay has been noted in the reporting of diagnostic test results.

6. A delay in initiating treatment has taken place due to an unreasonable delay in the repair of broken equipment.

7. The patient has developed an illness or condition not requiring the acute level of care, but remains hospitalized until surgical procedures are performed.
8. The performance of an elective procedure is delayed by previously diagnosed medical conditions which could have been treated on an out-patient basis.
9. The absence on the patient's chart of weekly documentation indicating aggressive attempts to place the patient at an appropriate alternate level of care. (An alternate level of care is defined as any level of care where certain skilled services or items may be rendered in other than an acute hospital setting, i.e., Skilled Nursing Facility (SNF), Health Related Facility (HRF), Intermediate Care Facility (ICF), and Home Care Program (HCP).

Carve-out guidelines for physician advisors

In reviewing any questioned day or group of days, the Physician Advisor (PA) must determine whether the period of time referred was medically necessary and appropriate and whether the delay was avoidable. To evaluate this type of situation, implicit rather than explicit criteria must be utilized. Existing criteria sets address indications for admission and extension of the initial stay. Intervening circumstances are not reflected and therefore professional judgement is necessary.

Whe determining medical necessity and avoidability, the PA will evaluate the following in each case:

1. The overall status and condition of the individual patient.
2. The feasibility of having certain procedures or workups performed on an outpatient basis.
3. The extent and basis of any delays.
4. The appropriateness in scheduling the admission, diagnostic and/or therapeutic procedures.
5. The time period expended in obtaining test results, consultations, etc.
6. Documentation reflecting attempts to expedite the administration of items or services.
7. The need for an acute level of care during the specified time period.
8. The medical necessity for hospitalization for all days within referred periods.

The Physician Advisor (PA) must weigh all the attendant circumstances in arriving at a medical judgement that (1) the days in question are or were medically unnecessary, and (2) the avoidance of these days could reasonably be expected to be within the control of the responsible physician of record and/or the hospital.

NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION

POLICY MEDICALLY UNNECESSARY AVOIDABLE DAYS OF HOSPITALIZATION, PHASE II—FEBRUARY 1, 1979

NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION,
New York, N.Y., December 28, 1978.

Recently, New York County Health Services Review Organization (NYCHSRO) solicited comments from Manhattan hospitals concerning Phase II of its policy on medically unnecessary, avoidable days. The comments received were considered carefully. (Individual responses to issues raised by specific hospitals are being sent to them under separate cover.)

Commencement of Phase II of NYCHSRO's policy, originally scheduled to begin January 15, 1979, has been re-scheduled for February 1, 1979 in all hospitals. This policy will extend fiscal impact to all types of days which are medically unnecessary and avoidable (See attachments). In addition, NYCHSRO is planning a phased-in preadmission certification program for selected, elective surgical procedures pursuant to an agreement with the New York State Department of Health.

Several hospitals have expressed the concern that, given the prevalence of such medically unnecessary, avoidable days in their respective institutions, denial of payment for these days could result in a substantial adverse effect on their financial viability. Accordingly, NYCHSRO will review hospital-submitted proposals which (1) identify specific problem areas (e.g., inadequate equipment, scheduling delays, etc.), (2) specify corrective actions planned, and (3) provide a detailed timetable for implementation and completion of such plan(s). If NYCHSRO finds the Hospital's plan acceptable, then fiscal impact of carved out, medically unnecessary, avoidable days may be suspended as long as the Hospital implements its corrective action plan according to the approved timetable.

If you have any questions, please feel free to get in touch with me.

Sincerely,

ELEANORE ROTHENBERG, PH. D.,
Executive Director.

GUIDELINES FOR IDENTIFYING POTENTIAL MEDICALLY UNNECESSARY AVOIDABLE DAYS

The following guidelines address some of those situations that would constitute medically unnecessary avoidable days.

1. A prolonged pre-operative stay has occurred without sufficient reason documenting the cause for delay prior to surgery. Particular attention should be directed to patients who are admitted on Friday or Saturday for elective procedures. (Abstract Denial Reason Code No. 07)
2. Any pass situation where the patient leaves the acute care facility for non-medical reasons.[1] (Abstract Denial Reason Code No. 08)
3. An unnecessary delay has been noted in scheduling diagnostic and/or therapeutic procedures, or booking operating room time. (Abstract Denial Reason Code No. 09)
4. An unnecessary delay has been identified in the performance of diagnostic and/or therapeutic procedures. (Abstract Denial Reason Code No. 10)
5. An unnecessary delay has been noted in the reporting of diagnostic test results. (Abstract Denial Reason Code No. 11)
6. A delay in initiating treatment has taken place due to an unreasonable delay in the repair of broken equipment. (Abstract Denial Reason Code No. 12)
7. The patient has developed an illness or condition not requiring the acute level of care, but remains hospitalized until surgical procedures are performed. (Abstract Denial Reason Code No. 13)
8. The performance of an elective procedure is delayed by previously diagnosed medical conditions which could have been treated on an out-patient basis. (Abstract Denial Reason Code No. 14)
9. The absence on the patient's chart of weekly documentation indicating aggressive attempts to place the patient at an appropriate alternate level of care. (An alternate level of care is defined as any level of care where certain skilled services or items may be rendered in other than an acute hospital setting, i.e., Skilled Nursing Facility (SNF), Health Related Facility (HRF), Intermediate Care Facility (ICF), and Home Care Program (HCP). (Abstract Denial Reason Code No. 15)
10. An unnecessary delay has been noted in responding to consultation requests. (Abstract Denial Reason Code No. 16)

CARVE-OUT GUIDELINES FOR PHYSICIAN ADVISORS

In reviewing any questioned day or group of days, the Physician Advisor (PA) must determine whether the period of time referred was medically necessary and appropriate and whether the delay was avoidable. To evaluate this type of situation, implicit rather than explicit criteria must be utilized. Existing criteria sets address indications for admission and extension of the initial stay. Intervening circumstances are not reflected and therefore professional judgment is necessary.

When determining medical necessity and avoidability, the PA will evaluate the following in each case:

1. The overall status and condition of the individual patient.
2. The feasibility of having certain procedures or workups performed on an outpatient basis.
3. The extent and basis of any delays.
4. The appropriateness in scheduling the admission, diagnostic and/or therapeutic procedures.
5. The time period expended in obtaining test results, consultations, etc.
6. Documentation reflecting attempts to expedite the administration of items or services.
7. The need for an acute level of care during the specified time period.
8. The medical necessity for hospitalization for all days within referred periods.

The Physician Advisor (PA) must weigh all the attendant circumstances in arriving at a medical judgment that (1) the days in question are or were medically unnecessary, and (2) the avoidance of these days could reasonably be expected to be within the control of the responsible physician of record and/or the hospital.

NEW YORK COUNTY HEALTH SERVICES REVIEW ORGANIZATION (NYCHSRO)—KEY CHRONOLOGY OF NYCHSRO'S SHARED HEALTH FACILITY (SHF) REVIEW PROGRAM

FALL 1976

Almost simultaneous with the release of the U.S. Senate Committee on Aging's Report on Fraud and Abuse in Medicaid mills, NYCHSRO was contacted by a

[1] Approval of pass days is predicted upon consistency with the medicare and medicaid coverability policies.

Senior Staff member of the Senate Finance Committee to determine NYCHSRO's interest in reviewing such facilities. Senator Moss's report was explicit in his condemnation of the ghetto-based clinics which were flourishing at that time in New York City with relatively little monitoring or control of utilization and quality. NYCHSRO quickly accepted the challenge to expand into the ambulatory care sector and to participate in the intervention of a potentially hazardous and fraudulent medical practice area.

Based on NYCHSRO's recommendations, legislation expanding PSRO review to cover Medicaid mills (known as shared health facilities) was developed and introduced by Senator Herman Talmadge and incorporated in the Fraud and Abuse legislation which was enacted in 1977 as Public Law 95-142.

LATE 1976 TO EARLY 1977

NYCHSRO proceeded to explore the background of shared health facilities and examine previous New York City and State agency experiences in monitoring these facilities. In February of 1977, NYCHSRO established an Ambulatory Care Review Committee composed of medical experts in ambulatory care, quality assurance, and the Medicaid system (chaired by Doctor Lowell Bellin, former Commissioner of Health, N.Y.C.). Their participation was instrumental in the approval by HEW of a project planning and development contract. These additional monies enabled NYCHSRO to hire Joseph Stamm, M.P.A., to direct the shared health facility review program.

SUMMER/FALL 1977

NYCHSRO concluded a thorough assessment of the shared health facilities in New York County and conceptualized a program for review in these facilities. A formal proposal to HEW requesting permission to conduct on-site reviews was submitted in October 1977, with full support of NYCHSRO's Ambulatory Care Review Committee, Board of Directors, and Executive Staff. It is important to note that NYCHSRO's philosophy throughout its shared health facility review efforts was to create a review program which would be applicable to a variety of ambulatory care settings including OPD and ERs in hospitals in order to assure comparable standards of care throughout the health care system.

APRIL 1978 TO PRESENT

NYCHSRO's shared health facility review proposal was approved on April 26, 1978. Review and administrative staff were recruited by May 15, 1978 and participated in a thorough orientation to the shared health facilities program. Physical facility and record review tools were tested, revised and reached final form by the end of June.

Assessment of 107 suspected shared health facility sites was necessary before the reviews could be initiated. In July, 1978 review staffs entered facilities throughout New York County to implement the review system.

Initial baseline reviews were completed early in 1979, at which time reaudits for impact and compliance were scheduled. Reaudits will be completed by October 1, 1979 in preparation for the new fiscal year. Outcome reviews of adult hypertension and diabetes, and for pediatric tonsillitis and pharyngitis have been developed and implemented in conjunction with these audits.

Concerns have been raised by legal counsel about a potential conflict with PSRO confidentiality legislations if NYCHSRO continues to communicate review findings to facility administrators. NYCHSRO therefore forwarded a proposed amendment to the Senate Finance Committee in July, 1979. The amendment reads:

RECOMMENDED AMENDMENT TO PUBLIC LAW 95-142

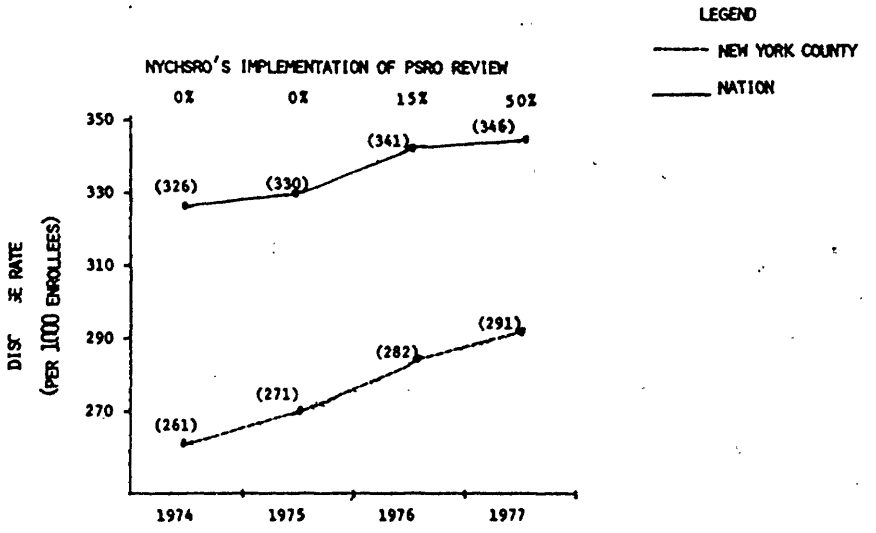
Insert new Section 1155(g)(2).

Where a PSRO has been designated responsibility for the review of services rendered in a shared health facility, the person identified by the PSRO as administratively responsible within the shared health facility, as specified in Section 1101(a)(9)(C), shall be accountable for the quality of care rendered therein. The PSRO shall communicate to such person its findings regarding the quality and necessity of health services provided within the shared health facility.

Renumber current Section 1155(g)(2) to become 1155(g)(3).

FIGURE 1

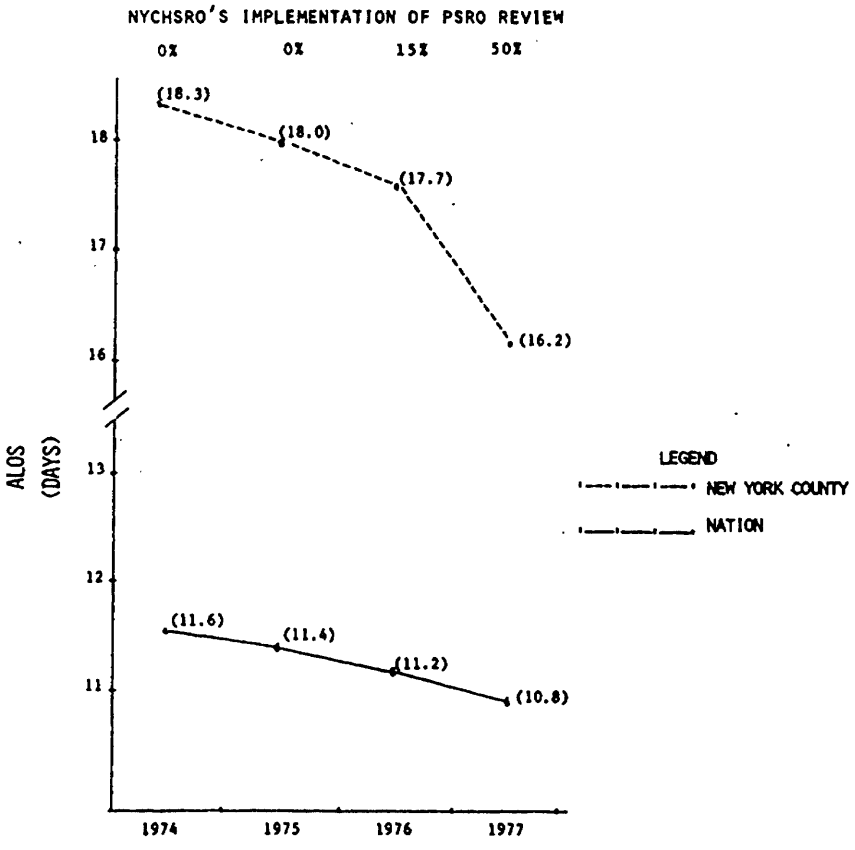
DISCHARGE RATES
FOR MEDICARE BENEFICIARIES
AGED 65 AND OVER
1974-77



SOURCE: HEALTH CARE FINANCING REVIEW/SUMMER 1979, HHS

FIGURE 2

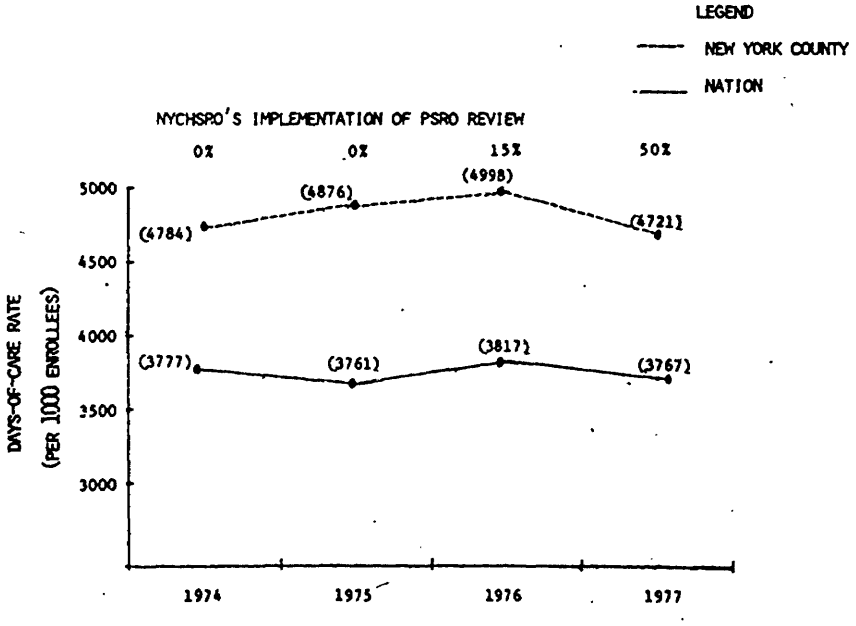
AVERAGE LENGTH OF STAY
FOR MEDICARE BENEFICIARIES
AGED 65 AND OVER
1974-77



SOURCE: HEALTH CARE FINANCING REVIEW/SUMMER 1979, DHEW

FIGURE 3

DAYS-OF-CARE RATES
FOR MEDICARE BENEFICIARIES
AGED 65 AND OVER
1974-77



SOURCE: HEALTH CARE FINANCING REVIEW/SUMMER 1979, DHEW

TABLE 1

MEDICARE PATIENT DAYS

(IN THOUSANDS)

NEW YORK COUNTY HOSPITALS (EXCLUDING MUNICIPALS)

1972 - 1977

	1972	1973	1974	1975	1976	1977
TOTAL DAYS	1,369.8	1,416.1	1,526.6	1,564.0	1,608.3	1,536.0
		Δ 1972/73	Δ 1973/74	Δ 1974/75	Δ 1975/76	Δ 1976/77
OBSERVED CHANGE		+3.3%	+7.8%	+2.4%	+2.8%	-4.5%

SOURCE: DHEW, MEDICARE BUREAU

TABLE 2

MEDICARE PATIENT DAYS
DELEGATED HOSPITALS UNDER BINDING REVIEW
1977 - 1978

Hospital	1977	1978*	△ 1977-78 N	%
214	104,969	107,169	+ 2,200	+ 2.1
202	48,726	46,628	- 2,134	- 4.4
237	92,408	95,676	+ 3,268	+ 3.5
204	85,904	93,326	+ 7,424	+ 8.6
219	54,674	50,166	- 4,508	- 8.2
206	43,187	43,353	+ 166	+ 0.4
225	26,788	26,114	- 674	- 2.5
227	80,052	82,801	+ 2,749	+ 3.4
205	74,826	71,705	- 3,121	- 4.2
235	87,159	89,816	+ 2,657	+ 3.0
236	83,919	85,923	+ 2,004	+ 2.4
212	21,807	22,048	+ 241	+ 1.1
233	64,659	68,239	+ 3,580	+ 5.5
231	135,123	103,522	- 4,601	- 3.4
221	4,324	962	- 3,362	-77.8
213	31,929	33,837	+ 1,908	+ 5.9
Total	1,040,491	1,048,285	+ 7,794	+ 0.7

*Includes only those claims processed through May, 1979

Source: DHEW, Medicare Bureau

TABLE 3

MEDICARE PATIENT DAYS
NON-DELEGATED HOSPITALS UNDER BINDING REVIEW
1977 - 1978

Hospital	1977	1978*	△ 1977-78 N	%
232	87	N.A.		
201	19,914	11,181	- 8,733	-43.9
226**	43,557	20,645	-22,912	-52.6
211	33,196	30,552	- 2,644	- 8.6
217	17,270	16,714	- 556	- 3.2
224	19,993	17,593	- 2,400	-12.0
209	50,830	49,517	- 1,313	- 2.6
215	12,913	12,623	- 290	- 2.3
218	7,899	7,417	- 482	- 6.1
222***	148,521	146,860	- 1,661	- 1.1
Total	354,180	313,102	-41,078	-11.6

* Includes only those claims processed through May, 1979

** Hospital closed in October, 1978

*** Delegation withdrawn in June, 1978

Source: DHEW, Medicare Bureau

Senator TALMADGE. Doctor, do you have any comparative data on the effectiveness of delegated versus nondelegated review?

Dr. ROTHENBERG. I would refer you to the tables following my prepared statement.

Senator TALMADGE. Would you submit that for the record?

Dr. ROTHENBERG. That is submitted for the record.

Specifically, under nondelegated review, in the 10 hospitals for which there are enough data for the period studied, there were at least 40,000 days reduced under the medicare program, representing 11.6 percent. Under the delegated hospitals, there was actually an increase in the aggregate of medicare days paid for. I think that answers your question.

Senator TALMADGE. It does.

How can HEW assure the Congress that a delegated hospital is effectively carrying out the review process?

Dr. ROTHENBERG. There are two methods of accountability: One is a monitoring program that is being carried out under the medicare program that I believe was written into the initial legislation.

In our experience, that monitoring program has worked quite effectively, with the medicare fiscal intermediary doing a sample review of our delegated hospitals and giving us information about what they believe to be the performance. That is, in addition to our own monitoring; and I must say, most of the questioned cases are found in our delegated hospitals.

The monitoring with respect to the State agency is another matter.

(Please see our prepared statement regarding PSRO/State agency relationships).

HEW should provide PSROs that find their delegated hospitals not performing—which can be verified through the medicare fiscal intermediary monitoring—supplemental funds which would allow PSRO's to withdraw delegation and bring their own teams in when they felt that was necessary.

Senator TALMADGE. Thank you very much, Dr. Pierson and Dr. Rothenberg. I think you both have made a very fine contribution to the committee's deliberations.

STATEMENT OF BEVERLEE A. MYERS, DIRECTOR, STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES, SACRAMENTO, CALIF.

Senator TALMADGE. The next witness is Beverlee A. Myers, director, State of California Department of Health Services, Sacramento, Calif.

Dr. Myers, we are happy to have you with us. If you will submit your full statement for the record and summarize, we would be grateful.

Ms. MYERS. Thank you.

My name is Beverlee Myers and I am director of the California State Department of Health Services, which is the single State agency for title 19 and for title V in the State of California, and I have submitted the full statement and will summarize it.

Ms. MYERS. I think our experience in California with PSRO's indicates what you, Mr. Chairman, said when you first announced these hearings, that some perform quite well. And you have heard

from one of those from California yesterday, area 23. And some PSRO's have a long way to go.

What I would like to do is outline California's experience in utilization review, describe the dimensions of the State PSRO relationships, discuss some of the major problem areas and conclude with some specific recommendations.

California's experience with many different kinds of utilization: We reviewed systems for our Medi-Cal clients, which is Medicaid in the State of California. The majority of our 600,000 MediCal hospital admissions come under a State-operated system which has been in operation since 1972, under a superior method waiver from HEW. Briefly, it provides for preadmission review of 100 percent of elective admissions by State-employed nurses and physicians, provides for onsite concurrent review in hospitals by nurses, and retroactive surveillance and utilization review using profile analysis, audits, et cetera.

A recent evaluation of the State's hospital preadmission review part of this system showed that for every $1 invested in it, an average of $8 was saved.

We prevented through that system 6 percent of proposed elective admissions, which presumably would have been unnecessary, and saved on the average a range of from $13 million to $20 million of Federal and State funds in a year; and that does not count the deterrent effect which might be two or three times greater.

There is no evidence that necessary hospital stays or the quality of care has been compromised by this system. With that kind of performance, perhaps you can understand California's reluctance to plunge headlong into turning over to private organizations these decisions on hospital utilization and expenditures.

STATE-PSRO RELATIONSHIPS

There are 27 PSRO's in California. We have 12 memorandums of understanding granting binding review, which cover about 180,000 Medi-Cal admissions or about 30 percent. HEW believes we are moving too slowly. But the State was unwilling to move very rapidly until we had an approved monitoring plan, on which we finally reached agreement with HEW a few months ago, and the details of that are in the statement.

I would be happy to provide for the record a complete copy of our monitoring plan.

[The monitoring plan referred to follows:]

ATTACHMENT 1.—CALIFORNIA STATE MEDICAID AGENCY STANDARD MONITORING PLAN FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATION REVIEW OF TITLE XIX, ACUTE INPATIENT HOSPITAL SERVICES, MAY 1979

I. INTRODUCTION

A. California State medicaid agency responsibility

The California State Medicaid Agency (State) has the responsibility for administering California's Medicaid program. Part of that responsibility is to evaluate the effectiveness of Professional Standards Review Organizations (PSROs) in performing utilization review of Medicaid services.

B. Monitoring plan purpose

This monitoring plan is designed to produce reasonable documentation of PSRO impact by detecting and documenting PSRO review practices that have detrimental impact on total state expenditures and on the appropriateness of medical care delivered under California's Medicaid program.

II. DEFINITIONS

A. Appropriateness of care

Under this plan, appropriateness of care refers to the medical necessity for inpatient hospital care as determined in the exercise of reasonable limits of professional discretion. Inpatient hospital care is deemed to be appropriate only when and for such period as such services cannot, consistent with professionally recognized health care standards, be provided more effectively on an outpatient basis or in an inpatient health care facility of a different type.

B. Appropriateness/inappropriateness of PSRO review decisions

PSRO review decisions are determined to be appropriate when the evidence in the medical record indicates that there was medical necessity for the inpatient hospital stay. PSRO review decisions are determined to be inappropriate when the evidence in the medical record does not support the medical necessity for the acute inpatient hospital stay. (Inappropriate review decisions will be viewed as resulting in inappropriate care. The costs associated with inpatient hospital stays resulting from inappropriate review and certification decisions by the PSRO when extrapolated to the universe of certified days used, constitutes a detrimental impact on total state expenditures under Title XIX.)

III. MONITORING PROTOCOLS

A. The State will review a random sample of PSRO-approved hospital stays generating at least a 90 percent confidence level. This procedure enables the State to review a minimum number of hospital stays and still make statistically reliable judgments that apply to all of the hospital stays approved by the PSRO during the period being monitored.

B. Prior to each monitoring cycle, the State will notify the PSRO of:

1. Sample size.
2. Identity of hospitalizations being sampled.

C. PSROs will not be monitored more frequently than on a monthly basis.

D. Monitoring frequency and sample specifications will be determined by the State based on previous PSRO monitoring results. Acceptable monitoring results may result in less frequent monitorings and less rigorous sample specifications (confidence level and error interval). Unacceptable monitoring results may result in more frequent monitorings with higher confidence levels and smaller error intervals.

E. Attachment 1 is the statistical design and formulae to be used in the State's monitoring of PSROs.

F. The State will require PSROs to make available, upon request and without charge, copies of PSRO reports on rates of denial of services requested/provided, including the number of hospitalizations where the total stay was denied.

G. The maximum period for questioning a PSRO review decision for monitoring purposes shall be 18 months following patient discharge. However, for those PSROs which are monitored on an annual basis, it will be necessary to extend this maximum period to 24 months.

IV. MONITORING PROCESS

A. The PSRO will maintain a monthly listing of all Title XIX discharges occurring in hospitals under their jurisdiction. The discharge listing shall contain:

1. A unique identifier for each discharge which will enable PSRO retrieval of review coordinator work sheets, and
2. The number of PSRO-certified days used for each discharge and aggregated to a monthly total.

B. The PSRO shall send a copy of each monthly discharge listing to the State within 30 days after the close of each calendar quarter.

C. By using a "systematic" (selection of every nth element) random sampling technique, the State will select the sample of hospitalizations to be monitored.

D. The State will return the discharge lising to the PSRO indicating the hospitalizations to be monitored. The PSRO will have two weeks following receipt of the discharge listing to prepare for the State's initial review.

PSRO preparation would include pulling the review coordinator's work sheets for the selected hospitalizations.

E. After initially reviewing the medical documentation available at the PSRO office, the State will identify those hospitalizations which require review of additional medical documentation prior to rendering a decision.

F. The PSRO will obtain copies of the requested medical records and forward them to the State's monitoring personnel, preferably within 30 days after receipt of the request from the State. However, the State may perform the review of additional medical documentation on site at the hospital if the State determines that the records volume is large enough to make an on-site review cost beneficial. The PSRO will be invited to participate in any onsite visits.

G. For each hospitalization where the State's medical consultant does not find evidence to support the PSRO's review decision, the consultant will prepare a concise written rationale.

Under this plan, the reasonable limits of professional discretion will be defined for each hospitalization reviewed by the State's medical consultant applying professional medical judgment which will be augmented, but not limited, by state and/or PSRO written medical practice criteria.

H. Following the State's completion of its review of the sampled hospitalizations, the State will send the preliminary monitoring results to the PSRO and offer an opportunity for an exit conference to be held within the next 30 calendar days.

I. At the exit conference, the PSRO may discuss any or all of the hospital days determined to be inappropriate or unnecessary by the State. The PSRO may present evidence concerning disputed hospital days. This includes clinical information which may not have been in the medical record at the time of the State's review but was utilized by the PSRO in making its original decision. The State's medical consultant may revise his original decision if he has determined that the additional evidence merits a change. The PSRO may have physicians familiar with the disputed cases at the exit conference for advice and consultation.

J. The state medical consultant may decide at the exit conference to refer a case to a specialist for consultation.

K. The PSRO may within five calendar days following the exit conference submit disputed cases (including medical records documentation, PSRO justification, and state medical consultant rationale) to the California Statewide Professional Standards Review Council for an advisory review. (If the state medical consultant referred any cases for specialist review after the exit conference, the PSRO may submit all disputed case documentation to the Council within five calendar days after receipt of the specialist's determination and rationale.)

L. Additionally, the PSRO will have 15 calendar days from the date of the exit conference to submit written comments to the State. These comments could include a summary justification for each of the disputed hospitalizations and/or comments on the monitoring process.

M. After receipt and review of the PSRO's comments (if any) and the results of the Council's advisory review (if any), the State will prepare a final monitoring report. PSRO comments and the Council's report will always accompany the final monitoring report.

N. Upon completion of the final monitoring report, the State will send the report to the PSRO and the Federal Government and will, if necessary, request a plan for corrective action from the PSRO.

V. APPLICATION OF MONITORING PLAN RESULTS

A. Monitoring result

The monitoring result is determined by computing the difference if any, between the number of PSRO-certified days used and the number of days where the State found adequate and appropriate evidence to support the PSRO's decision. The number of days for which the State did not find adequate and appropriate evidence to support the PSRO's certification are considered disallowed days. These disallowed days will be divided by the total number of state-approved days in the sample. This quotient then becomes the monitoring result subject to application of the error interval.

Therefore, this plan measures the frequency (expressed in percentage terms) of inappropriate review decisions made by the PSRO during the monitoring period.

B. Error interval

Error interval is the specified interval that represents the margin of error for a sampling technique. The interval is usually expressed in terms of plus or minus a certain percentage point, for example, ±5 percent.

The error interval is a function of the variability between the PSRO and state review decisions. The variability of the elements under this plan would range from the smallest number of inappropriate days during a single hospitalization to the largest number of inappropriate days during a single hospitalization. Therefore, the error interval cannot be calculated until after the monitoring process is completed.

1. ERROR INTERVAL APPLICATION TO THE MONITORING RESULT

The State has established a two percent tolerance level as this monitoring plan's measurement of success.

Since the error interval is the margin of error for a sampling technique, the State will apply the error interval to the monitoring result by subtracting it from as well as adding it to the monitoring result.

If subtraction of the error interval from the monitoring result results in a remainder of two percent or less, the PSRO shall have met this plan's measurements of success. Conversely, if the remainder is greater than two percent, the PSRO shall have failed to meet this plan's measurements of success.

2. ERROR INTERVAL APPLICATION TO CALCULATION OF DETRIMENTAL FISCAL IMPACT

The detrimental fiscal impact of inappropriate PSRO review decisions will be estimated by determining the number of days in the total universe where the State would have found the PSRO's review decisions to be inappropriate.

For example, assume that in a random sample of hospitalizations, the number of PSRO-certified days used was 2,400 whereas the State determined that 2,160 of those PSRO-certified days were appropriate. Furthermore, assume that there were 72,000 PSRO-certified days were used in the total universe of hospitalizations under the PSRO's jurisdiction during the monitoring period.

Then the estimated difference in the total universe can be found by applying the proportion

$$\frac{2{,}400}{72{,}000} = \frac{2{,}400 - 2{,}160}{X}$$

and solving for X. In this example, the estimated days of difference in the total universe is 7,200 days.

Taking into account the error interval, the State will then estimate the range of days of difference in the total universe. The low end of the range is the result of subtrating the minus side of the error interval from the days of difference obtained in the aforementioned equation. The upper end of the range is the result of adding the plus side of the error interval to the days of difference obtained in the aforementioned equation. (Assuming that the error interval in the aforementioned equation is ±5 percent, then the estimated days of difference in the universe would range from 6,840 days to 7,560 days, i.e., 7,200 days minus 5 percent (360 days) and plus 5 percent.)

The State will then apply one-half [1] of the statewide average hospital room and board costs to both ends of the estimated range of days of difference.

(Assume that the statewide average room and board cost is $150 per day. Using the aforementioned example, the State will multiply both ends of the range of days of difference by $75 to arrive at an estimated detrimental fiscal impact of $513,000 to $567,000.)

C. Conditions for requesting suspension of a PSRO's review authority

The State may request the Federal Government to suspend a PSRO's binding review authority for Title XIX under the following conditions:

1. The PSRO exceeds the two percent tolerance level for three consecutive monitoring cycles, or

2. The PSRO exceeds the two percent tolerance level by more than eight percent for two consecutive monitoring cycles, or

---

[1] In recognition of the fact that a utilization review system does not have a direct impact on a hospital's fixed costs (the President's Council on Wage and Price Stability estimates that a hospital's fixed costs account for 40–60 percent of a hospital's bill), the State will use 50 percent of the daily room and board figure to represent the variable costs over which the PSRO has control.

3. The PSRO exceeds the two percent tolerance level for the average of a 12-month period.

The State will not request suspension of a PSRO's binding review authority unless the PSRO has performed binding review for at least six months.

D. Federal Government consideration of State request for PSRO suspension

1. The State considers the monitoring results generated in accordance with this federally approved plan to be reasonable documentation of a PSRO's impact on total state expenditures under Title XIX and on the appropriateness of care received by Title XIX patients.

2. If the Department of Health, Education, and Welfare Secretary does not consider the State's monitoring results to be reasonable documentation, he shall inform the State of

(a) The existing criteria used by the Secretary in determining whether the monitoring results constitute reasonable documentation, and

(b) How the State failed to meet this criteria.

3. In considering all available evidence, the Secretary shall not be constrained from accepting documentation from sources other than the State.

E. Monitoring plan succession

1. This monitoring plan supersedes previously approved state monitoring plans and shall apply to all California PSROs.

2. This monitoring plan shall be superseded by any state monitoring plan subsequently approved by the Federal Government.

Attachment 1

State of California — Department of Health Services

Memorandum

To : Bud Lee
Field Services Section
8/1618

Date : February 27, 1979

Subject: PSRO Monitoring

Via: John Keith
Center for Health Statistics

Telephone: ATSS ( )
( )

From : Office of Planning and Evaluation
9/777 5-7026

The statistical design and formulae to be used in our PSRO monitoring tests are presented below.

NOTATION

N = Number of claims in universe.

n = Number of claims in sample.

x_i = PSRO allowed days in the i^{th} claim of the sample.

y_i = DHS allowed days in the i^{th} claim of the sample.

$d_i = x_i - y_i$ = Discrepancy between PSRO and DHS allowed days in the i^{th} claim of the sample.

$x, y, d = \sum_{i=1}^{n} x_i, \sum_{i=1}^{n} y_i, \sum_{i=1}^{n} d_i$ = Corresponding totals found in the sample.

$\bar{x}, \bar{y}, \bar{d}$ = Corresponding averages per claim found in the sample.

$$s_d = \sqrt{\frac{\left[n\sum_{i=1}^{n} d_i^2 - \left(\sum_{i=1}^{n} d_i\right)^2\right](N-n)}{n(n-1)\cdot N}}$$ = Standard deviation of the discrepancies found in the sample.

$s_d/\sqrt{n}$ = Standard error of the mean of the discrepancies found in the sample.

$d/y = \hat{\lambda}$ = Discrepancy found in the sample expressed as a proportion of the DHS allowed days in the sample. In other words, the sample results of the proportion of excess PSRO allowed days to the number of days DHS determined to be appropriate.

A = Actual proportion of excess PSRO allowed days to the number of days DHS determined to be appropriate.

$r = |\hat{A} - A|$ = Absolute precision of $\hat{A}$.

t = Normal deviate. For a one-tailed test with a significance level of 0.05, t = 1.645. A t equal to 1.645 is also used for figuring upper and lower confidence limits at a 90 percent confidence level.

With this information in hand, a test can easily be made after a sample of claims has been pulled and a DHS medical consultant has reviewed them to determine how many days he determined to be appropriate. The formulation of the null hypothesis would be as follows:

H_o: The PSRO is allowing a percentage excess of no more than two percent of the number of days that DHS would have allowed. In other words, $A \leq 0.02$.

A suitable alternate hypothesis would be:

H_a: The PSRO is allowing a percentage excess of more than two percent of the number of days that DHS would have allowed. In other words, $A > 0.02$.

We will accept H_o if our sample estimate of A deviates by no more than 1.645 standard errors from 0.02. We will reject H_o and accept H_a if our sample estimate of A deviates by more than 1.645 standard errors from 0.02. Thus, it is simply a matter of computing t in the formula

$$t \frac{\bar{x}-\bar{y}-0.02\bar{y}}{s_d/\sqrt{n}} = \frac{A-0.02}{s_d/\bar{y}\sqrt{n}}$$

to see whether or not t exceeds the normal deviate of 1.645, which corresponds to the significance level (0.05) of our tests. A significance level of 0.05 means that there is a 5 percent chance of rejecting H_o when it is actually true.

Precision requirements may be stated at any desired confidence level. A precision level of r at the 90 percent confidence level means

$$\text{Probability}\left(|\hat{A} - A| \leq r\right) = 0.90$$

To compute a sample size n given a precision requirement r at a confidence level of 90 percent, the formulae are

$$n^* = \left(\frac{1.645S}{r\bar{y}}\right)^2 \quad \text{where} \quad S = \sqrt{\frac{n\sum_{i=1}^{n} d_i^2 - \left(\sum_{i=1}^{n} d_i\right)^2}{n(n-1)}}$$

$$n = \frac{n^*}{1 + \frac{n^*}{N}}$$

How precise our estimates should be is simply a matter of how much of an excess we are willing to allow a PSRO to have and still pass our monitoring tests. A precision level of 0.04 means that a PSRO will pass a test if it had a sample excess rate of no more than 6 percent. Similarly, a precision level of 0.12 means that a PSRO will pass a test as long as the excess rate found in the sample does not exceed 14 percent. The less efficient a PSRO is operating, the less precise our estimate of its excess rate needs to be for us to demonstrate that it is not meeting the minimum requirements that you demand. For example, if we were to find from a sample that a PSRO has an excess rate of 19.5 percent, our estimate of 0.195 need only be precise within an absolute value of 0.174 to demonstrate with 95 percent certainty that the PSRO is allowing an excess of over 2 percent than that of which DHS determined to be appropriate. But suppose from another sample we were to find that another PSRO has an excess rate of 2.1 percent. The precision requirement would need to be less than 0.001 for us to show that the PSRO is not meeting the 2.0 percent minimum requirement.

In determining the upper and lower confidence limits of the PSRO excess rate at a 90 percent confidence level, the formula

$$\hat{\lambda} + \frac{1.645s_d}{\bar{y}\sqrt{n}}$$

is used to determine the upper limit, and

$$\hat{\lambda} - \frac{1.645s_d}{\bar{y}\sqrt{n}}$$

is used to determine the lower limit. Thus, the error interval surrounding the estimate is

$$\pm \frac{1.645s_d}{\bar{y}\sqrt{n}}$$

The formulae for s_d and n can be simplified by dropping the finite population correction factor (fpcf). By dropping the fpcf, the computed value of n* would serve as the value for n and the formula for s_d would simplify to

$$\sqrt{\frac{n\sum_{i=1}^{n} d_i^2 - \left(\sum_{i=1}^{n} d_i\right)^2}{n(n-1)}}$$

As the proportion of claims sampled in the universe diminishes, the less important the fpcf becomes. In practice, the fpcf is generally ignored when the portion sampled is less than five percent of the universe. The consequence of ignoring the fpcf would result in overstating the error interval of the estimate. Such an overstatement would be immaterial if the portion of the universe sampled is under five percent and possibly so even if the portion is higher. Since ignoring the fpcf will never be to the disfavor of the PSROs, it will be subject to my discretion whether or not it is employed on any particular test.

If you have any questions and/or wish further discussion, please feel free to call me at 5-7026.

Bill Maxfield

Bill Maxfield
Center for Health Statistics

cc: Dean Lan, 8/1618
Craig Miller, 8/1618

ATTACHMENT 2.—GENERAL PSRO COMMENTS ON DECEMBER 1978 VERSION OF THE STATE MONITORING PLAN

1. PSRO comment. If the medical record does not support the medical necessity of hospital care, it is invalid to assume that the PSRO review decision was inappropriate since the PSRO might not have made any decisions regarding the case.

State response. The PSRO has the responsibility of certifying the necessity and appropriateness of all Titles XVIII and XIX patients' hospital stays under the PSRO's jurisdiction. Therefore, the State assumes that if the PSRO certifies the hospital stay as payable, the PSRO has made a decision regarding the case.

2. PSRO comment. Length-of-stay guidelines and medical criteria to be used by the state monitors should be attached to the monitoring plan.

State response. The volume and evolutionary nature of current written medical practice criteria render its attachment to this plan as impractical. The plan states that: ". . . the reasonable limits of professional discretion will be defined for each case reviewed by applying professional judgment which will be augmented, but not limited, by State and/or PSRO written medical practice criteria."

Therefore, the State will use available written criteria, including the PSROs. Emphasis must be made, however, that length of stay and medical review criteria are guidelines only and that each review decision is uniquely rendered by a health professional exercising medical judgment.

3. PSRO comment. Under "Appropriateness/Inappropriateness of PSRO Review Decisions", modify: ". . . the costs associated with these stays will constitute an unreasonable and detrimental impact on total State expeditures under Title XIX." to ". . . the costs associated with stays resulting from such inappropriate PSRO review decisions will constitute an unreasonable and detrimental impact on total State expenditures under Title XIX."

State response. Partially adopted to read: The costs associated with inpatient hospital stays resulting from inappropriate review and certification decisions by the PSRO, when extrapolated to the universe of certified days used, constitutes a detrimental impact on total State expenditures under Title XIX.

4. PSRO comment. Reinstate 24-month limitation on claims retention for monitoring purposes.

State response. Modified to 18 months unless monitoring is conducted on an annual basis, in which case the 24-month limitation will apply.

5. PSRO comment. Object to any system of retrospective monitoring of activities that took place concurrently. The information available to the monitoring personnel is different than that that is available to a consultant making admission certifica-

tions and a review coordinator. The objectivity of the monitoring personnel in this environment is always suspect.

State response. Until such time as resources or technology permit a concurrent monitoring of PSRO activities, the Federal and State Governments (as well as PSROs with delegated hospitals) will be left with the less than perfect tool of retrospective evaluations.

6. PSRO comment. Object to PSRO's having to obtain copies of medical records for monitoring and forward them to the State.

State response. When a PSRO assumes Title XIX utilization review and certification authority, the State falls back into a monitoring mode. The PSRO then has on a regular basis (if not daily, particularly in a delegated mode) more immediate access to the medical records than the State will have through requests by mail. Additionally, the PSRO will have an opportunity to screen those cases to be reviewed which would be desirable, especially where the PSRO's review coordinator work sheets do not lend themselves to being a good monitoring tool.

7. PSRO comment. Object to the statement that: "PSRO review decisions are determined to be appropriate when the evidence in the medical record indicates that there was medical necessity for an inpatient hospital stay." Because it relies totally on documentation rather than medical judgment.

State response. Medical evidence which is not present in the record during the State's review may be presented at the exit conference. The State's medical consultant may modify his/her original decision based on the additional evidence. That evidence may then become a part of the medical record.

8. PSRO comment. Object to simultaneous notification of the PSRO and the Federal Government of final monitoring results. Also object to nonspecificity of "Federal Government".

State response. Final monitoring results are public information. The State has received many requests from state and federal governmental units for copies of *final* monitoring reports. Since the PSRO has already had an opportunity to comment on the monitoring process and results with those comments (if any) being attached to the final monitoring report, the State will continue with simultaneous notification to the PSRO and the Federal Government of final monitoring results.

9. PSRO comment. Object to emphasis on fiscal impact rather than on quality or appropriateness of service because the PSRO has no authority to be involved in the cost of care.

State response. The PSRO statute requires that state monitoring plans address impact on both cost and appropriateness of care.

10. PSRO comment. How will confidentiality be protected?

State response. The State is subject to all applicable federal and state laws pertaining to confidentiality of medical information.

PSRO review coordinator work sheets will only be reviewed at the PSRO offices.

Subsequent PSRO submittal of medical records to the State can be accomplished by watever means the PSRO feels most secure, e.g., mail, parcel delivery, hand carried, etc.

11. PSRO comment. Who will pay for the cost of state-requested copies of medical records?

State response. The hospital should bill the State through its reasonable cost reimbursement adjudication.

12. PSRO comment. What volume of medical records to be reviewed would be enough to warrant an on-site visit to the hospital by the State's monitors?

State response. There is no fixed number of records. It will be based on a combination of record volume, monitoring personnel availability to travel, and the distances involved.

13. PSRO comment. What will be the maximum random sample size?

State response. Any fixed, maximum sample size would be an arbitrary selection. It would be unwise, therefore, to establish a fixed maximum sample size since it will be based on previous PSRO performance and the performance may require a sample size larger than the arbitrarily selected sample size.

14. PSRO comment. The measurements of success in the Monitoring Plan Application do not specify how the sampling error interval is applied.

State response. The application of the error interval is now outlined in the Application of Monitoring Plan results.

15. PSRO comment. PSRO preparation of discharge listing for purposes of (including but not limited to) sample selection is too costly.

State response. Disagree with the PSRO's (3) comment that PSRO production of a discharge listing is inappropriate because:

(*a.*) The State will soon be providing basic utilization rate data (statewide and PSRO-specific) free of charge to PSROs.

(*b.*) Cost figures were not included in the PSRO's comments making it difficult to assess fiscal impact.

(*c.*) The 75 cents cap on data line costs has been removed.

(*d.*) Many PSROs express no problem with production of discharge listing.

16. PSRO comment. Clarify inclusion of totally state-funded Medi-Cal patients in Title XIX monitoring plan.

State response. References to totally state-funded Medi-Cal patients have been deleted.

17. PSRO comment. Determination of detrimental fiscal impact is not valid because it does not account for positive PSRO influences nor state administrative cost savings.

State response. If the State chooses to develop a monitoring plan, it must have the capability to produce reasonable documentation of a PSRO's unreasonable and detrimental impact on total state expenditures and on appropriateness of care delivered to Title XIX patients.

Current resource limitations do not permit the State to also systematically document positive PSRO influences. The PSRO is in the best position to document that impact.

Inclusion of state administrative cost savings are not included in the monitoring plan because as indicated in previous monitoring plan drafts, this plan is not a comparison of the state and PSRO review systems. The plan is a measurement of the frequency of inappropriate PSRO review decisions. (While the PSRO program was still in its developmental stages, the State proposed that the Federal Government conduct a demonstration project allowing a parallel review system to evaluate the comparative effectiveness of the State and PSROs. Since that proposal was not accepted, the State monitoring plan is left with the capability to detect PSRO review decisions which are not supported by evidence in the medical record.)

18. PSRO comment. Detrimental fiscal impact should be adjusted to the normal state-federal cost-sharing ratio.

State response. The State has basic control over expenditures of Medicaid funds in the State. Therefore, Medicaid expenditures inappropriately authorized by a PSRO have a detrimental fiscal impact on total state expenditures.

19. PSRO comment. Two weeks for the PSRO to prepare for the State's initial review of review coordinator's work sheets is inadequate.

State response. Since the sample size usually approximates 500 claims, two weeks should allow adequate lead time for pulling of review coordinator work sheets.

20. PSRO comment. The State should not use the PSRO's coordinator work sheets for monitoring because they were not intended for that purpose.

State response. The State has found PSRO review coordinator work sheets to be useful tools for screening cases and reducing the impact of medical record collection/reproduction on the hospitals.

21. PSRO comment. The State should notify a PSRO prior to an on-site visit to a hospital and invite them to participate.

State response. Agree.

22. PSRO comment. The State should use actual reimbursement figures for calculation of detrimental fiscal impact because the amount paid is an interim reimbursement subject to year-end audit adjustments.

State response. The State will use statewide average per diem rates for calculation of detrimental fiscal impact.

23. PSRO comment. The State should include the error interval in its premonitoring notice to the PSRO.

State response. The error interval cannot be specified in advance of the monitoring because the error interval is not a function of sample size. The error interval is a function of the variance between the decisions of the PSRO and the State (which is not known prior to the monitoring). Therefore, the requirement for an error interval of no more than ±5 percent has been modified to an equation that the PSRO passes a monitoring cycle when the percentage difference (monitoring result) minus the error interval equals 2 percent or less.

24. PSRO comment. The State needs to be more specific as to how monitoring results determine frequency of monitoring.

State response. The State will nonitor PSROs less frequently when they have acceptable monitoring results and more frequently when they have poor monitoring results.

Monitoring resource availability will also be a factor in the State's determination of monitoring frequency.

25. PSRO comment. The State should not require hospital identification on discharge listings. The State is responsible for monitoring the PSRO's overall performance and not that of individual hospitals.

State response. Agree.

26. PSRO comment. The State should randomly select hospital days (not stays) if the number of inappropriate days is to be used to calculate success or failure and detrimental fiscal impact.

State response. The frequency of inappropriate review decisions is the only element being monitored. The random sample of hospital stays leads to the statistical inference that the sample is representative of the total universe of hospitalizations. Therefore, the rate of inappropriate review decisions (expressed in number of inappropriate days authorized) found in the randomly selected sample should also be true for the total universe of hospital stays.

ATTACHMENT 3

PROFESSIONAL STANDARDS REVIEW ORGANIZATION,
Ventura, Calif., December 19, 1978.

Mr. BUD LEE,
Chief, PSRO Monitoring Unit, Department of Health Services, State of California, Health and Welfare Agency, Sacramento, Calif.

DEAR MR. LEE: The Ventura Area PSRO recently completed a review of your proposed Standard Monitoring Plan for PSRO review activity. As a result of this review, the following points and questions are stated:

1. Confidentiality is an issue of major concern of the VAPSRO. In supplying copies of certain worksheets and medical records to your office, it gives no specific indication on what method of exchange is planned nor what quarantees are available to assure access to or disclosure of these documents are planned. The competency of the mail service is of a questionable nature. In addition, no indication of who will be primarily responsible for document control as it relates to confidentiality is included. What submission procedures is VAPSRO required to follow?

2. VAPSRO is required to maintain a monthly listing of all Title XIX funded discharges by hospital and patient name. VAPSRO's data system produces a quarterly patient ID number index by hospital. Patient names are not a required data item under PSRO regulations; so, consequently, this is not being collected by the PSRO data system. Normally, this patient index is available within 30–45 days after the close of the reporting period quarter.

3. VAPSRO is required to obtain copies of State-requested worksheets and medical records. VAPSRO wants these costs absorbed by the State. As you know, a limited budget fund is available to the PSRO now.

4. Onsite secondary reviews of hospital medical records may occur, if the sample size is large enough. Can you give VAPSRO an idea what case number would constitute an onsite visit?

5. VAPSRO wants all exit conferences, if any, conducted at its office due to budget constraints.

VAPSRO looks forward to completing negotiation with the State of California on the review activities for Ventura County.

I look forward to receiving the responses to the above at your earliest convenience.

Sincerely,

RICHARD E. MICHEL,
Executive Director,
Ventura Area.

SAN JOAQUIN AREA PROFESSIONAL STANDARDS REVIEW ORGANIZATION,
Stockton, Calif., December 20, 1978.

BUD LEE,
Chief, PSRO Monitoring Unit,
Department of Health Services, Sacramento, Calif.

DEAR MR. LEE: As requested in your recent letter to all PSROs, attached are comments on the proposed State Agency Standard Monitoring Plan for PSROs.

Sincerely,

DANIEL P. SHEEHY,
Executive Director.

Attachment.

COMMENTS ON MEDI-CAL STATE AGENCY MONITORING PLAN DATED NOVEMBER 1978

1. The plan states in a number of places that a finding that a medical record does not support the medical necessity of hospital care would be interpreted as indicating that a PSRO review decision was inappropriate. This is not valid since the PSRO might not have made any decisions regarding the case.
2. The proposed method of having PSROs prepare a discharge listing of all Medi-Cal patients would be unnecessarily costly. Alternate less costly methods (e.g., sample from files, or using discharge statistics) could achieve the desired sample just as well.
3. The proposed method of determining fiscal impact is not valid since the method does not account for positive PSRO influences.
4. The proposed method of determining fiscal impact is also not valid because it does not account for State administrative cost savings.
5. It is not clear in Section V A of the plan how the 5 percent margin of error is included in the stated conditions.
6. The monitoring plan should have attached any length of stay reference guidelines (e.g., Michigan Air Force norms, Title 22 norms, etc.) which might be referred to by State medical consultants when performing monitoring.

JANUARY 8, 1979.

BUD LEE,
Chief, PSRO Monitoring Unit, Medi-Cal Field Services,
Department of Health Services, Sacramento, Calif.

DEAR BUD: We were pleased to receive the November 1978 revision of the PSRO Monitoring Plan for review and comment.

The revised Monitoring Plan clarifies the mechanics of the process. We are particularly pleased with the expansion of the Exit Conference process to include participation by a State Council physician.

We offer the following comments on the Monitoring Plan:

1. Page 2, Number 2, Appropriateness/Inappropriateness of PSRO Review Decisions. While we agree that a PSRO review decision which is not supported by evidence in the medical record is an inappropriate review decision, we do not agree that such decisions are automatically instances of inappropriate care.

We, therefor, recommend that the last sentence of Number 2 be rewritten to read: "The costs associated with stays resulting from such inappropriate PSRO review decisions will constitute an unreasonable and detrimental impact on total State expenditures under Title XIX."

2. Page 6, Number 3, Para. (a) seems to include State-funded medically indigents in the monitoring activities. We note that, although review of MIs is apparently included in both the Monitoring Plan and MOU, funding for this activity is not mentioned. Either MIs should be deleted from all sections or the funding arrangement should be referenced.

3. We note that the 24 month limitation on claims for purposes of monitoring has been deleted. We would like to see this limitation restored in the MOU and Monitoring Plan.

In general we found the revised Monitoring Plan a substantial improvement. With respect to the Memorandum of Understanding, we offer the following comments:

1. We note that the specific paragraphs requiring a period of parallel review and state or PSRO conduct of preadmission review have been deleted. Fred Foote reports that the deletion of preadmission review is an error. We would appreciate receipt of a corrected copy at your earliest convenience.

2. Page 6, Article VII B, is not clear to us. The last sentence states that "PSRO decisions modified by appeals have the effect of an original PSRO decision for purposes of payment but not for purposes of monitoring (Article XI)." Does this mean that PSRO decisions modified by appeals will be included in or excluded from monitoring?

3. We would like to see the 24 month limitation on claims for purposes of monitoring restored.

We appreciate this opportunity to comment on the Plan and MOU. We intend to develop a specific approach to prepare us for implementation of Title XIX review. I have discussed the State's concerns about the volume of Title XIX admissions (especially ER admissions) to Area XXIV hospitals with Fred Foote.

When we have developed this approach, we will be requesting a meeting to get your suggestions on any issues you feel we should include to best prepare for negotiation of an MOU and subsequent implementation of Title XIX review.

Sincerely,

MARVIS J. OEHM,
Executive Director.

SAN FRANCISCO PEER REVIEW ORGANIZATION, INC.,
San Francisco, Calif., January 9, 1979.

Re 1. PSRO Monitoring Plan—comments. 2. PSRO/Medi-Cal MOU—comments.

Mr. BUD LEE,
Chief, PSRO Monitoring Unit,
State Department of Health, Sacramento, Calif.

DEAR BUD: The SFPRO appreciates the opportunity to comment on the proposed PSRO Monitoring Plan. We also have commented on the proposed Memorandum of Understanding. Carl Ludwig of our staff and I have reviewed these two documents and offer Section A of this letter as our comments regarding the Monitoring Plan; Section B is our comments on the standard MOU.

A. PSRO MONITORING PLAN

I. Sampling methodology

The monitoring plan should be more specific in defining the sampling concepts so that the parties may be insured that proper inferences regarding approved hospital stays can be made. A major flaw in the monitoring plan is the State Agency's apparent failure to recognize that a sample of days is not random if the selection of days is based on the selection of an entire hospitalization. It should be noted that a sample random selection procedure and analysis are to be used in estimating the number of disallowed days per monitoring cycle, the sample must be drawn randomly from a population of days, not hospitalizations as suggested in the monitoring plan.

If the element of observation is to remain a hospitalization, the parameter that should be estimated for use in determining PSRO performance should be the average proportion of the hospitalization upon which the PSRO and the State Agency agree. This parameter is different from the number of days as demonstrated in the following example of ten hypothetical hospitalizations:

Sample case number	Actual LOS	PSRO/DOH agreed LOS	Proportion of LOS in agreement
1	6	5	0.8333
2	5	5	1.0
3	9	8	0.8888
4	8	5	0.625
5	8	8	1.0
6	7	7	1.0
7	12	10	0.8333
8	2	2	1.0
9	5	5	1.0
10	5	0	0
Total	67	55	.....

The total number of days upon which the PSRO and State Agency agree is 55 or 82.09 percent of all days. However, the average proportion of agreement is 92.54 percent, the average of the values in Column 3. These two values, 82.09 percent and 92.54 percent, are not the same because each agreed-upon-day is not distributed randomly throughout the hospitalizations, but are clustered within a few particular studies. The correct parameter to estimate when sampling hospitalizations is this average proportion of agreement (or disagreement) in the total number of days. The monitoring plan implies that the total number of days are to be estimated using this sampling scheme and thus the results would be statistically incorrect.

It is possible to easily select at random individual days (in hospitalizations) which can then be correctly used for estimating the total number of days agreed or disagreed upon between the PSRO and the State Agency. The process would involve a two-stage selection procedure where first, hospitalizations are selected for review by the State Agency and then, after all disagreed upon days have been identified, a subset of individual days are chosen randomly, one from each of the previously selected hospitalizations. These days will comprise the final sample to be included within the monitoring cycle.

For instance, if during a one-month monitoring cycle there are 3,000 hospitalizations with 18,000 total days of care, let us select a random number of days to be included in a monitoring sample. To estimate a "tolerance limit" of 2 percent with a proportion of error rate of ±5 percent, a sample of sufficient size is needed to detect this difference in days with a confidence level of 90 percent. Using the standard sampling formula of:

$$n = \frac{z^2(P)(q)}{E^2}$$

where z = corresponding value for a 90% level of confidence

P = maximum proportion to be detected in sample (.07)

q = 1-P

E = error rate (.05)

$$n = \frac{(1.65)^2(.07)(.93)}{(.05)^2}$$

$$= 70.8939$$

Thus, a minimum of 71 days should be selected from the total of 18,000 days in the population.

First, randomly select 71 hospitalizations from the list of 3,000 patient studies. At this point the number of days selected may range from 350 to 700 or more depending on the particular hospitalizations selected. However, this is only the first half of the selection procedure. The State Agency should then perform its full review of these hospitalizations to determine if there are any days upon which it and the PSRO disagree. Having identified the specific days (i.e., last two days of hospitalization, second preoperative day, etc.) disagree upon, one day from each of the 71 hospitalizations should be randomly selected for inclusion into the final sample.

The end result is a sample of 71 individual days that have been selected randomly and with equal probability from the total population of 18,000 days. The estimates of total number of days disagreed upon and the corresponding error interval could then proceed as described in the monitoring plan.

II. Precision of estimates

A second problem in the monitoring plan is found in the failure to specify proper sample size for each monitoring cycle. The size of the sample is dependent in part on the precision of the estimate to be made from the sample. The precision of the estimate is usually expressed in terms of a level of error or error rate. The smaller the level of error to be tolerated in the estimate, the larger the sample must be. Thus, if the State Agency wishes to obtain an estimate of the percent of days determined as unallowable and falling within a margin of error no more than ± 5%, this information must be used in determining an adequate (minimum) number of sampling elements to be selected. A sample smaller than this mimimum number may not yield an estimate with the required precision. Sampling formulas such as those found in the preceding section should be specified in the monitoring plan and followed by the State Agency in each monitoring cycle.

On page six of the monitoring plan we would also delete the requirement for the name of the hospital for each patient discharge entry on such list, as the State Agency should have no need to know the name of a hospital in generating a random

sample from such list. In fact, to introduce the name of the hospital for each entry introduces a potential for bias. *The PSRO is being monitored by the State Agency as to overall performance in the PSRO area and any random sampling should be on the total patient universe, not on a by-hospital universe.*

On page seven (section entitled "Documentation of Detrimental Physical Impact") we would suggest using the actual reimbursement figures for the room and board rate. As we understand it, hospitals are reimbursed on a per diem rate recognizing the approximate amount that Medi-Cal will allow for such charges. This may be the intent of this section, but is not clearly delineated.

In addition, we note the term "detrimental impact on state expenditures". Since the Medi-Cal program is a Federal/State matching program, it would be more correct to calculate the cost based on the State matching share or to change all references in the monitoring plan to detrimental impact on the "Medicaid" program.

B. PSRO/MEDI-CAL MOU

On page five, in section E, we would suggest the following language:

"All proposed review process modifications, other than those described in section "D" of this article, must afford the State Agency a period of at least thirty (30) days to comment."

If a PSRO is going to detail its monitoring plan in section D, it would not seem appropriate to have the State Agency review and comment on those parameters already delineated in section D.

On page six, in section A of article seven, we would suggest addition of language regarding surgical procedures performed on an inpatient basis. The way section A currently reads, the PSRO certifies the length of stay and the admission to the hospital, but not the surgical procedure which may have been either the reason for hospitalization or an outcome of hospitalization.

In section C of this article, we would also recommend that the language regarding exclusions as delineated in the attachment make reference to the fact that the attachment 2 has a complete list of Medi-Cal exclusions. From reading this MOU, it appears that the State Agency is to be knowledgeable of all PSRO procedures and criteria. It also appears that the PSRO is to be knowledgeable and actually involved in the process of applying Medi-Cal exclusions. It would, therefore, seem equitable and appropriate that the PSRO have a complete list of exclusions of the Medi-Cal program since they are referenced by this agreement.

From section F of article seven, it is quite clear that the PSRO has no authority in certifying administrative days. Because of this, we feel that the PSRO, therefore, should have no role in such certification. This appears to be a matter between the provider and the Department of Health; therefore, the requesting of administrative days should be a matter between the provider and the field office. We would suggest, however, that a PSRO capable of making adequate medical necessity decisions should be capable of making a decision as to whether a post-acute bed is available in the area. If the State chooses not to include such provisions in the MOU, we would suggest deletion of the relationship with the PSRO and the field office being mentioned in this MOU for purposes of certifying administrative days.

To coordinate with such change in section F, we would recommend that on page three, the definitions of administrative days as delineated in D be revised to indicate: "administrative days of stay are acute impatient hospital days which are certified payable only by State personnel upon request of the provider."

On page nine, article ten in section B, we would suggest in the first sentence the addition of Program Manual revisions and transmittals to the terms "State, Federal laws and regulations." Earlier in the MOU, PSRO Program Manual cites are used and references, and indeed, PSROs are bound by them. In fact, there are no currently applicable regulations for review and therefore transmittals and chapter revisions in the Program Manual take their place.

Thank you very much for the opportunity to comment on these two documents.

Sincerely,

TODD A. ANDERSON,
Executive Director.

SANTA CLARA VALLEY,
PROFESSIONAL STANDARDS REVIEW ORGANIZATION,
San Jose, Calif., January 11, 1979.

Re PSRO Monitoring Plan.

BUD LEE,
Chief, PSRO Monitoring Unit,
Department of Health Services, Sacramento, Calif.

DEAR BUD: Thanks for giving us the opportunity of commenting upon the November, 1978 version of the State's PSRO Monitoring Plan.

Our comments are restricted to the Monitoring Plan since the MOU does not apply to us.

As in the past, we continue to object to any system of retrospective monitoring of activities that took place concurrently. The information available to the monitoring personnel is different than that that is available to a consultant making admission authorizations and a review coordinator. The objectivity of the monitoring personnel in this environment is always suspect.

I. B. Third line:

Suggest you substitute ". . . and their . . ." for: ". . . that result in an unreasonable and detrimental . . ."

Reason: This is a very negative phrase. Hopefully, someday, the good as well as the bad will be measured.

II. A. Last sentence:

Suggest that the sentence be deleted in its entirety.

Reason: You cannot have a random sample if you focus on any area.

II. B. 2. (Page 2) Last sentence:

Suggest that the sentence be deleted in its entirety.

Reason: Not a definition—does not apply to the first sentence.

II. B. 3. b. (Page 2) Last sentence:

Suggest that the sentence be deleted in its entirety.

Reason: Not a part of a definition. I don't believe that "clearly defined margins of error" are "always" included in the statistics. The margin of error may be expressed in the sampling formula.

II. B. 4. b. (Page 3) Last sentence:

If this sentence is to stay in, suggest that it be stated that "month of service" or "month of discharge" will not be mixed in establishing the sample to be reviewed.

II. B. 4. c. (Page 3)

Have your statisticians told you that it is valid to select a sample based upon the number of hospital stays and measure results in the days used during the selected stays? It would seem that there should also be a weighting or measure of the average length of stay in the sample as opposed to the universe from which it was drawn.

II. B. 4. d. (Page 4)

Are the error intervals expressed in percentage points of days if the sample is selected on number of hospital stays (discharges)?

II. B. 4. f. (Page 5) Next to last line:

Suggest that ". . . would have determined. . ." be changed to ". . . determines. . .".

Reason: "Would have" denotes what we would like to have—comparison with what the consultants or nurses would have authorized as the event was occurring. The suggested change reflects how I understand the plan will operate.

II. B. 4. g. (Page 5) Last line:

I believe that "during" should be substituted for "for".

III. A. 3. a. (Page 6) Second line:

Is it proper to include ". . . totally state-funded discharges. . ." in a monitoring plan for Title XIX patients?

III. A. 3. a & b. (Page 6)

The maintenance of a monthly listing of Title XIX discharges is not needed for our internal management and would be an expensive item to us. The list which is specified cannot be produced by our data processor as patient name is not an input field. There may be some PSROs that capture the patient's name in their data system, but I do not know of any that do.

Such a report would have to be prepared by hand.

(Bud, could you and a few PSRO reps get together and try to come up with some way of getting the Department a list—or some method—for "grabbing" a sample. I certainly would want to work on this problem. Maybe Greg Thompson could build something into your new claim processing system.)

III. B. (Pages 7 and 8)

How will you determine the average room and board cost per day "in the universe"? This appears to be a toughie. We would have no way to help you.

I also assume that "detrimental fiscal impact" is adjusted to the normal State-Federal cost sharing.

V. A. 1., 2., and 3. (Page 9)

In the definitions section (Page 3), the "two percent tolerance level" does not include the "error interval" adjustment. The lead-in paragraph does not really provide for this adjustment.

In "3", do you mean "eight percent" or "eight percentage points"?

Most of our suggestions are cosmetic, Bud, but we do have a basic problem with how samples will be identified and selected.

We are willing to give the plan a try if we can select the samples from our worksheet file as we did this last time.

Sincerely,

H. C. BENNETT,
Executive Director.

GREATER SACRAMENTO PROFESSIONAL
STANDARDS REVIEW ORGANIZATION,
Sacramento, Calif., January 17, 1979.

Mr. BUD LEE,
Chief, PSRO Monitoring Unit,
Department of Health Services, Sacramento, Calif.

DEAR MR. LEE: The Greater Sacramento PSRO received a copy of the Department of Health Services revised plan for monitoring PSROs as well as a copy of the standard MOU on 15 December 1978. The staff has had a chance to review both documents and would like to offer the following comments:

1. . . . II, B, 2 (page 2) . . . This paragraph may create some problems in that it appears to rely totally on documentation rather than on medical judgment. We always have some concerns when the only determining factor appears to be linked to State expenditures.

2. . . . II, B, 4b (page 3) . . . We feel that the sampling procedure should be rewritten to accommodate the individual PSRO's filing system. For instance the Greater Sacramento PSRO files by month of discharge rather than by month of service. We also feel that the last sentence should be changed to reflect a more cooperative effort rather than "Whichever is determined to be most appropriate by the State agency".

3. . . . II, B, 4c (page 3) . . . We feel that this paragraph should emphasize that the tolerance level must be based on the total number of days rather than on the total number of bills submitted for the specific period.

4. . . . III, A, 3a (page 6) . . . We feel that this paragraph should be deleted since it is a time consuming and expensive record keeping mechanism which the PSRO is not now required to perform.

5. . . . III, A, 3b (page 6) . . . We would recomend that this paragraph be deleted since we feel it is the responsibility of the State agency to inform us of which patients will be selected for the monitoring cycle.

6. . . . III, A 3c, (page 6) . . . The two weeks as specified under this paragraph may not give the PSRO adequate time to prepare for the State's inital review of the selected hosptial stays.

7. . . . III, A, 3d 2 (page 6) . . . The second sentence of this paragraph may be impossible to accomplish. We feel that the records should be requested directly from the hosptial.

8. . . . III, A, 9 (page 7) . . . We are not terribly sure that the Statewide PSR Council should be involved in settling disputes between the local PSRO and the State, however, a copy of the procedure should be attached to this monitoring plan.

8. . . . III, A, 10 (page 7) . . . We disagree with the procedure that the State agency will notify the PSRO *and the Federal Government* of the monitoring results. We feel that the PSRO should be notified first and the specific level of Federal Government should be spelled out . . . i.e., Region IX or HCFA or whatever Federal agency the State intends to forward copies of the monitoring results.

9. . . . III, B, (page 7) . . . As stated earlier we are somewhat distressed that the greatest emphasis is placed on financial impact rather than on the quality or the appropriateness of service. The PSRO has no authority to be involved in the cost of care.

10. . . . IV, A, (page 8) . . . This sentence appears a bit ambiguous to us and we felt that it should be clarified.

11. . . . IV, D, (page 8) . . . We feel that the sampling frequency and confidence level are appropriate to be determined by past PSRO monitoring results, however error interval *should not* be placed in the same category. We feel that error interval is largely a byproduct of the sampling process and cannot be controlled by the PSRO.

12. . . . V, B, 1 (page 9) . . . 42 CFR 463.10(f)(1) is cited under this paragraph. We would recommend that a copy of this code of Federal Regulations be attached to the monitoring plan.

The following comments refer to the basic Memorandum of Understanding:

1. . . . Article V (page 3) . . . We feel that a definition for preadmission certification should be given.

2. . . . Article VI, C (page 5) . . . We feel that some consideration should be given to those PSRO's with a proven track record who should be exempt from this requirement.

3. . . . Article VII, D (page 6) . . . The fiscal intermediaries have made some procedural changes in the PSROs certification of medically necessary stays. It may be beneficial for the State agency to ascertain for sure that the new procedures do not have any effect on Title XIX admissions.

4. . . . Article VIII, C (page 8) . . . Feel that some consideration should be given to routine records and/or reports in this paragraph.

5. . . . Article VIII, E (page 8) . . . Post-Hoc notification of data release does not seem to be appropriate in matters relating to "PSRO identified bearing on the *performance* of the PSRO . . ." We feel that the PSRO should be notified prior to the release of any data or information concerning its performance.

We hope that these comments and suggestions will be taken into consideration prior to the final publication of the monitoring plan and the Memorandum of Understanding.

If there are any questions or any points which need specific clarification, please feel free to contact us.

Sincerely,

REG CLAYTOR,
Executive Director.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF SANTA BARBARA AND SAN LUIS OBISPO COUNTIES,
Santa Barbara, Calif., January 23, 1979.

To: Bud Lee, Chief, PSRO Monitoring Unit, Department of Health Services.
From: Jim Webb, Executive Director.
Subject: Comments, Newest (12-78) Monitoring Plan.

BUD: We're sorry for the delay in responding to your request for comments, and realize this may arrive too late for inclusion in your considerations; however, I am forwarding "marginal notes" on the pages in question.

If you have questions, please feel free to contact me.

Sincerely,

JIM WEBB.

Attachment.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY,
DEPARTMENT OF HEALTH SERVICES,
Sacramento, Calif.

DEAR PSRO'S AND ASSOCIATES: Attached is a revised plan for monitoring PSRO's review of Title XIX services provided in acute general hospitals.

We would appreciate your comments within 30 days of your receipt of this package.

Also attached for your information is the standard MOU we will be using in future negotiations.

If you have any questions, please do not hesitate to contact me at (916) 445-9166.

Sincerely,

BUD LEE,
Chief, PSRO Monitoring Unit.

f. Parameter

Parameter is the constant or the characteristic of a population that is under investigation. The parameter in this monitoring plan is the number of days the State Agency would have determined to be inappropriate or unnecessary at the acute level of care.

g. Element

Element is a single component of the population. Under this plan, an element would be a PSRO-approved hospital stay for the specified monitoring period.

h. Variability

Variability outlines the limits and ranges of the elements in a population. The population variability of the elements under this plan would range from the smallest number of days deemed inappropriate on a single hospital stay to the largest number of days deemed inappropriate on a single hospital stay.

III. MONITORING PROCEDURE

The monitoring cycles will be determined by the State Agency.

The State Agency will normally monitor each PSRO on a quarterly cycle; however, the State Agency reserves the right to shorten or lengthen the monitoring cycle as the PSRO's performance indicates, e.g., if a PSRO consistently meets the measurements of success, the State Agency may monitor on a less frequent basis. The minimum monitoring cycle will be on a monthly basis. The confidence level and error interval of the monitoring samples may be revised at the discretion of the State Agency; however, only a monitoring result at the 90 percent confidence level or greater, with an error interval of ± 5 percent or less, will be used to request suspension of a PSRO's Title XIX binding review authority.

A. Documentation of Inappropriateness of Medical Care

1. Under this plan, the reasonable limits of professional discretion will be defined for each case reviewed by applying professional medical judgment which will be augmented, but not limited, by State Agency and/or PSRO written medical practice criteria, hospital length-of-stay data, etc.

2. The State Agency will draw a random sample of PSRO-approved hospital stays for each monitoring cycle in which the PSRO is performing binding review of Title XIX h..pital stays.

3. a. PSRO's will maintain a monthly listing of all Title XIX and all totally state-funded discharges occurring in hospitals under their jurisdiction. This listing shall include, but is not limited to, the following information:

   i. Hospital.

   ii. Patient Name.

   iii. The data necessary to retrieve the PSRO certification form review coordinator worksheets.

   b. In addition to using this discharge listing for their own internal management purposes, the PSRO will provide a copy of this listing to the State Agency within 30 days after the close of each calendar quarter or monitoring period. The State Agency will use this listing in the sample selection for the next monitoring cycle.

   c. After selecting the random sample using a "systematic" method, the State Agency will return the discharge listing to the PSRO and request the PSRO to prepare for a State Agency initial review of the selected hospital stays at the PSRO office within two weeks following receipt of the discharge listing from the State Agency.

      Preparation would include making review coordinators' worksheets available for the State Agency's initial review.

   d. After initially reviewing the medical documentation at the PSRO office, the State Agency will identify those hospital stays which require review of copies of additional medical documentation prior to rendering a decision. The PSRO will obtain copies of the requested medical records and forward them to the State Agency. However, the State Agency may perform this secondary review onsite at the hospital if the State Agency determines that the sample size is large enough to make an onsite review cost-effective.

      The State Agency will then complete the review of the randomly selected sample.

4. For each hospital stay where the State Agency physician does not find documentation to support the appropriateness of the PSRO's judgment, he/she will prepare a concise written rationale.

5. After all sampled hospital stays have been reviewed, the State Agency will send the preliminary monitoring results to the PSRO and offer an opportunity for an exit conference to be held within the next 30 calendar days. At the exit conference, the PSRO may discuss any or all of the hospital days where the State Agency has found inappropriate review decisions.

6. The PSRO may present new evidence or information concerning these disputed hospital days. This may include clinical information which may not have been in the medical record but was utilized in making the original PSRO decision. The State Agency physician will revise his decisions on claims where he has determined that the new evidence merits a change of decision.

7. The PSRO may have physicians who are knowledgeable concerning the case at the exit conference for advice and consultation. The State Agency also reserves the right to utilize expert consultation.

8. After the exit conference where any or all of the disputed claims are discussed, the State Agency will offer the PSRO an additional 15 calendar days within which to provide additional written comment. These written comments will always accompany the final monitoring report.

9. When the volume of hospital stays/days remaining in dispute following the exit conference could affect the PSRO's success or failure in meeting this plan's measurements of success, the PSRO may request an advisory physician review of the disputed stays/days. This review shall be accomplished through a procedure previously arranged between the State Agency and the California Statewide PSR Council. The results of this review will be included in any State Agency appeals to the Federal Government.

10. Upon completion of the monitoring cycle, the State Agency will notify the PSRO and Federal Government of the monitoring results and will, if necessary, request a plan for corrective action.

5. Documentation of Detrimental Fiscal Impact

The financial impact of inappropriate PSRO decisions will be estimated by multiplying the projected difference from the sample by the average room and board cost per hospital day in the universe period. For example, assume that from a sample of hospital stays, it was found that the PSRO certified 2,400 days whereas the State Agency believes only 2,160 days were appropriate. Furthermore, assume that the PSRO certified a total of 72,000 days in the total universe of hospital stays. Then the estimated difference in PSRO and State Agency days can be found by applying the proportion

$$\frac{2,400}{72,000} = \frac{2,400 - 2,160}{X}$$

and solving for X. In this case, X equals the estimated day difference of the total universe which is 7,200.

Suppose that the average room and board cost per day in the universe was $250. The financial impact can be estimated by multiplying the 7,200 days by the $250 cost per day. This yields an estimated detrimental fiscal impact of $1.8 million. In recognition of the fact that a utilization review system does not have a direct impact on a hospital's fixed costs and because the President's Council on Wage and Price Stability estimates that a hospital's fixed costs account for 40-60 percent of a hospital's bill, the State Agency will use only 50 percent of the aforementioned detrimental fiscal impact figure as representing the variable costs over which the PSRO had control. The State Agency will obtain data necessary to determine room and board cost per day. The State Agency will also use the upper and lower limits of the error interval to calculate the range of the fiscal impact identified by this monitoring plan.

IV. MONITORING PROTOCOL

A. The State Agency will use the results of previous monitorings to determine sample size, confidence level, and error interval.

B. Prior to each monitoring, the PSRO will be notified as to (a) the confidence level and the error interval of each monitoring*, (b) the sample size and the formula used to determine the sample size, (c) the random selection procedure used in the sampling, and (d) the identity of the hospital stays being sampled.

C. PSROs may be monitored on a monthly, quarterly, semiannual, or annual basis. PSROs will not be monitored more frequently than on a monthly basis.

D. Sampling frequency, confidence level, and error interval will be determined by past PSRO monitoring results. Acceptable results may result in less frequent monitorings and less rigorous confidence levels. Unacceptable results may result in a more frequent monitoring with higher confidence levels and smaller error intervals.

* The sample size for a PSRO's initial monitoring cycle will be based on the State Agency's previous experience in PSRO initial monitorings. The confidence level and error interval for the initial monitoring will not be available until after the monitoring cycle is completed.

E. Following each monitoring, the PSRO will be advised of the monitoring cycle that will be used for the next monitoring.

F. The State Agency will require all PSROs to make available, upon request, copies of statistical reports on rates of denial of services requested/provided, including the number of admissions where the total stay was denied.

V. MONITORING PLAN APPLICATION

A. Measurements of Success

While allowing for the specified error interval at the specified confidence level, the State Agency may request the Federal Government to suspend binding review authority for a PSRO under the following conditions:

1. If the PSRO exceeds the two percent tolerance level for three consecutive monitoring cycles, or

2. If the PSRO exceeds the 2 percent tolerance level for the average of a 12-month period, or

3. If the PSRO exceeds the two percent tolerance level by more than eight percent for two consecutive monitoring cycles.

The State Agency will not request suspension of review authority until the PSRO has performed binding review for at least six months.

B. Application of Monitoring Plan Results

1. 42 CFR 463.10 (f)(1) requires that:

"The Secretary will notify, in writing, the appropriate State Agencies ... of

i. His determinations under paragraph (d) of this section and their effect;

ii. Any subsequent actions that he takes; and

iii. The basis of his actions."

REDWOOD COAST REGION,
PROFESSIONAL STANDARDS REVIEW ORGANIZATION,
Santa Rosa, Calif., January 26, 1979.

BUD LEE,
Chief, PSRO Monitoring Unit,
Department of Health Services, Sacramento, Calif.

DEAR MR. LEE: As requested, we have reviewed your most recent PSRO Monitoring Plan (November 1978) and have the following comments:

Section II, B, 2—Definitions

"PSRO review decisions are determined to be appropriate when the evidence of the medical records indicates that there was medical necessity for an in-patient hospital stay." This is contrary to Redwood Coast Region PSRO policy which encourages review coordinator contact with attending physicians for necessary information gathering. While documentation is encouraged to be adequate, this is not always controllable in the hospitals. As we all know, most hospital by-laws dictate that documentation be comprehensive and thorough, however, this is not always the case. Where it is impossible to get adequate documentation, the review coordinator may, in exceptional cases discuss verbally with a physician advisor or attending physician the case involved. In such an instance, the review coordinator may write the verbal discussion in review coordinator notes on the abstracts. In such cases, these notes are adequate for purposes of DOH monitoring assuming clear direction is provided as to what information the worksheet should include.

Section II, B, 3, a—Random samplings

Suggested random sampling methodologies include the possibility of representation being "within a particular degree of tolerance." Unless this is specifically quantified as to what the degree of tolerance may be, this sentence should be eliminated.

Section II, B, 4, a—Population

"Population is the total PSRO-approved hospital stays for a specific monitoring period". It is understood by this that: A—the sample *will not* be focused on the seventy-fifth percentile population, and B—cases *will not* be added to the sample on the basis of fiscal intermediary recommendations. Both of these practices have been incorporated as part of the monitoring process in the past and should not be allowable in the future.

Section III, A, 3, c—Monitoring procedure

The PSRO must be notified of the sample size in advance. This may affect its ability to comply with the two week preparation.

What will be the maximum sample size using a systematic method? This will affect the time necessary to pull records.

Section III, A, C

Preparation of monitoring includes having review coordinator worksheets available for the State agencies initial review. Unless specifically required to include specific information on the review coordinator worksheets, this is not an acceptable procedure. Currently, within this PSRO, review coordinator worksheets are intended to aid in the internal management and the review process within the PSRO. These notes were not designed to provide documentation for monitoring procedures. Also, unless specifically stated that these notes would be acceptable as appropriate decision making documentation, the review of these notes should not be accepted. (See comments Section II, B, 2).

Section III, A, 3, d

It should be required that prior to the State agency performing review on site at a hospital that PSRO be so notified and invited to participate in this visit if desired.

Section III, B

If the error interval is always less than the 2% tolerance level, then the fiscal impact will always be detrimental. The error interval needs to be stated. We suggest indicating an example which calculates the range of fiscal impact using the upper and lower limits of the error interval.

Section IV, B—Monitoring protocol

The formula for determining the sample size should be stated in the plan. The plan does not say whether the same formula will be applied each time the PSRO is monitored.

Section IV, D

There is a need to be more specific as to how previous monitoring results will determine frequency of monitoring. Frequency of monitoring should be tied to the error tolerance levels and specified in the monitoring plan.

We look forward to hearing from you regarding these comments.

Thank you for the opportunity to comment on this plan.

Sincerely,

ANNE L. MARTIN,
Executive Director.

Attachment 4.—PSRO MONITORING STAFFING

[Acute hospitals]

Class	Medical consultant	Associate Government program analyst	Medical transcriber	Statistical clerk	Statistical method arranger
Salary (monthly)	$3,472	$1,556	$800	$857	$1,352
(Salary savings—5 percent)	(174)	(78)	(40)	(43)	(68)
Subtotal	3,298	1,478	760	814	1,284
Benefits (.291)	960	430	221	237	374
Subtotal	4,258	1,908	981	1,051	1,658
Annual salary and benefits	51,096	22,896	11,772	12,612	19,896
(Administrative overhead—37 percent)	18,905	8,472	4,356	4,666	7,362
Total annual salary, benefits, and administrative overhead	70,001	31,368	16,128	17,278	27,258
Expenses:					
General	1,160	1,160	1,160	1,160	1,160
Rent	1,160	1,160	1,160	1,160	1,160
Travel	5,300	5,300	1,200	.....	2,500
Equipment	1,160	1,160	1,300	1,300	1,160
Total expense	8,780	8,780	4,820	3,620	5,980
Total salary, benefits, administrative overhead, and expenses	78,781	40,148	20,948	20,898	33,238
Number of positions	5	2	2	1	1
Subtotal	393,905	80,296	41,896	20,898	33,238
Total—all staff (11 positions)	.....	.....	.....	.....	570,233

Ms. MEYERS. Basically, our approved plan assesses the core of a PSRO's operation, that is, their utilization review and decisionmaking ability. We use State-employed physicians who review a statistical valid, random sample of PSRO-approved claims, and we review PSRO coordinator worksheets and hospital medical records as necessary. We calculate a disagreement rate, adjust it by an error interval, and if the remainder is 2 percent or less, the PSRO is passing in that monitoring cycle.

Some California PSRO's have reacted very positively to the educational aspects of our monitoring process; others dislike it.

So far, five PSRO's have passed our initial cycle of monitoring four have failed. If we extrapolate the detrimental fiscal impact to a statewide analyzed total, inappropriate review decisions by PSRO's have caused a n irecoverable, inappropriate expenditure in the range of $6 million to $23 million, and that I consider a conservative estimate.

Because of HEW's plans to move into focused review, we have recently initiated a process whereby we conduct an assessment of a PSRO's "capacity to result in an improved review effort," which is required by section 1153. We perform this assessment prior to turning our review authority over to the PSRO, applying our standard monitoring methodology to a random sample of PSRO-approved care, medicare-medicaid crossover claims. We are in varying phases of this process with four PSRO's now.

HEW is concerned about the potential impact on the rate of PSRO implementation in California. I think the Federal pressure to sign additional memorandums of understanding without regard to the marginal performance of most PSRO's to date is the most pressing problem that California has to deal with.

With regard to long-term care, we are in the process of completing demonstrations in three PSRO's that have experience in medicare long-term care. Unlike Rand's study, our demonstration projects are performance based, using a double blind review, randomly sampled cases and factoring out of error intervals.

Some of the PSRO's passed in some areas being measured, but none have passed in all three performance areas of level of care review, patient need assessment and appropriate referrals.

MAJOR PROBLEMS

There are three major problem areas as I view them: One is our concern with HEW's emphasis on focused review. This is a very embryonic area. Currently, there are inadequate baseline data to support the emphasis on focusing by diagnosis or procedure.

It would be more effective, it seems to us, to focus by physician or facility, because it is not the complexity of the diagnosis or procedure which governs whether it should be focused in or out; it is the physician's or the facility's capacity to handle those complex situations which should be the governing factor.

A second problem area is inappropriate admissions. Length of stay is not as much a problem in California. We are requiring all PSRO's to perform preadmission review on all elective admissions of medicaid patients for at least 6 months, in order to establish a baseline from which to focus their preadmission efforts.

Psychiatric services' review is also a major problem area; it is very difficult. We are trying to work with the statewide PSRO council to achieve criteria development in that area.

RECOMMENDATIONS

With respect to our recommendations, we believe that there should be a deemphasis on rigid, inflexible application of medical criteria; an opinion which I believe is supported by the Dikewood study, sponsored by HEW.

Second, there should be increased emphasis on developing alternative lower levels of care.

Third, the number of PSRO areas ought to be reduced; fourth, preadmission review should be required on a much broader scale; fifth, the amount of PSRO delegation to hospitals should be seriously evaluated; sixth consumers should have a greater voice in PSRO operation. Seventh an intensive study of the wide variances in length of stay across the nation should be done to determine if differences are justified. And finally California believes that if the Secretary approves the State agency's monitoring plan, then the Secretary should be willing to stipluate that the results generated in accordance with that approved process will constitute reasonable documentation of a PSRO's performance.

The burden of proof is continually applied on the State agencies, rather than where we believe it should be.

Senator TALMADGE. Ms. Myers, would you suspend at this time? We have three rollcall votes on the Senate floor now, back to back. Getting there and returning will take very nearly 1 hour.

Rather than keeping the witnesses waiting, who have come from all over the country, I am going to ask our very able staff member, Jay Constantine, to preside until some member of this subcommittee, hopefully myself, will be able to return. Jay will ask questions that we have propounded, or will propound questions to you.

The record of these hearings will be made available to every member of the subcommittee, and also every member of the Finance Committee.

I apologize for the necessity of having to leave you now, but it is imperative that I go over to the Senate and vote.

Mr. Constantine will take the chair.

Ms. MYERS. May I conclude the statement now then?

Mr. CONSTANTINE [presiding]. Yes.

Ms. MYERS. The results of all the Federal and state PSRO monitoring and evaluation efforts to date, I think, have done little to alleviate our concerns about private organizations determining levels of State expenditures. The results have heightened our concern, particularly when we believe that HEW's relentless push for PSRO implementation will replace what we believe to be an effective system.

We have about seven different utilization review processes in the California medicaid program. There are the PSROs, the State operation, the health maintenance organizations which are throughout the State. We also have a post services prepayment peer review in two counties in the State. We have an at-risk fiscal intermediary, the Redwood Health Foundation. We have totally retrospective review in Los Angeles County. And we have county-based utilization review plans for medical and mental health programs.

We believe that there is a unique opportunity for testing alternative methods of utilization review in California. Six months ago we proposed to HEW that we jointly develop a proposal to seek an independent evaluation of each of California's utilitzation review systems. HEW has indicated they are disinclined to participate because of timing and funding constraints. However, the State would welcome an opportunity to have an independent evaluator come in, for example, the Congressional Budget Office or GAO, and

apply the same definitions, and assumptions and analytical techniques to all the medicaid utilization review systems in California. And we for one would be willing to live with the results.

In summary, we are still quite uncertain about PSRO's and I think we are taking a prudent approach. We believe it is time for an intensive study of alternative methodologies. And our observation is that the success of the PSRO lies in the individual commitment of the PSRO boards of directors. If their attitude is they want to have a positive impact on cost and quality, they will find a way to be successful. If their attitude is they are there against their will to protect the status quo, they will not be successful in fulfilling their PSRO mission.

Thank you.

Mr. CONSTANTINE. Ms. Myers, these are Senator Talmadge's questions. You have indicated concern over the performance of some PSROs in your State. As you know, the law provides for reporting of a PSRO to the Secretary where the State finds indiscriminate and inappropriate approval of medicaid cases. Under the law the Secretary is required to evaluate and act on the State's recommendation within 30 days. How many PSRO's have been recommended for suspension by the State of California?

Ms. MYERS. Our monitoring plan was just approved a few months ago. We have just completed our first monitoring cycle. Our memorandum of understanding with the PSRO's with respect to that indicates that we will use at least three monitoring cycles before we make a judgment as to overall effectiveness. I don't think just one round of monitoring, which is what we have completed so far, and the indicated five have passed and four have not, is evidence, you know, to suggest that they are not effective.

So we will be completing two more monitoring cycles before we make any—they have to fail three in a row before they are reported, if you will, to HEW.

Mr. CONSTANTINE. I see. You have expressed concern over the emphasis on reducing program costs through so-called focused review. As a matter of fact, I think Senator Talmadge, during the discussion yesterday expressed his own concern about focused review. Do you believe that the PSRO program is underfunded to accomplish its objectives?

Ms. MYERS. I don't have an opinion on the amount of funding because I am not familiar with the level of funding. My concerns about focused review were not that it would, you know, promote some inefficiency and lack of economy, but the way HEW is proposing to focus, by diagnosis or procedure rather than what we feel might be more productive—focusing by facility and or by physicians, which is where we feel the appropriate focus might occur—is what I had in mind.

Mr. CONSTANTINE. Before PSRO's there was little effective governmental review of medical and hospital care. Now that we have a review program in place that utilizes the private sector, there are those who believe that the Government can do it better. The Government's track record does not always support that kind of confidence. For example, isn't your department the same one that for years failed to act to correct poor administration and fraud and abuse and substandard care in California's prepaid health care

program? I am referring to the findings of the Senate Permanent Subcommittee on Investigation and California's Little Hoover Commission.

Would you agree medicaid agencies have had their own problems of performance?

Ms. MYERS. I would agree medicaid agencies have had their own problems of performance. With respect to the prepaid health plan movement, I believe Governor Brown and his administration have effectively both sponsored legislation and administrative corrective actions so that we have solved most of the problems, I think, in the prepaid health plan area and are instituting what I have tried to outline here as a very effective, at least based on our evaluations—and I would be happy to make that evaluation available to the committee for the record in terms of preadmission review and concurrent review, which we think is as good as anything——

Mr. CONSTANTINE. Fine, I am sure the committee would like to have that.

[A copy of the evaluation to be provided for the record follows:]

BENEFITS AND COSTS OF MEDI-CAL PRIOR AUTHORIZATION

Beverlee A. Myers, Director
Department of Health Services

Carol Emmott, Chief Deputy Director
Policy, Planning and Enforcement

Joseph Hafkenschiel, Chief
Office of Planning and
Program Analysis

Gregory Roth, Chief
Program Analysis Section

Janet Wilson, Project Manager

State of California — Department of Health Services

Memorandum

To : Beverlee A. Myers
Director

Date : October 11, 1979

Subject: TAR Benefit-Cost Analysis

Telephone: ATSS ( )
( )

From : Carol Emmott, Ph.D.
Chief Deputy Director
Policy, Planning and Enforcement

The purpose of this memo is to transmit the most recent analysis of the benefits and costsof Treatment Authorization Request (TAR) processing, and to summarize our findings.

The findings listed below are based on an analysis of 8,930 Treatment Authorization Requests for hospital admission and other medical services. This sample represents two full days of TAR processing in June 1978 and another two days in October 1978. The reliability of the data presented here was inferred by calculating the correlation between the combined sample distribution and the population distribution as indicated by monthly Field Services Section statistical reports. The Spearman Rank correlation coefficient was r= .97 (1.00 being perfect). These data, therefore, are highly reliable overall.

Our key findings are as follows:

- Hospital admission TAR processing generates program savings (benefits) of $12.6 million to $18.8 million annually, with a mid-range savings estimate of $16.3 million.
- TAR processing for other medical services (e.g., physicians, psychiatrists, medical transportation) generates program savings of about $12.7 million annually.
- For each dollar spent processing hospital admission TARs, from $6.50 to $9.60 in program savings are generated. The mid-range benefit-cost estimate is 8.4:1.
- For each dollar spent processing TARs for other medical services, about $3.40 in program savings are generated.

You should note that ranges of estimated savings and cost-benefit for hospital admission TAR processing are presented. This reflects the inclusion in our analysis of various assumptions about the degree to which fixed hospital costs, apparently avoided due to denial of admission, are redistributed to other Medi-Cal patients in the hospital. Empirical data are not available to clearly define this redistribution pattern.

Also, note that this level of benefit is obtained with the denial or modification of only six percent of all requests for hospital admissions and 12.4 percent of requests for other medical services. Our measures of benefits are based solely on the value of services denied and do not include an estimate of the effects of deterrence. As you know, deterrence (services not requested because of the existence of the prior authorization system) is very difficult to quantify, particularly since prior authorization has been required since 1971 (1970 for hospital admissions). This eliminates reliable standards for comparative analysis. However, our review of the literature and available data to date indicate that the majority of TAR program savings probably result from deterrence.

This analysis can be refined. Due to staffing shortages, we have as yet been unable to adjust for the possibility that some denials of requested hospital admissions may result in emergency admissions. Also, the benefit-cost of prior authorization for admission to long term care facilities and of the onsite concurrent review program for some hospital extensions have not been investigated due to serious methodological problems and, again, staffing shortages.

Significant improvement in the factual bases for policy in this area will require more than these incremental improvements in this analysis. To most clearly address the issues involved in future utilization review structures, a thorough and rigorous comparison of California's system with other utilization review structures is required. Such an analysis must address all facets of system operation and must address quality as well as benefit-cost considerations. As you know, the Department of Health Services has made a proposal for such a study to the Department of Health, Education and Welfare.

I. BACKGROUND

The Medi-Cal program, California's version of the federal Medicaid program presently serves some 2.9 million eligible persons at an annual cost of about $3.8 billion, of which $1.2 billion is expended for hospital inpatient care. The program was initiated in 1966, offering a comprehensive scope of medical services to welfare grant recipients and the medically needy. In its first full year of operation (1967), $566.9 million worth of services -- of which $174.5 million was for hospital inpatient services -- were provided to some 1.4 million eligibles. By 1970, the proportions of the program had grown considerably. Total program costs had almost doubled to $1.06 billion ($380 million for hospital inpatient services) and the eligible population had grown almost 60 percent, to 2.2 million.

At that time, prior authorization for hospital admission and extension of stay beyond length of stay guidelines was initiated. The apparent initial success of this utilization control strategy led to its adoption for outpatient services in October of 1971 as an integral part of the Medi-Cal Reform Plan.

Prior authorization is currently required for non-emergency hospital admission, admission to long term care facilities, more than 8 psychiatric or allergy desensitization visits in a 120 day period, assistive devices and prosthetic/orthotic appliances costing more than $25, hearing devices, all home health services except for

initial evaluations, dialysis, all non-emergency medical transportation, all drugs not included in the Medi-Cal Formulary, and all outpatient physical, speech and occupational therapy. The system operates as follows. A provider wishing to render a service requiring prior authorization to an eligible beneficiary completes a Treatment Authorization Request form. This form is forwarded to one of 12 local Medi-Cal Field Offices where it is reviewed by the appropriate health professional and approved, modified (i.e., only part of a proposed treatment regimen is approved), deferred for additional information, or denied. The provider must attach an approved TAR to each claim for a service requiring authorization in order to obtain reimbursement from the fiscal intermediary.

The Department of Health Services currently employs 364 permanent full-time staff at an annual cost of $9.8 million to maintain the prior authorization system. In this era of fiscal frugality for government programs, particulary subsequent to the passage of Proposition 13 in California, the effectiveness of this expenditure has come under some scrutiny.

Questions as to the effectiveness of the prior authorization system have taken on added importance in light of the federal Professional Standards Review Organization (PSRO) strategy for utilization review. Since 1971, the California utilization review system has operated under the provisions of a "superior system" waiver to federally-mandated utilization review structures. To the extent

that PSROs are not able to prevent provision of inappropriate medical services as effectively as California's current system, the State Treasury may suffer a detrimental fiscal impact.

Within this context, in October of 1978 staff of the Office of Planning and Program Analysis worked with staff of the Medi-Cal Division to devise a methodological approach for assessing the benefits and costs of certain facets of the Medi-Cal utilization control system, specifically prior authorization for hospital admissions and other medical services.

The following report describes the study methodology, presents our analysis of the data, and presents our findings.

II. METHODOLOGY

The basic conceptual framework used in this study is that of a cost-benefit analysis, where cost is defined as the direct and overhead expenditure required to process Treatment Authorization Requests (TARs), and benefit is defined as the value of services denied via TAR processing.

Costs were based on budget and expenditure data for the Medi-Cal Field Services Section provided by the Department's Financial Management Branch. Based on the percentage of person years assigned to each function within each Field Office (e.g., hospital admission TAR review, medical service TAR review, or hospital onsite reviews), various costs were allocated to each function. The estimated total annual costs for hospital admission and medical service TAR processing were then divided by the annual volume of TARs processed for these two TAR categories to identify an average processing cost per TAR. To these per TAR Field Services processing costs, estimated per TAR costs for processing by the fiscal intermediary were added, yielding a total estimated cost to the Department for each TAR processed. It should be noted that no attempt was made to quantify and include any admistrative costs borne by providers due to TAR requirements.

Benefit data were more difficult to obtain. The net value of program savings derived from prior authorization requirements could

also be measured by overall changes in the utilization of services. However, since prior authorization began in 1970, it is difficult to attribute current changes in utilization to the present system; that is, observed changes in utilization patterns may be due to changes in professional practices or may be obscured by changes in reporting practices. Therefore, this study defines benefit as the value of services denied in the TAR process, adjusted for TARs resubmitted or for which substitute services were requested and approved.

It should be noted that such a definition tends to understate the overall benefit of the TAR system since it does not include service costs avoided due to the deterrent effect. Deterrence describes the situation wherein a provider doesn't request to perform a service because of the existence of a review process. By defining benefit as the value of services requested and denied, we do not include the value of services which were not requested but which may have been performed had prior approval not been required.

The data used to calculate the value of services denied are based on two samples of TARs. The first sample (Sample A) consists of all outgoing TARs from the six largest Medi-Cal Field Offices (accounting for 75 percent of total TAR volume) for June 27-28 and October 24-25, 1978. These TARs were reproduced and sent to the Office of Planning and Program Analysis by each Field Office. Each TAR was encoded onto a data form and then key-entered by the State

Franchise Tax Board for computer analysis. The key-entered data were summarized by use of the Statistical Package for the Social Sciences (SPSS) computer program.

The second sample (Sample B) is a "follow-up" sample on all modified, denied and deferred TARs from the June 27 and 28, 1978 portion of Sample A. The data for Sample B were collected by returning the modified, denied and deferred TARs to the originating Field Offices so that the rate of resubmitted and substituted TARs and their average dollar value could be calculated. In each Field Office, a Department physician reviewed the TAR and the beneficiary file to determine if the TAR was resubmitted or if a TAR requesting a substitute service was received by the Field Office in the ensuing six months. These data were then encoded indicating the final action and final dollar value of services approved, and forwarded to OPPA for key-entry and computer analysis.

Simply put, the computer analysis entailed summarizing the total dollar value of services initially denied in TAR processing by TAR category, summarizing the total dollar value of substitution or resubmission and approval of initially denied services by TAR category, subtraction of the latter from the former, and division of the net total value of services denied for each TAR category by the number of TARs processed in each category to derive a net value of services denied for each TAR processed. For hospital admission TARs, this figure was adjusted for various assumptions about fixed

and variable hospital cost relationships and about the percentage of Medi-Cal eligibles in the hospital inpatient population.

These figures were then compared to per TAR cost figures to identify benefit-cost ratios and were projected to annual TAR volume by TAR category to derive an estimate of total annual savings generated by TAR requirements.

Appendix I to this report details the derivation of TAR benefit data and Appendix II details the derivation of TAR processing costs.

Finally, it should be noted that, whenever judgment was applied in the computation or interpretation of these data, we purposefully made that judgment which tended to yield the most conservative estimate of benefit-cost. For example, all Field Services headquarters and field administrative costs were allocated to TAR processing, although some portion of those costs are related to other functions, such as annual medical review of Skilled Nursing and Intermediate Care patients and PSRO monitoring. This procedure leads to an overstatement of costs, generating a conservative estimate of the program's benefit-cost ratio.

III. Findings and Analysis

A. Projected Annual Benefits

Table 1 on the following page summarizes our findings on the total annual service cost savings derived from processing TARs for various medical services. As shown, medical TAR processing generates about $12.7 million in net annual service cost savings. This is equivalent to a $28 savings for every medical TAR processed.

Note that the categories of Home Health and Dialysis did not have sufficient data to quantify savings and were therefore not included. The "other" category is also less reliable due to the limited number of these cases in the sample. These three categories combined represent less than one percent in our sample.

Table 2 on page 10 summarizes our findings on the total annual service cost savings derived from hospital admission TAR processing. As shown, hospital admission TAR processing generates from $12.6 to $18.8 million in net annual service cost savings depending on fixed/variable cost relationships and Medi-Cal occupancy, with a mid-range estimate of $16.3 million. At the mid-range estimate, $94 are saved for each TAR processed.

Our sample indicated that approximately $20 million were saved

TABLE 1

Medical TAR Processing
Projected Annual Benefits

Category	Total Net Savings Per TAR	Projected Annual TARS "Population"	Projected Annual Benefits
Physician Office Visit	$ 24.45	26,204	$ 640,688
Assistive Devices	32.65	93,820	3,063,223
Prosthetic/Orthotic	33.43	54,196	1,811,772
Hearing Services	32.27	24,464	789,453
Psychiatry	91.45	36,968	3,380,724
Physical, Speech, Occup. Therapy	23.14	41,484	959,940
Home Health	No Data	17,957	No Data
Dialysis	No Data	1,336	No Data
Transportation	11.84	163,340	1,933,946
Other	143.73	740	106,360
TOTAL	$ 27.55	460,508	$12,686,106

TABLE 2
Hospital Admission TAR Processing
Projected Annual Benefits

% Fixed Cost	% Non-Medi-Cal Patients	Daily Rate Savings	Total Net Savings Per Tar	Projected Annual TARs "Population"	Projected Annual Benefits
40%	20%	$209.44	$ 87.11	173,068	$15,075,954
40	40	234.08	94.27	173,068	16,315,120
40	60	258.72	101.42	173,068	17,552,557
40	80	283.36	108.57	173,068	18,789,993
50	20	184.80	79.96	173,068	13,838,517
50	40	215.60	88.89	173,068	15,384,015
50	60	246.40	97.86	173,068	16,936,435
50	80	277.20	106.79	173,068	18,481,932
60	20	160.16	72.80	173,068	12,599,350
60	40	197.12	83.53	173,068	14,456,370
60	60	234.08	94.27	173,068	16,315,120
60	80	271.04	105.00	173,068	18,172,140

annually by hospital admission TAR processing (see page 24 of Appendix I). However, this figure assumes 100 percent savings of all per diem hospital inpatient costs, fixed and variable, or $308 per day. Since some undetermined portion of fixed costs are actually redistributed and paid for by Medi-Cal on behalf of other eligible patients in the hosital, we conducted a sensitivity analysis assuming varying fixed cost redistribution patterns. The following formula was used to determine adjusted daily rate savings:

F($308)(N) + V($308) = adjusted daily rate savings, where:
F = percent of the daily rate which represents fixed costs;
N = percent of non-Medi-Cal patients in facility; and,
V = percent of the daily rate which represents variable costs.

Using this formula, daily rate savings were calculated for fixed cost levels of 40%, 50% and 60%; and non-Medi-Cal inpatient populations of 20%, 40%, 60% and 80%. From this, net savings per hospital admission TAR were calculated and projected to the total annual hospital admission TAR population (as shown on Table 2).

B. Projected Annual Costs

As shown in Table 3, the Department expends an estimated $3.8 million annually processing TARs for various medical services at an average cost of $8.18 each. This cost includes estimated

TABLE 3
FY 1978-79
Projected Annual Costs

TAR Category	Annual TARs Processed	Annual Processing Cost	Cost Per TAR
Medical			
Physician Office Visit	26,204	$ 214,349	$ 8.18
Assistive Device	93,820	767,448	8.18
Prosthetic Orthotic	54,196	443,323	8.18
Hearing Services	24,464	200,116	8.18
Psychiatry	36,968	302,398	8.18
Phys., Speech, Occ. Therapy	41,484	339,339	8.18
Home Health	17,956	146,880	8.18
Dialysis	1,336	10,928	8.18
Transportation	163,340	1,336,121	8.18
Other	740	6,053	8.18
TOTAL	460,508	$3,766,955	$ 8.18
Hospital Admissions	173,068	$1,934,901	$ 11.18

fiscal intermediary costs of $1.00 for each medical TAR.

It should be noted that, though there could be some cost variation among the sub-categories of medical TARs, data were not sufficient to quantify such variation. Therefore, we prorated the total medical TAR cost among the sub-categories in proportion to their annual volume (see detail in Appendix II).

As shown in Table 3, the Department also expends almost $2 million annually processing TARs for hospital admission, at an average cost of $11.18 each. This cost includes estimated fiscal intermediary costs of $4.00 for each hospital admission TAR processed.

C. Benefit-Cost Ratios

Table 4 details the benefit-cost ratios for medical TAR processing. As shown, about $3.40 are saved for every dollar spent on processing medical TARs. These program savings are obtained even though only 12.4 percent of all medical TARs are denied or modified.

This benefit-cost ratio is skewed by the comparatively low benefit-cost ratio of Transportation TAR processing (1.5:1) which comprises about 35 percent of the annual total medical

TABLE 4
Medical TAR Processing
Benefit-Cost Ratios

TAR Category	(1) Projected Annual Benefits	(2) Projected Annual Cost	(1)÷(2) Benefit-Cost Ratio
Medical			
Physician Office Visit	$ 640,688	$ 214,349	3:1
Assistive Devices	3,063,223	767,448	4:1
Prosthetic/Orthotic	1,811,772	443,323	4:1
Hearing Services	789,453	200,116	4:1
Psychiatry	3,380,724	302,398	11:1
Phys., Speech, Occ. Therapy	959,940	339,339	3:1
Home Health	No Data	146,880	No Data
Dialysis	No Data	10,928	No Data
Transportation	1,933,946	1,336,121	1.5:1
Other	106,360	6,053	18.5:1
TOTAL	$ 12,686,106	$ 3,766,955	3.4:1

TAR volume. That is, 35 percent of the medical TAR processing effort is directed toward those TARs which generate the lowest benefits. If transportation TAR processing costs and savings are eliminated from the analysis, an overall benefit-cost ratio of 4.4:1 is obtained. It is noteworthy that experienced program staff feel that TAR requirements on medical transportation are justified primarily because of their deterrent value, perhaps more so than other professional services.

Table 5 presents a range of benefit-cost ratios for hospital admission TAR processing based on the range of projected annual benefits shown in Table 2. At the high end of the range, $9.60 are saved for each dollar of processing cost; at the low end, $6.50 are saved for each dollar of processing cost. The mid-range estimate is 8.4:1.

D. The Deterrent Effect

Though we have considered in our benefit-cost analysis only those savings generated by disapproval of requested services, it is also reasonable to expect that prior authorization would have some deterrent effect; that is, prior authorization requirements actually induce some reduction in service requests. That this effect exists has been postulated.[1] How-

[1] Holahan, John; "Physician Supply, Peer Review and Use of Health Services in Medicaid"; The Urban Institute; February 1976; p. 65

TABLE 5

Hospital Admission TAR Processing
Benefit-Cost Ratios

% Fixed Cost	% Non-Medi-Cal Patients	Projected Annual Benefits	Projected Annual Costs	Benefit-Cost Ratio
40%	20%	$15,075,954	$1,934,901	7.8:1
40	40	16,315,120	1,934,901	8.4:1
40	60	17,552,557	1,934,901	9.1:1
40	80	18,789,993	1,934,901	9.7:1
50	20	13,838,517	1,934,901	7.2:1
50	40	15,384,015	1,934,901	8:1
50	60	16,936,435	1,934,901	8.8:1
50	80	18,481,932	1,934,901	9.6:1
60	20	12,599,350	1,934,901	6.5:1
60	40	14,456,370	1,934,901	7.5:1
60	60	16,315,120	1,934,901	8.4:1
60	80	$18,172,140	$1,934,901	9.4:1

ever, to quantify this effect - i.e., to measure the number, type, and value of services not requested because of prior authorization requirements, presents some practical methodological difficulties. It requires the measurement of something which, by definition, has not occurred.

Nonetheless, several attempts have been made, all suffering from various methodological problems but each presenting a reasonably fair quantification of the deterrent effect. Since California has one of the most advanced prior authorization systems in the nation, these analyses have typically focused on the California system.

In 1972, Michael Crane and Richard Morey estimated that, on the average, for every dollar spent on TAR processing, $58 were saved, of which only 1 percent was due to service denial. The rest accrued from deterrence.[2]

In 1973, Bruce Stuart and Ronald Stockton found that with the implementation of prior authorization for hospital admissions and extensions, the Medi-Cal program paid for 100,000 patient days less in 1970 than in 1969, despite a 23 percent increase in eligibility. At the same time, only seven percent of requested

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[2]Crane, Michael A., Ph.D., and Morey, Richard C., Ph.D.; "The Cost Effectiveness of the Medi-Cal Controls Relating to Medical Visits"; Control Analysis Corporation; Palo Alto, CA; November 1972

hospital days were denied. The balance of the reduction is attributed to deterrence.[3]

In 1976, Anthony Capelli found that after the introduction of prior authorization for hospitalization in 1970, the Medi-Cal admission rate dropped 13.1 percent while only two percent of the requested admissions were denied. Capelli estimates that for Fiscal Year 1974, $75.91 million of savings in hospital costs were generated at an administrative cost of $1.2 million. He concludes that most of these savings were the product of the deterrent effect.[4]

Thus, though this deterrent effect has not been specifically identified and quantified, there is evidence to strongly suggest that deterrence is a major product of prior authorization. In fact, this experience suggests that benefits derived from deterrence may far outweigh the benefits identified in this report which derive solely from modification and denial of requested service.

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[3]Stuart, Bruce and Stockton, Ronald; "Control Over the Utilization of Medical Services"; The Milbank Memorial Fund Quarterly; Vol. 51, No. 3; 1973; p. 345

[4]Capelli, Anthony; "Impact of Utilization Controls on Medicaid"; Universal Analytical, Inc.; Plaza del Roy, CA; July 1, 1976; p. 158

APPENDIX I

Detailed Methodology for Calculating Benefits

The data used to calculate the benefits of the prior authorization system (value of services denied) are based on two samples of TARs. The first sample (Sample A) consists of all outgoing TARs from the six largest Medi-Cal Field Offices (accounting for 75 percent of total TAR volume) for June 27-28 and October 24-25, 1978. The second (Sample B) is a "follow-up" sample on all modified, denied and deferred TARs from the June 27 and 28, 1978 portion of Sample A. The data for Sample B were collected by returning the modified, denied and deferred TARs to the originating Field Offices so that the rate of resubmitted and substituted TARs and their average dollar value could be calculated.

The following describes the process and calculations used to project savings. This methodology consists of the following three sections:

I. Sample Validation

II. Savings Calculations

III. Projection of Sample Data to Population

I. SAMPLE VALIDATION

In order to evaluate whether the June part and October part of Sample A were representative of the population, we first tested the parts to each other statistically to see if they could be combined. Initial data received from computer runs indicated a non-normal distribution. Because parametric statistics require a normal distribution, this finding required the statistical analysis to be limited to non-parametric statistical methods. To test the similarity or dissimilarity of these two parts, several statistical tests were applied. Table I-2 shows the Spearman Rank Order Correlation Test comparing the June part with the October part. This Table indicates a correlation coefficient of .97 which is exceptionally high. Such a correlation statistically permits the inference that the June and October parts are both from the same population. Thus, both parts were combined into one sample (Sample A). Table I-3 shows the Spearman Rank Order Correlation Test comparing the Sample A with the Projected Annual TARs 1978-79 from Appendix II, Table II-2 (which will hereafter be referred to as the "population"). The results demonstrate a correlation coefficient of .97.

Therefore, we can make reliable inferences to parameters of the population from data found in the composite sample. Additional non-parametric statistical tests which further support the level of reliability are the Mann-Whitney U-Test (Table I-4) and the Wilcoxon Matched Pairs Signed Rank Test (Table I-5).

In order to arrive at a more accurate estimate for TAR dollar value projections, the Sample A data were truncated at $1.00 and $5,000 (Hospital Admissions were excluded). TARs indicating a value less than $1.00 and TARs exceeding $5,000 (except for Hospital Admissions) were eliminated from Sample A after discussions with program staff revealed that such values were almost impossible to achieve in the respective TAR categories. This process eliminated 18% of the TARs in the Sample. The truncated sample (here after referred to as Sample A_t) is displayed in Table I-6. The reliability of Sample A_t was compared to the population by use of the Spearman-Rank Order Correlation Test. Table I-7 presents the results of that test which shows a correlation coefficient of .93.

Additionally, the disposition of TARs from Sample A_t was compared to the disposition of TARs from the population and is presented in Table I-8. This comparison shows a percent difference between the two groups of TARs ranging from 0.1 to 6.9 percent and averaging 1.5 percent for Medical TARs and 3.5 percent for Hospital TARs. These test results indicate that Sample A_t can be used to make reliable projections to the population.

TABLE I-1

SUMMARY OF

SAMPLE A BY CATEGORY AND INITIAL ACTION[1/]

Category of TAR	June					October					TOTAL
	Denied	Modified	Deferred	Approved	Total	Denied	Modified	Deferred	Approved	Total	Combined
Physician Office Visit	9	8	22	142	181	10	19	25	124	178	359
Assistive Devices	35	16	70	336	457	65	10	69	323	467	924
Prosthetic Orthotic	36	1	45	384	466	30	2	40	278	350	816
Hearing Services	16	0	14	134	164	4	1	16	82	103	267
Psychiatry	3	42	17	259	321	16	46	31	251	344	665
Physical, Speech, and Occup. Therapy	8	14	35	100	157	17	24	35	140	216	373
Home Health	0	9	12	58	79	4	15	10	69	98	177
Dialysis	0	0	2	3	5	0	0	2	4	6	11
Transportation	115	4	153	652	924	51	13	88	535	687	1611
Other	3	0	1	12	16	1	0	2	2	5	21
Hospital Admissions	48	25	203	801	1077	25	14	92	605	736	1813
TOTALS	273	119	574	2881	3847	223	144	410	2413	3190	7037

1/ From computer printouts:

HDJPTDOL Job 6693 (Total TARs June)
HDJPTDOL Job 7824 (Denied TARs June)
HDJPTDOL Job 1996 (Modified TARs June)
HDJPTDOL Job 3375 (Approved TARs June)

HDJPTDOL 2 Job 8249 (Total TARs October)
HDJPTDOL 2 Job 7709 (Denied TARs October)
HDJPTDOL 2 Job 7681 (Modified TARs October)
HDJPTDOL 2 Job 6708 (Approved TARs October)

Table i-2
Spearman Rank Order Correlation Test
Comparison of June and October Parts
Of Sample A

Category	June 27-28		October 24-25	
	% of Total TARs	Rank	% of Total TARs	Rank
Physician Office Visit	5	6	6	7
Assistive Devices	12	3.5	15	3
Prosthetic/Orthotic	12	3.5	11	4.5
Hearing Devices	4	7.5	3	8.5
Psychiatry	8	5	11	4.5
Physical, Speech, Occup. Therapy	4	7.5	7	6
Home Health	2	9	3	8.5
Dialysis	.1	11	.2	10.5
Transportation	24	2	21	2
Other	.5	10	.2	10.5
Hospital Admissions	28	1	23	1
Total (including Hospital Admissions)	99.5[1]		100.4[1]	

Using $r_s = 1 - \frac{6 \sum_{i=1}^{n} D_i^2}{n(n^2 - 1)}$

$r_s = .97$

[1] Percentages do not add up to 100 due to rounding.

Table I-3

Spearman Rank Order Correlation Test

Comparison of Sample A and TAR Population

Category	Sample A % of Total TARs	Rank	Population % of Total TARs	Rank
Physician Office Visit	5	6.5	4	7.5
Assistive Devices	13	3	15	3
Prosthetic/Orthotic	12	4	9	4
Hearing Devices	4	8	4	7.5
Psychiatry	9	5	6	6
Physical, Speech, Occup. Therapy	5	6.5	7	5
Home Health	3	9	3	9
Dialysis	.2	11	.2	10
Transportation	23	2	25	2
Other	.3	10	.1	11
Hospital Admissions	26	1	27	1
Total (including Hospital Admissions)	100.5[1/]		100.3[1/]	

Using $r_s \; 1 - \frac{6 \sum_{i=1}^{n} D_i^2}{n^1 \; (n^2 1)}$

Sample A to Population $r_s = .97$

1/ Percentages do not add up to 100 due to rounding.

Table I-4

MANN WHITNEY U TEST

COMPARISON OF SAMPLE A AND POPULATION

Category	Sample A		Population	
	% of Total TARS	Rank	% of Total TARS	Rank
Physician Office Visit	5	10.5	4	8
Assistive Devices	13	17	15	18
Prosthetic/Orthotic	12	16	9	14.5
Hearing Devices	4	8	4	8
Psychiatry	9	14.5	6	12
Physical, Speech, Occup. Therapy	5	10.5	7	13
Home Health	3	5.5	3	5.5
Dialysis	.2	2.5	2	2.5
Transportation	23	19	25	20
Other	.3	4	.1	1
Hospital Admissions	26	21	27	22
Total (including Hospital Admissions)	11	128.5	11	124.50

This is a test for differences between the two groups: $H_0: \mu_{s_c} = \mu_{pop}$

Using $U^1 = n_1 n_2 + \frac{n_1(n_1+1)}{2} - R_1$

where n_1 = N in group 1

n_2 = N in group 2

R_1 = Sum of Rank of Group 1

$U^1 = 58.5$[1/]

Reference to Critical Values for U^1 indicate a U of 58.5 is not significant therefore the H_0 is not rejected (i.e., the groups are not significantly different.

Table I-5

WILCOXON MATCHED PAIRS SIGNED RANK TEST

SAMPLE A AND POPULATION

Category	Sample A %	Population	Differ	Differ By Rank	Rank With Negative Sums
Physician Office Visit	5	4	1	2.5	
Assistive Devices	13	15	-2	-4	-4
Prosthetic/Orthotic	12	9	3	6.5	
Hearing Devices	4	4	0	--	
Psychiatry	9	6	3	6.5	
Physical, Speech, Occup. Therapy	5	7	-2	4	-4
Home Health	3	3	0	--	
Dialysis	.2	.2	0	--	
Transportation	23	25	-2	-4	
Other	.3	.1	.2	1	
Hospital Admissions	26	27	-1	-2.5	-2.5

N = 11

T = -14.5[1/]

[1/] Reference to Critical Values of T indicate that to demonstrate a significant difference at the .10 level for a two tailed test would require at T value of 13 or lower (absolute value). Therefore, the two groups are not significantly different at the .10 level.

TABLE I-6

SAMPLE A_t TRUNCATED TARs BY CATEGORY AND INITIAL ACTION [1/]

Category of TAR	June					October					TOTAL
	Denied	Modified	Deferred	Approved	Total	Denied	Modified	Deferred	Approved	Total	Combined
Physician Office Visit	5	3	17	87	112	8	13	15	92	128	240
Assistive Devices	32	14	66	328	440	64	10	63	312	449	889
Prosthetic Orthotic	27	1	37	311	376	27	2	34	238	301	677
Hearing Services	14	-0-	14	134	162	3	1	16	81	101	263
Psychiatry	3	33	12	202	250	12	38	30	208	288	538
Physical, Speech, and Occup. Therapy	2	11	3	46	62	11	11	15	74	111	173
Home Health	-0-	-0-	6	18	24	-0-	2	4	21	27	51
Dialysis	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Transportation	87	3	82	470	642	43	9	58	369	479	1121
Other	1	-0-	-0-	11	12	-0-	-0-	1	2	3	15
Hospital Admissions	48	25	200	801	1074	25	14	91	605	735	1809
TOTALS	219	90	437	2,408	3,154	193	100	327	2,002	2,622	5,776

[1/] From computer Printouts:

HDRTDOL 1 Job 9151 (Truncated TARs - June) Pages 28-33
HDRTDOL 2 Job 8935 (Truncated TARs - October) Pages 28-33
HDRTDOL 1 Job 2280 (Total TARs - June) Page 17
HDRTDOL 2 Job 2290 (Total TARs - October) Page 17

TABLE I-7

Spearman Rank Order Test

Comparison of Sample A_t and Population

Category	Sample A_t		Population	
	%	Rank	%	Rank
Physician Office Visit	5	7	4	7.5
Assistive Devices	19	3	15	3
Prosthetic/Orthotic	14	4	9	4
Hearing Services	6	6	4	7.5
Psychiatry	12	5	6	6
Physical, Speech, Occup. Therapy	4	8	7	5
Home Health	1	9	3	9
Dialysis	0	11	12	10
Transportation	24	1	26	2
Other	.3	10	.1	11
Hospital Admissions	15	2	27	1

Truncated Sample A_t to Population r_s = .93[1/]

[1/] For Formula See Table I-2, Pg. 5

TABLE I-8

Comparison of Sample A_t and Population

Disposition of TARs

	Sample A_t		Population		Percent
	Number	Percent	Number	Percent	Difference
Medical	2,080	100.0%	460,508	100.0%	--
Denied	171	8.2	25,172	5.5	2.7
Modified	65	3.1	17,884	3.9	.8
Deferred	237	11.4	63,308	13.7	2.3
Approved	1,607	77.3	354,144	76.9	.4
Hospital	1,074	100.0%	173,068	100.0%	--
Denied	48	4.5	7,968	4.6	.1
Modified	25	2.3	15,980	9.2	6.9
Deferred	200	18.6	25,416	14.7	3.9
Approved	801	74.6	123,704	71.5	3.1

II. SAVINGS CALCULATIONS

Savings were calculated based on the value of services denied in each category. To calculate savings, each category of TARs in the sample was summarized by dollars denied and divided by the total number of TARs in that category. This resulted in savings per TAR. Where applicable, savings were adjusted for resubmitted TARs and substituted services from Sample B, resulting in a net savings per TAR.

Section A discusses savings from TARs initially denied. Section B discusses savings from TARs initially modified. Section C discusses savings from TARs initially deferred.

A. Savings Calculations for Denied TARs

TARs which are denied authorize none of the services requested. However, the provider may resubmit the TAR to the Field Office for further consideration or request a substitute service in its place. For this reason, two calculations were made for denied TARs. The first calculation summed all the denied TARs and total dollar savings by category from Sample A_t. The total dollar savings was divided by all the TARs in that category resulting in a dollar savings per TAR. Table I-9 details these savings.

The second calculation is an adjustment to the first calculation. Adjustments to savings were made for denied TARs resubmitted within six months and subsequently approved or modified, or, when a substitute service was requested within six months and subsequently approved or modified. This resubmission and substitution data were obtained from Sample B. Adjustments to the total apparent value of denied TARs were calculated on a per TAR basis using the following formula:

$$\text{Adjustment} = \frac{(Nd)(R)(V)}{N}$$

where

N = the number of TARs in Sample A_t

Nd = the number of initially denied TARs in Sample A_t

R = the proportion of TARs in Sample B which were denied and subsequently resubmitted and approved, or for which substitute services were requested and approved.

V = the average dollar value of services which were approved subsequent to the initial denial of a TAR in Sample B.

This adjustment factor is then subtracted from the computed gross per TAR savings derived from denials.

Adjustments for denied TARs which are subsequently modified were determined with the same methodology. Table I-10 details the adjustments per TAR due to denied/approved TARs and denied/modified TARs. The net savings per TAR is presented in Table I-11 and was calculated by summing adjustments per TAR for denied/approved and denied/modified and subtracting that adjustment from the initial savings from the initial savings from Sample A_t (Table I-9).

TABLE I-9

Savings For Denied TARs

Category	Dollars Denied TARs[1]	Total Number TARs in Category[2]	Dollar Savings Per TAR
Physician Office Visit	$ 1,052	240	$ 4.38
Assistive Devices	20,731	889	23.32
Prosthetic/Orthotic	20,702	677	30.58
Hearing Services	4,074	263	15.49
Psychiatry	7,845	538	14.58
Physical, Speech, Occup. Therapy	2,459	173	14.21
Home Health	-0-	51	-0-
Dialysis	-0-	-0-	-0-
Transportation	14,638	1,121	13.06
Other	2,156	15	143.73
Hospital Admissions	60,343	1,809	33.36

[1] Based on Computer Printouts:
HDTDOLT 1 #2280, Pages 12-17 (Sample A_t - June part)
HDTDOLT 2 #2290, Pages 12-17 (Sample A_t - October part)
HDJPTDOL #7824 and 7708, Page 4 (Hospital Admissions)

[2] From Table 1-6, Pg. 9, Sample A_t - Truncated TARs by Category and Initial Action.

TABLE I-10

Adjustments to Denied TARs[1/]

Category	APPROVED			MODIFIED		
	Dollars	#TARs[2/]	Adjustment Per TAR	Dollars	#TARs[2/]	Adjustment Per TAR
Physician Office Visit	-0-	240	-0-	-0-	240	-0-
Assistive Devices	$ 1,921	889	$ 2.16	$1,693.	889	$ 1.91
Prosthetic/Orthotic	2,363	677	3.49	-0-	677	-0-
Hearing Services	1,265	263	4.81	3.	263.	.01
Psychiatry	720.	538	1.34	900.	538	1.67
Physical, Speech, Occup. Therapy	2,439.	173	14.10	-0-	173	-0-
Home Health	-0-	51	-0-	-0-	51	-0-
Dialysis	-0-	-0-	-0-	-0-	-0-	-0-
Transportation	11,376	1,121	10.15	264.	1,121	.24
Other	-0-	15	-0-	-0-	15	-0-
Hospital Admissions	17,604.	1,809	9.73	-0-	1,809	-0-

1/ Based on Computer Printout:
TARSUB #2606 (Sample B)

2/ From Table I-6, Pg. 9, Sample A_t - Truncated TARs by Category and Initial Action.

TABLE I-11

Net Savings for Denied TARs

Category	Initial Dollar Savings Per TAR[1]	Adjustment Per TAR[2]	Net Savings Per Denied TAR
Physician Office Visit	$ 4.38	-0-	$ 4.38
Assistive Devices	23.32	$ - 4.07	19.25
Prosthetic/Orthotic	30.58	- 3.49	27.09
Hearing Services	15.49	- 4.82	10.67
Psychiatry	14.58	- 3.01	11.57
Physical, Speech, Occup. Therapy	14.21	- 14.10	.11
Home Health	-0-	-0-	-0-
Dialysis	-0-	-0-	-0-
Transportation	13.06	-10.39	2.67
Other	143.73	-0-	143.73
Hospital Admissions	33.36	- 9.73	23.63

1/ From Table I-9, Pg. 15, Savings For Denied TARs.

2/ From Tables I-10, Pg. 16, Adjustments to Denied TARs.

B. Savings Calculations for Modified TARs

TARs which are modified authorize only a portion of the services requested and deny the other portion. Savings from modified TARs are based on the portion of the requested value which is denied. The savings data for modified TARs was obtained from Sample B. The process for collecting data for Sample B for modified TARs is the same as for denied TARs.

The following calculation was made to estimate savings from modified TARs in Sample A_t:

$$\text{Savings for Modified TARs} = \frac{(Nm)(R)(V)}{N}$$

N = the number of TARs in Sample A_t

Nm = the number of modified TARs in Sample A_t

R = the proportion of TARs in Sample B which were modified and subsequently resubmitted and denied or modified, or for which substituted services were requested and denied or modified.

V = the average dollar value of services which were denied for modified TARs in Sample B.

Table I-12 details the denied value of modified TARs and average dollar savings per TAR.

TABLE I-12

Net Savings for Modified TARs

Category	Dollars[1] Denied	Total TARs[2] in Category	Net Dollar Savings Per TAR
Physician Office Visit	$ 3,686.	240	$ 15.36
Assistive Devices	1,717.	889	1.94
Prosthetic/Orthotic	44.	677	.06
Hearing Services	-0-	263	-0-
Psychiatry	5,335.	538	9.92
Physical, Speech, Occup. Therapy	2,915.	173	16.85
Home Health	No Data	51	No Data
Dialysis	No Data	-0-	No Data
Transportation	296.	1,121	.27
Other	-0-	15	-0-
Hospital Admissions	21,575.	1,809	11.93

[1] Based on Computer Printout:
TAR SUB #2606 pages 8-12, 27-31 (Sample B)

[2] From Table I-6, Pg. 9, Sample A_t - Truncated TARs by Category and Initial Action.

C. Savings Calculations for Deferred TARs

A deferred TAR is a TAR returned to the provider with no action taken. These TARs are returned due to either a lack of medical or administrative information. Savings are generated by TAR deferral when deferred TARs are resubmitted or a substitute service is requested and are subsequently modified or denied and when deferred TARs are never resubmitted nor is a substitute service requested.

Savings for deferred TARs were calculated separately by category for TARs which were modified, denied, or never resubmitted. The following formula was used to calculate savings for deferred TARs:

$$\text{Savings for Deferred TARs} = \frac{(Nd)(R)(V)}{N}$$

where N = the number of TARs in Sample A_t

Nd = the number of deferred TARs in Sample A_t

R = the proportion of TARs in Sample B which were deferred and never resubmitted or subsequently resubmitted and denied or modified, or for which substituted services were requested and denied or modified.

V = the average dollar value of services for deferred TARs in Sample B which were never resubmitted, or which were resubmitted and subsequently denied, or modified, or for which substituted services were requested and denied or modified.

Table I-13 details these net savings for deferred TARs.

TABLE I-13

Net Savings For Deferred TARs [1]

Category	Dollars Modified	Dollars Denied	Dollars Never Resubmitted	Total Savings	Number TARs in Category	Net Savings Per TAR
ician Office Visit	$ -0-	-0-	$ 1,130	$ 1,130	240	$ 4.71
ctive Devices	1,169.	$ 565.	8,450	10,184	889	11.46
thetic/Orthotic	-0-	65.	4,225	4,290	677	6.34
ing Services	-0-	729.	4,951	5,680	263	21.60
iatry	-0-	-0-	37,639	37,639	538	69.96
ical, Speech, p. Therapy	432.	-0-	636.	1,068.	173	6.18
ealth	-0-	-0-	-0-	-0-	51	-0-
sis	-0-	-0-	-0-	-0-	-0-	-0-
rtation	939.	823.	8,215	9,977	1,121	8.90
	-0-	-0-	-0-	-0-	15	-0-
ital Admission	11,614	20,489.	112,937.	145,040	1,809.	80.18

[1] Based on Computer Printout:
TARSUB #2606 Pages 5 and 6, 23, 24, 27-31

III. Projection of Sample Data to Population

To determine the savings from the TAR system on an annual basis, the total net savings per TAR by category was calculated first. This was done by a summing net denied savings per TAR (from Table I-11), modified savings per TAR (from Table I-12), and deferred savings per TAR (from Table I-13). Table I-14 illustrates these savings per TAR by category. The total net savings per TAR was then multiplied by the annual projected population of TARs resulting in the projected annual savings. These figures are shown in Table I-15.

Table I-16 is a projection of the annual TARs denied, modified and deferred by category based on Sample A initial actions. These projections were made by calculating the percentage of denied, modified and deferred TARs in Sample A (Table I-17) and applying that percentage to the population.

TABLE I-14

Total Net Savings Per TAR
By Category

Category	Denied $[1] Savings Per TAR	Modified $[2] Savings Per TAR	Deferred $[3] Savings Per TAR	Total Net Savings Per TAR
Physician Office Visit	$ 4.38	$15.36	$ 4.71	$ 24.45
Assistive Devices	19.25	1.94	11.46	32.65
Prosthetic/Orthotic	27.09	-0-	6.34	33.43
Hearing Services	10.67	-0-	21.60	32.27
Psychiatry	11.57	9.92	69.96	91.45
Physical, Speech, Occup Therapy	.11	16.85	6.18	23.14
Home Health	-0-	No Data	-0-	No Data
Dialysis	No Data	No Data	No Data	No Data
Transportation	2.67	.27	8.90	11.84
Other	143.73	-0-	-0-	143.73
Hospital Admissions	23.63	11.93	80.18	115.74

[1] From Table I-11, Pg. 17, Net Savings for Denied TARs.

[2] From Table I-12, Pg. 19, Net Savings for Modified TARs.

[3] From Table I-13, Pg. 21, Net Savings for Deferred TARs.

TABLE I-15

Projected Annual Savings

Category	Total Net Savings Per TAR [1]	Projected Annual TARs "Population"	Projected Annual Savings
Physician Office Visit	$ 24.45	26,204	$ 640,688
Assistive Devices	32.65	93,820	3,063,223
Prosthetic/Orthotic	33.43	54,196	1,811,772
Hearing Services	32.27	24,464	789,453
Psychiatry	91.45	36,968	3,380,724
Physical, Speech, Occup. Therapy	23.14	41,484	959,940
Home Health	No Data	17,957	No Data
Dialysis	No Data	1,336	No Data
Transportation	11.84	163,340	1,933,946
Other	143.73	740	106,360
Hospital Admissions	115.74	173,068	20,030,890

[1] From Table I-14, Pg. 23, Total Net Savings Per TAR by Category.

TABLE I-16
Percent of TARs Approved Modified, Denied
or Deferred in Sample A

Category	Sample A - Percent			
	Approved	Modified	Denied	Deferred
Physician Office Visit	74%	8%	5%	13%
Assistive Devices	71	3	11	15
Prosthetic/Orthotic	81.6	.4	8	10
Hearing Services	81.6	.4	7	11
Psychiatry	77	13	3	7
Physical, Speech, Occup. Therapy	64	10	7	19
Home Health	72	14	2	12
Dialysis	64	0	0	36
Transportation	74	1	10	15
Other	67	0	19	14
Hospital Admissions	78	2	4	16

TABLE I-17

Projection of Annual TARs
by Initial Action

Category	Approved	Modified	Denied	Deferred	Total
Physician Office Visit	19,392	2,096	1,310	3,406	26,204
Assistive Devices	66,612	2,815	10,320	14,073	93,820
Prosthetic/Orthotic	44,223	217	4,336	5,420	54,196
Hearing Services	20,035	98	1,712	2,619	24,464
Psychiatry	28,465	4,806	1,109	2,588	36,968
Physical, Speech, Occup. Therapy	26,550	4,148	2,904	7,882	41,484
Home Health	12,928	2,514	359	2,155	17,956
Dialysis	855	-0-	-0-	481	1,336
Transportation	120,872	1,633	16,334	24,501	163,340
Other	495	-0-	141	104	740
Hospital Admissions	134,994	3,461	6,922	27,691	173,068
TOTALS	475,421	21,788	45,447	90,920	633,576

APPENDIX II

Methodology Utilized for Field Services Section Field Office Budget Computations

The following narrative describes the methodology used to make computations for TAR processing costs. These calculations are the base figures used in all cost computations in this report. The narrative is organized by budget line item. Differences between the Budget Office figures and OPPA figures are noted in footnotes.

Personal Services

01 Gross Salaries and Wages $ 6,864,052 1/

Person Years 384.2 2/

Methodology: Budget Office supplied a list of budgeted positions in each field office. Based on annual salaries of those classifications also supplied by the Budget Office, a listing of all classifications and annual salaries was developed (see page 7 Appendix II). Each field office determined a breakdown of person years by function by classification. The annual salaries of each classification (within each field office) were multiplied by the number of person years

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1/ This figure is $63,793 higher than Budget Office figures due to the use of a standard annual salary per classification instead of actual salaries as used by the Budget Office. This discrepancy amounts to less than one percent of gross salaries and wages.

2/ The difference between Budget Office figures for number of budgeted positions and field office figures is two. The Budget Office figures show 1.0 HPT II in Fresno and 1.0 AGPA in San Diego. The field office figures do not show these positions.

assigned to that function. The annual salaries for all classifications within that function were summed. Gross salary and wages were figured by summing the salaries assigned to each function for all field offices. Person years were determined by summing all person years assigned to each function for all field offices.

05	Temporary Help Person Years 18.7 Methodology: These figures were supplied by the Budget Office.	$ 430,322
Total Salary and Wages	Methodology: Gross salaries and wages from computation ($6,864,052) plus temporary help salary and wages from Budget Office ($430,322).	$ 7,294,374
07	Salary Savings Methodology: Based on Budget Office figures, salary savings was -$1,259,343.[3/] Salary savings by Budget Office totals for gross salary and wages ($7,220,581). Based on this computation, the figure of 17% was applied to the gross salary and wage figure for each function for all field offices.	- $ 1,241,334

3/ The Budget Office figure for salary savings is $18,009 higher than that computed by OPPA due to the use of OPPA calculated gross salaries and wages (explained in 1/).

07-02 Salary Savings (Section 27.2) - $ 386,601[4/]

Methodology: Based on the Budget Office figures, salary savings was - $384,167. Salary savings percentage was computed by dividing salary savings by Budget Office totals for gross salary and wages ($7,220,581). Based on this computation, the figure of 5.3% was also applied to the gross salary and wage figure for each function for all field offices.

Net Total Salaries and Wages $5,666,439

This figure was computed by subtracting salary savings from gross salaries and wages. This is the methodology used by the Budget Office to determine net total salaries and wages.

08 Staff Benefits $1,631,936

Methodology: Based on Budget Office figures, staff benefits was $1,607,608. Staff benefits percentage was computed by dividing staff benefits by net salary and wages. Based on this computation, 28.8% was applied to the net salary and wages for each function for all field offices.

4/ This figure is $2,434 higher than the Budget Office figure due to rounding.

Total Personal Services $7,298,375[5/]

Methodology: Staff benefits were added to net salary and wage figures for each function (see Table II-1). Personal Services for each function were summed for Total Personal Services.

Operating Expenses and Equipment $1,073,848

12	Duplicating and Xerox	$ 25,000
14	General Expense	839,164
17	Communications	285,000
39	Equipment	16,591
88-02	Unallocated balance	- 91,907
	Total	$1,073,848

Methodology:

These figures were supplied by the Budget Office. Each field office was assigned a share of operating expenses based on the percentage of positions in the field office. (For example: Oakland has 32 positions out of 386.2 or 8.3%; therefore, Oakland was allocated $89,129 for operating expenses).

5/ The Budget Office figure for Total Personal Services is 113,696 less than OPPA figure amounting to a 1.5% difference. This is due to the use of Standard Salary Schedule as explained in 1/.

Each function within each field office was allocated operating expenses based on the percentage of person years assigned to that function. (For example: Oakland has 9.38 person years assigned to Medical TAR processing or 29% of the total person years in that office. Oakland Medical TAR processing was therefore allocated $25,847 for operating expenses).

19 Travel-in-State $ 251,963

Methodology: This figure was supplied by the Budget Office. 10% or $25,106 of the figure was designated as Administrative travel. Due to the size of Los Angeles, the thirteenth share was allocated to that office. The remaining travel was divided among the 110.36 positions allocated to Medical Review and the Hospital Acute Onsite program. Each position within these functions was allocated $2055.

28 Rent $ 410,585

The Accounting Office supplied the rent costs by field office. The rent for each office was divided among the functions in each office as a percentage of person years allocated to that function.

Total Operating Expense and Equipment		$1,736,396
Operating Expenses and Equipment	$1,073,848	
Travel	251,963	
Rent	410,585	
Total Operating Expense and Equipment	$1,736,396	

Administrative Overhead $ 732,707

Methodology: This figure was supplied by the Budget Office and allocated to each field office based on the percentage of personal services dollars in each office. (For example: Oakland has 9% of the personal service dollars and was allocated 9% or $65,944 of the Administrative Overhead.) These allocations were further divided by function based on the percentage of personal service dollars in each function within each office. This is the same methodology used by the Budget Office to figure Administrative Overhead.

Totals, Program

Total Personal Services	$7,298,375
Total Operating Expenses and Equipment	1,736,396
Administrative Overhead	732,707
Totals, Program	$9,767,478

LIST OF POSITION CLASSIFICATIONS AND ANNUAL SALARIES USED IN COMPUTATIONS FOR FIELD SERVICES FIELD OFFICES

CLASSIFICATIONS	ANNUAL SALARY
OA II	$ 10,044
OSS I	11,600
OSS II	14,004
Sr. Med. Trans.	12,288
SSM I	20,496
SSM II	27,180
SSA	13,782
MC I	44,964
MC II	46,044
Pharm. Cons. I	24,144
Pharm. Cons. II	26,520
HCSN II	17,433
HCSN III	20,154
SSC I	15,934
SSC II	17,016
MST	13,272
Ass't Clerk	6,633
Off. Occ. Clerk	8,536
AGPA	18,672
Med. Trans.	10,814
Sr. Steno	11,936
Steno	10,980
Office Ass't I	7,884
HPT II	14,208

TABLE II-1

BUDGET COMPUTATIONS FOR FSS FIELD OFFICES
BY FUNCTION AND BUDGET LINE ITEM

FUNCTION	TOTAL PERSONAL SERVICES	OPERATING EXPENSES	RENT	TRAVEL	ADMINISTRATIVE OVERHEAD	TOTALS PROGRAM
Administration	$ 690,111	$ 135,840	$ 57,894	$ 25,194	$ 72,474	$ 981,513
Hospital Admits Hospital Non-Onsites Medical TARs	2,824,643	365,593	132,888	-0-	304,645	$3,627,769
Hospital Onsites	1,134,643	180,676	52,056	109,686	119,512	$1,596,573
Nursing Homes	448,210	95,486	35,345	-0-	46,640	$ 625,681
Drugs	307,396	65,494	29,461	-0-	33,411	$ 435,762
Medical Review	1,365,601	218,130	94,293	117,083	145,914	$1,941,021
Day Health	10,574	1,407	1,008	-0-	879	$ 13,868
Out of State	37,711	7,034	5,044	-0-	4,396	$ 54,185
PSRO	50,493	4,188	2,596	-0-	4,836	$ 62,113
Temporary Help	428,993	-0-	-0-	-0-	-0-	$ 428,993
TOTALS	$7,298,375	$1,073,848	$ 410,585	$251,963	$732,707	$9,767,478

TABLE II-2

PROJECTED ANNUAL TARs 1978-1979
BY CATEGORY

CATEGORY	THIRD QUARTER 1978[1/]	ANNUAL PROJECTION[2/]
Physician Office Visit	6,551	26,204
Assistive Devices	23,455	93,820
Prosthetic/Orthotic	13,549	54,196
Hearing	6,116	24,464
Psychiatry	9,242	36,968
Physical Speech/OT	10,371	41,484
Home Health	4,489	17,956
Dialysis	334	1,336
Transportation	40,835	163,340
Other	185	740
Total Medical	115,127	460,508
Hospital Admits	43,267	173,068
Hospital Non-Onsite	14,117	56,468
Hospital Onsite	73,282	293,128
Total Hospital	130,666	522,664
Total Pharmaceutical	41,111	164,444
SNF/Initials	30,334	121,336
SNF/Reauth.	54,839	219,356
ICF/Initials	1,422	5,688
ICF/Reauth.	7,856	31,424
Total Nursing	94,451	377,804
Grand Totals	381,355	1,525,420

1/ From MC 3007 - FSS Monthly Activity Report.

2/ Third Quarter totals multiplied by 4.

TABLE II-3

BREAKDOWN OF TAR COSTS BY TYPE OF COST AND CATEGORY

CATEGORY	FIELD OFFICE COSTS TOTAL	FIELD OFFICE COSTS PER TAR	FIELD OFFICE ADM. COSTS TOTAL	FIELD OFFICE ADM. COSTS PER TAR	HEADQUARTERS COSTS TOTAL	HEADQUARTERS COSTS PER TAR	MIO COSTS TOTAL	MIO COSTS PER TAR	TOTAL TOTAL	TOTAL PER TAR
Physician Office Visit	$ 137,833	$ 5.26	$ 19,391	$ .74	$ 30,921	$ 1.18	$ 26,204	$ 1.00	$ 214,349	$ 8.18
Assistive Devices	493,493	5.26	69,427	.74	110,708	1.18	93,820	1.00	767,448	8.18
Prosthetic/Orthotic	285,071	5.26	40,105	.74	63,951	1.18	54,196	1.00	443,323	8.18
Hearing	128,011	5.26	18,103	.74	28,868	1.18	24,464	1.00	200,116	8.18
Psychiatry	194,452	5.26	27,356	.74	43,622	1.18	36,968	1.00	302,398	8.18
Physical Speech/OT	218,206	5.26	30,698	.74	48,951.	1.18	41,484	1.00	339,339	8.18
Home Health	94,449	5.26	13,287	.74	21,188	1.18	17,956	1.00	146,880	8.18
Dialysis	7,027	5.26	989	.74	1,576	1.18	1,336	1.00	10,928	8.18
Transportation	859,168	5.26	120,872	.74	192,741	1.18	163,340	1.00	1,336,121	8.18
Other	3,892	5.26	548	.74	873	1.18	740	1.00	6,053	8.18
Total Medical	$2,420,410*	5.26	340,776	.74	544,291*	1.18	460,508	1.00	3,765,985	8.18
Hospital Admits	910,338	5.26	128,071	.74	204,220	1.18	692,272	4.00	1,934,901*	11.18
Hospital Ext. Nononsite	297,021	5.26	41,786	.74	66,632	1.18	225,872	4.00	631,311	11.18
Hospital Onsite	1,596,573	5.45	245,378	.84	391,895	1.34	1,172,512	4.00	3,406,358	11.62
Total Hospital	2,803,932	5.36	415,235	.79	662,747	1.27	2,090,656	4.00	5,972,570	11.43
Total Pharmaceutical	435,762	2.65	88,336	.54	141,082	.86	82,222	.50	747,402	4.55
SNF/Initials	201,417	1.66	43,681	.36	70,375	.58	121,336	1.00	436,809	3.60
SNF/Reauth.	364,131	1.66	78,968	.36	127,226	.58	219,356	1.00	789,681	3.60
ICF/Initials	9,442	1.66	2,048	.36	3,299	.58	5,688	1.00	20,477	3.60
ICF/Reauth.	52,164	1.66	11,313	.36	18,226	.58	31,424	1.00	113,127	3.60
Total Nursing	625,681*	1.66	137,166*	.36	219,461*	.58	377,804	1.00	1,360,112*	3.00
Grand Totals	$6,285,785	$ 4.12	$981,513*	$ .64	$1,567,581*	$ 1.03	$3,011,190	$ 1.97	$11,846,069	$ 7.77

* Columns do not add to Category total due to rounding.

METHODOLOGY UTILIZED TO
FIGURE TAR COSTS BY TYPE OF
COST AND CATEGORY FOR TABLE II-3

The following is a narrative description of the methodology utilized to figure the cost of processing each TAR by type of TAR:

1. Field Office Costs

a. Total Medical TAR $ 2,420,410

Field office costs for these functions are based on Table II-1. In order to display the separate categories of Medical TAR processing, Hospital Admits and Hospital Non-Onsites, the following formula was used:

$$\frac{\$\ 3,627,769 \text{ (Budget dollars for Admits, Non-Onsites and Medical TAR Processing from Table II-1.)}}{690,044 \text{ (Projected number of Annual TARs for above categories from Table II-2)}} = \$\ 5.26 \text{ Cost per TAR)}$$

The projected annual TARs for each of the sub-categories (i.e., Physician Office Visits, Assistive Devices, Dialysis) was multiplied by $5.26 to calculate the annual cost per sub-category (see Table II-2 for annual projections). Total Medical TARs was calculated by summing the sub-categories.

b. Total Hospital $ 2,803,932

The projected annual number of TARs for the categories of Hospital Admits and Non-Onsites were multiplied by $5.26.

The Hospital Onsite category dollar figure is from Table II-1. Total Hospitals was calculated by summing the categories of Hospital Admits, Non-Onsites and Onsites.

c. Total Pharmacy (Drug) $ 435,762

Total Pharmacy (Drug) is from Table II-1.

d. Total Nursing Homes $ 625,681

Total Nursing is from Table II-1. The subtotal Nursing categories were figured from the following formula:

$$\frac{\$\ 625{,}681\ \text{(Budget Total for Nursing Homes from Table II-1)}}{377{,}804\ \text{(Projected number of annual TARs for Nursing Homes from Table II-2)}} = \$\ 1.66\ \text{(Cost per TAR)}$$

The projected annual TARs for each of the sub-categories (i.e., SNF/Initials) was multiplied by $1.66 to calculate the annual cost per sub-category (see Table II-1).

e. Grand Total $ 6,285,785

Totals for Medical, Hospital, Pharmaceutical (Drugs) and Nursing Homes were summed.

2. Field Office Administrative Costs

The total Field Office Administrative costs are from Table II-1. The costs were allocated to each category based on the total person years assigned to each category. Administrative costs were allocated by person years because most of field office administration consists of supervision and

personnel activities which are directly related to the number of staff. The allocation of person years to categories was determined by each Field Office. Below is a summation of all twelve Field Offices:

Category	Person Year	Percent of Total
Medical/Non-Onsite/ Hospital Admits	130.8	52%
Hospital Onsite	64.71	25%
Pharmaceutical (Drugs)	24.02	9%
Nursing Homes	34.37	14%
TOTAL	253.9	100%

a. Total Medical TAR $ 340,776

Since the categories Medical TAR, Hospital Admits and Non-Onsites make up 52% of the person years statewide, the categories were assigned 52% of the total field office administrative costs or $510,387. In order to separate the category Medical TARs from the categories of Hospital Admits and Non-Onsite TARs, $510,387 was divided by 690,044 (the projected number of annual TARs for the combined three categories) calculating a figure of .74¢ per TAR.

The projected annual TARs for each of the sub-categories (i.e., Physician Office Visits, Assistive Devices, Dialysis) was multiplied by .74¢ to calculate the annual cost per sub-category. Total, Medical TARs, was calculated by summing the sub-categories.

b. Total Hospital $ 415,235

The projected annual number of TARs for the categories of Hospital Admits and Non-Onsites were multiplied by .74¢.

Since the category Hospital Onsite makes up 25% of the person years statewide, 25% of the field office administrative costs, or $245,378 was assigned to the category of Hospital Onsite.

Total, Hospital, was calculated by summing the hospital sub-categories.

c. Total, Pharmaceutical (Drugs) $ 88,336

Since the Pharmaceutical category makes up 9% of the person years statewide, 9% of the field office administrative costs, or $88,336 was assigned to this category.

d. Total Nursing Homes $ 137,166

Since the Nursing Home category makes up 14% of the person years statewide, 14% or $137,166 was assigned to the Nursing Home category. In order to determine cost per sub-category the following calculations were made: 1) $137,166 was divided by 377,804 (projected annual TARs for Nursing Homes from Table II-2) to determine the cost per nursing home TAR. According to this calculation, each nursing home TAR costs .36¢ for field office administration. 2) The projected annual TARs (from Table II-2) in each sub-category (i.e., SNF/Initials) were multiplied by .36¢.

e. Grand Total $ 981,513

Totals for Medical, Hospital, Pharmaceutical (Drugs) and Nursing Homes were summed.

3. Headquarters Administrative Costs $ 1,567,581

The total Headquarters budget of $1,566,689[1/] was allocated to each category based on number of person years assigned to each category[2/]. The methodology is the same as utilized in Field Office Administration (see #2 above).

a. Total Medical TARs	$ 544,291
b. Total Hospital	662,747
c. Total Pharmaceutical	141,082
d. Total Nursing	219,461
e. Grand Total	$1,567,581

4. MIO Costs $3,011,190

MIO costs for TAR processing were allocated to each category based on an estimate of costs from the Fiscal Intermediary Section at the Medi-Cal Procurement Project. The following estimates were supplied by type of claim:

Outpatient (Medical), Nursing Homes	$1.00 per claim (TAR)
Pharmaceutical	.50 " " "
Inpatient (Hospitals)	4.00 " " "

In each category, the number of annual TARs was multiplied by the claim processing cost for that category. This figure became the annual MIO cost for that category. Total MIO costs were determined by summing all categories.

1/ Supplied by DHS Budget Office.

2/ Supplied by Field Offices. See Methodology for Table II-1.

Mr. CONSTANTINE. Senator Dole, who couldn't be here because of a series of votes coming at awkward times, had several questions for you. Would you be kind enough to provide your responses for the record?

Ms. MYERS. Yes, I will do so.

[The material to be provided for the record follows:]

Question. You indicate a desire to have consumers on PSRO Boards. What do you believe would be their role?

Response. Since PSROs are supposed to be an effective partner in health care cost-containment efforts and rising health care cost is a consumer issue, consumers on PSRO Boards can:

Heighten the PSRO Board's sensitivity to cost from a taxpayer's perspective.

Assure that appropriate PSRO information is disclosed to the:

A. General public for their decision making in the medical marketplace;

B. Agencies responsible for health planning activities for resource allocation determinations.

Review the appropriateness of the PSRO's Administrative Budget.

Overall, the physician members of PSRO Boards have to make many non-medical decisions regarding a PSRO's policies. While consumers would not be able to provide input on specific medical situations, e.g., hearing of appeals, consumers would be able to provide a separate and distinct consumer orientation and cost-consciousness to a publicly-funded entity. This orientation, which has ample precedent from other publicly-funded entities, would remove the stigma associated with the lack of objectivity inherent in self-regulation by professional groups.

Question. You indicate that four PSROs failed or are failing your monitoring program. What do you believe to be the primary problem with these organizations?

Response. The most prevalent problem areas are with:

Inappropriate admissions to hospitals which can result in unnecessary surgeries (which could be mitigated by a more extensive application of *pre*-admission review procedures).

Inappropriate admissions and lengths of stay of psychiatric patients. (We are working with the California Statewide PSRO Council to develop a recommended statewide set of inpatient psychiatric criteria for admission and length-of-stay.)

Question. You suggest we reduce the emphasis on the use of medical criteria in making decisions on the appropriateness of care. What alternative criteria do you suggest?

Response. We do not mean to imply that there is no utility for medical criteria. On the contrary, we believe medical criteria can serve as basic guidelines from which to make utilization review decisions. However, criteria should not be interpreted as standards of care. Rather, these guidelines should be flexible enough so that a medical professional, in assessing the unique needs of an individual patient, should not be constrained from referring a borderline situation to a physician advisor for consultation.

Furthermore, hospitals should be strongly reminded that if a PSRO has established a length-of-stay checkpoint at the 50th percentile, the hospital is not absolved of the responsibility to monitor the patient because 50 percent of the patients should have been discharged by that time. If the patient is ready for discharge before the next length-of-stay checkpoint, the hospital has the responsibility to assure that the discharge occurs in a timely manner, even if it is before the next PSRO-assigned checkpoint.

Question. What has been your experience with hospitals which have delegated review? Are they capable of such review? Are the criteria for their selection sufficient?

Response. Our monitoring plan is designed to assess a PSRO's overall performance and is therefore not targeted to specific hospitals nor their delegation status. Consequently, we have not compiled any quantitative evidence on the effectiveness of delegated versus non-delegated review.

We believe that there are good hospitals capable of performing effective delegated review. However, we suspect that many delegation decisions were not based on empirical performance data.

With a few notable exceptions, PSROs primarily rely on utilization rate data from fiscal intermediaries to make delegation decisions. We believe that delegation criteria could be significantly enhanced if PSROs were to make onsite assessments of hospitals which would include, but would not be limited to:

Monitoring of medical records to determine the hospital's previous utilization review decision-making ability.

Review of various committee minutes to see if the hospital diligently pursues corrective action when necessary, including physician censures as appropriate.

Interviews with hospital staff and Board members to determine intensity of commitment to fulfill the PSRO's mission.

Question. Because of the current budget constraints, focused review was viewed as one possible method of reducing costs. You suggest focusing on the physician or hospital. Do you believe there is sufficient data to support this method?

Response. Yes. We have often heard respected physicians say "We know who the bad guys are." Furthermore, PSROs are required by statute to conduct profile analyses by practitioner and facility. We believe that PSROs should use profile analyses to augment their physician's knowledge of the practice patterns of their peers in making focused review decisions. We must reemphasize that it is not the complexity of a diagnosis or procedure which should govern whether it should be focused out or in. Rather, it is the capacity of the practitioner or facility to handle those complex situations which should govern the focusing decisions.

Mr. CONSTANTINE. Thank you.

[The prepared statement of Ms. Myers follows:]

STATEMENT BY BEVERLEE A. MYERS, DIRECTOR
CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES
U.S. SENATE FINANCE HEALTH SUBCOMMITTEE HEARING
SEPTEMBER 19, 1979

PSROs

THANK YOU, MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE. MY NAME IS BEVERLEE A. MYERS. I AM THE DIRECTOR OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH SERVICES WHICH IS THE SINGLE STATE AGENCY FOR TITLE XIX IN CALIFORNIA. I WAS FORMERLY THE DIRECTOR OF NEW YORK STATE TITLE XIX AGENCY AND HAVE SPENT ELEVEN YEARS IN VARIOUS CAPACITIES WITH THE FEDERAL GOVERNMENT.

I WELCOME THE OPPORTUNITY TO PROVIDE YOU WITH CALIFORNIA'S PERSPECTIVES OF THE PSRO PROGRAM AND ITS PROSPECTS FOR THE FUTURE. LET ME PREFACE MY STATEMENT BY SAYING THAT PSROs ARE OPERATING IN A VERY DIFFICULT ENVIRONMENT TODAY. THERE ARE HIGH EXPECTATIONS JUXTAPOSED AGAINST SYSTEMIC PROBLEMS IN THE HEALTH CARE DELIVERY SYSTEM WHICH PSROs ALONE CANNOT RESOLVE. THEY SHOULD NOT BE EXPECTED TO BE A PANACEA FOR ALL OF THE ILLS IN THE HEALTH CARE DELIVERY SYSTEM TODAY. HOWEVER, TESTING OF THE CONCEPT WHETHER LOCAL PRACTICING PHYSICIANS CAN EFFECTIVELY CONTROL THE PRACTICE PATTERNS OF THEIR PEERS IS A UNIQUE OPPORTUNITY FOR THE MEDICAL PROFESSION THAT COULD HAVE A PROFOUND IMPACT ON THE COST AND QUALITY OF HEALTH CARE IN THE UNITED STATES.

CALIFORNIA EXPERIENCE

OUR EXPERIENCE WITH THE CALIFORNIA PSROs INDICATES THAT SOME PERFORM QUITE WELL, PERHAPS MOST NOTABLY, THE AREA 23 PSRO IN LOS ANGELES. OTHERS HAVE

ROOM FOR SIGNIFICANT IMPROVEMENT. I WILL BE OUTLINING SOME ALTERNATIVES AND RECOMMENDATIO'S FOR YOU LATER.

PROSPECTS FOR FOCUSED REVIEW

CALIFORNIA HAS ALWAYS SUPPORTED THE PRUDENT TESTING OF THE PSRO CONCEPT BUT HAVE HAD SERIOUS CONCERNS ABOUT HEW'S PSRO IMPLEMENTATION AND EVALUATION STRATEGY. WE ARE MOST CONCERNED RIGHT NOW WITH THE POTENTIAL IMPACTS OF HEW'S EMPHASIS ON FOCUSED REVIEW. THIS IS AN ATTEMPT TO REDUCE PSRO'S ADMINISTRATIVE COSTS BY HAVING THEM TRY TO TARGET THEIR REVIEW EFFORTS ON PROBLEM AREAS WHILE AUTOMATICALLY AUTHORIZING PAYMENT FOR OTHER HEALTH SERVICES WITHOUT CONDUCTING A REVIEW OF THEIR NECESSITY.

THE DEVELOPMENT OF EFFECTIVE FOCUSED REVIEW PLANS IS STILL VERY EMBRYONIC. THE DESIGN OF EFFECTIVE FOCUSED REVIEW IMPLEMENTATION AND EVALUATION PLANS MAY NOT BE INEXPENSIVE IN THE SHORT-TERM BECAUSE OF THE DEVELOPMENTAL NATURE OF THAT PROCESS. HOWEVER, THE LONG-RANGE POTENTIAL OF A WELL-DESIGNED FOCUSED REVIEW SYSTEM IS ENORMOUS. CURRENTLY, THERE IS INADEQUATE BASELINE DATA TO SUPPORT THE EMPHASIS ON FOCUSING BY DIAGNOSIS OR PROCEDURE. IT WOULD BE MORE EFFECTIVE TO FOCUS BY PHYSICIAN OR FACILITY BECAUSE IT IS NOT THE COMPLEXITY OF THE DIAGNOSIS OR PROCEDURE WHICH GOVERNS WHETHER IT SHOULD BE FOCUSED IN OR OUT -- IT IS THE PHYSICIAN'S OR FACILITY'S CAPACITY TO HANDLE THOSE COMPLEX SITUATIONS WHICH SHOULD BE THE GOVERNING FACTOR. WE ARE STARTING TO THINK SERIOUSLY ABOUT A FOCUSED REVIEW SYSTEM WHEREBY WE COULD "FOCUS OUT" OUR REVIEW IN GOOD HOSPITALS UNDER A PROSPECTIVE REIMBURSEMENT SCHEME.

OF MAJOR CONCERN TO US IS HEW'S APPARENT LACK OF A COMPREHENSIVE EVALUATION

STRATEGY FOR THE IMPACT OF FOCUSED REVIEW. WE AGREE WITH THE CONGRESSIONAL BUDGET OFFICE'S CONCERN THAT THE PRESENT METHOD OF FOCUSED REVIEW IMPLEMENTATION WILL CAUSE ITS IMPACT TO BE IMMEASUREABLE FROM A PROGRAM-WIDE POINT OF VIEW. FURTHERMORE, WE ARE CONCERNED ABOUT THE EMPHASIS ON IDENTIFYING THE REDUCED ADMINISTRATIVE COSTS DUE TO FOCUSED REVIEW, WHILE IGNORING THOSE INAPPROPRIATE INCREASES IN PROGRAM COSTS DUE TO A LESS-INTENSIVE REVIEW SYSTEM.

CALIFORNIA MONITORING METHODOLOGY

WITH REGARD TO OUR MONITORING EFFORTS IN CALIFORNIA, WE HAVE A FEDERALLY-APPROVED MONITORING PLAN WHICH ASSESSES THE CORE OF A PSRO'S OPERATION, THAT IS, THEIR UTILIZATION REVIEW DECISION-MAKING ABILITY. WE USE STATE-EMPLOYED PHYSICIANS WHO REVIEW A STATISTICALLY VALID RANDOM SAMPLE OF PSRO-APPROVED CLAIMS WHICH GENERATES A 90% CONFIDENCE LEVEL. AFTER AN INITIAL REVIEW OF THE PSRO REVIEW COORDINATOR'S WORKSHEETS AND, IF NECESSARY, THE MEDICAL RECORDS OF THE HOSPITAL, WE CALCULATE THE DISAGREEMENT RATE.[1] TO GIVE THE PSROS THE BENEFIT OF THE DOUBT, WE SUBTRACT THE SAMPLE'S ERROR INTERVAL [2]

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[1] The disagreement rate is determined by computing the difference if any, between the number of PSRO-certified days used and the number of days where the State found adequate and appropriate evidence to support the PSRO's decision. The number of days for which the State did not find adequate and appropriate evidence to support the PSRO's certification are considered disallowed days. These disallowed days will be divided by the total number of state-approved days in the sample. This quotient then becomes the disagreement rate subject to application of the error interval.

[2] Error interval is the specified interval that represents the margin of error for a sampling technique. The interval is usually expressed in terms of plus or minus a certain percentage point, for example, ±5 percent. The error interval is a function of the variability between the PSRO and state review decisions. The variability of the elements under this plan would range from the smallest number of inappropriate days during a single hospitalization to the largest number of inappropriate days during a single hospitalization.

FROM THE DISAGREEMENT RATE. IF THAT REMAINDER IS 2% OR LESS, THE PSRO IS PASSING THAT MONITORING CYCLE. IF THE REMAINDER IS GREATER THAN 2% THE PSRO IS FAILING THAT MONITORING CYCLE. WE THEN CALCULATE THE ESTIMATED DETRIMENTAL FISCAL IMPACT RANGE, [1] ± AFTER FACTORING OUT FIXED COSTS, USING THE UPPER AND LOWER LIMITS OF THE ERROR INTERVAL.

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[1] The detrimental fiscal impact of inappropriate PSRO review decisions will be estimated by determining the number of days in the total universe where the State would have found the PSRO's review decisions to be inappropriate.

For example, assume that in a random sample of hospitalizations, the number of PSRO-certified days used was 2,400 whereas the State determined that 2,160 of those PSRO-certified days were appropriate. Furthermore, assume that there were 72,000 PSRO-certified days were used in the total universe of hospitalizations under the PSRO's jurisdiction during the monitoring period. Then the estimated difference in the total universe can be found by applying the proportion

$$\frac{2,400}{72,000} = \frac{2,400 - 2,160}{X}$$

and solving for X. In this example, the estimated days of difference in the total universe is 7,200 days.

Taking into account the error interval, the State will then estimate the range of days of difference in the total universe. The low end of the range is the result of subtracting the minus side of the error interval from the days of difference obtained in the aforementioned equation. The upper end of the range is the result of adding the plus side of the error interval to the days of difference obtained in the aforementioned equation. (Assuming that the error interval in the aforementioned equation is ±5 percent, then the estimated days of difference in the universe would range from 6,840 days to 7,560 days, i.e., 7,200 days minus 5 percent (360 days) and plus 5 percent.)

The State will then apply one-half of the statewide average hospital room and board costs to both ends of the estimated range of days of difference. (In recognition of the fact that a utilization review system does not have a direct impact on a hospital's fixed costs (the President's Council on Wage and Price Stability estmates that a hospital's fixed costs account for 40-60 percent of a hospital's bill), the State will use 50 percent of the daily room and board figure to represent the variable costs over which the PSRO has control.)

WE THEN SEND THE PSRO A PRELIMINARY REPORT INDICATING THE RESULTS OF THE MONITORING SO FAR AND GIVE THEM AN OPPORTUNITY TO DISCUSS DISPUTED CASES AT AN EXIT CONFERENCE WITHIN THE NEXT 30 DAYS.

AFTER THE EXIT CONFERENCE, WHERE THE PSRO CAN BRING ADDITIONAL EVIDENCE OR MEDICAL SPECIALISTS, WE ADJUST THE MONITORING RESULT ACCORDING TO WHAT CHANGES, IF ANY, ARE MADE BY OUR CONSULTANT AT THE EXIT CONFERENCE. WE THEN ADVISE THE PSRO OF THE POST-EXIT CONFERENCE MONITORING RESULTS AND ADVISE THEM THAT THEY HAVE AN OPPORTUNITY TO SEND ALL OF THEIR DISPUTED CASE DOCUMENTATION TO THE CALIFORNIA STATEWIDE PSRO COUNCIL FOR AN ADVISORY REVIEW.

AFTER WE RECEIVE THE OPINIONS OF THE STATEWIDE COUNCIL, WE CHECK TO SEE IF THERE IS ANY ADDITIONAL EVIDENCE OR LOGIC WHICH WOULD CAUSE OUR MEDICAL CONSULTANTS TO CHANGE THEIR DECISIONS. (SO FAR, THE STATEWIDE COUNCIL HAS AGREED WITH THE PSROs IN APPROXIMATELY HALF -- 27 OUT OF 52 -- OF THE CASES SUBMITTED FOR REVIEW.) WE THEN PREPARE A FINAL MONITORING REPORT FOR THE PSRO AND, IF NECESSARY, ASK FOR A PLAN OF CORRECTIVE ACTION. I SHOULD POINT OUT THAT SOME CALIFORNIA PSROs HAVE REACTED VERY POSITIVELY TO THE EDUCATIONAL ASPECTS OF OUR MONITORING PROCESS.

WE HAVE SELECTED THIS MONITORING APPROACH FOR TWO MAJOR REASONS: (1) TO ASSESS THE PSROS' PRIMARY FUNCTION, THAT IS, TO MAKE APPROPRIATE UTILIZATION REVIEW DECISIONS AND (2) TO MEET THE STATUTORY REQUIREMENTS THAT A STATE'S MONITORING PLAN MUST BE CAPABLE OF DETECTING PSROS' UNREASONABLE AND DETRIMENTAL IMPACTS ON COST AND APPROPRIATENESS OF CARE.

WE DO PLAN TO EXPAND OUR MONITORING EFFORTS INTO OTHER AREAS: FOR EXAMPLE, (1) SOLICITING QUARTERLY POSITIVE IMPACT STATEMENTS [1] FROM THE PSROS WHICH, IF FISCALLY QUANTIFIED, MAY BE USED TO OFFSET THE DETRIMENTAL FISCAL IMPACTS IDENTIFIED THROUGH OUR MONITORING PROCESS, (2) REQUESTING PSRO APPROVAL AND DENIAL RATES, (3) CONTROLLED TREND ANALYSES OF UTILIZATION RATE BASELINE DATA, (4) THE ADMINISTRATIVE COSTS OF PSROS WHICH CAN LEAD TO A CALCULATION OF BENEFIT-COST RATIOS, (5) MCE STUDY RESULTS, AND ANY OTHER PERTINENT INFORMATION WE CAN USE IN EVALUATING A PSRO'S PERFORMANCE.

WE ARE SKEPTICAL, HOWEVER, ABOUT THE EFFICACY OF HEW'S EMPHASIS ON MEDICARE UTILIZATION RATE DATA AS A PERFORMANCE INDICATOR BECAUSE IT IS SUBJECT TO SIGNIFICANT CONSTRAINTS IN ITS APPLICATION: FOR EXAMPLE, TIMELINESS (IT IS OFTEN TOO DATED TO REFLECT CURRENT CONDITIONS) AND DATA ENTRY QUALITY CONTROL. WE DISAGREE WITH HEW OVER THE USE OF EVALUATION EFFORTS WHICH RELY ON DISAGREEMENT RATES BETWEEN PSYSICIANS. HEW DISCOUNTS THE UTILITY OF PSRO MONITORING PLANS WHICH USE DISAGREEMENT RATES BETWEEN PHYSICIANS TO BE THE PRIMARY PERFORMANCE INDICATOR. CALIFORNIA DOES NOT BELIEVE THAT AGGREGATED STATISTICS CAN SUBSTITUTE FOR PHYSICIANS' REVIEW OF THE APPROPRIATENESS OF CARE. THAT IS NOT TO SAY THAT STATISTICS ARE NOT USEFUL. THEY MUST BE USED WITH A GREAT DEAL OF CAUTION, HOWEVER, BECAUSE WE ALL KNOW THAT STATISTICS CAN BE MANIPULATED TO MEET CERTAIN NEEDS AND THEY CAN REFLECT FLUCTUATIONS WHICH SHOULD NOT BE ATTRIBUTED TO THE ENTITY (IN THIS CASE, A PSRO) BEING EVALUATED. HOWEVER, WE ARE WILLING TO CONSIDER STATISTICAL ANALYSES AS AN ADJUNCT TO THE RESULTS OF PHYSICIANS' REVIEW WHICH PROVIDE FOR A CERTAIN TOLERANCE LEVEL,

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[1] Positive impact statements would reflect the PARO's contention that it has saved money for the State which would have been otherwise been spent, e.g., more timely review and denial of inappropriate emergency hospital admissions.

FOR EXAMPLE, 2%, TO ALLOW FOR THE INEVITABLE PHYSICIAN DIFFERENCES OF MEDICAL OPINION.

SO FAR, FIVE PSROS HAVE PASSED OR ARE PASSING OUR INITIAL MONITORING CYCLE AND FOUR PSROS HAVE FAILED OR ARE FAILING THEIR INITIAL MONITORING CYCLE. IF WE EXTRAPOLATE THE ESTIMATED PSRO-CAUSED DETRIMENTAL FISCAL IMPACT IDENTIFIED IN OUR CURRENT MONITORING EFFORTS TO A STATEWIDE ANNUALIZED TOTAL, INAPPROPRIATE REVIEW DECISIONS BY PSROS WOULD HAVE CAUSED A NONRECOVERABLE INAPPROPRIATE EXPENDITURE RANGE OF APPROXIMATELY $6 MILLION TO $23 MILLION. WE MUST EMPHASIZE THE CONSERVATIVE NATURE OF THIS ESTIMATE BECAUSE (1) IT IS BASED ON A SAMPLE OF PSROS WHICH INCLUDES MANY WHICH ARE REPUTED TO BE AMONGST THE BEST IN THE UNITED STATES AND (2) THESE FIGURES WERE CALCULATED WHEN THE PSROS IN THE SAMPLE WERE GENERALLY PERFORMING REVIEW ON ALL HOSPITAL ADMISSIONS AND DOES NOT REFLECT THE PSRO' CURRENT PERFORMANCE UTILIZING A FOCUSED REVIEW SYSTEM. THE UNCERTAIN FISCAL IMPACT OF FOCUSED REVIEW MAY EXACERBATE THE FINDINGS.

ON THE OTHER HAND, WE HAVE BEEN PLEASANTLY SURPRISED AT THE POSITIVE RESULTS FROM HEW'S PROCESS-ORIENTED ONSITE ASSESSMENTS OF PSROS. WE HAVE FINALLY CARVED OUT A ROLE FOR OUR REPRESENTATIVES WHICH IS MORE THAN "OBSERVER" STATUS, THAT IS, WE PLAY AN ACTIVE PART IN THE ASSESSMENT. WE UNDERSTAND THAT THESE ASSESSMENTS, WHICH ARE REQUIRED BY SECTION 1171 OF THE PSRO STATUTE, ARE NOW EVOLVING INTO "TECHNICAL ASSISTANCE" AND WE ARE CONCERNED ABOUT WHAT OUR FUTURE ROLE MAY BE IN THESE EFFORTS.

PROBLEM AREAS

THE MOST PREVALENT PROBLEM AREA WE HAVE IDENTIFIED THROUGH OUR MONITORING EFFORTS IS INAPPROPRIATE ADMISSIONS. I UNDERSTAND THAT DR. SMITS TOLD

THE NATIONAL PSRO COUNCIL IN JANUARY OF THIS YEAR THAT HCFA'S 1978 PSRO PROGRAM EVALUATION SUGGESTED THAT TRULY AVOIDABLE CARE MAY LIE IN THE AVOIDABLE ADMISSIONS. THIS WOULD SEEM TO CONFIRM THE NEED FOR PREADMISSION REVIEW. CALIFORNIA HAS REQUIRED PREADMISSION REVIEW ON ALL ELECTIVE ADMISSIONS OF MEDICAID PATIENTS SINCE 1972. A RECENT STUDY[1] BY OUR OFFICE OF PLANNING AND PROGRAM ANALYSIS IDENTIFIED AN ESTIMATED RANGE OF BENEFIT-COST RATIOS, AFTER FACTORING OUT FIXED COSTS, FROM 6.5:1 to 10.5:1 ON THE PREADMISSION REVIEW COMPONENT OF OUR UTILIZATION REVIEW SYSTEM. WE ARE ALSO REQUIRING PSROS TO PERFORM PREADMISSION REVIEW ON ALL ELECTIVE ADMISSION OF MEDICAID PATIENTS FOR AT LEAST SIX MONTHS IN ORDER TO ESTABLISH A BASELINE FROM WHICH TO FOCUS THEIR PREADMISSION EFFORTS. WE BELIEVE MANY OF THE GOOD PSROS IN CALIFORNIA ARE PLEASED THAT WE HAVE ESTABLISHED THIS POLICY BECAUSE THEY RECOGNIZED ITS POTENTIAL EFFECTIVENESS AND THEY CAN TELL THEIR PHYSICIAN CONSTITUENCY THAT "THE STATE MADE US DO IT".

ANOTHER PROBLEM AREA -- WHICH IS NOT UNIQUE TO PSROS -- EVERYONE RECOGNIZES IT IS A DIFFICULT AREA -- IS REVIEW OF PSYCHIATRIC SERVICES. WE ARE WORKING WITH THE CALIFORNIA STATEWIDE PSRO COUNCIL TO DEVELOP A RECOMMENDED SET OF STATEWIDE INPATIENT HOSPITAL PSYCHIATRIC CRITERIA. I SHOULD MENTION AT THIS POINT THAT WE ARE VERY PLEASED WITH THE NEW ATTITUDE OF THE CALIFORNIA STATEWIDE PSRO COUNCIL BECAUSE THEY HAVE CHOSEN TO ADDRESS SOME VERY COMPLEX, VOLATILE ISSUES: FOR EXAMPLE, WORKING WITH HEW IN DEVELOPING SOME CRITERIA FOR CONSOLIDATION OF PSRO AREAS, AND LOOKING AT SOME INPATIENT SURGERIES WHICH MAY BE PERFORMED ON OUTPATIENT BASIS. WE LOOK FORWARD TO WORKING WITH THEM IN A NUMBER OF AREAS IN THE FUTURE.

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[1] TAR Cost Effectiveness Data, California State Department of Health Services' Office of Planning and Program Analysis, September 1979.

PRE-TITLE XIX MOU ASSESSMENTS

WE HAVE RECENTLY INITIATED A PROCESS WHEREBY WE CONDUCT AN ASSESSMENT OF A PSRO'S "...CAPACITY TO RESULT IN AN IMPROVED REVIEW EFFORT", AS REQUESTED BY SECTION 1153 OF THE PSRO STATUTE. WE PERFORM THIS ASSESSMENT PRIOR TO TURNING OUR REVIEW AUTHORITY OVER TO THE PSRO. OUR CONCERNS WHICH LED TO THIS PROCESS WERE CONFIRMED BY HCFA'S 1978 PSRO PROGRAM EVALUATION WHICH INDICATED IT IS NEARLY IMPOSSIBLE TO PREDICT WHAT A PSRO'S PERFORMANCE WILL BE. [1] WE APPLY OUR STANDARD MONITORING METHODOLOGY (WHICH I OUTLINED TO YOUR EARLIER) TO RANDOM SAMPLE OF PSRO-APPROVED MEDICARE/MEDICAID "CROSS-OVER" CLAIMS. THIS WILL GIVE US SOME GREATER ASSURANCES ABOUT THE PSRO'S CAPABILITY TO MAKE GOOD UTILIZATION REVIEW DECISIONS. WE ARE ON VARYING STAGES OF THIS PROCESS WITH FOUR PSROS NOW. HEW HAS TOLD US THEY WILL NOT PROHIBIT A PSRO FROM ENTERING INTO THIS PROCESS WITH US BUT HEW IS CONCERNED AB OUT ITS POTENTIAL IMPACT ON THE RATE OF PSRO IMPLEMENTATION IN CALIFORNIA. THE FEDERAL PRESSURE TO SIGN ADDITIONAL MOUS WITHOUT REGARD TO THE MARGINAL PERFORMANCE OF MOST PSROS TO DATE IS THE MOST PRESSING PROBLEM CALIFORNIA HAS TO DEAL WITH.

PSRO REVIEW OF LONG-TERM CARE SERVICES

WITH REGARD TO LONG-TERM CARE, WE ARE IN THE PROCESS OF COMPLETING DEMONSTRATION PROJECTS WITH THREE PSROS WHICH ARE EXPERIENCED IN MEDICARE LONG-TERM CARE REVIEW. UNLIKE RAND'S RECENT STUDY [2] WHICH ADDRESSED THE FEASIBILITY OF PSRO'S LONG-TERM CARE REVIEW — IT DID NOT ADDRESS PSRO EFFECTIVENESS IN LONG TERM CARE REVIEW — OUR DEMONSTRATION PROJECTS ARE PERFORMANCE-BASED USING A DOUBLE-BLIND REVIEW, RANDOMLY SAMPLED CASES, AND FACTORING OUT OF ERROR INTERVALS. WE HAVE AGREED TO A TWO PERCENT TOLERANCE LEVEL AND THE POST-EXIT CONFERENCE, PRE-APPEAL RESULTS INDICATE THAT SOME OF THE PSROS PASSED IN SOME OF THE AREAS BEING MEASURED BUT NONE HAVE PASSED IN ALL PERFORMANCE AREAS YET. THESE PERFORMANCE

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1. 1978 PSRO Program Evaluation, HCFA, January 1979, page 13
2. An Assessment of PSRO Long-Term Care Review, Rand Corporation, August 1979

AREAS ARE IN LEVEL OF CARE DETERMINATIONS, PATIENT NEEDS ASSESSMENTS, AND APPROPRIATENESS OF REFERRALS. ALTHOUGH THERE IS NO DEMONSTRATION OF CAPACITY FOR IMPROVED REVIEW EFFORT AS THE LAW REQUIRES, WE HAVE EXPRESSED OUR WILLINGNESS TO CONDUCT ADDITIONAL LONG TERM CARE DEMONSTRATION PROJECTS BUT HEW IS RELUCTANT TO FUND ADDITIONAL DEMONSTRATIONS WITHOUT GUARANTEES OF PSRO ASSUMPTION OF FINAL REVIEW AUTHORITY FOR LONG TERM CARE.

PSRO REVIEW OF AMBULATORY SERVICES

WITH REGARD TO PSROS REVIEW OF AMBULATORY SERVICES, THIS IS A VERY UNDERDEVELOPED AREA. WE WOULD RECOMMEND THAT PSROS SHOULD CONCENTRATE THEIR EFFORTS IN THOSE AREAS WHERE MOST OF THE DOLLARS ARE BEING SPENT, FOR EXAMPLE, IN THE INSTITUTIONAL SETTING: INAPPROPRIATE ADMISSIONS AND ANCILLARY SERVICES, AND IN THE NONINSTITUTIONAL SETTING: MEDICAL TRANSPORTATION, EXPENSIVE DURABLE MEDICAL EQUIPMENT, AND PSYCHIATRIC OUTPATIENT SERVICES.

RECOMMENDATIONS

IN TERMS OF OUR RECOMMENDED CHANGES, WE DO NOT HAVE ANY PANACEAS, BUT:

(1) WE BELIEVE THAT, IN ACCORDANCE WITH HEW'S DIKEWOOD STUDY,[1] THERE SHOULD BE A DEEMPHASIS ON THE RIGID, INFLEXIBLE APPLICATION OF MEDICAL CRITERIA. IT IS MORE COST-EFFECTIVE AND QUALITY-SENSITIVE FOR A REVIEW COORDINATOR TO REFER A CASE TO A PHYSICIAN ADVISOR WHEN THERE IS ANY DOUBT RATHER THAN APPROVING QUESTIONABLE CASES.

(2) THERE SHOULD BE INCREASED EMPHASIS ON DEVELOPING ALTERNATIVE LOWER LEVELS OF CARE SO THAT PATIENTS ARE NOT MAINTAINED AT THE EXPENSIVE ACUTE LEVEL BECAUSE THERE IS NO PLACE ELSE TO GO.

1 Assessment of Factors Which Impact on the Accuracy of Concurrent Review Decisions, Dikewood Corporation, January 1979.

(3) THE NUMBER OF PSRO AREAS OUGHT TO BE REDUCED TO ENHANCE ECONOMIES OF SCALE AND, HOPEFULLY, COST-EFFECTIVENESS.

(4) PREADMISSION REVIEW SHOULD BE REQUIRED ON A MUCH BROADER SCALE TO PREVENT UNNECESSARY COSTS FROM BEING INCURRED IN THE FIRST PLACE AND TO PREVENT UNNECESSARY SURGERIES.

(5) THE AMOUNT OF PSRO DELEGATION TO HOSPITALS SHOULD BE SERIOUSLY EVALUATED TO SEE IF THOSE DELEGATION DECISIONS WERE BASED ON THE HOSPITALS' PERFORMANCE OR ON POLITICAL OR FUNDING CONSIDERATIONS.

(6) CONSUMERS SHOULD HAVE A GREATER VOICE IN THE PSROS' OPERATIONS SINCE HEALTH CARE COST CONTAINMENT IS PRIMARILY A CONSUMER ISSUE.

(7) AN INTENSIVE STUDY OF THE WIDE VARIANCES IN LENGTHS OF STAY ACROSS THE NATION SHOULD BE DONE TO DETERMINE IF THE DIFFERENCES ARE JUSTIFIED DUE TO SCIENTIFIC OR DEMOGRAPHIC EVIDENCE OR UNIQUE CLIMATE OR GEOGRAPHIC CONDITIONS.

(8) THE EXISTING PSRO STATUTE IS DEFICIENT IN ITS LOGIC REGARDING THE STATE MEDICAID AGENCY MONITORING PLAN PROVIDISON (SECTION 1171(d)). IF A STATE AGENCY DEVELOPS A MONITORING PLAN AND RECEIVES THE STATUTORILY REQUIRED SECRETARIAL APPROVAL, AND THEN USES INFORMATION GENERATED THROUGH THAT MONITORING PLAN TO REQUEST SECRETARIAL SUSPENSION OF A PSRO, THE STATE AGENCY MUST SUBMIT A REQUEST TO THE SECRETARY S/HE WILL THEN DETERMINE, ON A CASE-BY-CASE BASIS, WHETHER THE STATE AGENCY'S DOCUMENTATION (42 CFR 463.10 (d) (2) and ALLEGATION (SECTION 1171 (d) (3) (A) of the PSRO STATUE) ARE REASONABLE. CALIFORNIA BELIEVES THAT IF THE SECRETARY APPROVES THE STATE AGENCY'S MONITORING PLAN, S/HE SHOUID BE WILLING TO STIPULATE THAT THE RESULTS GENERATED IN ACCORDANCE WITH A SECRETARILY-APPROVED PROCESS WILL CONSTITUTE REASONABLE DOCUMENTATION OF A PSRO'S PERFORMANCE. IF THE SECRETARY IS GOING TO DETERMINE THE REASONABLENESS OF A STATE AGENCY'S DOCUMENTATION AND ALLEGATION ON A

CASE-BY-CASE BASIS, CALIFORNIA WONDERS WHY IT IS NECESSARY TO OBTAIN SECRETARIAL APPROVAL OF THE STATE AGENCY'S MONITORING PLAN IN THE FIRST PLACE.

IT SHOULD BE POINTED OUT THAT THIS AMENDMENT WILL NOT LIMIT THE SECRETARY'S DECISION-MAKING AUTHORITY BECAUSE S/HE IS NOT CONSTRAINED FROM ACCEPTING COUNTER-ARGUMENTS AND EVIDENCE FROM OTHER PARTIES DURING AN APPEAL PROCESS. HOWEVER, THE AMENDMENT DOES REMOVE THE EXTRAORDINARY PROVISION WHICH PROHIBITS A STATE AGENCY FROM SEEKING JUDICIAL REVIEW OF EXECUTIVE BRANCH ACTIONS WHICH ARE ADVERSE TO A STATE AGENCY. (CALIFORNIA IS PREPARING LEGISLATIVE AMENDMENTS TO ADDRESS THE LAST THREE ISSUES.)

THE RESULTS OF ALL OF THE FEDERAL AND STATE PSRO MONITORING EFFORTS TO DATE HAVE DONE LITTLE TO ALLEVIATE OUR CONCERNS ABOUT PRIVATE ORGANIZATIONS DETERMINING LEVELS OF STATE EXPENDITURES. IN FACT, THE RESULTS HAVE HEIGHTENED OUR CONCERN, PARTICULARLY WHEN WE BELIEVE THAT HEW'S RELENTLESS PUSH FOR PSRO IMPLEMENTATION WILL REPLACE AN EFFECTIVE REVIEW SYSTEM. OUR UTILIZATION REVIEW SYSTEM HAS BEEN STUDIED EXTENSIVELY, BOTH FROM WITHIN STATE GOVERNMENT AND BY EXTERNAL AGENCIES, INCLUDING HEW AND OTHER STATES. THE FINDINGS HAVE ALWAYS BEEN THAT, WHILE NOT PERFECT, THE SYSTEM IS EFFECTIVE. IF YOU ARE THINKING OF ALTERNATIVE UTILIZATION REVIEW METHODOLOGIES, WE HAVE SIX DIFFERENT UTILIZATION REVIEW PROCESSES IN THE CALIFORNIA MEDICAID PROGRAM:

1. PSROS WITH AN EMPHASIS ON FOCUSED REVIEW
2. STATE-EMPLOYED PHYSICIANS AND NURSES IN LOCAL FIELD OFFICES WITH
3. POST-SERVICE, PRE-PAYMENT PEER REVIEW (LOCAL PRACTICING PHYSICIANS IN FRESNO AND MADERA COUNTIES REVIEW THE NECESSITY OF HEALTH SERVICES PROVIDED TO CALIFORNIA MEDICAID PATIENTS IN THOSE COUNTIES AFTER THE SERVICES ARE RENDERED, BUT BEFORE THE CLAIMS ARE SUBMITTED TO THE FISCAL INTERMEDIARY FOR PAYMENT.)
4. AN AT-RISK FISCAL INTERMEDIARY (THE REDWOOD HEALTH FOUNDATION (RHF) RECEIVES A MONTHLY CAPITATION RATE FOR MEDI-CAL ELIGIBLES IN A THREE-COUNTY AREA. THE RHF IS THEN AT RISK FOR FINANCING THE PROVISION OF APPROPRIATE HEALTH SERVICES TO MEDI-CAL PATIENTS IN THE THREE COUNTIES SERVED BY RHF.)
5. TOTALLY RETROSPECTIVE REVIEW IN THE LOS ANGELES COUNTY HOSPITAL SYSTEM. BECAUSE OF THE HIGH VOLUME OF MEDI-CAL PATIENTS SERVED BY THE LOS ANGELES COUNTY HOSPITAL SYSTEM, PRIOR AUTHORIZATION REQUIREMENTS HAVE BEEN WAIVED IN THE HOSPITAL SETTING. HOWEVER, L.A. COUNTY PROVIDES HEALTH SERVICES TO MEDI-CAL PATIENTS AT RISK SUBJECT TO A RETROSPECTIVE AUDIT AND, IF NECESSARY, RECOUPMENT OF INAPPROPRIATE EXPENDITURES.
6. COUNTY-BASED UTILIZATION REVIEW PLANS FOR MEDI-CAL/SHORT-DOYLE MENTAL HEALTH PATIENTS (CALIFORNIA COUNTIES WHICH PARTICIPATE IN THE MEDI-CAL/SHORT-DOYLE MENTAL HEALTH PROGRAM ARE REQUIRED TO SUBMIT A UTILIZATION REVIEW PLAN TO THE STATE FOR APPROVAL. THE STATE THEN MONITORS THE ONGOING EFFECTIVENESS OF THE COUNTY-BASED UTILIZATION REVIEW SYSTEMS).

WE BELIEVE A UNIQUE OPPORTUNITY EXISTS TO TAKE ADVANTAGE OF RECOMMENDATIONS BY THE CONGRESSIONAL BUDGET OFFICE AND THE GENERAL ACCOUNTING OFFICE: DEMONSTRATION PROJECTS SHOULD BE CONDUCTED TESTING ALTERNATIVE METHODS OF UTILIZATION REVIEW BEFORE FULL-SCALE IMPLEMENTATION OF A PROGRAM OF THIS MAGNITUDE. IF THIS OPPORTUNITY IS NOT SEIZED, THE GRADUAL ASSUMPTION OF REVIEW AUTHORITY BY PSROS WILL

ERODE THE OPPORTUNITY TO RIGOROUSLY EVALUATE EXISTING ALTERNATIVE UTILIZATION REVIEW METHODOLOGIES. SIX MONTHS AGO, WE PROPOSED TO THE FEDERAL GOVERNMENT THAT WE JOINTLY DEVELOP AN RFP TO SEEK AN INDEPENDENT EVALUATION OF EACH OF CALIFORNIA'S MEDICAID UTILIZATION REVIEW SYSTEMS RELATIVE IMPACTS ON COST AND QUALITY OF CARE. HEW HAS INFORMED US THAT THEY ARE DISINCLINED TO PARTICIPATE IN A STUDY OF THIS TYPE DUE TO TIMING AND FUNDING CONSTRAINTS. WE CAN THINK OF NO MORE IMPORTANT ISSUE TO ADDRESS IN UTILIZATION REVIEW THAN DETERMINING THE IMPACT OF UTILIZATION REVIEW ON COST AND QUALITY OF CARE. THIS STUDY WOULD BE MUCH BROADER THAN THE NEW YORK DEMONSTRATION PROJECT WHICH IS TESTING ONLY ONE ALTERNATIVE REVIEW PROCESS. WE WOULD WELCOME AN OPPORTUNITY TO HAVE AN INDEPENDENT EVALUATOR COME IN, FOR EXAMPLE, THE CONGRESSIONAL BUDGET OFFICE AND/OR THE GENERAL ACCOUNTING OFFICE, AND APPLY THE SAME DEFINITIONS, ASSUMPTIONS, AND ANALYTICAL TECHNIQUES TO ALL OF THE MEDICAID UTILIZATION REVIEW SYSTEMS IN CALIFORNIA. WE WOULD BE WILLING TO LIVE WITH THE RESULTS.

IN SUMMARY, WE ARE STILL QUITE UNCERTAIN ABOUT PSROS AND ARE TAKING A PRUDENT APPROACH TOWARD THEIR IMPLEMENTATION IN CALIFORNIA. WE BELIEVE IT IS TIME FOR AN INTENSIVE STUDY OF ALTERNATIVE UTILIZATION REVIEW METHODOLOGIES, PARTICULARLY WHEN NATIONAL HEALTH INSURANCE APPEARS TO BE CLOSER THAN EVER BEFORE. THERE SHOULD BE AN INCREASED EMPHASIS ON DEVELOPMENT OF ACCEPTABLE, CREDIBLE CRITERIA TO DETERMINE WHICH PSROS PERFORM WELL AND THEN TEST THE TRANSFERABILITY OF THAT PERFORMANCE TO OTHER PSRO AREAS. WE BELIEVE THE SUCCESS OF THE PSRO PROGRAM LIES IN THE COMMITMENT OF THE INDIVIDUAL PSRO BOARDS OF DIRECTORS. IF THEIR ATTITUDE IS THAT THEY WANT TO HAVE A POSITIVE IMPACT ON COST AND QUALITY OF CARE, THEY WILL FIND A WAY TO BE SUCCESSFUL. IF THEIR ATTITUDE IS THAT THEY ARE THERE, AGAINST THEIR WILL, TO PROTECT THE STATUS QUO, THEY WILL NOT BE SUCCESSFUL IN FULFILLING THE PSRO MISSION.

FINALLY, WE BELIEVE THAT THIS IS AN AREA THAT IS RIPE FOR MEDICARE-MEDICAID INTEGRATION AND ARE PUZZLED BY HEW'S RELUCTANCE TO PURSUE THIS PROJECT.

Mr. CONSTANTINE. The next witness is Dr. Kenneth N. Owens, president of the South Carolina Medical Care Foundation in Columbia, S.C.

STATEMENT OF DR. KENNETH N. OWENS, PRESIDENT OF THE SOUTH CAROLINA MEDICAL CARE FOUNDATION, COLUMBIA, S.C.

Dr. OWENS. Thank you. I would like to introduce the executive director of the South Carolina Medical Care Foundation, Mr. William Mahon, who accompanied me to Washington.

I am Dr. Kenneth Owens and I am the president of the South Carolina Medical Care Foundation which is the professional standards review organization for the State of South Carolina. In addition to my PSRO activities, I practice obstetrics and gynecology in Aiken, S.C.

I am pleased to appear before you today representing 85 percent of the licensed practicing physicians in South Carolina who are members of and support the PSRO. We in South Carolina believe that our PSRO is fulfilling the expectations that Congress had for the PSRO program when they enacted the law in 1972. The South Carolina Medical Care Foundation applied for and was funded as a PSRO in July 1974 even though our State medical association was on record as seeking to have Public Law 92-603 repealed.

Our first official action as a PSRO was to begin a nationwide search for an experienced executive to fill the position of executive director of the PSRO and in August 1974 we employed Mr. William Mahon. The foundation board assigned Mr. Mahon the challenging goals of creating a PSRO that would comply with our contractual commitments to the Federal Government, gain the support of South Carolina physicians and insure high quality medical care being delivered at the appropriate level when medically necessary.

On July 1, 1975, we received a contract as a conditional PSRO and began implementing review in the 75 acute care hospitals in South Carolina. This implementation was completed in June 1976. It is difficult to measure what the impact of PSRO has been in the acute care setting, but we do know that for medicaid the average length of stay has declined from 7.74 days in 1974 to 5.90 days, that the days utilized per 1,000 medicaid beneficiaries has declined from 998.7 in 1974 to 911.7 and that the expenditures for medicaid in South Carolina for fiscal year 79 were $26 million lower than the budget projections. In fiscal year 1976, 1977, and 1978, the expenditures were within 2 percent of the budget projections. The fiscal year 1979 total medicaid expenditures increased only $18 million compared to a $32 million increase the previous year.

The PSRO does not claim full responsibility for the reduction in medicaid utilization and expenditures, but we believe it to be more than coincidence that the declines parallel milestones of PSRO activity. Medicare utilization has increased slightly in South Carolina but a strong utilization review program existed prior to PSRO implementation. The occupancy rates in many hospitals in South Carolina are averaging below 50 percent

As a part of our acute care review program, we implemented review procedures for ancillary services in January 1976. Using dollar screens that the medicare intermediary had developed, we

screened every hospital bill, and where the ancillary charges exceeded the screen, we referred the case to a physician for review.

This methodology was found to be unsatisfactory, and we revised our ancillary review procedures to utilize retrospective areawide studies. In one of these studies, the use of inhalation therapy was reviewed and overutilization was discovered. Based on the results of the study the PSRO implemented stringent criteria regarding the indications for the use of inhalation therapy as well as requiring that the attending physician reorder the service every 3 days. This action resulted in a significant decrease in the use of this service. Another area of overutilization was discovered in the tests given a patient upon admission to the hospital. It was found that sheets listing available tests were provided by hospitals to the attending physician with a request that he check the tests he did not want. The PSRO implemented a requirement that physicians must check the tests they wanted, thus requiring them to think about what they were ordering rather than just signing the sheets and getting the works. This simple change reduced considerably the amount of admission testing being conducted.

In October 1976, the South Carolina Medical Care Foundation was awarded a contract to conduct a long-term care review demonstration project. Review in 130 South Carolina nursing homes began in October 1977, and we currently have one of the few long-term care review programs in the country that is reviewing all facilities with binding review authority from both the medicare and medicaid intermediaries.

The potential for impact in long-term care is significant when you consider that South Carolina spends over $67 million to care for 8,500 people in nursing homes as compared to $41 million for 54,000 hospital stays. The Federal matching funds are between 75 and 80 percent in the South Carolina medicaid program and nursing home care is the largest item in the medicaid budget.

When PSRO review began, 70 percent of the patients in nursing homes were at the skilled level of care, and today less than 30 percent are skilled. As a result of PSRO review, massive reclassifications were made by the PSRO to correct inappropriate level of care placement, and the State found it necessary to eliminate the practice of licensing beds as skilled or intermediate and to adopt a system whereby the patient's condition dictates the care received and not the license status of the bed.

The medicaid expenditures for fiscal year 1979 for long-term care were $67 million; the previous year the cost was $66 million even though in fiscal year 1979 an additional 1,361 patients were cared for under the program. This is the lowest increase in the history of the South Carolina medicaid program and is contrary to all national health care financial trends.

The PSRO in South Carolina has placed great emphasis on assuring that high quality medical care is delivered in our State. medical care evaluation studies have been conducted by the hundreds to insure that the care being rendered meets the standards established by the PSRO. Under the direction of our quality assurance committee, which is composed of 25 physicians representing the major specialty groups in the State, problems have been identified

with postoperative wound infections, mortality rates for heart patients, unnecessary surgery, and many more.

In every single case PSRO intervention has resulted in documented improvements in the quality of care. When a problem is identified, the PSRO notifies the facility administrator, chief of staff, and board of trustees and requests that a plan for correcting the problem be submitted to the PSRO within a specified time period; 6 to 12 months later a restudy is conducted to measure the results of intervention.

On occasion, it has been necessary for the PSRO to implement sanction proceedings in order to correct a problem that a hospital is unwilling or unable to deal with. To date sanction proceedings have been necessary in the case of three physicians and one hospital where the educational approach had failed to bring about the desired change. I personally participated in the first sanction proceeding where a physician discussed with 15 of his peers for 13 hours what he could do to improve the quality of his care. This experience convinced me that peer review, conducted in an organized fashion, will without a doubt upgrade the quality of medical care.

Quality assurance has been emphasized in our long-term program as well. Through workshops sponsored by the PSRO personnel, we have seen improvements in rehabilitative nursing, physicians visiting patients on a more timely basis, closer medical supervision of patients and a reduction in the use of medications.

Another interesting change we have recently implemented is to link the acute and long-term care review systems. Early evaluations of this change indicate that patients are moving from the hospital to the nursing home earlier than before this link was made. We have also implemented preadmission review for long-term care and find that fewer patients are coming to nursing homes from the community.

Overall these changes should result in more appropriate placement in both the acute and long-term care setting.

The PSRO in South Carolina has become a significant force in the health delivery system in our State, but many physicians are concerned that decreased funding will adversely affect our ability to perform effective review. In response to the funding limitations imposed last year, the PSRO implemented a focused review system and exempted 1,500 physicians from the concurrent review process. In addition, we have modified the review process to use severity of illness and intensity of service criteria as a further cost-cutting measure. We are concerned, however, with the recently approved PSRO appropriations which further reduces funding for PSRO's.

At our cost of $8.23 per discharge, we cannot cut any further without adversely affecting our review activities. Even if we were able to maintain our current level of activity, we lack the necessary resources to expand into the areas of emergency rooms, outpatient services, prescription drugs, and others where opportunities exist for impact.

One final concern that I wish to share with the committee is the scope of the PSRO program evaluations. I believe that future evaluations should include medicaid utilization as well as quality of care. A good percentage of our budget is spent in these areas, and

to calculate cost-benefit ratios based on medicare impact alone does not reflect the true value of the PSRO program to the American public.

We believe the PSRO program in South Carolina is fulfilling the requirements of the law and judge it to be a success. The success of our program can be attributed to strong leadership by the foundation board of directors, active participation and support from the majority of the State physicians, an excellent PSRO staff and the cooperation of the various governmental agencies and professional groups with whom we must interact.

The success of our program in the future depends on adequate resources, being able to keep our data confidential and the elimination of regulatory requirements which overlap and duplicate the PSRO function.

Thank you for allowing me the opportunity of appearing before this committee. I would be pleased to answer any questions you may wish to ask.

Mr. CONSTANTINE. Dr. Owens, we have two questions. For about a year or so we have been aware of what you have done, for example, in detecting high wound infection rates in some of the rural hospitals in South Carolina, and other areas of concern such as coronary treatment problems. I think that what is not in your statement but what is implicit is that you also found certain physicians performing surgery without appropriate clinical indications.

How would the confidentiality proposal, the disclosure of your specific review work in that area affect your ability to undertake that kind of effort? That is if patient, practitioner, and institution records were subject to public disclosure, would that affect your review ability?

Dr. OWENS. I would have to believe that if the situation of confidentiality were to be changed where these items were to become a matter of public record that it would practically paralyze the PSRO's and their ability to handle problems. I could not visualize that data in any way should be released in anything but aggregates. I can't see where specific items of data have something that should be released. I don't believe that in the sanction proceedings that I participated in that if there were any question of the release of this information until after the sanction proceeding has been completed that it would have been possible for us to have accomplished what we did accomplish.

Mr. CONSTANTINE. Just one more question and that is something that I think is intriguing quite a few people. When the PSRO legislation was originally enacted and during the drafting process, Senator Bennett looked to the PAS, the professional activities study data on lengths of stay by diagnosis as obviously the reference point, particularly the 50th percentile of a given diagnosis. And of course there is a great deal of understanding that the final diagnosis differs substantially from the tentative admitting diagnoses.

—A lot of people are interested in the potential of the "severity of illness and intensity of service" approach as probably a more accurate index of a patient's need for hospital care than the chartings of final discharge diagnosis: with a great deal of potential for economy and more accurate review.

Potentially it may very well be possibly one of the major breakthroughs in review in the last 10 years. We would be interested in your comments as to the potential of the severity of illness and intensity of service approach to review.

Dr. OWENS. May I defer the answer to Mr. Mahon, our executive director.

Mr. MAHON. The PAS data was very incomplete and insensitive to the review process. It tended to change as utilization was decreased. As the result of finding that PAS was inappropriate we developed our own length of stay formulas which covered Federal patients only, which was more appropriate for review. When the severity of illness and intensity of service criteria came along, we felt that this was the next step in technology.

I think that it is more appropriate to have accurate reflections by body systems, as in the case of this criteria, of problems and the treatments that could be rendered to measure what is actually going on with the patient than depending on the length of stay formula or the opinion of the review coordinator.

The guidance of this criteria is far more specific than any previous criteria we have had to work with. It is definitely less expensive we have found because the number of reviews go down considerably and thus coordinator effort is reduced. Better resource utilization can result from use of this criteria.

Mr. CONSTANTINE. Are you implementing that statewide in South Carolina?

Mr. MAHON. Yes, sir.

Mr. CONSTANTINE. We also have a further series of questions which Senator Dole had for you and if you would be kind enough to respond to these in written form, they will be made a part of the record.

[The material to be provided for the record follows:]

Question. Why have you held your evaluations only to the Medicare Utilization?

Answer. I am not sure what evaluation you are referring to. I believe our presentation to the committee reflected our Medicaid impact data. We use both Medicare and Medicaid for internal evaluation. We have been troubled by the fact the HEW uses only Medicare and feel this short changes the true impact of the program. It has been our experience that the Medicaid agency has always been able to provide the data we have requested and have been very willing to do so. Medicare data has been difficult to acquire and we generally rely on our in-house data system when evaluating Medicare.

Question. How do you compare the impact of delegated hospitals review as compared to that of non-delegated hospitals?

Answer. It has been the experience in South Carolina that the impact has been uniform regardless of delegation status. We found that there was more potential for impact in the non-delegated hospital but this was due to the fact that most non-delegated hospitals were small institutions in rural settings. Delegation is a status symbol in our State and a threat to remove it from an institution results in the desired changes taking place. One other factor is the use of a single review methodology in all hospitals. The PSRO has total control of data collection, review criteria and review methodology regardless of delegation status.

Question. What is the cost of review for long-term care as compared to that for acute care and their relative savings?

Answer. In August, 1979, Rand prepared a report for the Health Care Financing Administration, Department of Health, Education, and Welfare, in which the costs of LTC review as conducted in ten (10) PSRO areas was analyzed. It is Rand's conclusion that "the figures from South Carolina reflect most accurately the costs of an ongoing program and also represent a lower-bound figure for an operational review program".

The conduct of binding concurrent review and medical care evaluation studies of all Medicare beneficiaries and Medicaid recipients in skilled nursing, itermediate care and intermediate care-mental retardation facilities was calculated at $9.10 per review and $58.36 per patient. As pointed out in my presentation, the Medicaid budget for long-term care reimbursement increased by only $1,000,000 to provide care for 1,361 additional patients. Data for Medicare expenditures in long-term care are not readily accessible.

The current cost of review per patient in acute care is $8.23, well below the $8.70 ceiling established by the Health Standards and Quality Bureau. In delegated facilities, where focused review has been implemented, the maximum reimbursement rate is $4.05.

At this point in time, the acute care program is more cost effective than the long-term care program because of the focused review activity. The PSRO implemented in August an HSQB-approved focused review program in the long-term care setting which is expected to reduce costs and provide resources for enhanced quality assurance activities.

Question. What criteria is used to decide which physicians to exempt from concurrent review?

Answer. Each physician considered by the PSRO for exemption from review must first be evaluated by the utilization review committee in the hospital where the physician has privileges. This first level of review considers the physician's timeliness of chart completion and frequency of physician advisor referrals and terminations, as well as any other criteria the utilization review committee wishes to use which is not part of the Focused Review Plan. The recommendations are forwarded to the PSRO.

Profile analysis of each recommended physician is conducted by staff, the PSRO Medical Director, and a physician committee. The data are analyzed to account for the characteristics and expected case mix of the physician's specialty. These data include average length-of-stay, mortality rate, and average number of preoperative days. Fiscal intermediary data are also significant in assessing the utilization patterns of a physician. Any physician whose profile exhibits an aberration from the norm is referred back to the hospital utilization review committee for reconsideration and for additional information which would explain or justify the variation. If justification cannot be provided, concurrent review is continued for at least six months.

A Focused Review Plan is attached.

South Carolina Medical Care Foundation

Focused Review Plan

Introduction

Public Law 92-603 provides for focused review following implementation of a concurrent review program under the auspices of a Professional Standards Review Organization. The South Carolina Medical Care Foundation (PSRO) will consider approval of focused review of individual physicians who are practicing in acute care facilities and who have participated in an effective and efficient PSRO review program for at least one year when the requirements of this plan are met.

Request process

1. The hospital Peer Review Committee should evaluate each physician based on the past participation in the review program. If the Committee wishes to recommend this physician for focused review status, a letter of request should be submitted to the PSRO Professional Review Committee with at least the following information:

   a. The physician's license number and area of practice specialty.

   b. Frequency of Physician Advisor referrals: never, occasionally, or regularly. Please indicate the most common reasons for these referrals.

   c. Number of terminations during the past 2-year period: Indicate—None, Few or Many.

   d. Number of reconsiderations held during the past year, their disposition and the reasons for reversals or modifications.

   e. The Committee's opinion of this physician's efficient and timely documentation of his medical records (i.e., progress notes, orders and completion of discharge records).

2. The Foundation staff will provide profile data for evaluation of length of stay norms, complications, pre-op days, skilled care days, and average number of exten-

sions, etc. Validation of certain segments of the data submitted from the hospital may be done through PSRO data system.

3. Medicare and Medicaid audits will be considered.

4. Following an evaluation of all data available and comparison of the individual physician's data to statewide norms, the PSRO Professional Review Committee will forward their recommendations to the Foundation Board of Directors.

Monitoring

The PSRO Validation Survey Team will perform a semi-annual retrospective review of a 10% random sample of cases to determine the necessity of admission, appropriate level of care, services rendered, discharge planning and compliance with PSRO requirements. The Team will photocopy necessary chart documentation for review of questionable cases by a medical consultant. A summary report of the findings will be forwarded to the PSRO Professional Review Committee for necessary action. The hospital Peer Review Committee and the individual physician will be notified of any action taken by the PSRO Professional Review Committee which results in a suspension of exempt status.

A physician suspended from exempt status shall be provided an opportunity to appeal before the suspension takes effect. A suspension from exempt status will result in the reinstatement of the concurrent review process for this physician. No second requests for focused review status will be considered in less than six months.

Procedures for data submission for focused outpatients

1. Following completion of the patient's medical record after discharge, the Medical Record Department will forward a copy of the face sheet of the record to the Review Coordinator.

2. The Coordinator will then complete the PSRO data abstract for submission to PSRO.

3. The hospital Billing Office will forward the bill to the Coordinator for certification of the total stay. The bill will be compared to the face sheet of the record before certification is performed. Bills cannot be certified until the medical record face sheet has been received. Once the bill has been certified, it will be returned to the Billing Office for submission to the Intermediary.

Mr. CONSTANTINE. The next witness is Richard Berman, Director, Office of Health Systems Management, for the State of New York.

STATEMENT OF RICHARD A. BERMAN, DIRECTOR, NEW YORK STATE OFFICE OF HEALTH SYSTEMS MANAGEMENT

Mr. BERMAN. Thank you.

I appreciate this opportunity to testify, particularly because assuring the quality and appropriateness of institutional medical services provided in the State of New York has been a major concern of the office of health systems management as well as the personal commitment of Gov. Hugh Carey.

Rather than going through the details of my written presentation, I would like to focus on a couple of major areas in terms of our working relationships with the PSRO's and our evaluation of PSRO effectiveness.

The first point is that it is difficult to fully evaluate our experience with the PSRO's in New York State or in other States because of a continuing lack of consistent and reliable data or a rigorous analysis of either PSRO's or alternative medical review mechanisms. As the result, many of the arguments that you are hearing today are not very different than were heard in the same room some time ago, except that I think PSRO's are beginning to be a little more clearly understood in terms of their potential impact.

But as one can well imagine, with so many different standards and different objectives, the measurement of the effectiveness of PSRO's varies widely throughout the country as well as in New York State. However, I believe that New York State will again

demonstrate its leadership in national health care issues by allowing every opportunity for the PSRO peer review mechanism to work and control inappropriate hospital utilization. Thus we hope to foster quality of care, while at the same time insuring the State's ability to monitor and evaluate PSRO performance.

As we see it there are three essential elements to New York's State program. First, there must be clearly defined criteria and procedures for determining medical necessity against which the performance of the PSRO's can be measured. I think it important that we all understand this.

We were fortunate in describing specific criteria in our memorandum of understanding with the PSRO's, and I would like to highlight several of those criteria.

First the disallowance of weekend admissions, that is stays beginning on Fridays or Saturdays when procedures are scheduled for Mondays; these would not be accepted.

Second, limitations on preoperative stays to 1 day unless affirmative justification is presented to and accepted by the PSRO.

Third, expedited preadmission review of all admissions for 11 elective surgical procedures identified by the national professional standards review council.

Fourth, continued stay reviews in all cases 3 days after admission.

Fifth, the requirement of second opinions for overutilized or high risk procedures.

Finally the requirement that an agreed upon list of simple surgical procedures be performed only on an outpatient basis.

The second strategy has been to put in place a State capacity to effectively monitor the effectiveness and operations of the PSRO's. In New York we have now developed and implemented a detailed monitoring plan, which was reviewed by the PSRO's and approved by the Department of Health, Education, and Welfare. The plan focuses on evaluating the impact of PSRO review activities, on the necessity and appropriateness of services rendered by medicaid recipients and on the impact of PSRO review on medicaid expenditures in the State.

The monitoring program operates through a review of a selected sample of cases from all PSRO hospitals. And again I think there are some unique criteria in this plan. Each PSRO is measured separately whenever possible, the monitoring results provide information to the PSRO as well as to the hospital, and the data is analyzed in such a way that a range of PSRO responses to State findings can be provided.

More specifically it is important to note that the monitoring process consists of a retrospective review of not more than 20 percent of all medicaid discharges. Furthermore, if there is a significant difference, again clearly spelled out by statistical significance, which is the 95 percent confidence interval between the number of PSRO days and those OHSM monitors would have approved, OHSM will initiate concurrent review for the next 90 days to validate its findings.

If during concurrent review there is a significant difference between the PSRO and the State reviews indicating a continuing negative impact on State medicaid expenditures, again at the 95

percent confidence interval then the State can recommend to HEW that it consider removing the binding review authority for medicaid.

Finally, under the auspices of the New York statewide PSR Council, a three-member panel will review allegations by the State that a PSRO has adversely affected State medicaid expenditures in accordance with the monitoring plan. And the Department of Health, Education, and Welfare then only on the recommendation of the council will act to remove PSRO authority over medicaid review. In fact, we have created an agreed-to process of arbitration between the State and the PSRO.

I might note at this juncture that we promoted council involvement in this process because during the MOU negotiations we developed confidence in the integrity and leadership caliber of its members. The council has demonstrated its moderate and constructive influence in PSRO affairs and has worked with us to forge effective solutions to statewide health problems.

The third important piece of our program involves putting in place a plan for a rigorous, controlled evaluation of PSRO performance against established criteria and procedures. And in New York we have established a framework for such an analysis. You are familiar with our joint State-PSRO demonstration project which involves 53 hospitals.

It was agreed that the State and the PSRO would each review approximately 100,000 medicaid discharges annually at participating hospitals for a 2-year period. The 2-year period would begin when a third-party evaluator was selected by HEW.

Unfortunately this critically important evaluation effort has been temporarily disrupted as the result of litigation initiated by several affected hospitals and the Greater New York Hospital Association.

Obviously the State will oppose this decision and it is now planning an appeal.

While I feel constrained from arguing the merits of the case at this time, I would like to emphasize two points. The first is that if this decision is not promptly overturned on appeal, the premature termination of this demonstration project will seriously undermine any efforts to test many of the subjective and somewhat case oriented findings we are hearing today.

We in New York State concur fully with the conclusions of the recent Congressional Budget Office study on the need for further evaluation of PSROs.

Second, it seems quite clear to us that Congress, specifically through this committee, the efforts of Senator Moynihan and some of the statements by then Chairman Paul Rogers on the House floor made it clear that HEW did have the requisite authority. We are convinced that the express intent of Congress is to encourage this type of useful and necessary data gathering and evaluation, and we trust that our appeal will be successful.

I believe that we have, in fact encouraged a new relationship that is helpful to the PSRO's and evaluation of their effectiveness. In closing, I would like to raise two or three suggestions.

One is that we would like to see stronger Federal support for development of implicit measurable criteria for PSRO performance.

We urge Congress to authorize provisions for Federal funding of States for the purpose of performing monitoring of PSRO on medicare activity.

Second, we believe Congress should enact a provision insulating patients or their families from liability where a PSRO denies medicare or medicaid payment due to improper utilization practices of the hospital or physicians.

Finally, we would like to see a continued investment of Federal resources in the testing of alternative methods of performing medical reviews.

Thank you once again. That concludes my remarks.

Mr. CONSTANTINE. There is kind of an irony here. On the one hand some of the critics of PSRO argue that it is a system to ration care and some of the State people are contending that they are overfeeding with care.

I know Senator Talmadge in reviewing your testimony was concerned by your reference to hospitals and physicians turning to patients for payment for services PSRO's deny. Is that a widespread problem in New York?

Mr. BERMAN. I believe it is a practice that is now beginning to occur more and more frequently and since the intent under medicare of prohibiting the institution or the physician from going after that payment is not clear, it is beginning to be a troublesome area.

Senator TALMADGE. Thank you very much, Mr. Berman. My apologies for being unable to be present personally to hear your testimony but I will read it with much interest.

[The prepared statement of Mr. Berman follows:]

OFFICE OF HEALTH SYSTEMS MANAGEMENT

RICHARD A. BERMAN, *Director*

NEW YORK STATE

Remarks

Mr. Richard A. Berman
Director, New York State
Office of Health Systems Management
Before the Senate Finance Committee
United States Senate
On
Professional Standards Review Organization
Oversight Hearings
September 19, 1979

Mr. Chairman, distinguished Senators, I am Richard A. Berman, Director of the New York State Office of Health Systems Management. I appreciate having been given the opportunity to testify before you today concerning New York's experience with the Federally mandated system of medical reviews conducted by Professional Standards Review Organizations.

I appreciate it particularly because assuring the quality and appropriateness of institutional medical services provided under the Medicaid program has been a major concern of the Office of Health Systems Management since it was created by Governor Hugh L. Carey in 1977.

In establishing this new cabinet-level agency, the Governor sought to give a new organizational focus and an increased emphasis to the initiatives being taken by his administration to ensure that health care services of the highest quality are available to all of New York's people at an affordable price. Through formal delegation of statutory and regulatory authority formally vested in the Commissioner of Health, the Office of Health Systems Management has been given a range of powers that make it especially well-equipped to pursue its major objectives -- maintaining the quality of health care; improving access to health care; and controlling health care costs. The powers exercised by OHSM's fourteen hundred staff include review and approval of all proposals for development of institutional health programs (the certificate of need, or "CON" process); monitoring and regulating the delivery of both institutional and non-institutional health services; and setting rates and reimbursement policies for a wide range of health services under several third-party payment programs.

As Director of OHSM, I serve as a public member of the New York Statewide Professional Standards Review Council, the coordinating body for all of New York's PSROs; and until joining State government a few years ago, I was an associate administrator in one of New York's largest voluntary teaching hospitals. I have thus had an opportunity to see New York's PSRO program from several different perspectives.

MEDICAL SERVICE REVIEW IN NEW YORK STATE

Experience with the financing and delivery of hospital services in the early years of the Medicare and Medicaid programs gave rise to a widespread

conviction that a more structured approach to reviewing and controlling the utilization of hospital services was needed. This conviction led, in New York, to creation of the New York State Hospital Utilization Review system, or NYSHUR, which gave the State Health Department a new and powerful tool for analyzing utilization patterns among Medicaid patients, and for following up on evidence of overutilization. At the national level, a similar conviction led to enactment in 1972 of the Professional Standards Review Law, P.L. 92-603.

By 1976, however, neither of these initiatives seemed to have had much success in effectively controlling utilization of hospital services. As part of the Governor's comprehensive program designed to curb the explosive growth of Medicaid costs, legislation was passed which specifically initiated a program of having State personnel review inpatient hospital claims, prior to their submission for payment under the Medicaid program. The purpose of this program was to determine the necessity of the services delivered and their conformance to State utilization control standards. The legislation also spelled out in law some of the standards against which the State's "on-site" reviewers should judge claims being submitted for Medicaid payment.

By the end of 1976, the "on-site" program was operating in most of the large hospitals in the State that cared for significant numbers of Medicaid patients; and the State's new standards, combined with strict enforcement by "on-site" staff, were having the intended effect of reducing Medicaid expenditures for inappropriate and/or unnecessary hospital services. However, the "on-site" program brought the State into direct conflict with the fledgling PSROs, which claimed that under the terms of P.L. 92-603 they had exclusive authority to make binding decisions concerning the appropriateness of medical services for purposes of determining Medicaid reimbursement.

The fundamental legal issue which lay at the heart of the conflict between the State and the PSROs was resolved in 1977 with the passage of P.L. 95-142. The amendments to the original PSRO statute included in Sections 1154 and 1155 of this act made it clear that binding payment authority lay with the PSROs. However, thanks especially to the efforts of Senator Moynihan, P.L. 95-142 also explicitly recognized the role of states as full partners with the PSROs in assuring the appropriateness of medical care delivered under the Medicaid program. Working within the framework of this legislation, the Office of Health Systems Management and the PSROs proceeded to develop a memorandum of understanding that defined in detail a new, cooperative relationship between the PSROs and the State.

EVALUATING PSRO EFFECTIVENESS

It is difficult to evaluate our experience with professional standards review organizations in New York, or in other states, because of a continuing lack of consistent, reliable data, and of rigorous analysis of either PSROs or alternative medical review mechanisms. As a result, many of the arguments being heard about PSROs today are the same as those heard by this Committee two years ago -- indeed, seven years ago -- and they are being made in the same general terms.

However, I believe that New York State will again demonstrate its leadership in national health care issues by allowing every opportunity for the PSRO peer review mechanism to work to control inappropriate hospital utilization and to foster quality of care, while at the same time ensuring the State's ability to monitor and evaluate their performance. As we see it, there are three essential elements of New York's strategy.

First, there must be clearly defined criteria and procedures for determining medical necessity, against which the performance of the PSROs can be measured. The memorandum of understanding between the State and the PSROs includes such criteria and procedures, for example:

- Disallowance of "weekend admissions" -- that is, stays beginning on Fridays or Saturdays when procedures are scheduled for Mondays, in those hospitals not prepared to render full services to patients admitted on those days.

- Limitation of pre-operative stays to one day, unless affirmative justification is presented to and accepted by the PSRO.

- Expedited pre-admission review of all admissions for eleven elective surgical procedures identified by the National Professional Standards Review Council.

- Continued-stay reviews in all cases three days after admission.

- Requirement of second opinions for overutilized or high-risk procedures, and for individual practitioners deeded by the PSROs not to be performing in accordance with acceptable medical practice.

- Requirement that an agreed upon list of simple surgical procedures be performed only on an outpatient basis.

Second, the states must be able to monitor the performance of the PSROs on a regular basis. In New York, we have developed and implemented a detailed monitoring plan, which was fully reviewed by the sixteen New York State PSROs and approved by the Department of Health, Education and Welfare. The plan focuses on evaluation of the impact of PSRO review activities on the necessity and appropriateness of services received by Medicaid recipients and the resultant impact on Medicaid expenditures in the State. It operates through review of a randomly selected sample of cases from all PSRO hospitals. Among the highlights of this plan:

- Each PSRO is monitored separately.

- Wherever possible, monitoring results provides information on PSRO impact in individual hospitals, so that specific problem areas can be addressed by the PSROs.

- Outcomes must be available periodically, so that problems can be detected and handled in a timely fashion.

- The data must be analyzed in such a way that a range of PSRO responses to the State's findings can be provided.

- Wherever possible, each hospital should be subjected to equal probabilities of being visited by State monitors.

More specifically, the Monitoring program has the following innovative and important features:

- The initial monitoring process consists of retrospective reviews of not more than 20 percent of all Medicaid discharges, conducted on quarterly schedules by a team of nurses and an administrator, with a physician ultimately responsible for the resulting determinations.

- The actual facilities selected in each PSRO area for quarterly review are chosen based upon a statistically representative sample of hospitals with an appropriate variation in the proportion of Medicaid patients.

- Within the selected facility, the size of the sample of records scrutinized depends on a number of Medicaid claims paid for that given quarter. Random samples of claims are selected for retrospective review.

- If there is a significant difference (95% confidence interval) between the number of PSRO approved days and those OHSM monitors would have approved, then OHSM will initiate concurrent reviews for the next 90 days to validate its initial findings.

- If there is a significant difference during the concurrent reviews between the PSRO and the State reviews indicating a continuing of a negative impact on State Medicaid expenditures (at least at 95% statistical variation), then the State can recommend to the Department of Health, Education and Welfare that it consider removing binding review authority for Medicaid.

- Finally, under the auspices of the New York Statewide PSR Council, Inc., a three member physician panel will review allegations by the State that a PSRO has adversely affected State Medicaid expenditures. Only on recommendation of this Council panel will HEW act to remove PSRO authority over Medicaid review.

  I might note at this juncture that we promoted Council involvement in this process because, during the MOU negotiations, we developed confidence in the integrity and leadership caliber of its members.

> The Council has demonstrated its moderate and constructive influence in PSRO affairs and has worked with us to forge effective solutions to statewide health problems.

Although monitoring has begun on an intensive basis, it is expected that the intensity of the State's effort will be reduced over time, as certain PSROs prove themselves, and as the State's capacity to conduct automated monitoring through its Medicaid Management Information System increases.

Third, there must be in place a plan for rigorous, controlled evaluation of PSRO performance against established criteria and procedures, and in comparison with other forms of medical review. In New York we have established a framework for such comparative evaluation, through the development of a demonstration project that compares the performance of PSROs in a selected group of hospitals with that of OHSM's "on-site" staff conducting reviews according to the same criteria in a second group of hospitals. Performance of binding review by State staff in this latter group of hospitals was voluntarily agreed to by the PSROs, through a formal delegation of authority back to the Office of Health Systems Management, and was approved by the Secretary of Health, Education and Welfare.

The joint State-PSRO demonstration project involves fifty-three hospitals in Manhattan, the Bronx, Brooklyn, Queens and Erie County. It was agreed that the State and the PSROs would each review approximately 100,000 Medicaid discharges annually at participating hospitals for a two year period. This two year period would begin when a third-party evaluator is selected by the Department of Health, Education and Welfare to assess the impact of OHSM and PSRO reviews on expenditures, utilization, quality of care, and administrative costs. The State and PSROs began reviews on March 1, 1979, in anticipation of the selection of this evaluator.

Unfortunately, this critically important evaluation effort has been at least temporarily disrupted, as a result of litigation initiated by several affected hospitals and the Greater New York Hospital Association. On September 5, the United States District Court for the Eastern District of N.Y. granted summary judgment for the plaintiffs, enjoining New York State from continuing to operate the demonstration project in those hospitals named in the suit. The State, of course, vigorously opposes this decision and is now planning an appeal. While I feel constrained from arguing the merits of the case at this time, I would like to emphasize two points.

First, if the Federal Court's decision is not promptly overturned on appeal, the premature termination of this demonstration project will seriously undermine our efforts to eliminate costly and unnecessary utilization. The information produced by the project would be an invaluable addition to our understanding of the effectiveness of PSROs, and utilization review in general. We in New York State concur fully with the conclusions of a recent Congressional Budget Office study on the need for further evaluation of PSROs. Unfortunately, for the time being, the Court has halted such evaluation.

Second, it seems quite clear that the Congress of the United States intended that the Secretary of Health, Education and Welfare grant waivers for the purpose of conducting research and demonstration projects relating to PSROs. Section 1115 of the Social Security Act provides broad powers

to authorize demonstration projects related to the financing and delivery of services under the Medicaid program. The Ninety Fifth Congress directly addressed the issue of whether this section authorizes the Secretary to conduct PSRO demonstrations. As I am sure you will recall, Senator Moynihan specifically included, and the Senate explicitly endorsed a provision sanctioning such demonstrations under the original version of P.L. 95-142. However, as the distinguished former chairman of the Health Subcommittee of the House Commerce Committee, Mr. Paul Rogers, told House colleagues at the time, the House-Senate Conference Committee concluded that "the existing authority of HEW to carry out demonstration projects made the amendment suggested by the Senate to mandate large scale demonstrations of alternate State systems unnecessary in our view, and the Senate receded from it."

We are convinced that it was the express intent of the Congress to encourage the course we have pursued in New York, and we trust our appeal will be successful.

CONCLUSIONS

As I stated earlier, Mr. Chairman, New York has taken a moderate, pragmatic approach toward the issue of what the role of the PSROs should be in reviewing services provided under the Medicaid program. We have accepted the clear expression of Congressional intent regarding the PSROs role that we embodied in P.L. 95-142. At the same time, we have used the authority provided to the States in that law to hold the PSROs strictly accountable for their performance with regard to Medicaid patients. We have recognized that some of the State's PSROs have been successful, while others have not yet achieved any measurable success -- OHSM is working with all the State's PSROs to improve their performance. Perhaps of most importance, we have promoted a close working relationship with the State PSR Council. Since its inception, the Council has proven itself to be a constructive force in the utilization review programs, and it has served to foster reasonable and coherent PSRO programs on a statewide basis. This was particularly evident in the complex negotiations between the PSROs and the State. In fact, without the Council's efforts, there is some doubt whether these negotiations would have been successfully concluded.

Mr. Chairman, we believe there are a number of areas where the State and the PSROs are in basic agreement, and where we can expect close cooperation. For instance:

- The integration of the PSRO data systems with the HCFA funded statewide data collection system (SPARCS). Such integration would effect significant savings and avoid duplication of data collection efforts by each hospital.

- The State and the PSROs are establishing work groups to address the problem of hospital patients awaiting long term care placement. We are currently exploring the potential to convert unnecessary acute care beds to long term care use, the need to extend services, as well as, improve discharge planning efforts at the hospital level.

- The State and the PSROs have worked closely with HEW toward the establishment of a single set of criteria to be used for Titles XVIII and XIX SNF patient placement.

This cooperation between the State and the Council resulted in a major milestone in the development of rigorous, responsible utilization review of long term care patients in New York State. A memorandum of understanding was signed last week between the State and four PSROs, under which the PSROs will assume responsibility for binding payment reviews for skilled nursing home services under the Medicaid program. The PSROs have agreed to use the State's existing assessment instrument, the DMS-1, in performing these reviews, and to work with the State on redesigning that instrument in the future. They have agreed to perform pre-admission assessment wherever possible -- something which the State had lacked the capacity to do, and which could do much to reduce or eliminate inappropriate placements. And they have agreed to supply the State with data on a regular basis, so that the State can carefully monitor their performance.

We in New York are committed to working with the PSROs to ensure the appropriateness and quality of services provided to Medicaid recipients. We believe that existing Federal law provides a sound basis for doing so. There are, however, several things that Congress can do to support our efforts:

- We would like to see stronger Federal support for the development of explicit, measurable criteria against which PSRO performance can be judged.

- We urge the Congress to authorize the provision of Federal funding to the states for the purpose of performing monitoring of PSRO Medicare activities.

- We believe Congress should enact provisions insulating patients or their families from liability where the PSRO denies Medicare or Medicaid payment due to improper utilization practices of the hospital or physician.

- We would like to see a continued investment of Federal resources in the testing of alternative methods of performing medical reviews. And although we are convinced that Federal law already authorizes the testing of such alternative methods, we would appreciate a reaffirmation of the Congressional intent in this regard that was so clearly expressed in 1977.

Thank you once again, Mr. Chairman, for the opportunity to present New York's views to this distinguished committee.

Senator TALMADGE. The next witness is Dr. Douglas Westhoff, president of Mid-Missouri Professional Standards Review Organization Foundation, Jefferson City, Mo. Doctor, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF D. DOUGLAS WESTHOFF, M.D., PRESIDENT, MID-MISSOURI PROFESSIONAL STANDARDS REVIEW ORGANIZATION FOUNDATION, JEFFERSON CITY, MO.

Dr. WESTHOFF. Thank you very much, Mr. Chairman and members of the subcommittee. My name is D. Douglas Westhoff, M.D., president of the Mid-Missouri PSRO Foundation. I would like to thank you for the opportunity to discuss the PSRO program as it exists in Missouri, PSRO area II, with an office located at Jefferson City, Mo., which is west of the Alleghenies.

I. BACKGROUND

The Mid-Missouri Professional Standards Review Organization Foundation—MMPSROF—was organized as a planning PSRO in July 1974. MMPSROF received conditional designation on June 1, 1976. There are 606 physician members of Mid-Missouri PSRO of an eligible 1,124 physicians in our area. This is a 54-percent membership rate.

The MMPSROF board of directors consists of 12 M.D.'s and 9 D.O.'s, which reflects the physician population ratio of the MMPSROF area. At our next annual membership meeting in October 1979 an amendment to the bylaws will be submitted adding health care practitioners other than physicians—HCPOTP's—as members of the board.

MMPSROF is responsible for the review activities in 33 hospitals covering an area of 35 counties, approximately 24,000 square miles in central and northeastern Missouri. This is a very rural portion of Missouri with one metropolitan area exceeding 50,000 population.

There are 3,450 acute-care beds in the 33 area hospitals with a total of approximately 50,000 discharges annually. There are only five medicare participating skilled nursing facilities in our area, with a total of 125 beds.

II. MID-MISSOURI PSRO REVIEW PROCESS

MMPSROF implemented review in five area hospitals October 1, 1976. Each month additional hospitals were implemented until all 32 hospitals were performing review. By May 1, 1977, a 9-month period of time, all institutions were performing the required PSRO activities. In January 1978 review began in one newly constructed hospital, bringing our total number to 33 hospitals performing PSRO review.

Due to the increasing Federal pressure to lower review costs and the mandatory $8.70 per patient review cost figure imposed for MMPSROF, focused review was begun in two hospitals January 1, 1979. By July 1979, 21 area hospitals were performing focused review and since then an additional seven.

Our board of directors and staff have determined that, at least for the present time, the five remaining hospitals, three of which are State-operated health care facilities, will remain on 100-percent concurrent review. Focused review in our PSRO is limited to physicians being focused in or out and there are no immediate plans to focus by specific diagnoses.

The number of patients who were issued termination of medicare-medicaid benefits letters in 1978 was 739. With the initiation of focused review this rate may decrease because fewer patient charts are being reviewed.

To date the Mid-Missouri PSRO Foundation has reviewed and rendered decisions on 29 requests for reconsiderations of PSRO determinations. In about half of these appeals the original PSRO determination was upheld.

Mid-Missouri PSRO currently has nine staff members—seven full-time, two part-time—who are committed to the accomplishment of the program's goal as set forth by the board of directors.

In December 1978, the Mid-Missouri PSRO was given a performance assessment by the project assessment branch, a division of PSRO program operations. It is my understanding that all committee members have received a copy of the PSRO performance assessment report.

One of the Mid-Missouri PSRO's strongest areas indicated in the report was that of program management. A corrective action plan has been implemented for the weaker areas which the assessment team felt need improvement.

III. IMPACT

A. Per patient review costs: Preliminary data indicate that MMPSROF is having an impact on the delivery of health care to medicare beneficiaries. Overall utilization appears to be decreasing when comparing 1977-78 to 1974-76, pre-PSRO.

The discharge rate per 1,000 enrollees, which indicates the use of facilities, increased until 1978, when it decreased by 7.2 percent, while the number of eligible enrollees increased by 1 percent in 1978. This indicates that there are fewer eligible enrollees being hospitalized.

Average length of stay has decreased at a greater percentage in 1977 and 1978 than from 1974 to 1976. The percentage of decrease seems to have been greatest in 1977, with leveling off noticeable in 1978. This leveling trend seems to be appearing in groups of diagnoses, such as heart diseases.

This phenomenon appears to be correlated with the days-of-care rate per 1,000 enrollees. The days-of-care rate increased during the years 1974-76, pre-PSRO, and decreased in 1977 and 1978, post-PSRO. This decrease seems to indicate that the reduced number of patients are utilizing the hospital facilities for a shorter period of time.

If these apparent trends continue we can assume that the patients needing hospitalization are getting care and they are not staying longer than is necessary, indicating to us that a cost saving has occurred.

As an example, medicare data indicates that for 1977 Mid-Missouri PSRO's medicare days of care per 1,000 were 4,504. Our own data indicate for 1978 the medicare days of care per 1,000 was 4,098. This is a reduction of 406. Multiply the medicare eligibles, 98.7, times 406 days of care saved; that equals 40,072. Multiply the 40,072 times the current average hospital room and board cost for Missouri of $93; a dollar figure of $3,726,696 is derived.

Assuming Mid-Missouri PSRO was directly responsible for 25 percent of the projected savings, or $943,674, the savings would be twice the operating budget of Mid-Missouri PSRO. This information indicates we are effective in reducing cost.

We feel that the same reductions are occurring in medicaid, although unfortunately we do not have pre-PSRO data with which to compare our current data to identify these possible reductions. Missouri has implemented a medicaid management information system—MMIS—as of August 1, 1979.

B. Length of stay impact: At one of our area psychiatric hospital acute care units the average medicare length of stay for 1976 was 49.1 days. We began 100 percent concurrent review in that hospital on March 1, 1977. At the end of 1978 the average medicare length of stay was 35.42 days. It is our objective to decrease the average length of stay in that hospital to an average number of certified days of 25.12.

C. Quality of care impact: A specific example of impact of quality of patient care occurred when an excessive number of chest X-rays was noted during the review by the Mid-Missouri PSRO Peer Review Committee of five patient charts of one physician. In these cases it was noted that daily chest X-rays were given to patients; some of these were small children.

To change this physician's practice patterns, four physicians from our board and a staff member met informally and discussed the problem, and to date the overutilization of X-rays by this physician has not reoccurred.

D. Focusing or focused review: As indicated earlier in my testimony, we have implemented focused review in most of our hospitals. We agree that 100-percent concurrent review is not cost-effective. Mid-Missouri PSRO's budgeted—actual—and negotiated—estimated—part IV average per patient review costs were $8.19 for July through December 1977. The first half of 1978 review costs were increased to $8.76 and the last half of 1978 review costs increased to $10.28.

We began implementing our focused review plan in January 1979. From January to June 1979 our cost dropped from $10.28 to $9.61 due to a less intensive review process. Our current costs are $8.05, and this figure is well below the $8.70 ceiling.

We have implemented time and motion studies in many of the hospitals to identify areas where we can further reduce the negotiated costs. We have increased our monitoring to head off any increase in utilization due to a less intensive review process. At this time we do not believe there has been an increase in utilization of services.

E. Award for review for ancillary services: The Mid-Missouri PSRO Foundation was awarded $40,000 for the current fiscal year to develop an ancillary services review plan and begin a limited

demonstration project. We have the plan written and should have the review in 16 selected area hospitals implemented by January 1980.

IV. PROBLEM AREAS

Since Mid-Missouri PSRO began concurrent review in 1976, we have identified several problems, and some of these are identified as follows:

A. Waiver of liability and grace days: I would like to cite a recent example. A patient was admitted to the hospital on Monday and the PSRO review personnel reviewed the admission on Tuesday. The PSRO found the admission to be not medically necessary and issued a termination of benefits letter to the patient and notified all parties involved on the same Tuesday.

The patient later, within the appropriate 60-day time frame, requested an appeal of this denial. The PSRO begins the appeal procedures, which include PSRO staff time, the medicare intermediary staff time, and time and cost to obtain the medical record for our medical director to review the chart.

The appeal committee then reviews the chart to see if these days should have been certified. The patient or his or her representative may personally appear at the appeal committee meeting. Again more costs are incurred for the patient and additional time is used.

A decision to uphold the denial is made and medicare is notified of this decision. The hospital enjoys a favorable waiver presumption therefore liability is waived and the provider will be paid for services rendered Monday and Tuesday, the day notice is given. One grace day would also be provided.

Had the patient or provider not otherwise known, this would be appropriate. Had the provider and patient been notified in advance that under certain circumstances the services would not be certified medically necessary, the current law would provide the same waiver presumption, thereby creating the same expensive process as discussed earlier.

Senator TALMADGE. Doctor, I hate to call time on you.

Dr. WESTHOFF. Mr. Chairman, may I bring one other point to your attention?

Senator TALMADGE. Sure.

Dr. WESTHOFF. We have noted in our area that there are several hospitals which treat patients on an outpatient basis and inpatient basis with radiation therapy and chemotherapy, and many of these patients come distances of over 200 miles. It is very difficult if not impossible to obtain repetitive transportation.

We feel that most of these patients do not require acute care bed occupancy in the hospital. We would like to entertain with the Department of Health, Education, and Welfare, medicare and the Congress a demonstration project in our area to study the feasibility of arranging with a local hotel or motel to get their room and board reimbursed by medicare. Our projected savings are approximately 60 to 65 percent of the costs or hospitalizing those patients for those same treatments.

Thank you, and I am sorry for running over my time.

[Dr. Westhoff's prepared statement and attachments follow:]

STATEMENT OF D. DOUGLAS WESTHOFF, M.D., PRESIDENT, MID-MISSOURI PROFESSIONAL STANDARDS REVIEW ORGANIZATION FOUNDATION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, MY NAME IS D. DOUGLAS WESTHOFF, M.D., PRESIDENT OF THE MID-MISSOURI PSRO FOUNDATION. I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY TO DISCUSS THE PSRO PROGRAM AS IT EXISTS IN MISSOURI - PSRO AREA II, WITH AN OFFICE LOCATED AT JEFFERSON CITY, MISSOURI.

I. BACKGROUND

THE MID-MISSOURI PROFESSIONAL STANDARDS REVIEW ORGANIZATION FOUNDATION (MMPSROF) WAS ORGANIZED AS A PLANNING PSRO IN JULY, 1974. MMPSROF RECEIVED CONDITIONAL DESIGNATION JUNE 1, 1976.

THERE ARE 606 PHYSICIAN MEMBERS OF MID-MISSOURI PSRO OF AN ELIGIBLE 1,124 PHYSICIANS IN OUR AREA. THIS IS A 54% MEMBERSHIP RATE.

THE MMPSROF BOARD OF DIRECTORS CONSISTS OF 12 M.D.S AND 9 D.O.S WHICH REFLECTS THE PHYSICIAN POPULATION RATIO OF THE MMPSROF AREA. AT OUR NEXT ANNUAL MEMBERSHIP MEETING IN OCTOBER 1979, AN AMENDMENT TO THE BYLAWS WILL BE SUBMITTED ADDING HEALTH CARE PRACTITIONERS OTHER THAN PHYSICIANS (HCPOTPS) AS MEMBERS OF THE BOARD.

MMPSROF IS RESPONSIBLE FOR THE REVIEW ACTIVITIES IN 33 HOSPITALS COVERING AN AREA OF 35 COUNTIES, APPROXIMATELY 24,000 SQUARE MILES IN CENTRAL AND NORTHEASTERN MISSOURI. THIS IS A VERY RURAL PORTION OF MISSOURI WITH ONE METROPOLITAN AREA EXCEEDING 50,000 POPULATION.

THERE ARE 3,450 ACUTE CARE BEDS IN THE 33 AREA HOSPITALS WITH A TOTAL OF APPROXIMATELY 50,000 DISCHARGES ANNUALLY. THERE ARE ONLY FIVE MEDICARE PARTICIPATING SKILLED NURSING FACILITIES IN OUR AREA WITH A TOTAL OF 125 BEDS.

II. MID-MISSOURI PSRO REVIEW PROCESS

MMPSROF IMPLEMENTED REVIEW IN FIVE AREA HOSPITALS OCTOBER 1, 1976. EACH MONTH ADDITIONAL HOSPITALS WERE IMPLEMENTED UNTIL ALL 32 HOSPITALS WERE PERFORMING REVIEW. BY MAY 1, 1977 (A NINE MONTH PERIOD OF TIME) ALL INSTITUTIONS WERE PERFORMING THE REQUIRED PSRO ACTIVITIES. IN JANUARY 1978 REVIEW BEGAN IN ONE NEWLY CONSTRUCTED HOSPITAL, BRINGING OUR TOTAL NUMBER TO 33 HOSPITALS PERFORMING PSRO REVIEW.

DUE TO THE INCREASING FEDERAL PRESSURE TO LOWER REVIEW COSTS, AND THE MANDATORY $8.70 PER PATIENT REVIEW COST FIGURE IMPOSED FOR MMPSROF, FOCUSED REVIEW WAS BEGUN IN TWO HOSPITALS JANUARY 1, 1979. BY JULY 1979 TWENTY-ONE AREA HOSPITALS WERE PERFORMING FOCUSED REVIEW. OUR BOARD OF DIRECTORS AND STAFF HAVE DETERMINED THAT, AT LEAST FOR THE PRESENT TIME, THAT THE FIVE REMAINING HOSPITALS, THREE OF WHICH ARE STATE OPERATED HEALTH CARE FACILITIES, REMAIN ON 100% CONCURRENT REVIEW. FOCUSED REVIEW IN OUR PSRO IS LIMITED TO PHYSICIANS BEING FOCUSED IN OR OUT, AND THERE ARE NO IMMEDIATE PLANS TO FOCUS BY SPECIFIC DIAGNOSES.

THE NUMBER OF PATIENTS WHO WERE ISSUED "TERMINATION OF MEDICARE/MEDICAID BENEFITS" LETTERS IN 1978 WAS 739. WITH THE INITIATION OF FOCUSED REVIEW THIS RATE MAY DECREASE BECAUSE FEWER PATIENT CHARTS ARE BEING REVIEWED.

To date the Mid-Missouri PSRO Foundation has reviewed and rendered decisions on 29 requests for reconsiderations of PSRO determinations. In about half of these appeals, the original PSRO determination was upheld.

Mid-Missouri PSRO currently has 9 staff members who are committed to the accomplishment of the Program's goals as set forth by the Board of Directors.

In December 1978 the Mid-Missouri PSRO was given a performance assessment by the Project Assessment Branch, a Division of PSRO Program Operations. It is my understanding that all Committee members have received a copy of the PSRO Performance Assessment Report. One of Mid-Missouri PSRO's strongest areas indicated in the report was that of Program Management. A corrective action plan has been implemented for the weaker areas which the Assessment Team felt needed improvement.

III. IMPACT

A. Per Patient Review Costs - Preliminary data indicates that MMPSROF is having an impact on the delivery of health care to Medicare beneficiaries. Overall utilization appears to be decreasing when comparing 1977 - 1978 to the years 1974 - 1976 (pre-PSRO). The discharge rate per 1,000 enrollees, which indicates the use of facilities, increased until 1978 when it decreased by 7.2%, while the number of eligible enrollees increased by 1% in 1978. This indicates that there are fewer eligible enrollees being hospitalized.

AVERAGE LENGTH OF STAY HAS DECREASED AT A GREATER PERCENTAGE IN 1977 AND 1978 THAN 1974-1976.[1] THE PERCENTAGE OF DECREASE SEEMS TO BE GREATEST IN 1977 WITH LEVELING OFF NOTICEABLE IN 1978. THIS LEVELING TREND SEEMS TO BE APPEARING IN GROUPS OF DIAGNOSES, SUCH AS HEART DISEASES.[2]

THIS PHENOMENA APPEARS TO BE CORRELATED WITH THE DAYS OF CARE RATE PER 1,000 ENROLLEES.[1] THE DAYS OF CARE RATE HAS BEEN INCREASING DURING THE YEARS 1974-1976 (PRE-PSRO) AND DECREASING IN 1977-1978 (POST-PSRO). THIS DECREASE SEEMS TO INDICATE THAT THE REDUCED NUMBER OF PATIENTS ARE UTILIZING THE HOSPITAL FACILITIES FOR A SHORTER PERIOD OF TIME.

IF THESE APPARENT TRENDS CONTINUE WE CAN ASSUME THAT THE PATIENTS NEEDING HOSPITALIZATION ARE GETTING CARE AND THEY ARE NOT STAYING LONGER THAN IS NECESSARY, INDICATING TO US THAT A COST SAVINGS HAS OCCURRED.

EXAMPLE: MEDICARE DATA INDICATES THAT FOR 1977, MID-MISSOURI PSRO'S MEDICARE DAYS OF CARE PER 1,000 WERE 4,504. OUR OWN DATA INDICATE FOR 1978 THE MEDICARE DAYS OF CARE PER 1,000 WAS 4,098. THIS IS A REDUCTION OF 406. MULTIPLY THE MEDICARE ELIGIBLES--98.7 X 406 DAYS OF CARE SAVED = 40,072. MULTIPLY THE 40,072 X THE CURRENT AVERAGE HOSPITAL ROOM AND BOARD COST FOR MISSOURI OF $93.00[3], A DOLLAR FIGURE OF $3,726,696 IS DERIVED. ASSUMING MID-MISSOURI PSRO WAS

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1. INFORMATION DERIVED FROM "HEALTH CARE FINANCING REVIEW" SUMMER 1979, PG. 100.
2. SEE CHARTS ON HEART DISEASES SHOWING LENGTHS OF STAY AT MMPSROF.
3. MISSOURI HOSPITAL ASSOCIATION BULLETIN, AUGUST 10, 1979.

DIRECTLY RESPONSIBLE FOR 25% OF THE PROJECTED SAVINGS OR $943,674, THE SAVINGS WOULD BE TWICE THE OPERATING BUDGET OF MID-MISSOURI PSRO. THIS INFORMATION INDICATES WE ARE EFFECTIVE IN REDUCING COST.

WE FEEL THE SAME REDUCTIONS ARE OCCURRING UNDER MEDICAID, UNFORTUNATELY WE DO NOT HAVE PRE-PSRO DATA WITH WHICH TO COMPARE OUR CURRENT DATA TO IDENTIFY THESE POSSIBLE REDUCTIONS. MISSOURI HAS IMPLEMENTED A MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) AS OF AUGUST 1, 1979.

B. LENGTH OF STAY IMPACT - AT ONE OF OUR AREA PSYCHIATRIC HOSPITAL ACUTE CARE UNITS, THE AVERAGE MEDICARE LENGTH OF STAY FOR 1976 WAS 49.1. WE BEGAN 100% CONCURRENT REVIEW IN THIS HOSPITAL ON MARCH 1, 1977. AT THE END OF 1978 THE AVERAGE MEDICARE LOS WAS 35.42 DAYS. IT IS OUR OBJECTIVE TO DECREASE THE AVERAGE LENGTH OF STAY IN THIS HOSPITAL TO AN AVERAGE NUMBER OF CERTIFIED DAYS OF 25.12.

C. QUALITY OF CARE IMPACT - A SPECIFIC EXAMPLE OF IMPACT ON QUALITY OF PATIENT CARE OCCURRED WHEN AN EXCESSIVE NUMBER OF CHEST X-RAYS WAS NOTED DURING THE REVIEW BY THE MID-MISSOURI PSRO PEER REVIEW COMMITTEE OF FIVE PATIENT CHARTS OF ONE PHYSICIAN. IN THESE CASES IT WAS NOTED THAT DAILY CHEST X-RAYS WERE GIVEN TO PATIENTS--SOME OF THESE WERE SMALL CHILDREN. TO CHANGE THIS PHYSICIAN'S PRACTICE PATTERNS, FOUR PHYSICIANS FROM OUR BOARD AND A STAFF MEMBER MET INFORMALLY AND DISCUSSED THE PROBLEM, AND TO DATE THE OVER UTILIZATION OF X-RAYS BY THIS PHYSICIAN HAS NOT REOCCURRED.

D. Focusing or Focused Review - As indicated earlier in my testimony we have implemented focused review in most of our hospitals. We agree that 100% concurrent review is not cost effective. Mid-Missouri PSRO's budgeted (actual) and negotiated (estimated) Part IV average per patient review costs were $8.19 for July through December 1977. The first half of 1978 review costs increased to $8.76 and the last half of 1978 review costs increased to $10.28. We began implementing our Focused Review plan in January of 1979. From January to June 1979 our cost dropped from $10.28 to $9.61 due to a less intensive review process.

Our current costs are $8.05 which is well below the $8.70 ceiling. We have implemented time and motion studies in many of the hospitals to identify areas where we can further reduce the negotiated costs. We have increased our monitoring to head off any increase in utilization due to a less intensive review process. At this time we don't believe there has been an increase in utilization of services.

E. Award for Review of Ancillary Services - The Mid-Missouri PSRO Foundation was awarded $40,000 for the current fiscal year to develop an ancillary services review plan and begin a limited demonstration project. We have the plan written and should have the review in 16 selected area hospitals implemented by January 1980.

IV. PROBLEM AREAS

Since Mid-Missouri PSRO began concurrent review in 1976 we have identified several problems, some of these are identified as follows:

A. Waiver of Liability and Grace Days - I would like to site a recent example. A patient was admitted to the hospital on Monday and the PSRO review personnel reviewed the admission on Tuesday. The PSRO found the admission to be not medically necessary and issued a "Termination of Benefits Letter" to the patient and notified all parties involved on the same Tuesday.

The patient later, within the appropriate sixty day time frame, requested an appeal of this denial. The PSRO begins the appeal procedures which includes PSRO staff time, the Medicare Intermediary staff time, and time and cost to obtain the medical record and time for our Medical Director to review the chart. The Appeal Committee then reviews the chart to see if these days should have been certified. The patient or his/her representative may personally appear at the Appeal Committee meeting. Again, more costs are incurred for the patient, and additional time is used.

A decision to uphold the denial is made and Medicare is notified of this decision. The hospital enjoys a favorable waiver presumption, therefore, liability is waived and the provider will be paid for services rendered Monday and Tuesday, the day notice is given. One grace day would also be provided. Had the patient or provider not otherwise known, this would be appropriate. Had the provider and patient been notified in advance that under certain circumstances the services would not be certified medically necessary, the current law would provide the same waiver presumption, thereby creating the same expensive process as

DISCUSSED EARLIER. A CHANGE IN THE REGULATIONS OR LAW IS NEEDED IN THIS AREA. IF THE PHYSICIAN OR HOSPITAL REALLY WANTED TO USURP THE PSRO REVIEW PROCESS UNDER THE CURRENT LAWS, THEY COULD ADMIT PATIENTS FOR AS MANY AS FOUR DAYS KNOWING BEFOREHAND THE PSRO WOULD DENY THESE DAYS AND THESE DAYS WOULD BE PAID ANYWAY UNDER MEDICARE REGULATIONS.

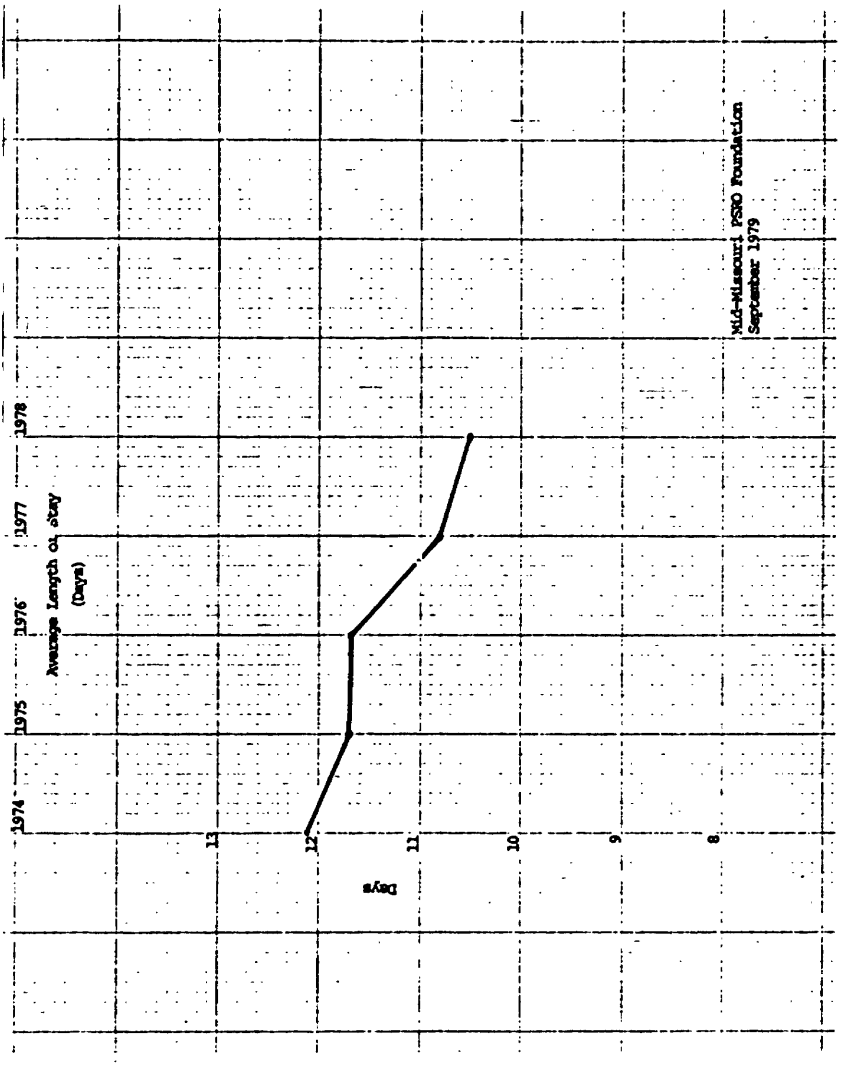
B. PER PATIENT DELEGATED REVIEW COST SETTLEMENT BY THE INTERMEDIARY - ANOTHER PROBLEM WE HAVE ENCOUNTERED IN NEGOTIATING PART IV (HOSPITAL DELEGATED REVIEW) COSTS IN OUR AREA HOSPITALS IS THAT, AFTER WE FINALLY NEGOTIATE AN AGREEABLE REIMBURSEMENT RATE, WHEN THE HOSPITALS' FINAL COST SETTLEMENT IS MADE AT THE END OF THE HOSPITALS' MEDICARE COST REPORTING PERIOD, THE PSRO CAN ONLY COMMENT AND MAKE RECOMMENDATIONS. THE MEDICARE INTERMEDIARY HAS FINAL AUTHORITY OVER THE SETTLEMENT. IF THE HOSPITAL CHOSE TO EXPEND A HIGH COST FOR THE REVIEW THEREBY INCREASING THE ACTUAL COST, MEDICARE MAY SETTLE FOR THE HIGHER COST EVEN THOUGH THE PSRO DISAGREED. REGULATIONS NEED TO BE WRITTEN ALLOWING THE PSRO FINAL COST SETTLEMENT AUTHORITY. WE ARE RESPONSIBLE FOR STAYING UNDER THE $8.70 CEILING.

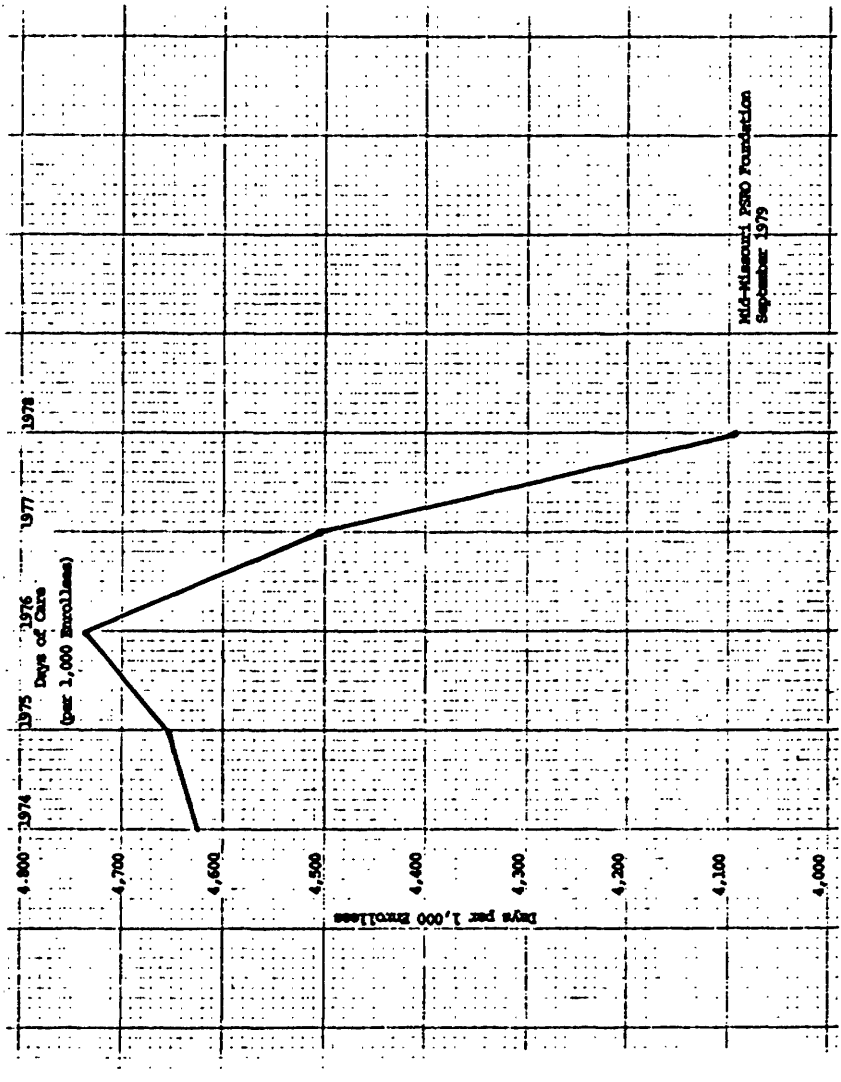
C. HIGH COST MOTEL SERVICE - AT ONE OF OUR HOSPITALS WHICH IS A CANCER HOSPITAL, WE HAVE IDENTIFIED A PROBLEM WHEREBY PATIENTS ARE BEING REFERRED TO THE HOSPITAL BY THEIR FAMILY PHYSICIANS FOR CHEMO-THERAPY AND RADIATION THERAPY. MANY PATIENTS LIVE 200 OR MORE MILES FROM THIS FACILITY AND REPEATED TRAVEL ARRANGEMENTS FOR THE PATIENT ARE DIFFICULT TO OBTAIN. MANY OF THESE PATIENTS DO NOT NEED AN ACUTE CARE BED WHEN

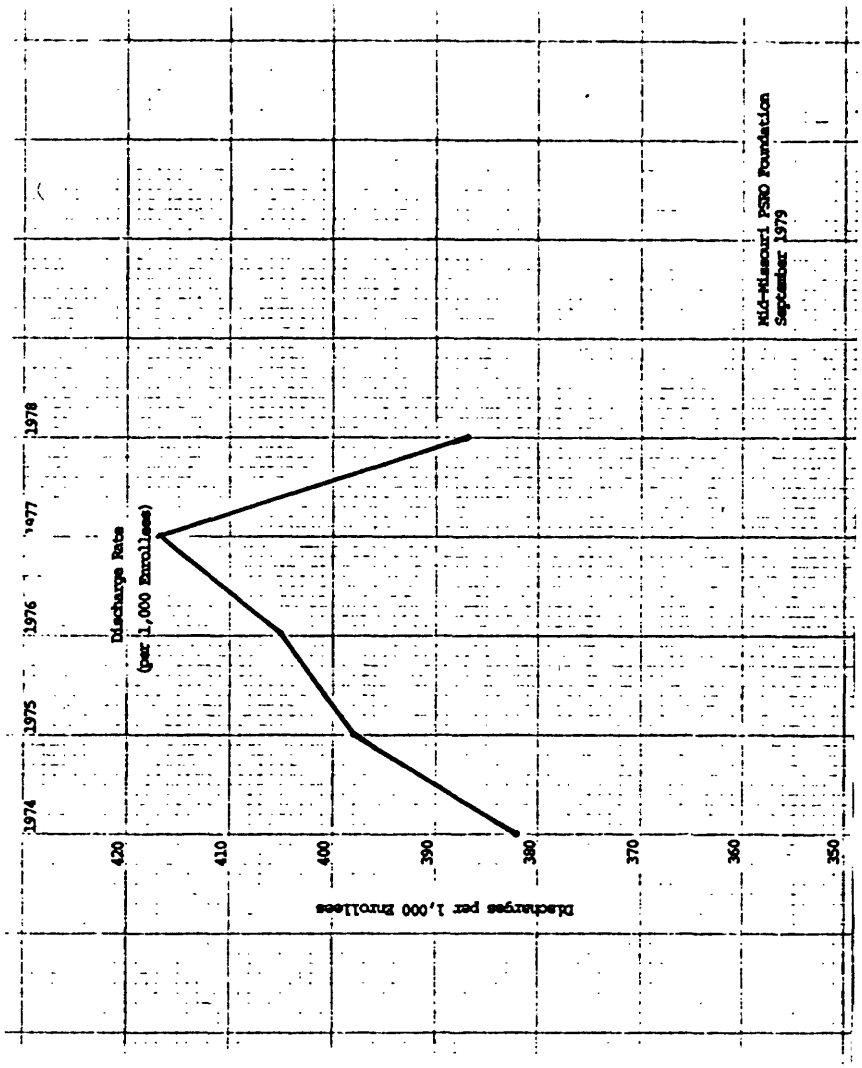
THEY RECEIVE THERAPY ONLY ONE TO THREE TIMES A WEEK. THESE PATIENTS COULD BE TREATED ON AN OUTPATIENT BASIS AT A MUCH LESSER COST IF WE COULD WORK OUT AN ARRANGEMENT WITH A LOCAL HOTEL OR MOTEL AND GET THEIR ROOM AND BOARD REIMBURSED BY MEDICARE. WE HAVE FOUND OTHER HOSPITALS IN OUR AREA THAT HAVE SIMILAR PROBLEMS. THE SAVINGS OVER TIME WOULD BE TREMENDOUS. MID-MISSOURI PSRO WOULD BE WILLING TO WORK WITH THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, MEDICARE AND CONGRESS TO DEVELOP A DEMONSTRATION PROJECT IN OUR AREA TO STUDY THE FEASIBILITY OF THIS TYPE OF ARRANGEMENT.

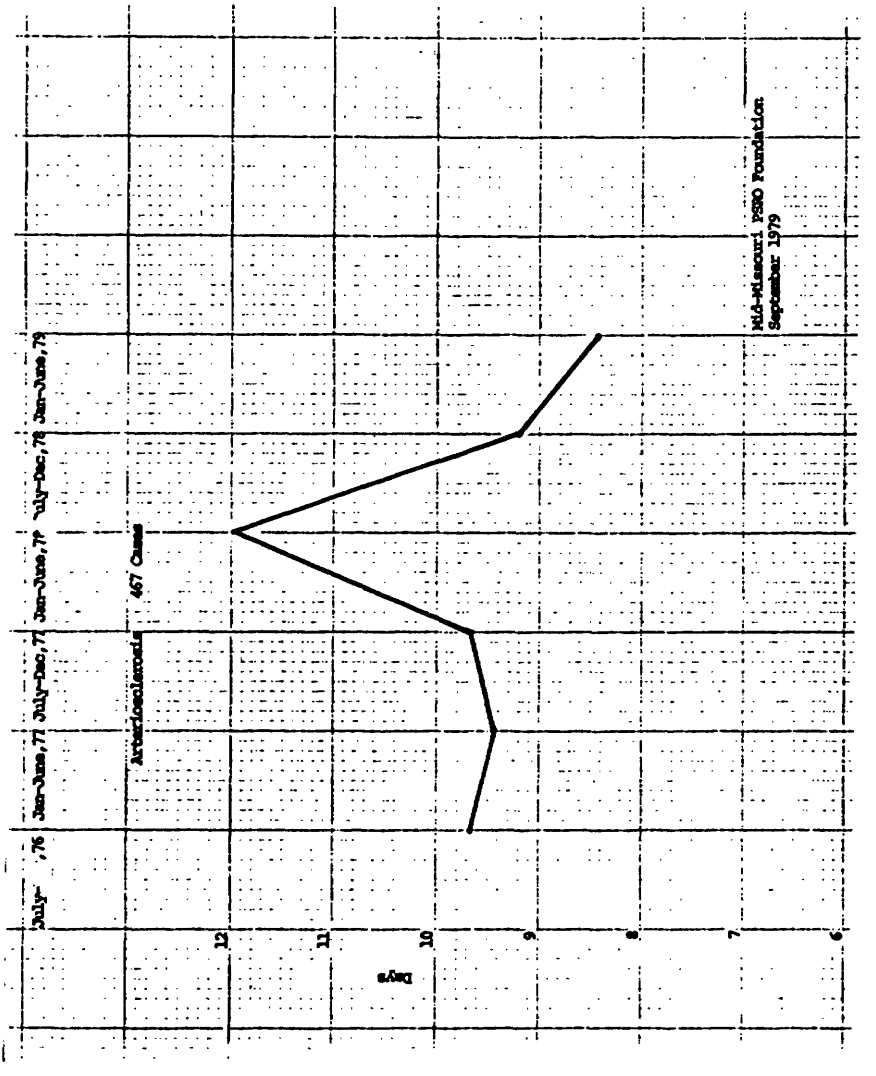
D. SWING-BEDS IN AN ACUTE CARE FACILITY - ANOTHER AREA WE HAVE IDENTIFIED WITH THE POTENTIAL FOR SAVINGS WOULD BE THE DEVELOPMENT OF A REIMBURSEMENT SYSTEM COMMENSURATE WITH THE LEVEL OF CARE A PATIENT RECEIVES IN AN ACUTE HOSPITAL SETTING. THIS COULD BE DONE BY PSROs' IDENTIFYING THE APPROPRIATE LEVEL OF CARE, I.E., SKILLED NURSING LEVEL, WHEN NO SKILLED BED IS AVAILABLE. THIS COULD ALSO BE APPLIED TO ICF OR INTERMEDIARY CARE LEVELS. THE HOSPITAL WOULD BE REIMBURSED AT A LOWER RATE THAN THE CURRENT ACUTE CARE RATE DUE TO THE LESS INTENSIVE LEVEL OF CARE RENDERED TO THIS PATIENT AND THE CONTINUITY OF CARE WOULD NOT BE INTERRUPTED.

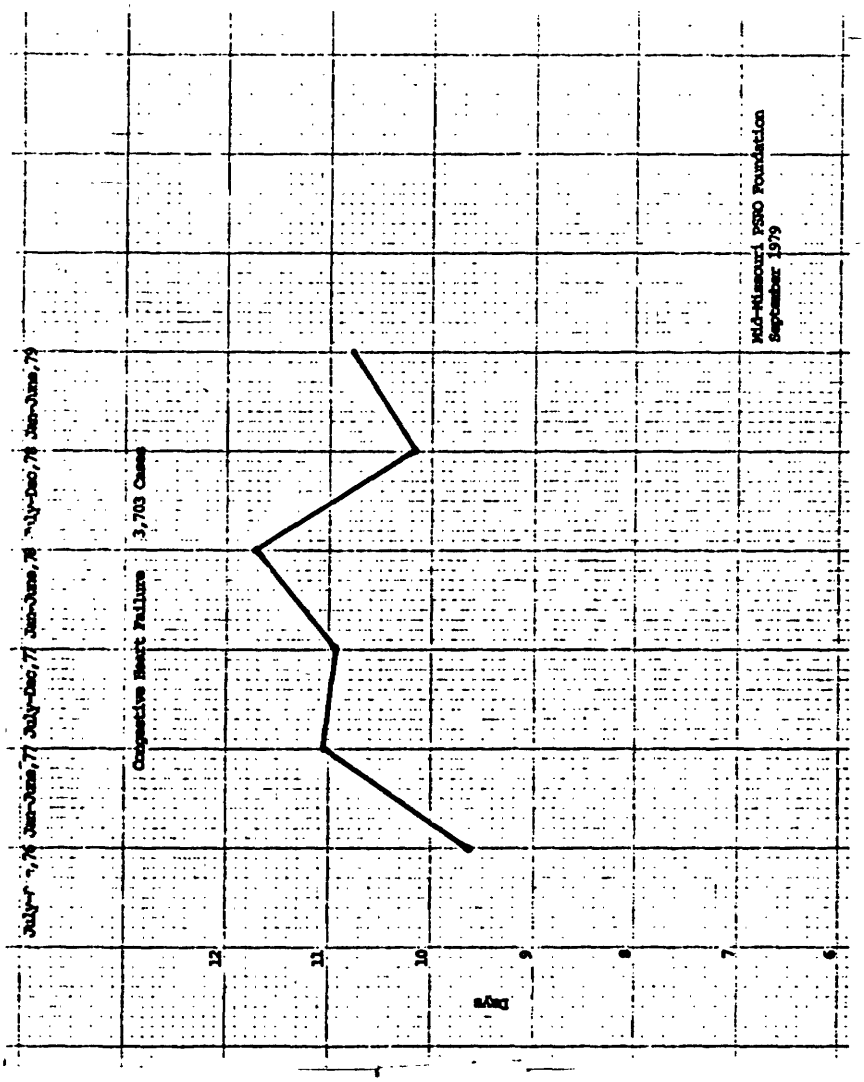
THIS CONCLUDES MY TESTIMONY TO THE COMMITTEE. I WILL BE HAPPY TO ENTERTAIN ANY QUESTIONS THE COMMITTEE WISHES TO ASK. OBVIOUSLY WE COULD NOT COVER ALL THE AREAS IN THE TIME FRAME ALLOTTED, BUT I FEEL I HAVE COVERED THE MORE IMPORTANT POINTS.

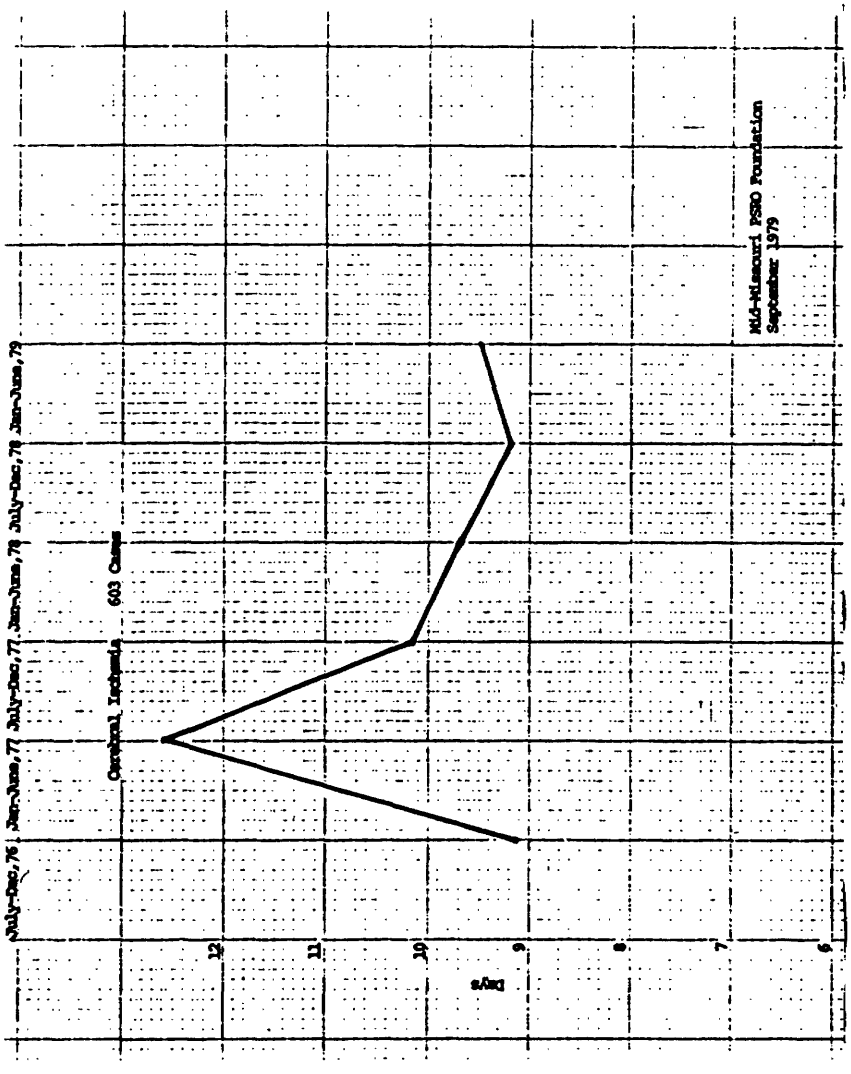


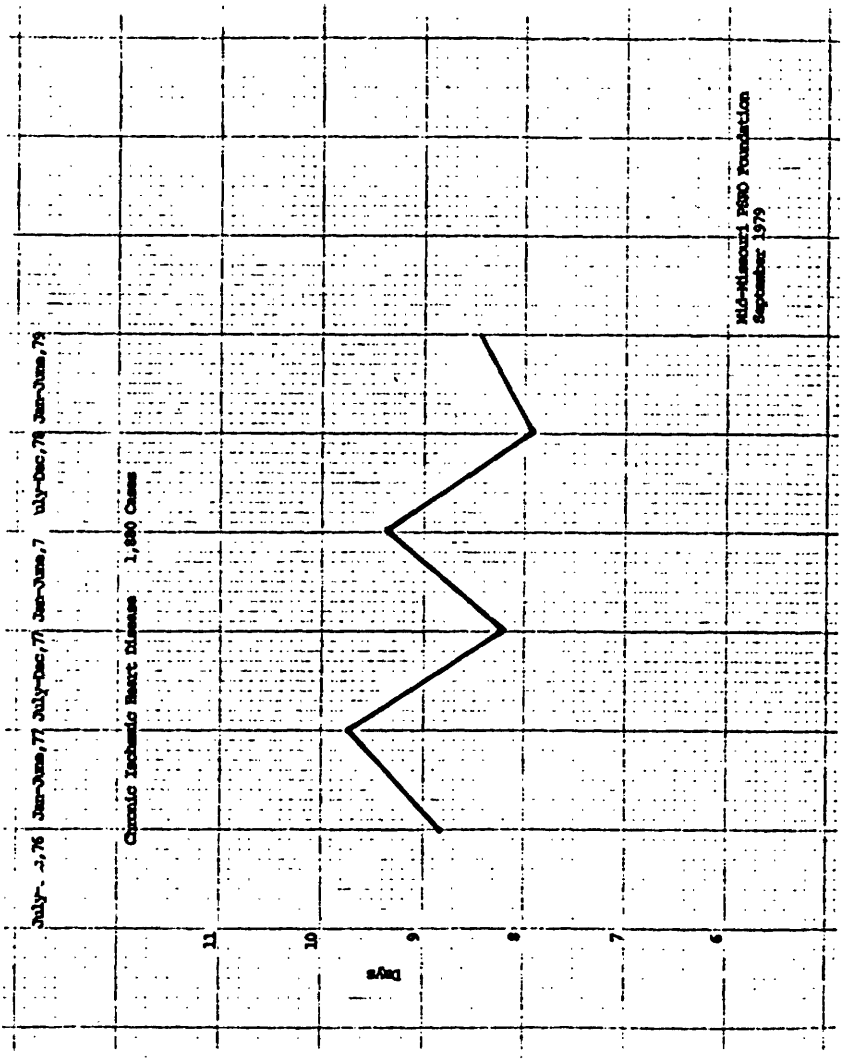


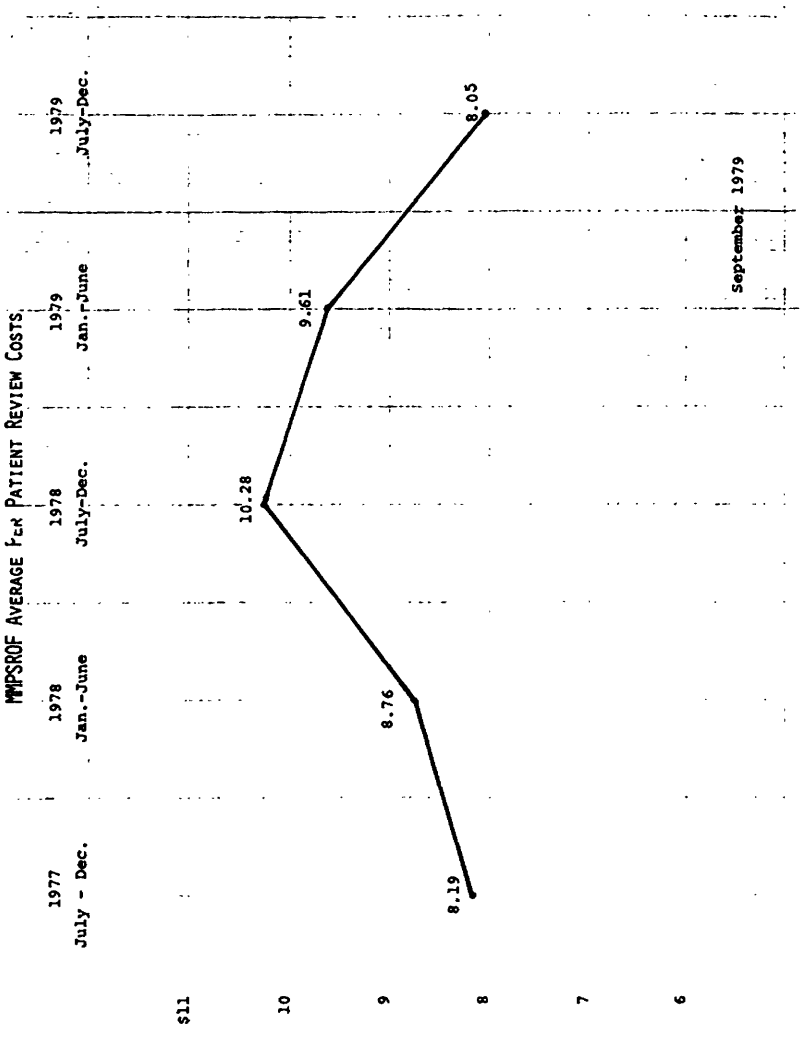












Senator TALMADGE. Thank you very much. In my opinion that last suggestion is an excellent one. It is absolutely absurd to put people in the hospital if they do not need to be there and if we can have them accommodated elsewhere.

So I would appreciate it if you would send us your suggestions on how we can do that with the proper safeguards. I wish you would send us the several suggestions you have to make.

[The supplemental statement to be furnished follows:]

ATTACHMENT A

MISSOURI MEDICAID

MEMORANDUM OF UNDERSTANDING WITH

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

This Memorandum of Understanding is entered into between Mid-Missouri PSRO Foundation, the Professional Standards Review Organization (PSRO) for Area II of Missouri under Title XI of the Social Security Law, and the Missouri Department of Social Services, the single State Agency for the Administration of Medicaid under Title XIX of the Social Security Law, to set forth the operational procedures that the parties have agreed will be followed with respect to the review of certain covered medical services for which payment may be made under Title XIX of the Social Security Act (Medicaid Program). This Memorandum may be amended by mutual consent of the parties and with the concurrence of the Secretary of Health, Education, and Welfare or his delegate, and its terms are subject to modification in accordance with amendments to the Social Security Act or Missouri State Medical Assistance enactments, and with regulations or general instructions issued by the Secretary or the Missouri Department of Social Services. Any alterations, variations, modifications, or waiver of provisions of this agreement shall be valid only when they have been reduced to writing, duly signed, and attached to the original of this agreement. This Memorandum recognizes that the State Agency has complete responsibility and authority in regard to determination of recipient eligibility, scope of covered benefits, and rates and methods of reimbursement for approved services.

This Memorandum recognizes that the PSRO has complete responsibility and authority in regard to determination of the quality, appropriateness, and necessity of services rendered or proposed to be rendered as specified hereunder.

I. TYPES OF REVIEW TO BE PERFORMED BY THE PSRO

In accordance with the provisions of its contract with the Secretary of Health, Education, and Welfare, and under the terms of this agreement, the PSRO will conduct or delegate reviews of acute-care services and items provided on an inpatient basis in hospitals, for which payment may be made in whole or in part under Title XIX (and Title V). The primary purpose of review will be to determine quality, medical necessity, and appropriateness of rendered service as to type, level, extent, and duration of care. Modes of review activity will be: admission certification, continued-stay review, medical-care-evaluation studies, and profile analysis. From time to time, the PSRO may exempt from concurrent review, in whole or in part, services and items provided by practitioners and hospitals, based on the PSRO's determination that the cost of such review exceeds the benefit. The PSRO will nevertheless certify such exempt services and items for payment. The PSRO will exercise its authority in delegating PSRO review activities and functions to hospitals in part or whole; will conduct regular and continuous monitoring and evaluation of the institutions' capabilities and effectiveness in performing reviews; and will provide training, technical assistance, and continuing education toward improving institutions' awareness and application of professionally recognized standards of care.

II. PLAN AND SCHEDULE FOR PHASING-IN PSRO REVIEW IN SHORT-STAY HOSPITALS

The PSRO will routinely provide the State Agency and the affected short-stay hospital 30 days' advance notice of the exact date upon which it expects that review operation in each of the acute-care hospitals in its area will become binding on the Agency for payment purposes. The PSRO will also provide the State Agency 15 days advance notice of any change in delegation status of hospitals in which the PSRO has assumed responsibility for review.

III. PLAN AND SCHEDULE FOR PHASING-IN PSRO REVIEW IN LONG-TERM CARE FACILITIES

The operational procedures that the parties will follow in conducting review of long-term care and the schedule for implementing these procedures will be included in a separate Memorandum of Understanding.

IV. THE TIME WHEN THE HOSPITALS' REVIEW FINDINGS WILL BE ACCEPTED FOR PAYMENT PURPOSES

Prior to the assumption of binding review responsibility by each delegated hospital that will perform review on behalf of the PSRO, the PSRO will provide a 60-day training period in the hospital, to assure that it will follow PSRO procedures.

As provided in Section 1155 of the Act, each PSRO is responsible for assessing the capability of hospitals' utilization mechanisms to perform required review activities in a timely and effective fashion. The PSRO will provide written notification to the State Agency as to (1) the date a participating hospital is authorized to perform such review, (2) the nature and extent of the delegated review activity, and (3) the date when such authorization is

terminated or modified. The notification will also include a copy of the hospital's review plan and names and sample signatures of those individuals authorized to communicate review decisions on behalf of the PSRO and/or the delegated hospital. All such notifications will be furnished at least 30 days prior to the effective date of the hospital's undertaking binding review activities.

For non-delegated hospitals, the PSRO'S review determinations shall be binding on the State Agency at the end of the 30-day notification period. For delegated hospitals, the review determinations of the hospitals' utilization mechanisms shall be binding on the State Agency at the end of the 30-day notification period and the 60-day training period.

Where the PSRO has authorized a hospital to perform review, the State Agency will abide by the review determinations of the hospital. A copy of the Memorandum of Understanding between each hospital and the PSRO and any modification thereto will be sent to the State Agency in advance of implementation.

The State Agency recognizes that review in certain hospitals (listed in Schedule A) already is binding on it. Review determinations by such hospitals shall continue to be binding until the State Agency is notified to the contrary by the PSRO or by the Secretary of Health, Education, and Welfare.

V. TYPES OF REVIEW AND MONITORING TO BE CONTINUED BY THE STATE AGENCY

For those hospitals where the PSRO has not yet assumed review authority, the State Agency will continue to maintain full authority for performing utilization review.

Following the 30-day notification period in each hospital, delegated or non-delegated, during which period the State Agency will retain final authority for making payment decisions based on issues of medical necessity or appropriateness, the State Agency will accept as binding on it for payment purposes the determinations of medical necessity or appropriateness of services and/or items ordered in that hospital made by the PSRO or the delegated hospital. The State Agency shall nevertheless retain authority for payment decisions based on issues of recipient eligibility, scope of covered benefits, and rates of reimbursement. Where a determination of medical necessity or appropriateness, whether on a prospective, concurrent, or retrospective basis, is an integral part of a coverage decision, the PSRO's determination shall bind the State Agency in reaching its decision.

Concurrent with the beginning of the 60-day training period, the State Agency will begin to monitor the effectiveness of PSRO review in each hospital, utilizing a monitoring plan approved according to Social and Rehabilitation Service Action Transmittals SRS-AT-76-140 and 141.

VI. SPECIFICATION OF A MECHANISM BY WHICH THE STATE AGENCY WILL PERFORM POST-PAYMENT MONITORING OF REVIEW

It is the mutual intent of the PSRO and the State Agency to act cooperatively and to share information gained by either party that may be of benefit to the other. Where, by its monitoring, the State Agency identifies problems involving Title XIX recipients and providers, it will report these problems to the PSRO, which will

investigate and make a timely report to the State Agency about its findings and any action it takes concerning such problems. Where, by its review, the PSRO identifies problems involving Title XIX recipients and providers, it will report these problems to the State Agency, which will investigate and make a timely report to the PSRO about its findings and any action it takes concerning such problems.

The State Agency and the PSRO will meet at least quarterly to review developments, discuss problems and issues, and evaluate the effectiveness of review procedures. More frequent contacts may be made at the desire of either the PSRO or the State Agency.

VII. SPECIFICATION OF HOW THE PARTIES WILL BE INVOLVED IN PROCESSING, STORAGE, AND/OR REPORTING OF DATA

The manner of processing Medicaid data is to be developed in such a way as to be acceptable to both parties. This agreement does not imply that any new or revised data-processing activities will be developed by the State Agency for the specific benefit of the PSRO, or by the PSRO for the specific benefit of the State Agency. In the event that the PSRO or the State Agency should request any new data reports or report formats from the other party, the production of and reimbursement for such reports will be negotiated by the parties.

Reports generated routinely from data collected by the PSRO or by the State Agency which reflect the utilization patterns of hospitals, including the utilization of ancillary services, will be available to the other party upon request and at cost, subject to established confidentiality requirements.

The PSRO will be responsible for the collection, processing,

storage, and reporting of data collected through its activities, except as may be specified by the Secretary of HEW or his delegate. Policies and procedures for sharing of data held by the parties and concerning services and items provided in settings other than acute-care hospitals shall be included in separate Memoranda of Understanding.

VIII. A PLAN FOR THE EXCHANGE OF INFORMATION AND COMMUNICATION BETWEEN THE PSRO AND THE STATE AGENCY

For inpatient hospital review, the PSRO'S review decisions will be communicated to the State Agency as follows:

A. The PSRO will notify the State Agency of the certified length of stay by attaching the original copy of the Mid-Missouri PSRO Foundation's Certification half-sheet (MM 100).

B. The PSRO will attach a copy of the denial notification, if any, to the MS-3 claim.

C. The PSRO will send a copy of each final reconsideration determination to the State Agency. If a claim has been filed already with the State Agency, the PSRO will attach a copy of the original claim to the determination. The State Agency will then adjust the provider reimbursement appropriately.

D. In the event that the State Agency receives a claim for which the PSRO has assumed review responsibility, itself or under delegation, and the claim has not been certified by the PSRO or the hospital's review system, the claim will be returned immediately to the hospital, and a copy of the notification to the hospital will be sent to the PSRO.

E. In the event that the State Agency, in its processing and editing procedures, discovers an error in certification, the

claim will be returned to the hospital immediately, and a copy of the notification to the hospital will be sent to the PSRO.

IX. FINANCING OF PSRO REVIEW

The State of Missouri will assume no responsibility for the financing of PSRO review in acute-care hospitals, delegated or non-delegated. The PSRO will assume no responsibility for the financing of the State's monitoring activities.

This Memorandum will be effective for admissions on and after January 1, 1979, and the provisions included herein shall remain in force until December 31, 1979, or until they are abrogated or modified in writing by one or both parties. The provisions may be modified at any time by written agreement of both parties, the timing of the modification being at the discretion of the parties. Each and every provision of this Memorandum may be abrogated by either party upon written notice served upon the other party by certified mail at least 90 days before the effective date of the action described in the notice. Termination of this Memorandum may not be initiated for the purpose of avoiding the intent of the Social Security Act, as mended. It is further provided that this Memorandum may be modified or terminated with less than 90 days' notice if State legislative action, Federal legislative action, or DHEW regulatory action should result in instructions to either party contrary to the provisions of the Memorandum, or if DHEW and the PSRO should terminate their contract.

MISSOURI DEPARTMENT OF SOCIAL SERVICES

Donald B. Kammerer

Donald B. Kammerer
Acting Director

Date January 25, 1979

MID-MISSOURI PSRO FOUNDATION

President

Earl L. Loyd, M.D.
Medical Director

Executive Director

Date Dec. 12 1978

SCHEDULE A

MID-MISSOURI PSRO FOUNDATION AREA HOSPITALS
PERFORMING PSRO REVIEW

AREA II

Audrain Medical Center	Mexico
Boone County Hospital	Columbia
Callaway Memorial Hospital	Fulton
Community Memorial Hospital	Moberly
Cooper County Memorial	Boonville
Ellis Fischel State Cancer Hospital	Columbia
Fulton State Hospital	Fulton
Grim-Smith Hospital	Kirksville
Hermann Area District Hospital	Hermann
Keller Memorial Hospital	Fayette
Kirksville Osteopathic Hospital	Kirksville
Laughlin Hospital and Clinic	Kirksville
Levering Hospital	Hannibal
Memorial Community Hospital	Jefferson City
Mid-West Columbia Regional Hospital	Columbia
Mid-Missouri Mental Health	Columbia
Pershing Memorial Hospital	Brookfield
Phelps County Memorial Hospital	Rolla
Pike County Memorial	Louisiana
Pulaski County Hospital	Waynesville
Putnam County Memorial Hospital	Unionville
St. Elizabeth's Hospital	Hannibal
St. Francis Hospital	Marceline
St. Mary's Health Center	Jefferson City
Salem Memorial Hospital	Salem
Samaritan Memorial Hospital	Macon
Scotland County Hospital	Memphis
Still Osteopathic Hospital	Jefferson City
Sullivan Community Hospital	Sullivan
Sullivan County Memorial	Milan
University of Missouri Medical Center	Columbia
Woodland Hospital	Moberly
Lake of the Ozarks General Hospital	Osage Beach

ATTACHMENT B

Mid-Missouri
Professional Standards Review Organization Foundation

September 21, 1979

John Hall, Deputy Director
Division of Family Services
P.O. Box 88
Jefferson City, Missouri 65103

Dear Mr. Hall:

The Mid-Missouri PSRO Foundation Board of Directors has met and authorized this letter to be sent to you on the recommendation of our Legal Affairs and Bylaws Committee as well as our attorney.

There have been recent certification changes in procedures that occurred due to the contract entered into between Missouri Medicaid, Title XIX, and EDS Federal which altered our Memorandum of Understanding which was signed by Mr. Donald B. Kammerer, Acting Director, effective January 1, 1979 through December 31, 1979.

The specific sections of the Memorandum of Understanding which have been altered are as follows:

Page 1, 1st paragraph, 3rd sentence, and I quote
"Any alterations, variations, modifications, or waiver of provisions of this agreement shall be valid only when they have been reduced to writing, duly signed, and attached to the original of this agreement."

Page 7, VIII, Item A
"The PSRO will attach a copy of the denial notification, if any, to the MS-3 claim." This is no longer applicable due to the change of the claim form.

Page 4, Section IX, 2nd paragraph, 1st and 2nd sentences
"This Memorandum will be effective for admissions on and after January 1, 1979, and the provisions included herein shall remain in force until December 31, 1979, or until they are abrogated or modified in writing by one or both parties. The provisions may be modified at any time by written agreement of both parties, the timing of the modification being at the discretion of the parties."

The Board of Directors finds modifications are necessary since in effect we no longer have a viable Memorandum of Understanding. Our Board of Directors feels that 30 days would be sufficient time to make the necessary modifications and obtain the appropriate signatures. This should be accomplished prior to the Medicaid/PSRO regular quarterly meeting scheduled for October 19th.

The Board fully realizes the MOU is not a mandatory requirement by law, but a Secretarial decision. We feel the Memorandum is a viable instrument, delineating Medicaid's and the PSRO's responsibility as indicated in Public Law 92-603.

We have negotiated previous MOUs in good faith and cooperation, and intend to pursue this negotiation with the same attitude. We would appreciate the revision of the Memorandum as expeditiously as possible for our mutual benefit.

Sincerely,

Thomas E. Mangus
Executive Director

TEM:lm

ATTACHMENT C

Mid-Missouri
Professional Standards Review Organization Foundation

September 12, 1979

Jim Conley, Project Officer
HCFA, HSQB, PSR
Federal Office Bldg., Rm. 275
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Conley:

This is in response to your visit to our office on July 19-20, 1979 and your request of a written plan of corrective action of the identified areas in our assessment by the Central Office.

I will address these in the order of the Assessment.

I. Organization
III. Quality Assurance Functions
IV. Data Management, and
V. External Relations

If there are any questions regarding the already implemented or proposed corrective actions, please call me.

Sincerely,

Thomas E. Mangus
Executive Director

TEM:je

Enclosure Committee Functions
Organizational Chart
Physician Brochure

Mid-Missouri PSRO Foundation
PLAN FOR CORRECTIVE ACTION
(Central Office Assessment - Dec. 18-22, 1978)

I. ORGANIZATION

Committee Structures and Involvement

We have reviewed the findings and recommendations and implemented the following:

We have written appropriate functions for each Committee, specifically Data, MCE, and Health Care Guideline Committees (copies attached). Regarding the frequency of the meetings of these Committees, our Data Committee will be meeting monthly beginning in October. Our MCE Committee already meets on a regular basis but at the time of the Assessment this Committee was not functioning at its fullest capacity.

The Health Care Guidelines Committee will only meet as needed. The function of this Committee was to review criteria or norms that were submitted by the hospitals in modifying our approved norms and criteria which are currently PAS and the Tennessee Foundation for Medical Care Criteria, as well as the AMA Criteria. We feel that more frequent meetings of this Committee would not be cost effective.

Board Operations

We take exception to the statement that there is little documented evidence of Board involvement in major policy issues or in contract requirements. We have sufficient Board minutes which indicate the contrary.

Physician Membership and Recruitment

We have reviewed the recommendation and have planned the following:

Our Membership Chairmans, one from each of our three geographic areas, will meet September 20th to discuss a proposed plan for a formal recruitment of new members. Our intent is to have--

1) A mass mailing to non-members.
2) Give Board members, or a PSRO member practicing at a hospital the list of non-members in their respective hospitals, and have these members individually contact those non-members for recruitment purposes.
3) We have prepared a physician information pamphlet which should encourage physicians to become members and get involved in the PSRO program. (Copy of the pamphlet is attached).

Involvement with HCPOTPs

An amendment to our bylaws, which is necessary to change the composition of our Board of Directors, will be presented to the entire membership for approval at our Annual Membership

Meeting. This amendment, if approved, will include HCPOTPs as advisory ad hoc members of our Board. Therefore, the implementation of this provision cannot be accomplished until after our October 18th Annual Membership Meeting.

Training

We have reviewed the recommendation and find this particular item is mute since the Director of Operation position has been dissolved and the individual no longer employed at MMPSROF.

Organizational Structure

We have reviewed the recommendation and take exception to the statement regarding the Organizational Chart. We sent a revised organizational chart to the team members prior to the assessment. Obviously this chart was ignored and the original chart was referred to in this report. Attached is a revised Organizational Chart.

III. QUALITY ASSURANCE FUNCTIONS

Revision of Norms, Standards, and Criteria

In each individual hospital's signed Memorandum of Understanding with the Mid-Missouri PSRO Foundation it is stated in Part II, Norms, Criteria and Standards, Section D. "The hospital may request modifications in norms, criteria and standards for concurrent review at any time. Documentary evidence supporting the requests shall accompany such requests to the PSRO. At no time shall review activity cease pending final decision on such requests." Therefore, hospitals were informed revisions of norms, standards and criteria could be made. We will endeavor by December 1, 1979 to send a notification to the hospitals stating that they may submit to the Health Care Guidelines Committee any modifications to the criteria, norms and standards for review, approval or disapproval.

Organization of Review Staff

We have reviewed the recommendation and find that it is no longer applicable since there is no longer a Director of Operations position. The Regional Coordinator staff reports directly to the Assistant Director. This was effective September 1.

Education of Hospital Personnel/Communication of Findings and Monitoring Feedback

We have taken exception to the statement that the review findings during the monitoring is only discussed on a request basis. The process is:

1) The Regional Coordinator gives the hospital advance notice when they will be monitored, notifying the administration, Physician Advisor, Chief of Staff and Patient Review Coordinator.
2) The hospital monitoring is performed by the Northern or Southern Regional Coordinator.
3) After completing the monitoring, depending upon the problem encountered, on-site discussions regarding these problems are

held with the Review Coordinator, Physician Advisor, (if applicable), and hospital administration.

4) These monitoring visits are followed up with a written report back to the hospital to the administration and Review Coordinator.

With regard to education of hospital personnel, i.e., Physician Advisors, Patient Review Coordinators, and Administrators, it is our plan to hold coding/abstracting workshops at least three times during our current grant period. We will hold at least two Physician Advisor seminars, as well as individual visits to hospitals that have a change in Physician Advisors for the purpose of educating the new PAs of their role. We have held two of these training Sessions--one in August and one in September 1979.

Every six months at each hospital, we will hold a meeting with the hospital administration, coordinators and physicians regarding the monitoring findings, problems encountered, and recommend a plan of correction. We will also present and discuss the previous six months data reports with regard to LOS, pre-op days, focused review reconsiderations from physician profiles, trends with patient profiles, and data related to problem areas for suggested MCE topics, etc.

Feedback of Review Information to Physicians

We have reviewed the recommendation and disagree with the findings. The Hospital Review Committee, rather than the Peer Review Committee, review our monitoring reports and other data compiled by the staff, and make appropriate recommendations to the Board for action. Our Hospital Review Committee is responsible for the efficiency and effectiveness of the PSRO review system.

Due to budget constraints our Peer Review Committee is only scheduled to meet quarterly for the current period. This will ensure the efficient use of physician time on the Committee. The Peer Review Committee will be looking at cases which are questioned by our monitoring, rather than those cases received from the intermediaries. The Medicare intermediary is no longer monitoring Mid-Missouri PSRO since the disagreement rate was less than 3%.

Area-wide MCEs

With regard to an Areawide MCE we have now chosen a topic, developed the criteria and requested hospitals to voluntarily participate in our Areawide MCE. This audit should be completed by December 1979.

A summary of the Areawide MCE will be forwarded to you upon completion.

Analysis of MCEs

We have reviewed the recommendations and have accomplished our objective in the review and analysis of MCEs submitted by each hospital in our area. We have currently evaluated 30 MCEs from our 33 hospitals. Since the assessment one MCE has been

completed at one of our non-delegated hospitals. We have made appropriate recommendations back to those hospitals that did not meet our MCE criteria.

Linking Review Findings to CME Providers

We have reviewed the recommendation, however, due to the medical and political environment of the Mid-Missouri PSRO area, it is extremely difficult to initiate direct involvement or input into Continuing Medical Education curricula which identify problems from our delegated hospitals, areawide MCEs and profiles. We are continuing, through our Board members who are faculty members on each of our area's medical schools, to suggest subjects which could be included in the curriculum for Continuing Medical Education. The road to accomplishing this objective will be long and time consuming.

IV. DATA MANAGEMENT

We have reviewed the four recommendations in the data area and refer you back to our response in Section III (Quality Assurance Functions) which identify feedback of data to hospitals and physician committees through the utilization of our data reports. Our plan is to activate the Data Committee which will be chaired by our current president, as his tenure as president expires in October. We therefore, feel these areas have been covered adequately.

V. EXTERNAL RELATIONS

Health Care Practitioners Other Than Physicians

Please refer to our plan of organization which refers to HCPOTPs.

CME Cooperation

As indicated earlier, we will attempt to cooperate and work with the medical schools, medical and osteopathic associations in the development continuing education programs.

Title V

We have reviewed the recommendation and have sent a letter with two signed copies of our proposed Memorandum of Understanding to the Title V Agency on January 12, 1979, and as of this date have not received any response.

Senator TALMADGE. Now, several PSRO's, including your own, have testified about widespread problems with psychiatric hospitalization. What, in your opinion, are the underlying causes of those inappropriate admissions and excessively long hospital stays?

Dr. WESTHOFF. Mr. Chairman, I think most are related to the fact that the patient with psychiatric illness in many instances has underlying medical problems. In our area the psychiatric physicians do not feel that they are capable of handling this, so they are transferred to an acute care institution to have the medical problem taken care of.

Most of the time in this institution the psychiatric care is not being rendered. What we need to do is develop a program whereby the medical care can be rendered in the psychiatric institution. Most of these people do not need to be certified at an acute care level but rather for immediate care or even a boarding situation.

Senator TALMADGE. Thank you very much. We appreciate your contributions. Senator Dole has some questions. I will submit them to you and will you respond in writing for the record, please? Thank you.

[The questions by Senator Dole to Dr. Westhoff and the responses to be submitted thereto follow:]

DR. WESTHOFF:

Question 1a. WHAT HAS BEEN YOUR EXPERIENCE IN DEALING WITH THE STATE MEDICAID PROGRAM?

b. HAS THERE BEEN SUPPORT OR OPPOSITION TO YOUR REVIEW ACTIVITIES?

a. Our Mid-Missouri PSRO Foundation was able to negotiate for all five PSROs in the state a Memorandum of Understanding with the previous administration. At that time our review activities were accepted and few problems were present.

b. Brief and active resistance from the State Medicaid office has increased noticeably in the past six months and specific difficulty in the review process has occurred since Electronic Data Systems (EDS) was awarded a statewide contract for Medicaid data gathering.

The specific difficulties and/or conflicts are outlined in the enclosed letter.
(See Attachment A--MMPSROF/Division of Family Services Memorandum of Understanding; and
Attachment B--Letter sent to modify the existing Memorandum)

Dole

DR. WESTHOFF:

Question 2. CAN YOU DOCUMENT STATISTICALLY THAT YOUR PSRO WAS DIRECTLY RESPONSIBLE FOR THE DECREASE IN THE NUMBER OF MEDICARE DAYS?

Data from the American Hospital Association, as reported in their publication *Hospitals* indicate that contrary to the national and regional trends, Mid-Missouri PSRO has had impact.

"While growth of admissions followed the general pattern of population growth, three "maverick" regions show the effect of aging on hospital utilization. The West North Central Region ranked eighth out of nine in population growth, yet ranked fifth in growth of admissions, largely the result of a growth rate for the elderly population (7 percent) that was six times the growth rate of the hospital population of the region (1.6 percent)."[1]

"Length of stay is declining more slowly in regions where the proportion of the population over 65 is rising more rapidly."[2]

1. *Hospitals*, March 16, 1979, pg. 69.
2. *Hospitals*, March 16, 1979, pg. 69.

QUESTION 2. Continued

Growth of Regional Utilization and Population, 1973-78[3]

Region	Percentage Increase/Decrease			
	Population*	Population Over 65	Admissions	ALOS
West North Central	1.6%	6.1%	5.0%	(4.0%)

* 1973-1977

After twelve months of concurrent review in all 33 acute care hospitals in the Mid-Missouri PSRO area, the Medicare days of care indicates a decrease.

The Mid-Missouri PSRO experience indicates a 1.3% change in admissions (1974-1978) with a decline of 7.2% in 1977-78. The average length of stay declined 13.2% (1974-78). This seems to indicate that Mid-Missouri PSRO has done considerably better then the region in reducing admissions and ALOS.

To our knowledge no other external quality assurance program nor utilization review program was simultaneously implemented. Therefore, either we (Mid-Missouri PSRO) or chance (an act of God) was responsible. We believe in the former, not that we don't believe in God.

3. *Hospitals*, March 16, 1979, pg. 69.

DR. WESTHOFF:

Question 3. WHAT WERE THE AREAS IDENTIFIED AS WEAKNESSES IN YOUR PROGRAM?

The areas of weakness were identified during the Assessment Team visit in December 1978. Our plan for corrective action dealing with each of these problems is outlined in the letter which we hope will be self-explanatory.
(See Attachment C)

Gole

DR. WESTHOFF:

Question 4a. WHY HAVE YOU CHOSEN TO FOCUS YOUR REVIEW ON PHYSICIANS RATHER THAN DIAGNOSIS?

b. IS THERE SUFFICIENT DATA TO PERFORM THIS TYPE OF REVIEW?

a. Physicians admit patients to the hospital, not the diagnoses. Also this allows monitoring of any given physician's activities in all the hospitals in our area to which he/she admits patients.

b. Yes, our data base was gathered (collected) during the concurrent review process and has been compared with a comparable patient mix for each physician.

DR. WESTHOFF:

Question 5. WHAT SPECIFIC ACTIONS HAVE YOU TAKEN TO MONITOR UTILIZATION ON A BROAD BASIS NOW THAT YOU ARE INVOLVED IN FOCUSED REVIEW IN MOST INSTITUTIONS?

1) Quarterly review of all hospital admission data (Federally funded admissions)

2) Quarterly review in each hospital for all
   A. Long stays greater than 30 days
   B. Pre-op days
   C. Readmissions
   D. Short stays

These are in contrast to written sampling review occurring during monitoring and concurrent review process.

The quarterly on-site monitoring of hospitals occurs prior to the completion of physician profile information. At the present time these monitoring visits are made prior to our quarterly re-evaluations of focusing decisions. Our future plans are to utilize the same system except that we will utilize profile data information on a semi-annual instead of a quarterly basis for the purpose of focusing physicians "in or out" at each hospital.

Additional monitoring visits are made to hospitals depending on the problems identified.

Example: Documentation--Inhouse patients' charts are reviewed in depth at appropriate intervals varying from 4-6 weeks versus a 6-8 week interval in which all monitoring of the review process is retrospective.

Senator TALMADGE. The next witness is Dr. McMahon, medical director, Montana Foundation for Medical Care.

Senator Baucus is recognized.

Senator BAUCUS. Mr. Chairman, I am sure you are going to find in the next session here that Dr. McMahon and Dr. Hayward are two terrific Montanans. I was at first a bit skeptical of the PSRO program several years ago but I can tell you that in the last several years the Montanans have done a great job.

I can say that because I am from the State of Montana but, in addition to that, apart from my obvious bias, they have done, if you will pardon the pun, a sterling job. I wish to thank them publicly and praise them for the work they have done. Thank you, Mr. Chairman.

Senator TALMADGE. Thank you.

You may insert your full statement in the record and summarize it.

STATEMENT OF JOHN W. McMAHON, M.D., MEDICAL DIRECTOR, MONTANA FOUNDATION FOR MEDICAL CARE, HELENA, MONT., ACCOMPANIED BY STERLING HAYWARD, M.D., PRESIDENT

Dr. MCMAHON. Thank you. I will summarize. It is impossible to accurately measure cost savings as a result of PSRO activity. PSRO's are definitely underfunded. MTFMC has submitted four sanction reports recommending removal of four physicians from the eligibility reimbursement roles of medicare and medicaid.

Subscribers to private insurance companies, as well as taxpayers, have saved money as a result of PSRO activity. Hospital utilization in Montana is down 493.6, or 13 percent, days of care per 1,000 medicare recipients as a result of PSRO review. PSRO-sponsored medical audits have improved the quality of medical care in Montana.

What makes PSRO's effective? Substantial physician involvement and support; staff, physician and nonphysician, commitment to the peer review concept is mandatory; strong medical direction from the board of directors; willingness to use every method available, including sanctions, to ensure quality care.

We need dedicated and competent staff. PSRO's are patient advocates and not necessarily physician advocates. We need recognition by State and Federal Governments that the ultimate decisionmaker in certifying appropriate and necessary care is physician peer review. We believe that PSRO's should follow our lead in concentrating on quality and that cost efficiency will follow.

Mr. Chairman, committee members and staff, thank you sincerely for the opportunity to present testimony and answer your questions regarding our experience with the PSRO program in Montana. I am Dr. Jack McMahon, a practicing surgeon and medical director for the Montana Foundation for Medical Care, which serves as the PSRO for the entire State. With me is Dr. Sterling Hayward, a practicing orthopedic surgeon and our president.

We are here, in our judgment, representing the people of the State of Montana. The term foundation is actually a misnomer for our organization. We do not barter insurance. We are strictly a peer review organization and our function is to insure the necessity

and appropriateness of the medical care delivered by ourselves and our colleagues to the patients in our State. It is also our purpose to ensure that care is delivered in as cost-efficient a manner as possible.

History: Our organization was founded by the Montana Medical Association before the legislation originating PSRO was ever passed. We are governed by a 21-member board of directors representing approximately 1,100 physicians in the State, 470 of whom are foundation members. In addition, many physicians who are actually not members of the foundation function in peer review capacities for our organization. Our board is elected by the general membership and is required to represent geographically the entire State as well as a variety of medical specialties.

The PSRO program is professionally unique to physicians and moreover our review is unique to the United States. We know of no additional instance where any single profession is mandated through governmental contract with private corporations to assure that the public they serve does, in fact, receive the best possible service in a quality sense in the most cost-efficient manner possible. We are patient advocates. In our judgment the worst error we could make would be to deny necessary care to a single patient.

I am addressing you today in an economic climate of runaway inflation. I recognize that health care is one of the leaders in that runaway. It is appropriate that you do everything in your power to insure that every health care dollar spent delivers a dollar's worth of quality health care. You have assured, in our judgment, a mechanism for so protecting the public by the establishment and your continued support of the PSRO program.

Accomplishments: In all assessments of the PSRO program I have seen to date, attempts are being made to apply cost-benefit ratios to the program. In our judgment this is equivalent to attempting to determine the amount of water in a lake with a 20-mile perimeter, 45 bays and unknown depth.

How much money is saved when, through education, a physician no longer hospitalizes patients for general physical examinations, operations which can be done on an outpatient basis and/or illnesses which can be managed satisfactorily at home? Those figures appear nowhere in cost-benefit statements.

How much money is saved when physicians elect, through an educational process, to utilize the least expensive of appropriate antibiotics or other drugs? How much money is saved when physicians, again through educational processes, elect to no longer remove the tonsils of every patient in their pediatric practice?

How much money is saved when the physician, by actually being dropped from the medicare-medicaid programs by the Department of Health, Education, and Welfare at the urging of the PSRO, is no longer hospitalizing patients who do not have to be hospitalized?

How much money is saved when I discharge my patients after gall bladder removal on their fifth postoperative day instead of their seventh postoperative day? How much money is saved when Dr. Hayward, my orthopedic colleague, no longer admits his elective surgical cases three days preoperatively but one day preoperatively?

We cannot give you those figures nor can anyone else. We can, however, very clearly demonstrate that we have changed physician behavior in our State. We can further demonstrate that, when that physician behavior is not changed in the best interests of the public, our organization is willing to go one step further and ask the Federal Government to remove that individual, whose patients are eligible to receive Federal health care dollars under the medicare-medicaid programs, from the remibursement eligibility rolls.

It is our understanding that our organization is unique in its willingness to ask the Department of Health, Education, and Welfare to remove certain physicians from the medicare-medicaid programs if they refuse to change inappropriate practice pattern through educational processes. We do believe, however, that when our story is more widely publicized—and we do intend to widely publicize it—other PSRO's in the United States will follow our lead.

There are other indirect cost-efficient spinoffs from the PSRO program in our State that cannot be precisely calculated. The executive director of Montana Blue Shield has recently told me that our efforts have very definitely benefited their membership and that we are saving them considerable amounts of money. Again this is not a measurable figure. It is not measurable for the same reasons I have previously described.

The staff members of Montana Blue Cross are so enthusiastic about our programs that they have asked us to submit a proposal for ancillary review for part A of the medicare plan as well as for the Blue Cross private pay program. We have an ambulatory review program with the State medicaid agency for all providers who are eligible for reimbursement under the medicaid system. We also have a total long-term plan system that covers both medicare and medicaid.

Hospital utilization in our State is down 493.6 days of care per 1,000 medicare recipients, or 13 percent, since we instituted review. We have initiated formal continuing medical education programs for Montana physicians based upon the results of our medical audits and, even more important, we have initiated a weekly television public educational program for some of our Montana communities and we are at this time actively attempting to circulate this program on a statewide basis.

Budget considerations: Our current budget stands at $8.45 per Federal admission. Quite frankly this reduction was inappropriately excessive over the period of the last fiscal year. We were forced to discharge 30 employees. Many of our accomplishments which I have just related to you were possible only with a most productive and competent staff.

We are extremely concerned about what the future holds for us as well as for all other PSRO's in the United States. The efficiency of our program is deteriorating. We recommended to our Denver regional office a budget of $12.45 per admission but were forced to comply with the $8.45 figure. Essentially we were $4 short per admission. Obviously the service we can deliver will be $4 short.

We have severe reservations as to the effectiveness of the job we can continue to do under the present budget. We are less visible throughout the State. We no longer have coordinators in each

facility. We already have preliminary figures which indicate that the average length of stay in some of our smaller hospitals where we have been forced to eliminate coordinators is on the increase.

We find ourselves making administrative mistakes since many of our key employees are overburdened with work and they cannot keep up with it. Our enthusiasm of investigate and proceed with sanction procedures against physicians who will not turn around their practice patterns through education has been affected. Much of our success is directly dependent on the guidance and involvement of our board of directors and other physicians. Our current budget does not allow us to continue such involvement at an adequate level.

It is farther from one end of Montana to the other than it is from Washington, D.C., to Chicago. We can do nothing to make it closer. Our problem is travel. We could live on $8.40 per admission if all of our business were in downtown Washington, D.C. In summary, the people of the State of Montana are not being as well served by us as they would be if we were adequately funded.

OUR SUCCESS STORY

We feel that strong medical society support for the PSRO in any particular area is essential to PSRO success. We further believe that experience is necessary before PSRO's can demonstrate effectiveness. Although we have had the PSRO contract in Montana only since 1975, in actuality we were doing peer review from 1973 on.

We firmly believe that the majority of physicians nationally will have the courage to step forward and insure the appropriateness and necessity of medical care in their areas if they are given the opportunity to do so. Stepping into this arena is not like calling out the National Guard when a local crisis occurs. When the National Guard appears, in most instances the chaos and catastrophe is rather rapidly policed and the public is protected.

Physicians unfortunately are generally suspicious of government. Too often they forget that they are part of government, as are all citizens. We are looked upon by some of our colleagues as "Washington, D. C., West."

PSRO's must be willing to ultimately take decisive steps and ask the Secretary of HEW to remove specific physicians from the reimbursement rolls of medicare and medicaid if they fail to change inappropriate practice patterns after reasonable educational processes are enacted.

It has been our experience, in looking at some PSRO's elsewhere who are felt to not be effective or who have had major financial problems, that the staff has been less than candid with its board of directors and that the board of directors has not been as closely involved in directing the activities of the PSRO as it should have been. Physician involvement and education is the key to PSRO success.

We have a very good working relationship with the State medicaid agency and the fiscal intermediary for medicare. Our president is a member of the Montana rate review system, and I was personally involved with the development of the HSA in the State of

Montana. Some of our board members are active on the State Board of medical examiners. Many of our board members are officers in the Montana Medical Association. I am the legislative chairman for the Montana Medical Association. We have an excellent relationship with the health standards and quality bureau both in the Denver region and in Washington.

We believe in proceeding with honesty and integrity and being totally open with our programs both with physicians and with hospital administrative personnel. We have many disagreements with both of these groups. We have been recently informed that some physicians plan to advise the Montana Medical Association that their support of us should be terminated. This certainly should dispel the fear that some have that we are, in fact, "the fox guarding the chicken coop."

Our Washington-elected officials regularly receive correspondence from some physicians and hospital administrators in the State requesting their help in reversing decisions we have made about their practices or practice patterns. The majority of physicians do, however, support our efforts and recognize that our primary interest is not in making physicians happy but assuring quality care for the patients in our State.

We very firmly believe that the PSRO program in general has erred in attempting to demonstrate to you that they have been cost-containment organs. We are a quality assurance organization. If we insist on delivering quality care, cost-effectiveness will follow. We consider utilization of medical facilities to be a quality issue. If health care dollars are wasted on unnecessary care, those same health care dollars will not be available to pay for necessary and appropriate care for other patients.

I sincerely wish to thank you for the opportunity to tell you our story. I urge you to increase the funding for the PSRO program by at least 30 percent. You can make only 12 complete sandwiches out of a 24-slice loaf of bread unless you decrease the size of the sandwich. Thank you very much.

Senator TALMADGE. Thank you very much, Doctor. I have only one question. What would be the effect on PSRO review in Montana if doctor and patient profiles were required to be made public?

Dr. MCMAHON. We would close our doors.

Senator TALMADGE. You would do what?

Dr. MCMAHON. We would quit.

Senator TALMADGE. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Jack, I think it would be helpful if you could also outline fully the reasons why we have greater costs in Montana. You might point out that the size of the population of Washington, D.C., alone is the same as Montana as well as noting the great distance of travel in Montana.

But in addition to population and distances and transportation costs, what are some of the other reasons why costs in sparsely populated States like Montana tend to be higher?

Dr. MCMAHON. Surprisingly enough the cost of administration and the cost of medical care, say the services I deliver in contrast to the services a physician would deliver in San Francisco, well, I am cheap. I guess that is an ad. If you live in San Franscisco, come to Montana and I will operate on you.

The fact is, however, that we have had to cancel or cut down massively on the numbers of meetings we have with our board of directors and our executive group. In fact, at the present time our budget puts us below what the Federal requirements are for those meetings. Not only is there a long distance in Montana but there is not an airport at every community with a population of 10 people. We have many hospitals with an average incidence of three patients. Most of those hospitals are allowed to continue to operate and are supported by the county taxpayers. They want their hospitals.

This may sound preposterous when we are sitting here in Washington, D.C.; however, when the next community with a facility is 100 miles away and there is a winter storm, you want to somehow be geared up locally. So transportation is a major problem; accessibility to transportation is a major problem. Patient access to medical care is superb if you eliminate those transportation problems.

Senator BAUCUS. Do you think the regulations should therefore be changed to address the different circumstances in various States, such as the size and——

Dr. MCMAHON. I think taking up the pie and dividing it by x number of Federal admissions and saying everybody has to come up with $8.50 is absurd.

Senator BAUCUS. You have some agreement in the audience, and I wholeheartedly agree with you. In addition to that—you must have given some thought to this—do you have any ideas as to how the Congress or HEW can separate the wheat from the chaff—that is, the PSRO's that are doing a good job from those who are not?

You know that obviously part of the problem is that there is a certain amount of dollars to expend on the program and obviously we would like to help those programs that are doing well and somehow give some carrots or sticks, particularly sticks, to those who are not but to somehow devise a way to separate the good from the bad here. How can we do that?

Dr. MCMAHON. I think that all citizens in the country deserve to have their local physicians be their advocates through the formalized PSRO program or peer review program; and, politically some PSRO programs are not very efficient.

We have had the option of electively accepting the Federal contract. Many PSRO's, unfortunately, sort of have had this forced down their throats; if we don't do it the Government will. That is absurd. We came forward voluntarily and said we want to do this for the public, and later on PSRO came along.

As more PSRO's developed that atmosphere, in other words, as stated, if the Federal Government makes regulations we can't live with, we will "quit." Now, when more PSRO's get that attitude, I think they will turn it around, that they are doing this as a service to their patients. They are not a tool of the Federal Government. How can you judge what is what? I believe in peer review.

The best way to find out what kind of PSRO you have is to have other individuals involved with the PSRO program review it. I have been on onsite visits and we have had site visits. I know one I was on—I don't know what the ultimate result was—but 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 or not a PSRO is operating effectively.

Senator BAUCUS. Well, the problem to some degree though is that most American taxpayers hope that their dollars are spent efficiently. That raises the whole problem, the old bugaboo of Federal strings attached to Federal dollars that are spent in local areas.

I agree that we should move as much as possible toward local determination and control, and peer reviews, et cetera; but to some degree all of us have some kind of obligation to make sure the money is spent somewhat effectively and wisely. If that is the case, it seems that perhaps we should give some thought to looking at those programs that do better than others and rewarding those programs compared with those other programs that are not.

Dr. MCMAHON. It is so easy in this field to throw out the baby with the bath water. The PSRO program is a solid program; it is founded to protect the public; it has taken the most knowledgeable people available and asked them to determine what is quality health care and what is appropriate health care, and is it necessary care.

Now, because every area does not have the same level of expertise at this point to perform those tasks, I would like to see us exhaust every effort possible to educate those organizations to upgrade them to have them be efficient organizations. Where they can't, it is quite possible, I think, that neighboring PSRO's could absorb their role.

On the other hand, this won't make more money available for other PSRO's because the same money will just be spent in a more efficient manner.

Senator TALMADGE. Thank you, Senator.

Thank you very much, Doctor, for an excellent statement, and I compliment you and your associates for what you are doing.

[The prepared statement of Dr. McMahon follows:]

TESTIMONY PRESENTED BY JOHN W. MCMAHON, M.D., MEDICAL DIRECTOR, MONTANA FOUNDATION FOR MEDICAL CARE

Summary of major points

1.0 It is impossible to accurately measure cost savings as a result of PSRO activity.

2.0 PSROs are currently underfunded.

3.0 Accomplishments

3.1 MTFMC has submitted four sanction reports recommending removal of four physicians from the eligibility reimbursement roles of Medicare and Medicaid.

3.2 Subscribers to private insurance companies, as well as taxpayers, have saved money as a result of PSRO activity.

3.3 Hospital utilization in Montana is down 493.6 (13 percent) days of care per thousand Medicare recipients as a result of PSRO review.

3.4 PSRO sponsored medical audits have improved the quality of medical care in Montana.

4.0 What makes PSROs effective?

4.1 Substantial physician involvement and support.

4.2 Staff (physician and non-physician) commitment to the peer review concept.

4.3 Strong medical direction from Board of Directors.

4.4 Willingness to use every method available, including sanctions, to ensure quality care.

4.5 Dedicated and competent staff.

4.6 PSROs are patient advocates and not necessarily physician advocates.
4.7 Recognition by state and Federal Government that the ultimate decision maker in certifying appropriate and necessary care is physician peer review.
4.8 PSROs should follow our lead in concentrating on quality and cost efficiency will follow.

Mr. Chairman, Committee Members and Staff: Thank you sincerely for the opportunity to present testimony and answer your questions regarding our experience with the PSRO program in Montana. I am Dr. Jack McMahon, a practicing surgeon and Medical Director for the Montana Foundation for Medical Care, which serves as the PSRO for the entire state. With me is Dr. Sterling Hayward, a practicing orthopedic surgeon and our President. We are here, in our judgment, representing the people of the state of Montana. The term "Foundation" is actually a misnomer for our organization. We do not barter insurance. We are strictly a peer review organization and our function is to insure the necessity and appropriateness of the medical care delivered by ourselves and our colleagues to the patients in our state. It is also our purpose to insure that care is delivered in as cost efficient a manner as possible.

History

Our organization was founded by the Montana Medical Association before the legislation originating PSRO was ever passed. We are governed by a 21 member Board of Directors representing approximately 1100 physicians in the state, 470 of which are Foundation members. In addition, many physicians who are actually not members of the Foundation function in peer review capacities for our organization. Our Board is elected by the general membership and are required to represent geographically the entire state, as well as a variety of medical specialties.

The PSRO program is professionally unique to physicians and moreover our review is unique to the United States. We know of no additional instance where any single profession is mandated through governmental contract with private corporations to assure that the public they serve does in fact receive the best possible service in a quality sense in the most cost efficient manner possible. We are patient advocates. In our judgment, the worst error we could make would be to deny necessary care to a single patient. I am addressing you today in an economic climate of runaway inflation. I recognize that health care is one of the leaders in that runaway. It is appropriate that you do everything in your power to insure that every health care dollar spent delivers a dollar's worth of quality health care. You have assured, in our judgment, a mechanism of so protecting the public by the establishment and your continued support of the PSRO program.

Accomplishments

In all assessments of the PSRO program I have seen to date, attempts are being made to apply cost benefit ratios to the program. In our judgment, this is equivalent to attempting to determine the amount of water in a lake with a 20 mile perimeter, 45 bays, and unknown depth. How much money is saved when through education a physician no longer hospitalizes patients for general physical examinations, operations which can be done on an outpatient basis, and/or illnesses which can satisfactorily be managed at home? Those figures appear nowhere in cost benefit statements. How much money is saved when physicians elect through an educational process to utilize the least expensive of appropriate antibiotics or other drugs? How much money is saved when physicians, again through educational processes, elect to no longer remove the tonsils of every patient in their pediatric practice? How much money is saved when the physician, by actually being dropped from the Medicare/Medicaid programs by the Department of Health, Education and Welfare, at the urging of the PSRO, is no longer hospitalizing patients who do not have to be hospitalized? How much money is saved when I discharge my patients after gall bladder removal on their fifth post-operative day instead of their seventh post-operative day? How much money is saved when Dr. Hayward, my orthopedic colleague, no longer admits his elective surgical cases three days preoperatively, but one day pre-operative? We cannot give you those figures nor can anyone else. We can, however, every clearly demonstrate that we have changed physician behavior in our state. We can further demonstrate that when that physician behavior is not changed in the best interests of the public, our organization is willing to go one step further and ask the Federal government to remove that individual, whose patients are eligible to receive Federal health care dollars under the Medicare/Medicaid programs, from the reimbursement eligibility rolls.

It is our understanding that our organization is unique in its willingness to ask the Department of Health, Education and Welfare to remove certain physicians from the Medicare/Medicaid programs if they refuse through educational processes

to change inappropriate practice patterns. We do believe, however, that when our story is more widely publicized, and we intend to widely publicize it, that other PSROs in the United States will follow our lead.

There are other indirect cost efficient spinoffs from the PSRO program in our state that cannot be precisely calculated. The Executive Director of Montana Blue Shield has recently told me that our efforts have very definitely benefitted their membership and that we are saving them considerable amounts of money. Again, this is not a measurable figure. It is not measurable for the same reasons I have previously described above. The staff of Montana Blue Cross is so enthused about our programs that they have asked us to submit a proposal for ancillary review for Part A of the Medicare plan as well as for the Blue Cross private pay program. We have an ambulatory review program with the state Medicaid agency for all providers who are eligible for reimbursement under the Medicaid system. Hospital utilization in our state is down 493.6 days of care per thousand Medicare recipients (or 13%) since we instituted review. We have initiated formal continuing medical education programs for Montana physicians based upon the results of our medical audits and even more important, we have initiated a weekly television public educational program for the populace of some of our Montana communities and we are at this time actively attempting to circulate this program on a statewide basis.

Budget considerations

Our current budget stands at $8.45 per federal admission. Quite frankly, this reduction was inappropriately excessive over the period of the last fiscal year. We were forced to discharge 30 employees. Many of our accomplishments, which I have just related to you, were possible only with a most productive and competent staff. We are extremely concerned about what the future holds for us, as well as for all the PSROs in the United States. The efficiency of our programs is deteriorating. We recommended a budget of $12.45 per admission to our Denver Regional Office, but were forced to comply with the $8.45 figure. Essentially we were $4.00 short per admission. Obviously service we can deliver will be $4.00 short. We have severe reservations as to the effectiveness of the job we can continue to do under the present budget. We are less visible throughout the state. We no longer have coordinators in each facility. We already have preliminary figures which indicate that the average length of stay in some of our smaller hospitals where we have been forced to eliminate coordinators is on the increase. We find ourselves making administrative mistakes since many of our key employees are over-burdened with work and they cannot keep up with it. Our enthusiasm to investigate and proceed with sanction procedures against physicians who will not turn around their practice patterns through education has been affected. Much of our success is directly dependent on the guidance and involvement of our Board of Directors and other physicians. Our current budget does not allow us to continue such involvement at an adequate level. It is farther from one end of Montana to the other than it is from Washington, D.C. to Chicago. We can do nothing to make it closer. Our problem is travel. We could live on $8.40 per admission if all of our business were in downtown Washington, D.C. In summary, the people of the state of Montana are not being as well served by us as they would be if we were adequately funded.

Our success story

We feel that strong medical society support for the PSRO in any particular area is essential to PSRO success. We further believe that experience is necessary before PSROs can demonstrate effectiveness. Although we have only had the PSRO contract in Montana since 1975, in actuality we were doing peer review from 1973 on. Most critical to the success of any PSRO, in our judgment, is to have substantial and competent physician involvement. Fortunately we have a staff at the Foundation who believe in the peer review concept and who even more strongly believe, as we do, that it is essential that physicians direct staff activity. Without strong physician involvement, and dedicated staff who respect the judgment of physicians in medical matters, no PSRO can be successful.

We firmly believe that the majority of physicians nationally will have the courage to step forward and insure the appropriateness and necessity of medical care in their areas if they are given the opportunity to do so. Stepping into this arena is not like calling out the National Guard when a local crisis occurs. When the National Guard appears in most instances, the chaos and catastrophy is rather rapidly policed and the public is protected. Physicians, unfortunately, are generally suspicious of government. Too often they forget that they are part of government, as are all citizens. We are looked upon by some our colleagues as "Washington, D.C., West."

PSROs must be willing to ultimately take decisive steps and ask the Secretary of HEW to remove specific physcians from the reimbursement rolls of Medicare and Medicaid if they fail to change inappropriate practice patterns after reasonable educational processes are enacted.

It has been our experience in looking at some PSROs elsewhere who are felt to not be effective or who have had major financial problems, that the staff has been less than candid with their Board of Directors and the Board of Directors has not been as closely involved in directing the activities of the PSRO as they should have been. Physician involvement and education is the key to PSRO success. We firmly believe that well over 90 percent of the physcians in practice in this country today practice with the intent of providing the best possible medical care to their patients. We must reinforce this intent with good educational programs based on our medical audit. At the same time we must accept the fact that some physicians do not practice in this manner and should be removed from the eligibility rolls of the Medicare/Medicaid programs if educational processes fail. We have been willing to make those decisions. We look upon ourselves as a private corporation which has accepted as one of their obligations a contract with the Federal government. We are not now nor will we ever be a government agency. When the philosophies of our organization conflict with the regulations of the Federal government, we will look at our philosophies to see if in fact they can be modified to come into compliance with the regulations. I must be candid, however, and tell you that should those philosophies ever conflict so significantly that we believe that it would not be in the best interests of our patients to comply, we will refuse to do so. If that means that we no longer have a PSRO contract, so be it. Our concern is now and will remain what we believe to be in the best interests of the public we serve. It is our hope and expectation that the regulations and guidelines developed by the Federal Government will also be in the best interests of our patients. We reserve the right to be the final judge.

In general, our relationships with the hospitals in our region have been good. We have found that most hospital administrators are supportive of peer review as long as our programs do not infringe excessively upon their daily hospital operation. As a matter of fact, on some occasions we have been contacted by hospital administrators asking us to take a closer look at certain practices in their medical staff. We have done so only after the appropriate data has been provided to us.

We have a very good working relationship with the state Medicad agency and the fiscal intermediary for Medicare. Our President is a member of the Montana Rate Review System and I was personally involved with the development of the HSA in the state of Montana. Some of our Board members are active on the State Board of Medical Examiners. Many of our Board members are officers in the Montana Medical Association. I am the legislative Chairman for the Montana Medical Association.

We have an excellent relationship with the Health Standards and Quality Bureau, both in the Denver Region and in Washington.

We believe in proceeding with honesty and integrity and being totally open with our programs both with physicians and with hospital administrative personnel. We have many disagreements with both of these groups. We have been recently informed that some physicians plan to advise the Montana Medical Association that their support of us should be terminated. This certainly should dispel the fear that some have that we are in fact the "fox guarding the chickencoop." Our Washington elected officials regularly receive correspondence from some physicians and hospital administrators in the state requesting their help in reversing decisions we've made about their practices or practice patterns. The majority of physicians do, however, support our efforts and recognize that our primary interest is not in making physicians happy, but assuring quality care for the patients in our state. We very firmly believe that the PSRO program in general has erred in attempting to demonstrate to you that they have been cost containment organs. We are a quality asurance organization. if we insist on delivering quality care, cost effectiveness will follow. We consider utilization of medical facilities to be a quality issue. If health care dollars are wasted on unnecesary care, those same health care dollars will not be available to pay for necessary and appropriate care for other patients.

I sincerely wish to thank you for the opportunity to tell you our story. I urge you to increase the funding for the PSRO program by at least 30 percent. You can only make 12 complete sandwiches out of a 24 slice loaf of bread unless you decrease the size of the sandwich.

STATEMENT OF WARREN R. BETTY, M.D., TREASURER, RICHMOND COUNTY PSRO OF NEW YORK, STATEN ISLAND, N.Y., ACCOMPANIED BY SHERYL L. BUCHHOLTZ, EXECUTIVE DIRECTOR

Senator TALMADGE. The next witness is Dr. Warren Betty, treasurer, Richmond County PSRO of New York, Staten Island, N.Y.; accompanied by Sheryl L. Buchholtz, executive director.

Doctor, you may insert your full statement in the record and summarize it, if you will, sir.

Dr. BETTY. Thank you very much.

My name is Warren Betty. I practice pediatrics in Staten Island, in a prepaid group setting, in which the delivery of quality medical care in a cost-effective manner is our primary mission.

For the past 2 years I have been a member of the Richmond County Professional Standards Review Organization board of directors. The principal mission of the board of directors has been the monitoring of the delivery of quality care in a cost-effective manner, as it is given to patients eligible under title V, XVIII, and XIX of the Social Security Act.

To serve on the Board of Richmond County PSRO is a challenging opportunity and a demanding responsibility. Our board requires the active participation of each of its members in the day operations of the review program, and we are fully aware of our legal and moral commitment of attempting to provide an effective peer review program in our community.

I do not feel it would be an overstatement of the truth to say that the passage of Public Law 92-603 in 1972 was viewed by many physicians as an unreasonable intrusion of the Federal Government into the prerogatives and practices of the private sector of medicine. Some still feel that way.

The law wisely states that only physicians are qualified to judge whether services ordered by other physicians are necessary, correct, or proper. This clearly places the responsibility of quality assurance upon the profession. The Richmond County PSRO accepts this responsibility and obligation, as does the medical community in general in our area.

Congress had been myopic in the passage of the 1965 and the 1966 medicare and medicaid laws, in failing to include the cost-control mechanisms the PSRO legislation sought to establish. In 1969 it cost the Federal Government $10.8 billion to support title V, XVIII, and XIX. In 1978 the cost was $43.3 billion.

Senator TALMADGE. Doctor, will you suspend at this point. There is a rollcall vote, Doctor. I will ask Mr. Constantine to again preside and take the chair.

It is possible that I won't get back before Dr. Boyd also testifies. If the last witness has completed his testimony, Mr. Constantine, you can recess this subcommittee pending the call of the Chair.

Thank you, and my apologies for having to leave.

Dr. BETTY. The cost of health care will rise, regardless of our most determined efforts to hold the line. We will continue our best efforts to do what we can, however.

PSRO will have little direct impact on controlling such important factors contributing to the escalating costs of delivery of medical services such as advances in technology, increasing complexities

of health services, expanding specialization and subspecialization, the costly practice of defensive medicine, vis-a-vis litigation, to name but a few. The costs of health care will rise regardless of our most heroic efforts to hold the line. We will, however, continue our best efforts to do whatever we can.

The program should not be subjected to inappropriate and unrealistic expectations on the part of its evaluators. All we as physicians can do is to insure that the health services reimbursed under Public Law 92-603 are medically necessary, are provided in the most economical fashion possible, and meet the professionally recognized standards of quality, ever conscious that our own personal integrity, professionalism and credibility with our patients is dependent upon our ability to succeed. That is to paraphrase Dr. McMahon's patient advocate statement.

It is critical that the program have sufficient time to be properly implemented and refined. Its evaluators should not be too hasty to measure its achievements lest they deny it the right of achieving its intrinsic potential for improvement of cost-effectiveness and quality of care.

Those lawmakers who look to immediately balance the ledger by comparing the cost of the program implementation with an equal or greater reduction in the cost of health care have fallen victim to a cost/benefit argument which takes on the characteristics of an apples-and-oranges equation. Shortcomings will inevitably be identified in the early stages of a program and such a fluctuating condition cannot be placed on the same scale as the status quo of the extant health delivery system.

By way of explanation of my point, may I relate to you a quick example of how the Richmond County PSRO has achieved significant impact, impact which would not appear on today's ledgers of cost-effectiveness, yet which will have far reaching, significant impact in the not too distant future.

The Richmond County PSRO has consistently identified and documented that on any given day in our community approximately 120 acute-care, high-cost beds are being occupied unnecessarily because of the unavailability of lower-cost nursing-home beds.

The Richmond County PSRO worked closely with its counterpart, the health systems agency, to document this bottleneck in the health care delivery system, by supporting an application to the New York State Planning Council for an additional 80 long-term-care beds for our region. The facts presented by our PSRO certainly were taken into consideration by State officials when just last week the application was approved.

The projected savings to the system, however, cannot be realized until these paper beds become a reality; and in the final analysis of cost/benefit will the PSRO be credited with this achievement? I am not so sure they will. We have achieved significant impact in this area, yet sufficient funds have not been allotted to the program to allow us to acquire essential support staff and consultants to pursue study in the areas of long-term care or ancillary review.

I have tried to present to you, the committee, the honest reflections of a board member of a PSRO as to why the program should be allowed to prove itself and be granted sufficient resources to

achieve its potential. Our dedication and commitment are present; what we need now is the time and the money to move forward.

Miss Buchholtz will provide the committee with a chronology of our corporation, along with additional comments.

Ms. BUCHHOLTZ. Just to pick up, with the long-term cost survey, we were first in the country to come up with a study, and a year ago we found 36 patients waiting in our five acute-care hospitals approximately 2 weeks.

A repeat 1-day study just recently revealed that it had increased to 120 patients waiting a period of several days to several weeks. In 1978 this accounted for 10,000 days of care in our hospitals when all of these patients could have gone to a lower and lesser level of care.

We have five hospitals, and recently included in this is the public health, which has voluntarily decided to join up and become a part of our PSRO, although they are not federally mandated.

Since we have begun review at the public health service hospital, in the 6 months that they were told that they would be coming under review to about the end of August, their length of stay has dropped from 20.2 days to 15.2 days average for all medicare patients.

I would like to just quickly summarize one or two other important points and say that while many of the physicians in our community resent the regulations we represent, they are committed to working with us. In 1979, the Richmond County Board had decided to establish some policies concerning admission practices to our hospitals.

The hospitals were informed that they would be allowed only one day preop, except in extreme cases of medical necessity, and on four specific procedures for surgery, we have found that in 4 months the preoperative length of stay for a colisustectomy dropped from 2.2 days to 2 days; lens extraction has dropped from 1.7 days preop to 1 day; and transurethral prostatectomy has dropped from 4.1 days to 1.6; hysterectomy patients have dropped from 1.9 to 1 day preoperatively. Anything over a day preop requires a review by a physician-advisor and another policy by the Board insists that any patients admitted for surgery must be admitted by a surgeon, not their attending physician. We hope this cuts down on unnecessary consultations and speeds up the process while the patient is in the hospital.

Additionally, another Board policy requires that patients must be placed on the OR schedule prior to being brought into the hospital. This insures unnecessary delays.

Had we not had the physician commitment necessary for the implementation of some of these requirements, I doubt we would have accomplished anything. The RCPSRO physicians are a cofactor for our success and local peer review does help to modify behavior.

Thank you.

Mr. CONSTANTINE. Thank you.

Dr. Betty, or Ms. Buchholtz, one of the other problem areas that has been raised as a source of potential overservicing of patients, raised by some of the New York PSRO's as well, is in hospital outpatient departments.

Do you have any impressions or have you done any evaluation with respect to services in outpatient departments of hospitals?

Dr. BETTY. No, we don't have this under review as of yet.

Our area does not have any free-standing facilities either, and so, all ancilliary services are provided by our hospitals. As soon as funds are available and we have negotiated the necessary contract, we certainly plan to bring this form of review under our auspices.

Mr. CONSTANTINE. Do you have any visceral impressions?

Ms. BUCHHOLTZ. We don't have any outpatient testing centers. Thus, testing at our hospitals is a more costly endeavor.

Mr. CONSTANTINE. The allegation has been made of overservicing of patients admitted to emergency rooms and so on. Well, that is all right. We will let that question go. Senator Talmadge had a couple of questions for you.

Ms. Buchholtz, in your written testimony you referred to verbal threats. Apparently the review has been vigorous in Staten Island. Have there actually been threats of violence as the result of your work that you can describe?

Ms. BUCHHOLTZ. In the beginning there were threats. I have been accused of trying to catch my physicians with their britches down when we go in and monitor as a staff. And unfortunately we have had a few instances at review meetings where there have been heated arguments. But we have physicians on the committees and on the Board who I refer all of these problems to and they deal with these occurrences. We did have an instance of a medicare intermediary going out and visiting one of the hospitals and a physician was complaining and saying that peer review is a life-threatening job. And it is under control now.

Mr. CONSTANTINE. Did any of these involve, guns or anything of that sort?

Ms. BUCHHOLTZ. One physician, yes. Carries—this physician claims it is a life-threatening job. She has since been replaced at the hospital and is no longer a member of our committees.

Mr. CONSTANTINE. The threat has been removed?

Ms. BUCHHOLTZ. We sent her to the Bronx, in fact.

Mr. CONSTANTINE. You describe your 1-day census approach in Staten Island, which apparently originated and was carried out I believe twice in New York on a statewide basis. Have any other States to your knowledge picked up on that idea of doing 1-day censuses of patients to determine those who should be in say in a lesser level of care than acute?

Dr. BETTY. Yes, it is my understanding pursuant to our efforts and findings that the AAPSRO is planning in the near future, probably the spring if not sooner to do a nationwide 1-day PSRO review on this type of overutilization or at least costly utilization.

Mr. CONSTANTINE. Dr. Betty, the Finance Committee a couple of months ago approved an amendment, now pending in H.R. 934, to try to deal with the nonacute patient in an acute bed in an area where there is a surplus of hospital beds. Basically what the Finance Committee approved was Senator Talmadge's proposal that following a determination by a PSRO that the patient no longer needed acute care, after a 24-hour administrative stay the hospital would be only paid at a skilled nursing rate, that is the hospital day would be carved out. This would take effect 6 months from the

effective date. The committee also voted a program of grants and loans to facilitate conversion of surplus hospital beds to long-term usage.

Now based upon your findings in New York, do you believe that that would have significant effect, that is if you could go into the hospitals and make those determinations?

Dr. BETTY. Unquestionably this would have a significant impact on costs. Three or two of our acute care hospitals have census such that they would not have many beds not being used, in other words, their census is almost 100 percent full time. However, one of the hospitals with a 75-percent utilization or occupancy rate where such beds are available and could be decertified and reclassifed as long term, certainly this would have a tremendous impact.

Mr. CONSTANTINE. Thank you very much.

Excuse me, Senator Dole also had a series of questions which we would appreciate your responses. Thank you.

[The following was subsequently supplied for the record:]

QUESTIONS SUBMITTED TO DR. BETTY AND HIS RESPONSES TO THEM

Question. Have the other PSRO's in your area had successful working realtionships with the planning agencies?

Answer. Yes. After the first census study we performed, a follow-up study by the 5 PSRO's in New York City also utilized the services of the Health System Agency. Their responsibility was to contact the nursing homes in their respective areas and find out how many, if any, available beds there were. In Staten Island, for example, there was one (1) bed available for the 46 patients waiting.

Additionally, the other PSRO's have helped to identify utilization trends, etc., to these agencies.

Question. In what areas, other than the instance you cite in your testimony, have you worked with the local health planning agency?

Answer. We have an excellent and on-going relationship with them. The RCPSRO has been involved in the establishment of CAT Scan guidelines, need for Heart Pump/Cardiac Catherization laboratory services and review of several applications processed through their project review committees.

[The prepared statements of Dr. Betty and Ms. Buchholtz follow:]

STATEMENT OF WARREN R. BETTY, M.D.

My name is Warren Betty. I practice Pediatrics in Staten Island in a pre-paid group setting in which the delivery of quality medical care in a cost-effective manner is our primary mission.

For the past two years I have been a member of the Richmond County Professional Standards Review Organization Board of Directors. The principal mission of the Board of Directors has been the monitoring of the delivery of quality care in a cost-effective manner, as it is given to patients eligible under Titles V, XVIII and XIX of the Social Security Act. To serve on the Board of Richmond County PSRO is a challenging opportunity and a demanding responsibility. Our Board requires the active participation of each of its members in the day operations of the review program.

My position on the Board is that of Treasurer. Our fiscal policies are quite stringent. Money management procedures are reviewed by the Board's Oversight Committee weekly. A financial monthly statement prepared by our accountants is reviewed by the Executive Committee and/or the full Board. Needless to say, the Board takes this financial obligation seriously. Additionally, we are fully aware of our legal and moral commitment in attempting to provide an effective peer review program in our community.

I do not feel it would be an overstatement of the truth to say that the passage of Public Law 92-603 in 1972, was viewed by many physicians as an unreasonable intrusion of the Federal Government into the prerogatives and practices of the private sector of medicine. Some still feel that way. The Law wisely states that only physicians are qualified to judge whether services ordered by other physicians are necessary, correct or proper. This clearly places the responsibility of quality assur-

ance upon the profession. The Richmond County PSRO accepts this responsibility and obligation, as does the medical community, in general, in our area.

Congress had been myopic in the passage of the 1965 and 1966 Medicare and Medicaid Laws in failing to include the cost control mechanisms the PSRO legislation sought to establish. In 1969, it cost the Federal Government $10.8 billion to supprot Titles V, XVIII and XIX. In 1978, the cost was $43.3 billion.

PSRO will have little direct impact on controlling such important factors contributing to the escalating costs of delivery of medical services such as advances in technology, increasing complexities of health services, expanding specialization and subspecialization of the costly practice of defensive medicine, vis-a-vis, litigation to name but a few. The costs of health care will rise regardless of our most heroic efforts to hold the line. We will however continue our best efforts to do whatever we can.

The program should not be subjected to inappropriate and unrealistic expectations on the part of its evaluators. All we as physicians can do is to insure that the health services reimbursed under Public Law 92-603, are medically necessary, are provided in the most economical fashion possible and meet the professionally recognized standards of quality, ever conscious that our own personal integrity, professionalism and credibility with our patients is dependent upon our ability to succeed.

It is critical that the program have sufficient time to be properly implemented and refined. Its evaluators should not be too hasty to measure its achievements, lest they deny it the right of achieving its intrinsic potential for improvement of cost-effectiveness and quality of care. Those lawmakers who look to immediately balance the ledger by comparing the cost of the program implementation with an equal or greater reduction in the cost of health care have fallen victim to a cost-benefit argument which takes on the characteristics of an apples and oranges equation. Shortcomings will inevitably be identified in the early stages of a program, and such a fluctuating condition cannot be placed on the same scale as the status-quo of the extant health delivery system.

By way of explanation of my point, may I relate to you a quick example of how the Richmond County has achieved significant impact; impact which would not appear on todays ledgers of cost effectiveness, yet which will have far reaching, significant impact in the not too distant future.

The Richmond County PSRO has consistently identified and documented that, on any given day in our community, approximately 120 acute care, high cost beds, are being occupied unnecessarily because of the unavailability of lower-cost nursing home beds. The Richmond County PSRO worked closely with its counterpart Health Systems Agency to document this bottleneck in the health care delivery system, supporting an application to the New State Planning Council for an additional 80 long term care beds for our region. The facts presented by our PSRO certainly were taken into consideration by State officials when, just last week, the application was approved. The projected savings to the system, however, cannot be realized until these paper beds become a reality. And in the final analysis of cost-benefit, will the PSRO be credited with this achievement? I am not so sure they will. We have achieved significant impact in this area, yet sufficient funds have not been allotted to the program to allow us to acquire essential support staff and consultants to pursue study in the areas of long term care or ancillary review.

I have tried to present to you, the Committee, the honest reflections of a Board member of a PSRO, as to why the program should be allowed to prove itself, and be granted sufficient resources to achieve its potential. Our dedication and commitment is present. What we need now is the time and money to move forward.

STATEMENT OF SHERYL L. BUCHHOLTZ, EXECUTIVE DIRECTOR, RICHMOND COUNTY, N.Y., PSRO

My name is Sheryl L. Buchholtz and I am the Executive Director of the Richmond County PSRO. I have been involved in PSRO's since 1974, having helped to write the original planning contract for the Kings County PSRO in Brooklyn. I have been with the Richmond County PSRO since May of 1976 and am very proud of our success and the overwhelming commitment of my areas' physicians.

The reason I am here today, is to tell you about that commitment in addition to what a grass roots organization can achieve.

I would like to share with you some very basic facts about why this program must be funded at a level which can and will yield greater results.

I am a Registered Nurse also, and know all too well the frustrations physicians and nurses feel daily in attempting to get people well, out of hospitals and back into their community.

Once you, the Government, decide to work with the professionals primarily responsible for this billion dollar industry, you made a commitment to improve the quality of health care. And now, years later, your partnership is working.

The Richmond County PSRO received planning funds in July, 1974, and remained in that status for over two years. The progress was slow, and many did not think it would survive. With only 5 institutions, 400 physicians and, at that time, approximately 12,000 Federal discharges annually, Richmond County did not receive priority funding for conditional, binding review designation. Conditional designation was granted October, 1976.

To speed up my report on our results, let's look at RCPSRO'S personal diary that documents its progress. We'll start in the Fall of 1976—as an infant organizaiton about to take its first steps after crawling for a long period of time.

October 1976—Conditional designation is granted and formal assessments of the hospitals begin. We're walking without holding on, the committees are activated and criteria are developed.

November 1976—RCPSRO is informed by Federal Officials that it would not be allowed to review the U.S. Public Health Service Hospital. That hospital is 20% of the areas' hospitals, we protest, but this serves no purpose. How can we be responsible for our area's health care if ⅕ is exempt. Our first tumble with only one scraped knee.

January 1977—Hospitals are sent protocals for delegation and meetings are arranged. The New York State Department of Health refuses to sign a Memorandum of Understanding with all N.Y. State PSROS. We wonder how can we mandate a review program when one of the principals refuses to acknowledge us? A second tumble, two scraped knees.

March 1977—Our Board of Directors now expanded, we decided to go ahead and perform the reviews we were mandated to do. Wounds healing nicely.

May 1977—Our first hospital signs on and both admissions and length of stay begin to drop.

September 1977—Our two large teaching hospitals join.

December 1977—The last of our four hospitals sign up. Committees are working, reviews are being performed, monitoring now replaces assessments. Physicians are asking why patients are still hospitalized when they no longer require acute care.

January 1978—Length of stay is dropping but excessive delays are noted by PSRO. We perform a study and prove delays in X-Ray and Ancillary services. Overall hospital census' are dropping, where's the bed shorage we always had? We're walking well now, and enjoying the stroll. Even help a hospital get new equipment to improve X-Ray services.

March 1978—Hospitals complaining, doctors complaining, its getting harder to get elderly patients out. We accuse a hospital of not performing well. It's threatened with loss of delegation and they get angry. We receive angry letters and verbal threats. Board wonders, is this what PSRO is about? Now we're running.

April 1978—We decide to perform a one-day census and see what kinds of patients are in our hospitals. Hospitals still have not received adequate monies to pay for program, so, they want us to conduct our own studies. Study reveals that 34 patients are waiting to get into nursing homes, each of these patients are waiting an average of over two weeks. All Island SNF beds are filled. Staten Island Advance runs lead story about our findings. We contact nursing homes—approximately 60% of the residents are not Island patients. Our doctors feel better, our review program is working. It's the system that is clogged up. The toddler PSRO is discovering the difficulties of growing up.

June 1978—N.Y. State PSROs decide to try our idea—and the 17 areas conduct a similar study. Numbers of patients waiting increases to over 50 in our area, as does their average waiting time. PSRO Board examines the results, thousands of days being wasted. State Health Department still not cooperating and attempting to intsitute a parallel review system. We're not emerging into our adolesence.

There's still a lot to do and discover. Our allowance is growing tighter, yet we still gain in strength. Our physicians are commited.

August 1978—We do a study on Hysterectomy—not a popular topic. We discover excess pre-operative stays, poor documentation, excess delays. Physicians and hospitals notified about findings. We're still following Long Term Care problems, but there are no funds for us to review them.

October 1978—Out data system is beginning to function. Trends are being compiled on the care being delivered in our area. Doctors are monitoring more closely now, bullet biting time and quality issues being debated. Changes to our review plan are implemented. DHEW and RCPSRO negotiate 78/79 contract—less money, more work.

December 1978—While the Island population is increasing over 2 percent annually, the other Boroughs are diminishing. Days of care and length of stay dropping nicely. Almost 10,000 Medicare days or 5 percent of total days of care, were wasted in our acute care hospitals this past year because patients were waiting to go to a lesser level. The cost was $200+dollars per day compared with $60 dollars at another level. Two-thirds of our Federal admissions are patients over 65, many of them are from nursing homes. We try to cut additional days from the front-end too, by identifying the need for more efficient pre-op testing.

February 1979—RCPSRO Board policy sent to all hospitals stating that one-day pre-op must be implemented immediately. One hospital just opened a new wing and we are faced with additional beds, another is moving to a new facility. We perform an area-wide study on cataracts. Findings reveal excessive delays and poor documentation. As a result, O.R. scheduling is reorganized at 2 institutions to comply with PSRO requirements of shorter stays and carve outs of unnecessary days. Medicaid MOU is finally signed, now we're legitimate. One of our area's Long Term Care facilities gets approval from the State Health Planning Commission for an additional 80 beds, this is based on RCPSRO surveys.

March 1979—Due to increasing demands, and cost constraints, focus review plan is implemented in area hospitals, budgets for review are cut. A full educational carve-out program is implemented. Wasted and unnecessary days are to be closely monitored, our denials increase. Island physicians notified of changes.

April 1979—RCPSRO is informed by DHEW officials that next year's budget is going to be tighter. Our physicians decide to focus in on L.O.S. of specific diagnoses and carefully monitor performance.

June 1979—Staff is reduced to attempt to save organizations and maximize available funds. RCPSRO Board decides to utilize staff from surrounding PSROs one day a week. We retain key staff and increase their productivity. We attempt to save money for organizations involved and ourselves. RCPSRO study reveals that pre-op L.O.S. for several frequent diagnoses dropping significantly. Cholestectomy—2.2 to 2.0 days, Lens Extraction—1.7 to 1 day, Transurethal Prostectomy—4.1 to 1.6 days, Hysterectomy—1.9 to 1 day.d Pre-admission and day of admission testing program working and only after 4 months implementation. The teenage PSRO is getting better daily and more confident.

We're informed that Public Health Service Hospital will now be eligible to join in. We note that their Medicare Length of Stay was 20.2 in '77, as compared to 15.3 for the rest, we're told its dropping significantly as they prepare for our review. Now we can truely monitor the delivery of care in our area.

August 1979—Shared staffing is helping us reduce costs significantly, by approximately 25%. RCPSRO doctors are working harder and a Quality Care Committee is organized to set objectives for the organization. Two other area-wide studies are initiated; one on the use and misuse of our 5 Emergency Rooms, the other on the types and conditions of patients admitted to hospitals from Long Term Care Facilities. Another study conducted on waiting days shows that our elderly patients are waiting even longer for a nursing home bed and their number increases daily (over 100 patients).

Where we are today—

September 1979—New Medpar Data shows that in '77—Medicare days were reduced by 12.1 percent from 17.3 days to 15.3 days. Our data additionally shows that in '78 L.O.S. has gone down an additional half day to 14.8. If people could have gone to nursing homes, it would automatically drop an additional day. Our days of care dropped 215 days per thousand between '76 and '77 and '78 statistics will reveal an additional drop of another 150 plus days. We also note that general population is increasing 2 percent annually and Medicare enrollees have also increased. We still do not have funds to review nursing home (Long Term Care) patients. We are concerned that 60 percent of these patients are not Island residents and we plan to carefully study their admissions to the Island hospitals. The number of patients awaiting a Long Term Care bed has increased to 120!! Acute bed availability has increased 17 percent in the past year, and empty beds tend to get filled, this trend will be closely monitored by RCPSRO. The U.S. Public Health Hospital's Length of Stay has dropped to 15.2 days since they started reviewing in the Spring.

We're proud of these achievements. Had we not had the physician commitment necessary for the implementation of our requirements, I doubt we would have accomplished anything. The RCPSRO physicians are the key factor for success, local peer review helps modify behavior.

As a young adult, the Richmond RSRO's goals and objectives are clearly mapped out for the years ahead. We need the funds and support of you, the Federal officials if we are to continue. I've had the opportunity to visit other RSROs and I know

many of them are achieving excellent results. A program of assessments of RSRO progress by the individual Regions is helping to tighten up the loose threads from years past. While many of the physicians in my community resent the regulations we represent, they respect our work and recognize that it is their professional and moral obligation to deliver quality medical care, in the appropriate setting and in a reasonable length of time. Having physicians and other health professionals establish criteria, monitor its implementation and correct action where appropriate proves that local peer review grass roots organizations do work effectively. If this process didn't work, chances are, the regulatory agencies that once were responsible for review, would still be wondering how to control the billion dollar industry we've become.

[From the Staten Island Sunday Advance, Sept. 2, 1979]

NURSING HOME BED SHORTAGE CRITICAL

120 HOSPITAL PATIENTS WAITING FOR BEDS IN ISLAND NURSING HOMES

(By Chris Olert)

Staten Island faces its worst backlog of patients waiting in hospital beds for nursing home placement. About 120 persons on discharge lists are sitting in the borough's five hospitals, while no Island nursing home beds are available and those in the rest of the city remain scarce.

Many patients have been waiting for months—one has waited five months. "We have never had so many patients waiting such a long time," Barbara Stack, the discharge planning coordinator in Doctors' Hospital, said.

The Concord hospital, the Island's smallest with 146 beds, had 19 patients last week waiting for skilled nursing beds, including one man who was waiting to be discharged to a nursing home since June 13.

At the same time, the hospital was getting reimbursed at nursing home rates while the 19 patients occupied hospital beds.

"There are less beds for those who are truly sick," Mrs. Stack explained.

A one-day survey last spring by the Richmond County Professional Standards Review Organization (PSRO) showed that 46 patients were waiting for placement in nursing homes. Last week, an Advance survey found, the number of patients has more than doubled in a few short months.

The federally funded PSRO plans to initiate a study next month on the problem, and anticipates collecting data from all five Island hospitals.

Sheryl Buchholtz, executive director of the PSRO, again last week identified the backlog as the borough's "number one health care problem."

"It's staying very stagnant. We want to look into some of the problems of patients," she explained.

Harry Singh, director of this PSRO project, said the study will include 50 cases from each hospital.

"We will be tracing patients from the time of admission to the hospital and the involvement of discharge planners—looking at the management of the patient while they are in the hospital. We want to try to identify patterns," Singh said.

St. Vincent's Medical Center has 30 waiting patients who require skilled nursing beds, including some who have waited four to six months for placement.

Staten Island Hospital has 12 patients who require either skilled nursing or health-related beds.

Richmond Memorial Hospital is housing 26 patients requiring skilled nursing care; two who require health-related beds, and two patients who are eligible for adult homes.

One patient, said a hospital spokesman, had been waiting for a skilled nursing bed since the end of May.

The U.S. Public Health Service Hospital, Clifton, has 33 patients requiring some type of nursing home care. About half of them, according to Dr. James Borland, chief of social work, are Staten Island residents, and one patient has been waiting for placement in a nursing home since March.

There are approximately 2,800 nursing home beds on Staten Island.

Besides the fact patients waiting for nursing home beds is causing a crunch in hospitals, it is a costly dilemma. The statwide PSRO found in February that more than $500,000 a day was being wasted while nursing home patients sat in hospital beds.

The PSRO calculated that figure based on about $200 a day for a hospital bed, compared with about $45 a day for a nursing home bed. Since the city and state, through Medicaid, and the federal government, through Medicare and also Medicaid, pick up the majority of the bills, the backlog hits everyone's pocketbook.

"I think the nursing homes are aware of the problem," said Olivia Brennan, a social worker at Doctors' Hospital. "They are trying to get more beds. The nursing homes are not insensitive."

And while the hospitals deal with the would-be nursing home patients, the nursing homes are in a bind of their own.

"We are getting at least four times as many applications as we can handle. It is typical of every home," Paul Jensen, an administrator in Eger Nursing Home, said.

"We have both hospital and community requests and are trying to give priority to hospitals," he explained.

Jensen said Eger has received 120 applications for skilled nursing beds in the last month. Eger has 29 persons on a waiting list and at its current rate of turnover, it will be six months before those 29 could be admitted

Eger is waiting for word from the state Office of Health Systems Management on its application to add 80 more health-related beds to its sprawling Egbertville complex. A state spokeswoman said director Richard Berman should be reviewing the application early this month.

Compounding the placement problem in nursing homes, according to a St. Vincent's Medical Center spokesman, is the patient with multiple health problems.

"The patient who requires a nursing home and has psychiatric problems is almost impossible to place," he said.

Because of state regulations, social workers and discharge planners face frustrating hours of phoning nursing homes two or three times a week, documenting that they have phoned them only to be reminded of what they already knew before they call the first time—there are no beds available for their patients.

The statewide PSRO council, along with the state Department of Social Services and Office of Health Systems Management, is looking at discharge planning and how most appropriately to place patients, so that they receive the optimal care. Hospital administrators admit that one of the problems that recurs with nursing home and potential nursing home patients is frequent transfer from hospital to adult home or nursing home and back to the hospital.

"If everyone is in the right level of care," suggests an OHSM executive, "then is there a bed shortage?"

Until that question is resolved, and it won't be soon, patients who don't belong in hospitals will remain there, costing thousands of unnecessary dollars.

[Staten Island Advance, Aug. 9, 1979]

Hospital, Group Agree on Review of Patients

DOCTORS GROUP TO CHECK ON CARE

Administrators from the U.S. Public Health Service Hospital, Clifton, and the Richmond County Professional Standards Review Organization (PSRO) yesterday signed an agreement allowing the physician-run group to conduct the same review of hospital patients that has been going on in Staten Island's other four acute-care hospitals.

The process, called utilization reviews, makes the 7-bed facility only the second public health service hospital in the country to join the PSRO process.

Utilization review is the process hospitals and physicians use to be certain that patients get the most appropriate care.

The Clifton hospital has had its own utilization review process prior to yesterday's agreement, but by signing with the Richmond County PSRO, the hospital will have the same criteria applied to its Medicaid- and Medicare-eligible patients as those applied to patients in St. Vincent's Medical Center, Staten Island, Richmond Memorial and Doctors' Hospitals.

The review will begin Wednesday.

Dr. Florence J. Kavaler, director of the federal hospital, the largest in the Public Health Service, said hospital physicians had been members of the PSRO board for some time.

"We are glad to be invited to participate. It's part of our voluntary effort to be part of the community health structure—to have the same forms, processes and reviews," she said yesterday morning after signing ceremonies in her office.

The physician-administrator also said she expects the agreement will help strengthen the relationship the hospital has with the Richmond County Medical Society.

The society has been critical of the federal hospital, at times charging that its opening of services to the community is jeopardizing the financial viability of the three voluntary hospitals.

Voluntary hospital administrators have charged that when they made their plans for expansion, the Clifton facility was not taking the volume of community patients they have been treating in the last two to three years.

PSROs are federally funded, physician-run agencies that oversee hospital-based care.

The first Island hospital to sign with the Richmond County unit was Richmond Memorial in May 1977.

Through the PSRO's work, it has helped Island hospitals reduce the average length of stay for most patients in every hospital. Reducing the length of stay helps save money for both patients and hospitals. Another goal of the agency is to assure that patients are getting competent care during their hospital stay.

The first Public Health Service hospital to sign with a PSRO for supervision of its utilization review was the Baltimore hospital. It joined PSRO earlier this year. There are eight Public Health Service hospitals in the country.

Mr. CONSTANTINE. The last witness is Dr. John H. Boyd on behalf of the Texas Institute for Medical Assessment, Austin, Tex.,

STATEMENT OF DR. JOHN H. BOYD, D.O., ON BEHALF OF TEXAS INSTITUTE FOR MEDICAL ASSESSMENT, AUSTIN, TEX., ACCOMPANIED BY LOUIS GARCIA, DIRECTOR OF OPERATIONS FOR TIMA

Dr. BOYD. Thank you.

I am accompanied today by Mr. Louis Garcia, who is the director of operations for TIMA. Mr. Flynn, the executive director could not be here.

I want to thank the subcommittee for the opportunity to present this testimony. The Texas Institute for Medical Assessment has been in existence since 1973, but had not been a professional standards review organization—PSRO—until September 28, 1978, when TIMA received a 12-month planning contract. This 5-year gap in PSRO activity was not caused by procrastination on the part of the medical community in the State of Texas, but by the refusal of the Department of Health, Education, and Welfare—HEW—to consider another way—a better way—to institute and manage professional standards review in Texas.

Mr. Constantine and I have discussed this previously.

The background of the battle over area designation is in the written statement. I would like to go on here to the meat of the thing.

The TIMA has worked the last 12 months to complete the planning required to attain conditional PSRO status, 'and to prepare to implement the proposed review process. We have garnered the support of the medical and health care communities to the extent that more than 5,000 of the approximately 18,000 licensed and practicing physicians of the State are members of the TIMA. And those memberships are presently coming in at a rate that approaches 100 a week.

We have had the support of the Texas Medical Association, Texas Osteopathic Medical Association, the Texas Hospital Association, the Texas Osteopathic Hospital Association, the Texas Nursing Home Association, the medical schools—D.O. and M.D.—and various State agencies from the earliest stages of the TIMA's development.

Today TIMA continues to have strong support and cooperation from these organizations and agencies. As of August of this year, we had built up an overwhelming amount of momentum and en-

thusiasm for the implementation of professional standards review in Texas. Our review and implementation plans are complete to the point of response to the concerns of our project officer and State agencies. Both TIMA and HEW feel that review plan mechanics could have been resolved in a very short time frame.

Six weeks before our expected conversion to conditional status, immediately after having been actively encouraged by both national and regional HEW personnel to submit start-up schedules and final budget projections for implementation of our review program, we found ourselves shocked by the HEW decision to prohibit our conversion to conditional status during Federal fiscal 1980. When the effect of congressional action related to fiscal austerity became clear, the physicians in Texas began accommodating themselves, reluctantly, to the arbitrary decision to delay the implementation of professional standards review in Texas.

Immediately following the HEW decision to disallow TIMA's conversion to conditional status, discussions started with HEW Region VI personnel regarding activity levels and funding available during our forced additional year of planning. We were informed that a maximum of $310,000 of 1979 fiscal year funding would be available to TIMA during an extended 12-month planning period.

No 1980 funds were to be provided to Texas. The expectation of region VI was to maintain a status quo as a planning organization. This is totally unacceptable to the physicians in the State of Texas. After intense negotiations, we have been informed by region VI that additional funds may be available but that an expanded scope of work must be accomplished.

We can live with the expanded scope of work provided there are additional funds. But I have word since this statement was prepared that the additional funds are very minimal.

We understand that the fiscal constraints placed upon HEW by the budget for Federal fiscal year 1980 required some dramatic action in order to maintain the PSRO program. However, we question the appropriateness of selecting the simplest solution, or taking the easy way out, by attempting to maintain the fiscal year 1979 level of activity through 1980, with a clear disregard for the effectiveness of the fiscal year 1979 level of activity.

We feel that the PSRO program and the taxpayers of the United States would be better served by a weeding out of ineffective PSRO's and a consolidation of PSRO's. This would realize savings in administrative activity rather than simply halting any extension of review. We, in Texas, have grave concern that HEW attempted no other solutions to this problem and we doubt that the Congress intended that its mandate be carried out in this manner.

I think it important to point out that this bulge on the south border of the United States is occupied by approximately 10 percent of the Federal recipients of the federally funded programs and about the same percentage of the providers. And it did seem untimely to us that an action was taken that simply excluded these people from further participation in the program.

Mr. CONSTANTINE. Dr. Boyd the record is replete with the concerns of the PSRO's overfunding. The problem doesn't appear to be the Senate. The Senate Appropriations Committee and the Senate voted substantial funding. The problem seems to be with the House

Appropriations Committee. Has anyone in Texas, anyone other than the Federal Government indicated any interest in using TIMA?

That is, has Blue Cross and Blue Shield indicated that they would propose to use your review?

Dr. BOYD. Yes; we have had discussions with them preliminarily but we have talked with them and we have had some discussions with some of the private companies. But our machinery is not intact yet and we can't start any kind of review until we have the overall organization put together.

Mr. CONSTANTINE. During the course of your planning, have you identified any problems in Texas? Do you suspect there may be problems in the quality of care or overutilization? Have you picked up anything so far?

Dr. BOYD. Yes, sir. We have not been without a review program as you know. We have had a peer review program going on with the medicaid patients. It has been operated and is called the Texas admission review program—TARP—and it has been operated by the Texas Medical Foundation with which some of us have been active. And on the basis of this we know that we have some problems, yes, sir.

Mr. CONSTANTINE. We were just curious about that because as you know in 1969 and 1970 this committee did a lot of investigative work and held many weeks of hearings. And during the course of that there were six practitioners identified in rural areas of Texas who coincidentally were owners of nursing homes and hospitals and there were high and apparently strange aberrant patterns of practice. That information was referred to the Texas Medical Association at that time by Social Security and the response, we were told, was that these were acceptable patterns of practice in those areas.

But we assume that review is more vigorous now.

Dr. BOYD. Well, I think that, I am not familiar with all of those cases. And since I am not and have not ever been and will not ever be a member of the Texas Medical Association, I can't tell you about their internal mechanics. But we hope to have a very strong effect on some patterns of practice within the State.

And as is usual where people are active in the professional organizations, we probably could put our fingers on 90 percent of the problems without going to the statistics.

Mr. CONSTANTINE. Dr. Boyd, one point I think I should make. Dr. Smits yesterday seemed to indicate the Department's frustration with PSRO funding levels. And while HEW is often a convenient target and often a justifiable target, in all fairness I think the Department testified strongly, as did the administration, in support of a larger appropriation than the one that has been voted and the Senate also voted for the larger appropriation.

[The prepared statement of Dr. Boyd follows:]

STATEMENT OF JOHN H. BOYD, D.O., PAST PRESIDENT, TEXAS INSTITUTE FOR MEDICAL ASSESSMENT

The Texas Institute for Medical Assessment (TIMA) has been in existence since 1973, but had not been a Professional Standards Review Organization (PSRO) until September 28, 1978, when TIMA received a twelve month planning contract. This five year gap in PSRO activity was not caused by procrastination on the part of the

medical community in the state of Texas, but by the refusal of the Department of Health, Education and Welfare (HEW) to consider another way—a better way—to institute and manage professional standards review in Texas. I refer specifically to a 1973 request by the TIMA, the Texas Medical Association and the Texas Osteopathic Medical Association for designation of the state of Texas as a single PSRO area.

The request for single area designation for the state of Texas was made by TIMA at public hearings held by HEW in August and October of 1973. In August, 1973, William Cherry, M.D., the HEW Regional Medical Director, recommended a single area PSRO designation for Texas. Despite the medical community's request and despite the recommendations by the Regional Medical Director, in March, 1974, HEW designated nine PSRO areas in Texas.

Area designation was made with complete disregard for the wishes of the health care community of Texas who, when polled in January, 1974, voted overwhelmingly (90 percent) to support a single area designation for Texas, and voted in the same numbers to support the TIMA as the PSRO for Texas.

Texas physicians did not accept HEW's designation and Texas Medical Association filed suit in May, 1974, asking that HEW's decision be set aside. The suit was heard in January, 1976, and the U.S. District Court set aside the nine HEW designated areas and directed the Secretary of HEW, David Matthews, to reconsider area designation for PSRO activities in Texas.

In the ensuing two year period, HEW (1) filed notice of appeal, and (2) later withdrew it; (3) received a second physician poll, which resulted in 86.2 percent of the more than 11,000 physicians polled voting in favor of a single statewide PSRO; and (4) in December, 1976, HEW Secretary Matthews published in the FEDERAL REGISTER his proposal to designate Texas a single PSRO area. A succeeding Secretary of HEW set aside this proposal and single area designation did not occur until September, 1978. This designation was quickly followed by the granting of a planning contract to the TIMA on September 28, 1978.

The TIMA has worked the last twelve months to complete the planning required to attain conditional PSRO status, and to prepare to implement the proposed review process. We have garnered the support of the medical and health care communities to the extent that more than 5,000 of the approximately 18,000 licensed and practicing physicians of the state are members of the TIMA. We have had the support of the Texas Medical Association, Texas Osteopathic Medical Association, the Texas Hospital Association, the Texas Osteopthic Hospital Association, the Texas Nursing Home Association, the medical schools (D.O. and M.D.) and various state agencies from the earliest stages of the TIMA's development. Today TIMA continues to have strong support and cooperation from these organizations and agencies. As of August of this year, we had built up an overwhelming amount of momentum and enthusiasm for the implementation of professional standards review in Texas. Our review and implementation plans are complete to the point of response to the concerns of our project officer and state agencies. Both TIMA and HEW feel that review plan mechanics could have been resolved in a very short time frame.

Six weeks before our expected conversion to conditional status, immediately after having been actively encouraged by both national and regional HEW personnel to submit start-up schedules and final budget projections for implementation of our review program, we found ourselves shocked by the HEW decision to prohibit our conversion to conditional status during Federal fiscal 1980. When the effect of Congressional action related to fiscal authority became clear, the physicians in Texas began accommodating themselves, reluctantly, to the arbitrary decision to delay the implementation of professional standards review in Texas.

Immediately following the HEW decision to disallow TIMA's conversion to conditional status, discussions started with HEW Region VI personnel regarding activity levels and funding available during our forced additional year of planning. We were informed that a maximum of $310,000 of 1979 fiscal year funding would be available to TIMA during an extended twelve month planning period. No 1980 funds were to be provided to Texas. The expectation of Region VI was to maintain a "status quo" as a planning organization. This is totally unacceptable to the physicians in the state of Texas. After intense negotiations, we have been informed by Region VI that additional funds may be available but that an expanded scope of work must be accomplished. These additional activities were considered vital by TIMA to maintain support of the medical and health care community to maintain the momentum and enthusiasm already established. The exact amount of funding available remains in question, and this will determine if reasonable activity level can be reached.

We understand that the fiscal constraints placed upon HEW by the budget for Federal FY 1980 required some dramatic action in order to maintain the PSRO program. However, we question the appropriateness of selecting the simplest solu-

tion, or taking the easy way out, by attempting to maintain the FY 1979 level of activity through 1980, with a clear disregard for the effectiveness of the FY 1979 level of activity. We feel that the PSRO program and the taxpayers of the United States would be better served by a weeding out of ineffective PSROs and a consolidation of PSROs. This would realize savings in administratively activity rather than simply halting any extension of review. We, in Texas, have grave concern that HEW attempted no other solutions to this problem and we doubt that the Congress intended that its mandates be carried out in this manner.

Finally, the TIMA would like to ask, what was the real intent of Congress when they placed a cap on FY 1980 professional standards review activities? What is the future intent of Congress in terms of continued professional standards review? Are we to interpret this funding as the Congress' attempt to respond to conflicting reports of PSRO effectiveness, or is this budget merely a forewarning of Congress' intention to abandon professional standards review?

We feel that clarification of these issues is imperative in order to actively chart future efforts in establishing professional standards review in the state of Texas.

ORGANIZATIONS SUPPORTING THE TEXAS INSTITUTE FOR MEDICAL ASSESSMENT

Texas Medical Association
Texas Osteopathic Medical Association
Texas Hospital Association
Texas Osteopathic Hospital Association
Texas Nurses Association
Texas Dental Association
Blue Cross-Blue Shield of Texas
Texas Podiatry Association
Texas Dietetic Association
Texas Medical Record Association
Texas Society of Utilization Review Coordinators
Texas Nursing Home Association
Texas Pharmaceutical Association
Texas Society of Hospital Pharmacists
Texas Psychological Association
Texas Occupational Therapy Association
National Heritage Insurance Co.

Mr. CONSTANTINE. Now as directed by the Chairman, this hearing is adjourned, will stand in recess, subject to the call of the Chair.

[Whereupon, at 4 p.m. the subcommittee hearing adjourned, subject to the call of the Chair.]

[By direction of the chairman the following communications were made a part of the hearing record:]

CHARLES RIVER HEALTH CARE FOUNDATION,
Wellesley Hills, Mass., September 20, 1979.

Senator HERMAN E. TALMADGE,
Committee on Finance, Subcommittee on Health,
U.S. Senate, Washington, D.C.

DEAR CHAIRMAN TALMADGE AND MEMBERS OF THE COMMITTEE: This letter is in response to your Press Release No. H-53 of August 13, 1979, calling for written statements to be presented to the Committee in its consideration of the administration and operation of the PSRO program.

As a member of one of the originally funded PSRO's and as its present Executive Medical Director, I wish to be firmly on record as decrying the current and prospective policy of Congress to cut down on the funding of the PSRO program.

This year, after the program nationwide has finally been almost completely implemented, the second PSRO progress report (Professional Standards Review Organization 1978 Progress Evaluation) was published, indicating that cost-effectiveness of the program had been achieved. This report concerns 1977, only five years after the PSRO legislation was originally passed. It is true that the Congressional Budget Office, reviewing this report, came to the conclusion that cost-effectivness had not been achieved, but its suggestion was—even though admitting that a cost-significant number of Federally paid days of care had been saved—that the overall cost of medical care in the United States had not been reduced because hospitals

had cancelled the reduction of costs for Federal patients by passing on the costs to the payors in the private sector. This seems to me to be an entirely unfair assessment; it puts blame on the PSRO's for a development which is beyond their control.

Implementation of the PSRO review system nationwide has been a huge job, and it is only now that it has achieved a point where significant and comparable data is accumulating, and where individual PSRO's have gained enough experience to be able to do a more and more effective job of review. This job has been done despite a cut in funds last year, and this in face of the fact that the cost of the entire program is only 0.3% of the cost of the Federal programs that it reviews—surely a small enough cost for oversight of this sort.

The benefit to cost ratio of the PSRO program—the dollars saved compared to the cost of the PSRO review program—was 2.67 for the five PSRO's in Massachusetts in 1977. The benefit-cost ratio for the 96 PSRO areas studied was 1.10. These figures demonstrate two things: 1, that nationwide the program has demonstrated its cost-effective potential, and 2, that the potential savings in the future could be far more than the present nationwide experience indicates. In addition, further refinements in the system, dictated by accumulating experience, should increase the savings even more.

That Congress should at this point elect to decrease the funds available to PSRO's seems to me to set a course in precisely the wrong direction. Since there is real danger that the decrease in funds will damage a program that appears to be proving viable financially, a program which is carrying out a purpose that is acknowledged by Congress itself to be vitally necessary, I would urge that your Committee reconsider the present posture of Congress, and vote to restore the PSRO funding cuts.

In your Committee's Press Release. the statement is made that "a substantial number of PSRO's are making measurable progress . . .", and it goes on to point out that other PSRO's are not doing a good job. But I am sure the Committee would agree that to penalize the entire program because of the failure of a segment of it is not a sensible solution.

PSRO's have received endorsement from both the U.S. Chamber of Commerce, and the American Medical Association—neither group being known for its support of slipshod or pie-in-the-sky ventures.

Medical costs in this country are continuing to rise, and some sort of cost and quality control is essential. The PSRO system would seem to be the logical answer to this problem. It would seem to be no time to jeopardize its health or threaten its existence.

Sincerely,

RICHARD C. KERR, M.D., *Executive Medical Director.*

STATEMENT OF THE NATIONAL CAPITAL MEDICAL FOUNDATION, INC.

INAPPROPRIATE USE OF DISTRICT HOSPITALS, 1978

Last year, the National Capital Medical Foundation (NCMF) provided to the public a report detailing the inappropriate hospital stays for all public program patients discharged from the thirteen acute care hospitals in the District of Columbia during 1977. This report revealed that 1,116 public program patients spent a total of 40,302 inappropriate days in District hospitals.

NCMF has just completed the Inappropriate Hospital Stay Study for public program patients discharged during 1978. The data reveal that 1,509 patients spent a total of 40,857 inappropriate days in the District hospitals. The number of patients who had an inappropriate stay in D.C. hospitals climbed by 35 percent from 1977 to 1978, however, the actual number of inappropriate days increased by only 1 percent. This comparison indicates that while the review process is identifying more patients who are inappropriately placed, those patients are staying a shorter period of time in the hospital after the inappropriate stay is identified. This suggests that more efficient mechanisms have developed within area hospitals for placing patients after their acute stay had ended. It may also suggest that a more finely tuned review process which identifies more inappropriate stays has evolved since the first year of review.

A comparison of the types of inappropriate stays during the two years shows that denied and non-covered stay patients climbed from 602 patients in 1977 to 975 patients in 1978. Conversely, the number of non-acute certified stay patients declines from 1977 to 1978. This was due, in part to a clarification of coverage guidelines for Medicare patients waiting for intermediate care placement. The number of denied/non-covered days increased slightly between 1977 and 1978. These are days which will, for the most part, not be paid for by Medicare or Medicaid (some

"grace days" are paid by Medicare). The total denied/non-covered days was 27,001 for 1977 and 27,412 for 1978.

The pattern of disposition at discharge was the same in 1977 and 1978. In both years, more than half the denied patients went home. Although the reasons for certification of non-acute patients were not studied in 1977, this data was collected in 1978. About two-thirds of the non-acute certified patients were waiting for skilled care. The remainder were waiting for intermediate care or were children waiting for placement. Only 20 percent of these patients were placed in nursing homes, although almost all were waiting for nursing home beds. About half went home and almost 15 percent died in the hospital.

NCMF believes that if community resources, such as home care and nursing homes, were more available to inappropriate stay patients then significant dollar savings could be realized. These savings would occur since nursing homes and home health care costs between $30-$50 a day and hospital care costs between $200 and $300 a day.

In summary, the main findings of the study are:

1. There were more denials in 1978 than in 1977 but patients who were denied left the hospital in a more timely manner.
2. It is still extremely difficult to place patients in nursing home beds.

NATIONAL CAPITAL MEDICAL FOUNDATION, INC. 9/12/79

APPROPRIATE AND INAPPROPRIATE HOSPITAL STAYS FOR PUBLIC PROGRAM PATIENTS
DISCHARGED FROM 13 D.C. ACUTE HOSPITALS DURING 1978

APPROPRIATE STAY PATIENTS

	Discharges	Days Appropriate	Average Length of Stay	Patient's Final Disposition (%) Other Hospital	Nursing Home	Home	Died	Other
MEDICARE	25,374	321,436	12.7	.7%	3.1%	87.3%	7.1%	1.6%
MEDICAID	27,572	204,823	7.4	.4%	.4%	95.7%	1.7%	1.8%
OTHER PUBLIC PROGRAMS	6,146	59,732	9.7	.4%	.3%	92.2%	3.5%	3.6%
MATERNAL AND CHILD HEALTH	75	485	6.5	-	-	98.7%	1.3%	-
TOTAL	59,167	586,476	9.9	.5%	1.6%	90.9%	4.3%	1.9%

INAPPROPRIATE STAY PATIENTS

	Discharges	DAYS Appropriate	DAYS Inappropriate	Average Length of Stay	Patient's Final Disposition (%) Other Hospital	Nursing Home	Home	Died	Other
MEDICARE	956	30,042	20,808	53.2	.6%	21.9%	57.9%	9.3%	10.1%
MEDICAID	379	12,629	12,581	66.5	1.6%	9.1%	67.1%	10.2%	11.0%
OTHER PUBLIC PROGRAMS	174	5,817	7,468	76.4	1.2%	5.8%	67.3%	12.1%	13.7%
MATERNAL AND CHILD HEALTH	0	0	0	0	-	-	-	-	-
TOTAL	1,509	48,488	40,857	59.2	.9%	16.9%	61.3%	9.9%	10.9%

13 D.C. ACUTE CARE HOSPITALS IN 1978

NON-ACUTE CERTIFIED STAY PATIENTS

	Discharges	DAYS Appropriate	Non-Acute Certified	Average Length of Stay
MEDICARE	145	7,648	4,594	50.0
MEDICAID	137	5,107	3,911	65.8
OTHER PUBLIC PROGRAMS	32	940	356	40.5
TOTAL	414	13,695	8,861	54.5

DENIED STAY PATIENTS

a. ADMISSION DENIALS

	Discharges	DAYS Appropriate	Denied	Average Length of Stay
MEDICARE	31	93	1,655	56.3
MEDICAID	48	113	1,252	28.4
OTHER PUBLIC PROGRAMS	39	68	1,380	37.1
TOTAL	118	274	4,287	38.6

b. CONTINUED STAY DENIALS

	Discharges	DAYS Appropriate	Denied	Average Length of Stay
MEDICARE	420	12,678	5,873	44.2
MEDICAID	163	5,200	3,103	50.9
OTHER PUBLIC PROGRAMS	91	3,732	4,072	85.8
TOTAL	674	21,610	13,048	51.4

c. TOTAL DENIALS

	Discharges	DAYS Appropriate	Denied	Average Length of Stay
MEDICARE	451	12,771	7,528	45.0
MEDICAID	211	5,313	4,355	32.9
OTHER PUBLIC PROGRAMS	130	3,808	5,452	71.1
TOTAL	792	21,884	17,335	49.5

NON-COVERED STAY PATIENTS

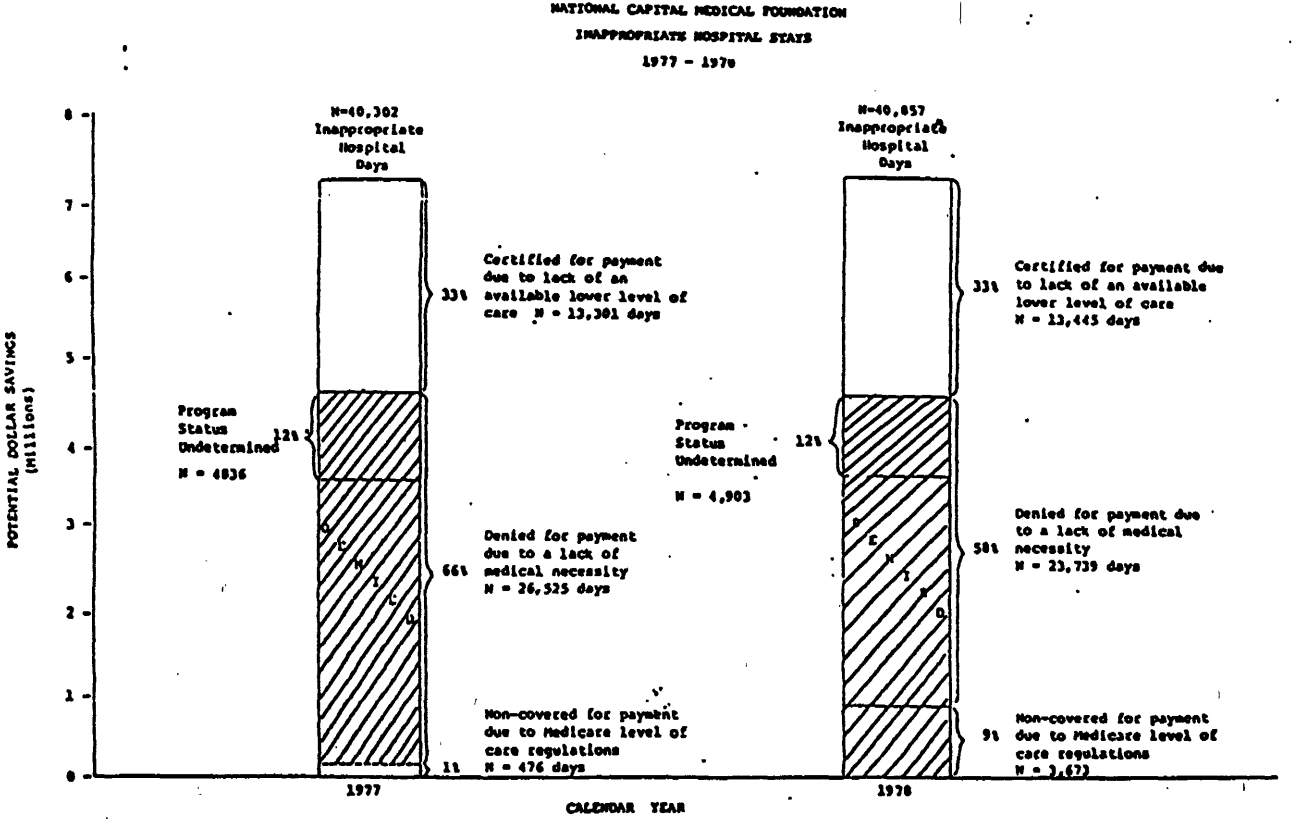
	Discharges	DAYS Appropriate	Non-Covered	Average Length of Stay
MEDICARE	183	6,170	2,850	49.3
TOTAL	183	6,170	2,850	49.3

MORE THAN ONE TYPE OF INAPPROPRIATE STAY

	Discharges	Days Appropriate	Inappropriate Days Denied	Non-Covered	Non-Acute Certified	Average Length of Stay
MEDICARE	77	3,453	2,416	691	2,729	120.6
MEDICAID	31	2,209	2,822	0	1,493	210.4
OTHER PUBLIC PROGRAMS	12	1,077	1,298	0	362	228.1
TOTAL	120	6,739	6,536	691	4,584	154.6

ALL INAPPROPRIATE STAY PATIENTS

	Discharges	Days Appropriate	Inappropriate Days Denied	Non-Covered	Non-Acute Certified	Average Length of Stay
GRAND TOTAL	1,589	48,488	23,871	3,541	13,445	59.2



PATIENTS DISCHARGED FROM 13 D.C. ACUTE HOSPITALS IN 1978
REASONS FOR DENIAL AND NON-COVERED STAY
AND
PATIENT'S FINAL DISPOSITION

REASONS FOR ADMISSION DENIAL	No. of Cases	Patient's Final Disposition: Other Hospital	Nursing Home	Home	Died	Other
Tests, treatment or procedure could have been provided as an outpatient	15		0	14	0	1
Patient admitted for purely social reasons	42	2	3	22	4	11
Court ordered admission	4	0	1	2	0	1
Documentation is either absent or inadequate	7	0	0	6	0	1
Known contact exclusion (eg. cosmetic surgery, etc.)	1	0	0	0	0	1
Patient needs intermediate care	1	0	0	1	0	0
Patient needs custodial care	5	0	0	2	2	1
Inappropriate pre-operative days	15	1	0	14	0	0
REASONS FOR CONTINUED STAY DENIAL						
Inadequate documentation by the attending physician	81	0	3	63	9	6
Physician or hospital delays (eg. surgery scheduling, etc.)	36	0	3	31	1	1
Patient delays (eg. patient refuses placement, indecision about surgery, etc.)	43	1	3	32	2	5
Court ordered	1	0	0	1	0	0
Absence of a medically suitable discharge environment; inadequate social service documentation	15	0	2	11	1	1
Mainly social placement; patient has resolved or stable medical problems	107	0	17	81	1	8
Patient on a pass	5	0	0	5	0	0
Patient needs intermediate care	257	1	74	136	15	31
Patient needs custodial care	82	0	11	56	4	11
Purely social placement	101	1	9	57	22	12
Other	17	0	0	15	0	2
TOTAL.	835	6	126	549	61	93

* Not included in the total were one hundred forty-eight (148) denial cases that had no physician advisor denial reason coded.
Includes patients who had both denied stays and non-acute certified stays.

PEER REVIEW SYSTEMS, INC.,
Columbus, Ohio, September 17, 1979.

Re: Written Statement for the Subcommittee on Health's PSRO Hearings.

Mr. MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: It has come to our attention that the Subcommittee on Health of the Committee on Finance will be reviewing the administration and operation of the Professional Standards Review Program. In order to assist the Committee in their review, we wish to offer our comments on the activities which Peer Review Systems, Inc. (PRS) has found to have resulted in successful PSRO performance in our Region X area.

In light of the time constraints and anticipated volume of comments that the Committee may receive, I will limit my comments to the top five activities where PRS has demonstrated successful program performance impact. The top five PRS' program activities are: Patterns of Practice Clinic Series, Hospital Performance Assessment Program, Medical Care Evaluation Study Program, the PRS' Areawide Educational Program, and the Long Term Care Program.

PATTERNS OF PRACTICE CLINICS—POP CLINICS

In March of 1979, PRS began an on-site hospital series of Pattern of Practice (POP) Clinics. The POP Clinics are developed and sponsored by the PRS' Medical Education Committee and consist of a one-hour program in each participating PSRO Region X hospital. The purpose of these clinics is to provide medical staff and hospital administrators with information on PSRO medical profiles.

The Education Committee has identified the following objectives for these on-site series:

1. To advise medical staffs and hospital administrators about the data collected, processed, analyzed and reported by their PSRO.
2. To demonstrate some of the basic comparative analyses of practice patterns to which phsysicians and hospitals have access.
3. To inform physicians and administrators about how their own hospitals and staffs' patterns of practice compare with local, regional, and national patterns.

Education and Profile Committee members participate in each on-site program and are available to answer questions and discuss issues relative to the presentation.

Based on the issues raised and the specific interests elicited during these clinics, the Education Committee is going to develop a curriculum for an areawide PSRO Profile Analysis Seminar which will focus on developing physicians' skills in assessing, analyzing, and utilizing the wealth of available aggregate health data and statistics in their own medical practice activities.

Increase of physician and hospital administration awareness of PSRO's potential to assist in promoting a quality health care delivery system has been observed in hospitals where clinic presentations have been made. Physicians' interest as well as hospital administrators in patterns of practice and hospital performance comparative analysis with local, regional, and national trends has caused an increase in requests for PSRO technical assistance. It is anticipated that in the long run, the information presented in the clinics complied with the increases awareness of the area's necessitating improvement will in itself provide the necessary direction to the parties involved to implement corrective action.

HOSPITAL PERFORMANCE ASSESSMENT PROGRAM

This year an important perspective was incorporated into the annual PRS Hospital Delegation Reassessment Protocol. The PRS Peer Review Committee, responsible for conducting the hospital delegation reassessments, examined a review program performance worksheet with delegated hospital representatives which identified hospital peer review performance with area-developed standards. Hospital delegation reassessment visits also continue to review hospital procedures and processes for delegated peer review/quality assurance programs, as well as the outcome of these processes. By using the performance approach to delegation reassessment, various types of peer review information, i.e. concurrent review, MCEs, profile analysis, can be interlinked to create a total, comprehensive picture of peer review effectiveness.

To date, the first application of the performance worksheet has interfaced and complimented the total reassessment protocol. The Hospital performance worksheet

is one of several factors used by the Peer Review Committee in approving continued hospital delegation status. Delegated hospital representatives submitted comments and provided feedback on the applicability of the Hospital Performance Assessment Worksheet/Report. These comments were invaluable as the worksheet was further refined and validated to reflect continuing changes in hospital peer review activities.

As the national focus in the PSRO Program is centering on performance and impact, the Hospital Performance Assessment Worksheet/Report has been designed to compliment and support performance goals and objectives set by the PRS' Board of Trustees. By working together, PRS and area hospitals have been able to demonstrate how an effective PSRO program can facilitate a positive impact on patient care and health resources.

MEDICAL CARE EVALUATION STUDY PROGRAMS

Medical Care Evaluation (MCE) studies focus upon known or suspected problem areas in delivery or outcome of health care. Along with topic selection, criteria setting, variation analysis and corrective actions, the value and effectiveness of MCEs are contingent upon performing restudies.

The restudy step is the primary mechanism that measures the effectiveness of recommended corrective actions and documents whether or not deficiencies have been resolved. The restudy step is thus the critical link between the conduct of the study and the impact of the study. Unless the restudy step is included in the MCE process, there is no effective evaluation of corrective action and/or continuing medical education programs. Recently PRS assessed the MCE restudy correction rates for the past two years. The results showed that a large majority of hospitals in the Region X area demonstrated a restudy correction rate greater than 70%. PRS' MCE program has had a significant impact in the Region X area. For example: An areawide MCT study was performed which focused on discharge placement problems and the incidence of extra hospital days due to such problems. The results of the study were presented to all area hospitals, health systems agency and various other health agencies. The results of this study were instrumental in the health systems agency approving an additional 250 long term care beds for the Region X area.

Discharge planning personnel had also been hired into almost every hospital in the Region X area. This addition to the hospital discharge planning process provided the review program with timely identification of patients with placement problems. To date, hospital personnel have indicated that there has been a decrease in discharge placement problems due to the addition of the hospital discharge planning personnel and the implementation of the PRS' long term care review program. The PRS' MCE program, like many other PSRO MCE programs, has had similar findings and has also come to the conclusion that a well-administered MCE program can have a direct effect on the delivery of health care services.

AREAWIDE EDUCATIONAL PROGRAMS

In addition to the inherent educational benefits of the programs which I have discussed so far, PRS also is constantly active in promoting areawide educational programs through the major educational channels. PRS has found much educational success, as I had stated before in the presentation of the POP Clinics. Other ways which PRS has turned to for promoting areawide education has been through local television, radio and newspaper publications. Direct results of this educational program have been increased physician organizational membership and involvement in PRS' activities. Public awareness due to promotions through television, radio and public speaking by various PRS' staff members has also been a very successful approach to promoting PSRO.

In an effort to streamline the review process to make the system more effective and efficient, PRS has several pilot studies underway to focus in on the challenges that face the PSRO program. One such study was just completed where the 50th percentile review was focused out as part of the review process for specific diagnosis. The results collected from individual review coordinator time sheets showed significant reductions in the review at the 50th percentile as expected and an increase in the number of reviews performed per day. Areawide reduction in review time ranged as high as 60 percent of a review corrdinator per hospital/year and from 4 hours to 48 hours of physician time per year. This translates to real dollar savings.

LONG-TERM CARE PROGRAM

Our long term care (LTC) review program is operating in 86 skilled and intermediate nursing homes, three mental retardation facilities, and we shall be phasing in

psychiatric review in two institutions. The LTC program involves approximately 4,984 patients under review on any given day and 7,835 certified beds with over 28,000 reviews being performed annually. Although it is too early to define impact in this area, feedback from facilities, physicians, and the state agency has been positive. We anticipate this may be a particularly important area, both in quality assurance and dollar savings, for PSROs to be involved.

These are the key program activities which PRS has incorporated in order to effectively and responsibly perform the duties of a PSRO. The best minds today are struggling with how to validly measure quality and the impact of PSROs. The technical problems of successful measurement are tremendous. It may well be that the most important impacts of PSRO are not measurable—that changes in physicians and hospital behavior, educational programs for health professionals and the consumer, just the *presence* of a peer review program, identification and correction of poor quality care, etc. are important enough alone. We know this will continue to be a national debate which may never be settled in the face of the pressure of hard economics. However, we do hope that the "softer" values and impacts of the PSRO program are also weighed carefully in any considerations for policy decisions and/or recommendations.

Thank you for your attention in this important matter and for reviewing our comments. If we may provide you with additional information, please do not hesitate to call upon us.

Sincerely,

ROBERT P. STONE, M. Sc.,
Executive Director.

NEW HAMPSHIRE FOUNDATION FOR MEDICAL CARE—LONG-TERM CARE REVIEW IMPACT STATEMENT: PART II

PREAMBLE

The Long Term Care Review Impact Statement for this past year of review is documented evidence that the Foundation has been successful in achieving the goals established for the long term care review program. The unique characteristics of long term care review have indeed made a significant difference in both the areas of utilization and quality of care for patients in skilled nursing facilities and intermediate care facilities under the Medicare and Medicaid programs.

The Board of Directors approved the development of the impact statement at its meeting of March 6, 1979. When the Long Term Care Committee approved the development and format of the statement at its meeting of March 8, 1979, they noted the increase in dialogue between physicians concerning patient care since implementation of long term care review. Both the Long Care Committee and the Long Term Care Advisory Group at its joint meeting of April 12, 1979 noted that bedside review and term approach have been effective and well received by the long term care facilities.

The data compiled at both acute and long term care levels give a complete picture of the utilization of beds for both levels of care. Many factors affect the health care environment and therefore the availability of appropriate facilities and services for Medicare and Medicaid patients. Pre-admission review data reveal significant problems with placement in specific areas of the State. The data highlight the problem areas which health planning agencies need to review in depth with the Foundation in order to make informed decisions concerning the need for health care facility beds and health services throughout the State.

Involvement of health care practitioners other than physicians who act as consultants in staff education, direct patient review consultation, and in medical care evaluation studies is effecting improvement in quality of care. Only through motivated and knowledgeable staff and physicians are we able to work effectively for the benefit of the long term care facility patients and residents.

The impact statement addresses the impact which we have made because of the unique characteristics of our program. Each aspect is addressed separately—but each part is not effective alone. It is the review program as a whole—the people in it that make the difference.

PHYSICIAN INVOLVEMENT—PEER REVIEW

Physicians are directly involved in long term care review in several ways. When Regional Review Team staff are unable to approve a level of care ordered for a patient either before admission or during a continued stay review, a Review Physi-

cian is contacted. The Review Physician, after discussion with the attending physician, makes the level of care determination. Review Physicians are contacted by Regional Review Team staff for consultation in quality of care issues. Review Physicians participate in Medical Review—on-site sample review of patients to review the quality of patient care and to monitor the effectiveness of the Regional Review Team activities. The process provides for intervention, by physicians, where deficiencies in care either due to the attending physician or other health care professionals are identified.

Objectives

Review for level of care determination.

Review for quality of care and services ordered.

Increase attending physician involvement with long term care institutionalized patients.

Assure timely documentation of the patient's status and health care needs.

Inform physicians of community resources available as alternatives to institutional care.

Examples

Regional Review Team staff found physician documentation lacking in a large intermediate care facility indicating that the attending physicians did not visit their patients on at least a quarterly basis. Facility administration and staff identified this as an extremely difficult problem to resolve. The Regional Review Team implemented the following plan of action:

The Regional Review Team recommended that attending physicians be called by the facility staff. Level of care certifications were withheld. A follow-up visit was scheduled for the following month. A Review Physician was asked to speak with the attending physicians concerning timely physician visits.

The follow-up visit to check on physician documentation showed attending physicians had visited their patients and updated medical orders and progress notes. Subsequent reviews showed minimal problems with physician documentation.

In a skilled nursing facility the Regional Review Team noted a patient under review appeared acutely ill. The facility staff had been unsuccessful in contacting the attending physician and the patient was transferred to an acute care hospital to receive appropriate treatment.

Review Physicians have talked with attending physicians because medications were ordered without proper laboratory studies to monitor the effects of the medication on electrolyte balance. These cases resulted in appropriate medical orders.

The Long Term Care Committee identified the importance of knowing the availability of rehabilitation services in the community when discussing cases with attending physicians. A survey of the availability of these services in home health agencies and intermediate care facilities, Statewide, was performed. This information was published in a booklet for use by physicians, discharge planners, and the Regional Review Teams in September 1979.

Review Physician discussion with attending physicians identified difficulty in discharge planning for patients with chronic obstructive pulmonary disease. The Foundation conducted a Statewide survey of skilled nursing facilities and intermediate care facilities in June 1979 to determined conditions under which these facilities would accept chronic obstructive pulmonary disease patients. An educational meeting on chronic obstructive pulmonary disease was held for Regional Review Teams with a consultant respiratory therapist. Level of care and quality of care criteria are being developed in this area, resulting from physician concern.

TEAM APPROACH

"Team Approach" refers to the multidisciplinary aspect of review. The Regional Review Teams are composed of registered nurses and medical social workers. Review physicians serve as adjunct members of the Teams. Other health care professionals are available as consultants to the Teams—physical therapists, occupational therapists, dieticians, pharmacists and others.

Objectives

Comprehensive review of the patient's health care needs (level of care and quality of care).

Identify problems relating to patient care to appropriate persons in the facility and recommend a plan of action.

Involve facility staff in multidisciplinary care planning, frequent assessment of each patient's status, and discharge planning.

Involve other health care professionals (pharmacists, dieticians, therapists) as consultants to provide an objective assessment and suggestion as to different approaches with problem cases.

Involve physicians.

Address documentation problems from a medical/social standpoint.

Examples

In one case a patient had exhibited severe behavior problems. The Regional Review Team discussed the case and drug regimen with a Review Physician, the attending physician and the consultant pharmacist. The attending physician subsequently admitted the patient to the hospital for a complete reassessment. The attending physician also visited and reassessed the drug regimen of several other patients in this facility.

One patient in an ICF had fallen and sustained a fracture of her hip. The patient had a surgical repair in the hospital and was transferred back to the ICF without an order for physical therapy or x-ray recheck. Six months after transfer, when reviewed by the Regional Review Team, the patient had not had any physical therapy and had not been seen by her physician for four months. Shortly after the review and problem identification, the patient's hip was rechecked and she was started on ambulation.

The Regional Review Team presence in the long term care facilities throughout the year has identified attitudinal and facility team coordination problems which affect the care patterns in some facilities. These have become evident as a result of medical record review and discussions with facility staff. The lack of effective multidisciplinary care planning and follow through, the overuse of restraints, the lack of consideration for stimulating activities, and for discharge planning are a few of the areas where the Review Teams have worked with facility staff to effect attitudinal changes resulting in improved quality of care and cost savings. These problems were addressed during exit interviews, in facility reports, and at educational meetings. Attending physician and facility staff attention to these areas became evident at the time of subsequent reviews both in discussion with facility staff and in medical record documentation.

The Foundation's physical therapy consultant was requested by the administrator of a long term care facility to perform and on-site review to assess the medical necessity and quality of physical therapy services provided.

Educational meetings with the physical therapist consultant highlighted the type of physical therapy which can be effectively provided in the home. As a result of this, the Regional Review Teams are working with facility staff to encourage more timely discharge to home with physical therapy being continued through Home Health Agency services. The Foundation also perfomed a Medical Care Evaluation study at the skilled nursing facility level to determine whether physical therapy certified at skilled level could have been appropriately provided through alternative community resources.

Consultant pharmacists have been working with Foundation staff on a drug utilization study at the intermediate care facility level and have given several educational presentations to the Regional Review Teams emphasizing important aspects of drug therapy. Impact resulting from the educational sessions with the consultant pharmacist is emphasis on careful review of the drug regimen ordered and the medication administration record. In numerous facilities, recommendations were made that the attending physician and staff completely reassess the drug regimen of each resident reviewed because of inconsistencies between the medication orders and the medication record. Recommendations were followed by all facilities. Many drugs were discontinued as unnecessary. Needed drugs were ordered in a more realistic manner. Review Teams monitor this area during every review; therefore responsible facility staff are becoming more conscious of the need for careful review of the medication regiment with the attending physician on a regular basis.

Regional Review Teams work closely with facility social service personnel in discharge planning. One intermediate level of care patient was denied. An appeal was requested. Additional time was given for discharge planning for teaching the patient to administer her own medications. The Regional Review Teams work closely with facility staff to effect a smooth transition for patients.

Regional Review Teams have been asked to address discharge planning and referral form documentation to facilitate appropriate continuity of care at acute care hospital inservice meetings and medical staff meetings. Significant improvement in referral form documentation has occurred in three hospitals where problems in this area had been identified. Varied health care associations have request-

ed that long term care review staff speak at association meetings on the review process and their responsibilities in relation to documentation.

BEDSIDE REVIEW

During on-site continued stay reviews Regional Review Team staff focus on the patient—his or her health and social needs, and how these needs are met. The medical record is reviewed to ascertain the overall plan of care established by the various disciplines, to assure that physicians and others are documenting on the record in a timely and proper manner, to determine whether the patient continues to require the certified level of care, and to review the discharge plan. During bedside review Regional Review Team staff also observe and communicate with the patient to assess the patient's condition, the quality of the services the patient is receiving, and to compare the stated objectives on the plan of care with the observed outcome.

Objectives

Review documentation, or lack of documentation, in the medical record concerning the patient health problems, needs, services ordered, and services provided.

Compare and validate information on referral forms and assessment forms with the medical record for level of care certification.

Validate that services ordered are provided.

Observe and communicate with the patient, evaluate quality of care provided, assess the patient environment, and observe relationship between staff and patient.

Example

In one facility Foundation staff discovered through conversations with a patient that physical therapy services were not provided as ordered. After discussion with key facility personnel, anotner physical therapist was employed and services were provided.

In one facility Foundation staff noticed mobility of patients was restricted to one area and no stimulation was provided to these patients. After discussion with key facility personnel and related correspondence, the Foundation staff observed attitudinal changes of facility staff resulting in increased social group activities for patients throughout the facility.

In several instances, patients informed Foundation staff that a medication was not reacting well. Staff informed the attending physicians and medication orders were changed.

In one facility Foundation staff observed that residents in wheelchairs and geri chairs were not ambulated at intervals. Documentation in the medical record was non-specific in this area. Documentation on follow-up reviews indicate that residents were being ambulated more frequently.

A Medical Care Evaluation study on the use of physical restraints in long term care facilities has been undertaken for three purposes: (1) to evaluate the current policies and procedures on restraints, (2) to assess the current usage of restraints, and (3) to develop criteria for restraint usage and explore alternatives. A task force established by the Foundation with representation from facilities and the State Survey and Certification Agency has been meeting to discuss these areas.

In one facility Foundation staff discovered serious problems with documentation of services, particularly with nursing services. Charge nurses demonstrated a lack of understanding of individual patient problems. Foundation staff discussed the problem with key facility personnel, the magnitude of the problem was acknowledged, and the nursing department was decentralized. Charge nurses are now invloved with patient care plans using Foundation assessment forms.

In one facility the Regional Review Team noted that the functional level of some residents had improved considerabley in a one year period. The medical records of these residents did not identify any specific plan of care designed to improve functional level, nor did the record note a change in the. functional level. The Regional Review Team used this situation to teach the facility the importance of documenting the care which they do provide which affected the wellbeing of these residents.

Long term care facility administrators, nursing directors, social workers and physicians have expressed appreciation for the bedside review process:

"The one outstanding feature of the program so far has been the fact that our patients are considered in a humanistic fashion, not as so much data on a form."

"Visual judgment as well as documented information makes for a more complete review."

". . . one picture is worth a thousand words. To see a patient is to understand the psychosocial data that would take reams of paper to adequately describe."

"Our patients have accepted the PSRO representatives as one more person very concerned with their care and welfare. The manner in which they present themselves puts the patient at ease. By their visiting the patient and viewing decubitus ulcers healing, incisions, and talking with and observing CVA patients the representative has a complete picture."

"We were impressed with the concern shown for the patients and their problems, and appreciate your respect for our assessment of those problems."

". . . this could prove to be very beneficial to the patient as well as another check and balance tool for the facility."

"This practice should continue as both myself and our nurse coordinator feel it would be to the advantage of the patient."

"On several residents a medical record review proved inadequate to meet ICF criteria when observation and interaction with the resident justified ICF stay as well as the need for additional documentation."

"Sometimes the patients themselves can give information which helps to complete the already documented material . . . in the past Medicare reviewers have felt that if they could have visited with the patient that perhaps the patients would have received a longer certified stay."

". . . our residents enjoyed the visit."

Statistics

From January 1979 through June 1979 the following numbers of on-site reviews were conducted:

Medicare skilled level patients	2,016
Medicaid skilled level patients	207
Medicaid skilled pending placement	158
Medicaid intermediate care patients	2,885

PATIENT SPECIFIC LENGTH OF STAY ASSIGNMENT

Initial length of stay assignment is made after the Regional Review Team receives a completed referral form and is based on the particular needs of the patient. During continued stay review the need for extension of the patient's stay is assessed and, if necessary, an additional length of stay is assigned. Skilled level of care Medicare patients are reviewed at a maximum interval of 14 days. Skilled level of care Medicaid patients are reviewed at a maximum interval of 30 days. Intermediate level of care Medicaid patients are reviewed within the first 30–45 days of admission, and then at a maximum interval of 180 days.

Objectives

Assure that patients receive the appropriate health care services for the appropriate length of time.

Monitor complex cases closely, including cases where quality of care is an issue.

Control the cost of health care through appropriate utilization.

Examples

A patient with chronic obstructive pulmonary disease, advanced emphysema, partial pneumothorax of left lun, and left thoracatomy was admitted to an SNF for skilled observation of his unstable condition. The patient required vital sign monitoring twice a day, continuous oxygen and diuretic medication. The Team certified seven days for monitoring this unstable condition.

A patient with terminal cancer was admitted for skilled observation of her rapidly deteriorating condition and to prevent complications. In this instance the Team certified only seven days because the attending physician had not visited the patient for six weeks. After consultation with the attending physician the Review Physician certified a shorter lenght of stay to assure that the attending physician would visit the patient whose need for medical care was still evident.

A diabetic patient with an unhealed pacemaker wound was certified for eight days for Betadine soaks and sterile dressings three times a day. It was anticipated that the wound would heal by eight days.

A patient who was status post Femoral Popliteal Bypass with a draining surgical wound was certified for seven days. The wound drainage was decreasing and it was anticipated that the sterile dressings would decrease from twice a day to once a day. The patient's vital signs were stabilizing. The patient was to be taught to do her own dressings. It was anticipated that these goals could be accomplished in seven days.

A patient with mephrosclerosis, cardiovascular insufficiency, and anemia was referred for ICF placement for medication administration and supervision due to her disorientation. Upon the initial on-site review no indication of disorientation was found or documented. The patient was certified for 45 days for discharge planning and for teaching administation of medications.

An alcoholic patient with Wilson's disease and bronchial asthma was referred for ICF placement for assistance with activities of daily living and to monitor functional status. On-site review revealed that the patient's overall health status was improving not deteriorating. General strength was increasing and with continued progress the patient would need only supervision as available in a group home. The patient was initially certified for 45 days and then given a 30 day extension with the goal of promoting continual improvement in health status, encouraging self-care and discharge planning.

Statistics

Average length of stay—skilled level Medicare:
7/77-12/77=32.2 days (prior to PSRO review)
7/78-12/78=30.6 days
1/79- 6/79=29.6 days
From 7/78-6/79;
Total days certified=52,074;
Total "medically necessary" days=49,253;
Total waiver days=2,053;
Total grace days=778;
Total discharges=1,728.

The cost per patient, per day, for skilled patients varied from $31.00 to $96.02. This included both free-standing and hospital-based facilities.

A decrease of 2.6 days from the average length of stay in skilled facilities represents 2,277 fewer days in a six month period in 1979 than in a corresponding period in 1977—prior to PSRO review.

The Foundation does not claim sole responsibility for the decrease, and cannot realistically claim an undisputable dollar amount savings. Nevertheless, days not used are days not directly paid for and 2,277 days not used accounts for $125,000* expense avoidance.

PREADMISSION REVIEW

Preadmission review is the process of assuring the need for a patient's admission to a long term care facility at either skilled or intermediate level of care prior to the admission.

Objectives

To assure that the patient meets the criteria for the level of care ordered by the physician, therefore assuring the medical necessity of the admission.

To estimate the length of stay required to accomplish the health care goals as determined by the physician and other health professionals.

To assure that sufficient pertinent information concerning the patient's health care needs is documented on the referral forms so that the patient's needs can be met adequately in the receiving facility.

Identification of the need for redistribution of acute and long term care beds.

Statistics

January 1, 1979–June 30, 1979
Hospital discharge data show
504 Medicare patients stayed in acute care hospitals awaiting placement to skilled nursing facilities, for 3,395 days.
145 Medicaid patients stayed in acute care hospitals awaiting placement to intermediate care facilities for 1,457 days.
Long term care discharge data show
93 Medicaid patients stayed in skilled care facilities awaiting placement to intermediate care facilities for 6,953 days.
If appropriate level beds had been available there would have been an expense avoidance of:

3,395	×	$45	= $152,775.00
1,457	×	$75	= 109,275.00
6,953	×	$30	= 208,590.00
			$470,640.00

* This figure is based on an average per diem charge of $55.

NOTE.—Discharge data does not include the large numbers of patients still awaiting placement. Expense avoidance dollars were based on $100/day for hospitals, $55/day for SNF's and $25/day for ICF's.

THE KANSAS FOUNDATION FOR MEDICAL CARE, INC.,
Topeka, Kans., September 7, 1979.

Hon. BOB DOLE,
U.S. Senate,
Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR DOLE: Thank you for your letter of August 28, 1979, regarding the Senate Finance Subcommittee on Health's scheduled hearings regarding the administration and operation of Professional Standards Review Organizations (PSRO). I will be unable to attend the hearings on September 18, and 19; however, I appreciate the opportunity to address some of the concerns we have regarding the operation of the PSRO program.

As you know, the Kansas Foundation for Medical Care, Inc. (KFMC) has been the conditional PSRO for the State of Kansas since September 30, 1977. Since that time, the KFMC Board of Directors and staff have diligently pursued the course of implementing PSRO review in Kansas hospitals. In fact, the KFMC is the largest conditional PSRO in the country by virtue of the number of hospitals in which PSRO review has been implemented. (142 hospitals effective October 1, 1979) This implementation, coupled with the fact that the KFMC has relatively small full time equivalent total staffing complement of 18.5 people, has served to make us acutely aware of any problems that exist within the program.

In my opinion, the most pressing problem facing all PSROs across the country is the limited funding available to the program as a whole. For Congress to cut the funding level from the previous fiscal year funding, with seemingly little thought to the ever-increasing intensity of PSRO review implementation required by the law, and the burden of double digit inflation, would cause a myriad of dilatory effects upon the KFMC as well as the PSRO program as a whole. In order for the KFMC and other PSROs to accomplish their stated goals and objectives, the funding level must be commensurate with the tasks required. To inadequately fund the program will only serve to lessen the degree of PSRO effectiveness and thereby make it impossible for PSROs to accomplish the intent of the law.

Another problem encountered on a frequent basis is two-fold in nature, but the resulting effect is usually the same. On one hand is the problem of the ever-changing scope and intensity of the entire PSRO program as evidenced by a continual outpouring of rules and regulations issued by the central office of the Health Standards and Quality Bureau (HSQB) of the Health Care Financing Administration (HCFA) in Baltimore. Coupled with that is the extended time period required for the central office to make determinations on issues and questions raised by individual PSROs. In many cases the time involved in receiving an answer from central office could be conservatively called inordinate. The result of this two-fold problem is that the KFMC, the hospitals of Kansas, the physicians of Kansas, and the hundreds of people who work with the PSRO program on a daily basis in the hospitals, must stay in limbo, so to speak, while awaiting a decision from central office. The net result of this is that the level of frustration goes up while the level of productivity goes down.

We believe that the PSRO program can be an effective method of quality assurance which will serve the intent of the PSRO law. Additionally, we feel that the KFMC/PSRO program in Kansas has been, and continues to be, successful in the accomplishment of our stated goals and objectives. Future success, however, can only be accomplished through appropriate funding for the PSRO program, consistency in the rules and regulations and the flexibility to allow the KFMC to structure our program according to the inherent characteristics of the Kansas Health Care Delivery System, and continued cooperation from the members of that delivery system. Any support you might choose to give in addressing solutions to our concerns would certainly be appreciated.

Once again, thank you for the opportunity to state our views to you. Your continued cooperation and assistance are sincerely appreciated.

Respectfully yours,

JAMES E. AGIN,
Executive Director.

TESTIMONY OF PSRO OF QUEENS COUNTY, INC.

In consideration of the Subcommittee on Health's interest in the role of PSRO in the accomplishment of the objectives outlined in Public Law 92-603; namely, that Federal patients receive medically necessary care at the appropriate level and meeting professionally recognized standards, the following position is being submitted for the Committee's consideration:

This paper is being divided into 3 discrete parts. The first will describe the existing health care environment as we see it. The second, in an admittedly superficial fashion, will describe how the PSRO attempts to deal with the environment and some suggested legislative changes which can help to alter this environment. And finally, in the last section, the very real impact and progress that this PSRO has demonstrated over the past two years and our hopes for the future.

This Committee is well aware of many of the issues which contribute to the ever-rising costs of health care, both in total dollars and as a percentage of the U.S. gross national product.

The initiation of the Medicare/Medicaid programs, along with the increased coverage of employer contributed insurance plans, has eliminated many of the financial barriers which stood in the way of patients receiving medical care. While it is true that State determined Medicaid fee schedules are low; that Medicare prevailing fees are below physicians' usual charges; that private insurance indemnity schedules are less than 50 percent of charges; by and large, more Americans than ever have access to the health system than ever before. This increased demand is one reason for increased costs.

If there is one single cause for the escalation beyond the cost of living increases in the rest of the economy, it is primarily the reimbursement methodology created by government and private insurers to pay the claims of patients who receive health care.

Hospital per diem reimbursement based upon "costs plus" has over the years compounded inefficiencies, eliminated any incentive to share or curtail services, and forced hospitals to keep patients as long as possible. It is not too difficult to understand that if an administrator receives $200 for each and every day and that during the first days of a patient's stay all of the expensive diagnostic and laboratory testing is accomplished at an average of $400, then a large number of $100 a day "hotel days" (i.e., little hospital service other than room, board and general supervision) must be accomplished prior to the discharge of a patient.

From the administrator's point of view, the hotel days are the profit days. Any business, including a hospital, must recover the costs of operating and profit days are an essential way of doing that.

There quite simply has been no incentive for the administrator to reduce the length of stay for patients. In point of fact, there still is no incentive, at least financially, to reduce the length of stay. It is rather a PSRO requirement that drives the reduction.

Furthermore, because of reimbursement mechanisms, there is no incentive to either utilize the hospital maximally seven days per week or to initiate extra shifts in the operating room or in other ancillary departments. This results in increased lengths of stay, particularly for patients whose stay involves a weekend. The weekend again becomes one of the "hotel days." The additional burdens placed upon hospitals by the labor unions who fought vigorously and won 35-hour, 5-day work weeks with weekend/night differentials also precludes the administrator from moving aggressively into new areas. Inevitably, the increased short run costs of making scheduling changes and paying increased labor costs are not matched by per diem reimbursement which usually lags at least 2 years behind in terms of recouping today's costs.

Other weekend problems relate to the utilization of the Operating Room. In hospitals where bed supply is tight, either all year round or seasonally, physicians anxious to operate often allow patients to be admitted when the hospital "finds a bed" and after admission, the case is scheduled for surgery. In this instance, delays in pre-operative time add to the cost of the patient's hospital stay.

Other reimbursement problems for the hospital are in the area of physician services. As the salary requirements for salaried physicians has increased, new and inventive financial arrangements have been created in order to solve the hospital problem of specialty and sub-specialty coverage, while not having to pay in full the large salaries which inevitably must come out of the hospital per diem. These new arrangements usually provide office space and allow physicians to bill privately for a certain percentage of services. The ease of consultation between and amongst physicians makes this arrangement attractive to the physician and the hospital as

well. The result is a tendency to overutilize physician sub-specialty services for inpatients which are billable directly to Medicare and/or Medicaid.

Add to this the incredible escalation in energy costs since 1972; the astronomical technology revolution; the incredible rise in petroleum derived disposable equipment, and you have an idea of why despite the ever-increasing reimbursement, hospitals are less likely to be financially solvent.

A third and very real external factor which must be addressed, is the issue of malpractice and the current practice of defensive medicine. It cannot be emphasized how the practice patterns of physicians and the required testing in hospitals is driven by the fear of malpractice. Quite frankly, the number of damage suits and the resultant settlements has left every health provider "gun shy."

How can you expect an emergency room physician to not order a skull series on any patient with a possible head injury? Despite the 98 percent negative rate, despite the presence of criteria indicating that a skull series is indicated only if specific signs and symptoms, i.e., history of unconsciousness, skull penetration, skull depression, discharge from ear, etc., despite all of this, how do you counter the argument, "What if a person with a head complaint arrives at the Emergency Room and you do not do a skull series and that one person has clinical evidence which does not show itself in the established criteria?" Who will protect the provider?

Similarly, the elderly who despite the technology available cannot undergo the treatment which the expensive technology has discovered are not being deprived of the diagnostic tests. A brain scan, EEG, and/or neurological consultation on an 85 year-old would uncover a tumor which because of the age of the patient remains inoperable. Yet, how do you tell the physician not to order or perform at least the minimum necessary to arrive at a diagnosis. Is there a certainty that a malpractice suit won't be initiated by a family who "wants everything for mother or dad", or an aggressive lawyer who says "it doesn't hurt to try to see if we can win some money!"

A more recent development along the lines of defensive medicine, is the requirement that before considering to have a child, a special genetic test for Tay-Sachs disease is in order for families of Jewish origin. This test was never routinely recommended to young people until a recent malpractice award indicated that an obstetrician is liable if all possible genetic disorders are not fully explored. So, at the recommendation of your physician, a $50 lab test is ordered. Last year, it was not considered necessary; now this test is routine.

A fourth external factor which has a crucial effect upon utilization is the hospital bed supply. Again, this Committee is well aware of the Hill-Burton Legislation and the subsequent building programs which resulted in the 1950's and 1960's. The common fact is that if you build a bed; you will use a bed. The administrator's job is to keep the beds full or as near capacity as possible, since the overhead for an empty bed is around 80 percent. Furthermore, reimbursement penalties are initiated when census fall below a certain percentage (80 percent for medical surgical beds in New York). This requires that ways and means be found to fill beds. Additionally, the proliferation of beds has created a surplus which is not properly distributed. While many higher peformance hospitals are filled to capacity, and need and should receive new beds, many marginal institutions continue to hold on to their beds. The patients in these hospitals are sick and so while the overall census of the marginal institution (marginal defined as poor structure, poorly qualified medical staff, outmoded equipment, poor management, poor accreditation status, poor delegation status, etc.) remains low, the empty beds remain empty; while the high performing hospital runs overloaded and because overall beds are above bed/population ratios, new beds cannot be built.

The administrator of the active hospital is confronted with the problem of overloaded departments, filled operating rooms, under-equipped and staffed laboratory and x-ray departments, etc., which result in patients being bumped, rescheduled and delayed in overall stay. The administrator of the slow hospital is confronted with the problem of devising elaborate schemes to fill beds, i.e., detox units, rehab units, arrangements with nursing homes, etc.

A fifth factor involves patients who need to be placed in nursing homes or other custodial environments after their hospital episode. To describe the organization of alternative health services for the elderly as a "travesty" is an understatement. Add to this a restrictive Medicare law which allow payment for only a very skilled nursing need for a short period of time and a Medicaid eligibility system which can take 6 weeks to process an application.

Now let's see what happens: A patient after 2 weeks convalescing from a stroke is in need of a nursing home. The nursing home is fully aware that after about 3 weeks of physical therapy and rehabilitation, benefits will be denied for Medicare,

yet the patient will need continued care for up to 6 months, a year or the rest of his/her life. Quite legitimately, the nursing home wants a guarantee that somebody will be responsible for the patient's bill. Therefore, until Medicaid applications are approved or enough family money is provided as a deposit, no placement takes place. If it takes up to 6 weeks to process a Medicaid application, you can see the problem.

Approximately 7 percent of the federal patients in Queens County fall into this category. On the average, these patients wait between 15 and 30 days. It is not unusual to have patients wait from three to five months! Without going into an indepth financial analysis, it costs and additional $100 per day, on the average, to keep a patient in a hospital when they could have been in another less intensive environment.

A sixth problem involves the PSRO/Hospital relationship, which more often than not is delegated. The legislation specifically requires a PSRO to consider delegation if the hospital can demonstrate compliance. As in any agency review, prior notice to a hospital allows for a "dressing up" of the institution. It is no coincidence that in preparation for a PSRO visit, problem cases are discharged prior to the visit. Of course, continued hospital performance is a requisite for continued delegation, however, as currently construed, the legislation makes non-delegation a difficult undertaking.

Delegation as a concept has outlived its usefulness, especially since a minimum dollar allocation has been established by Congress. Whatever scarce dollars are available, when you delegate you must monitor the delegated hospital performance. In other words, you end up paying twice; once to the hospital to make the decision and on a percentage of cases, and a second time to the PSRO to check the hospital decision. There is no doubt that the PSRO is more likely to make the proper decision when compared to a delegated hospital. From a managment and control perspective, the non-delegated arrangement is the more sensible approach.

A seventh and final factor is the knowledge or information deficiency engendered by any rapidly expanding technological industry. Into this category, one must address both the knowledge level of the institutional setting, the practitioner, and the PSRO.

One very real limitation is the available information from which decisions are made. Until the late 1970's, there was little diagnostic or procedure specific information available on a national, regional, State or local level. That which was available was oft times incorrect, not comparable to other data available, or incomplete. The data base is still only available on a national basis for Medicare and here it is only specific at the diagnostic level for 3 years. No Provider base line data is in useable formats without tremendous staff efforts, no Medicaid base line data is readily available beyond scanty glimpses at failed computerized endeavors.

Despite the perceived notion of excessive surgical utilization, data on utilization rates is unavailable. HEW recently released surgical data for cataract surgery for 1975. One cannot deduce very much from this. Medicaid has never released any rate data for any procedure at any time. Yet there is the continuous accusation that too much surgery is being performed.

The lack of reliable data in useable formats has resulted in a basic "ignorance in performance." It is only natural to believe that your behavior and performance is "typical", reflective of the community experience, and within accepatble limits. Hospitals have not been able to compare with any regularity their LOS experience against their peer hospital(s). Yes, there is PAS, but its data base is limited to PAS participants and its accuracy suspect. Yes, there are Medicare reports for key diagnoses from Blue Cross, but only for hospitals where Blue Cross is the intermediary (less than 50 percent in Queens). Yes, there is the Medicare national data base, but it is not at all current in terms of diagnostic information and not Provider specific.

If this shortage of data exists for hospital performance, there is even less physician specific data and none of it has ever been routinely shared with practitioners. In the absence of feedback, performance and variation in performance are difficult, if not impossible, to ascertain and correct.

This represents the environment within which the PSRO must attempt to accomplish its legislative mandate. Many of the problems described go far beyond the limited authority within which the PSRO interacts. Attempts at cost control realistically cannot only come from curtailment of utilization. Simple arithmetic will show you that at 10 percent increases per annum in health care costs, a commensurate 10 percent decrease in utilization would need to be accomplished in order to stabilize costs. There is not that much over-utilization to contain.

Notwithstanding the above, there are many ways to deal with the above constraints. Many of the solutions directly or indirectly related to the PSRO and its operations. Described below are the PSRO attempts at dealing with the environmental constraints previously identified:

1. Increased demand for health services—To begin with, the admission rates per 1,000 population need to be reduced (see PSRO Impact section). This can be accomplished by a number of mechanisms including the use of selective pre-admission and admission review for known or suspected problem conditions or practitioners. In addition, the development of ambulatory surgery departments within existing hospitals and free standing units would help to move patients out of the inpatient setting. In New York State, a compendium of abulatory procedures is being developed by the State in cooperation with the local PSRO's.

It must be recognized however that so long as private insurance policies (which Blue Cross controls 70 percent of in New York metropolitan area) continue to offer paid-in-full hospital benefits for inpatients but only limited indemnity for out-of-hospital benefits, ways and means will be construed to admit the patient to the hospital. The insurance incentive must be changed.

Furthermore, so long as the control of utilization under PSRO precludes the inclusion of private patients, about 40 percent of the beds will be under less than ideal surveillance. If I were an administrator, I would manipulate my patients so that federal patients were in compliance with PSRO, and private patients would pick up the slack. There is simply no way for an insurance company to have the intimate knowledge of hospital utilization patterns that PSRO has. The curtailment of weekend admissions, the limitations on pre-operative workups, etc., can easily be transferred over to the private sector. The result is that whatever potential savings exist in the federal sector are lost to the private sector. The Congressional Budget Office alluded to this fact in its recent report to the House Ways & Means Oversight Committee (June, 1979).

2. Reimbursement—The current mechanisms require very specific types of activities to take place in order to reduce utilization. Some of these include:

a. A review and denial of "hotel days" at the end of a patient's stay.

b. A pre-admission scheduling system so that elective surgery can only be admitted after a confirmed OR date is received.

c. A limitation of elective weekend admissions unless a hospital has the capability of providing specific services.

d. The initiation of a procedure to identify discrete areas where efficiency and effective patient management are not being delivered. This is commonly known as a carve out and it identifies groups of days where a delay in the initiation of a test delays the treatment.

e. Establishment of hospital performance for diagnoses adjusted by age and severity whenever possible and the initiation of specific reduction goal objectives.

Each of the above has been implemented in the Queens PSRO details of which are provided in the attachments.

The net result of the above will be to reduce income to the hospital without providing a means for the reduction of the costs of operating an institution. If all the hotel days are removed and no adjustments are made in the per diem for the expensive diagnostic and treatment days, hospitals will simply go broke. If the cost of operating an empty bed is 80 percent of the cost of an occupied bed and 30-40 percent remain empty on weekends because services are not available 7 days per week, the hospital will find itself in an untenable financial situation.

The implications of the above are that given current operating costs and revenues, it doesn't take very much in terms of decreased utilization to push a hospital into a deficit.

Clearly, only new reimbursement schemes will solve the problem. The experiment in New Jersey scheduled for January 1, 1980, would pay hospitals by condition irrespective of the time in the hospital. Evidently, the incentive would be to treat a patient as promptly as possible so that discharge could be arranged. Indeed, the entire role of PSRO would change from denying patients from staying too long to assuring that patients stayed long enough. All disincentives (excluding perhaps union recalcitrance) would be removed, from weekend services; extra shifts during the early evening, etc.

3. Malpractice and defensive medicine—The answers here are not so clear cut or easy to design. However, there are some specific types of actions which the PSRO does have at its disposal such as:

a. The dissemination of specific information to refute the defensive medicine mystic.

b. Attempt to use voluntary efforts to curtail unnecessary ancillary utilization, i.e., Director of Radiology reviewing requests for G.I. series to determine need, establishment of specific criteria.

c. Constant PSRO chart surveillance and critiques to identify weak areas.

d. Development of continuing education agendas which are required attendance for recertification.

This issue must be vigorously pursued in the legislative arena. Liability definitions of other health systems may serve as models.

4. Bed supply—The relationship between the PSRO and its constitutent HSA is an important element for success in this area. Unfortunately, the essential element of HSA "appropriateness review" (Whereby each facility would be assessed as to its need in terms of community, quality, access, etc.) has been eliminated as an HSA requirement.

Nonetheless, decisions as to where to place new beds requires some input from the PSRO in terms of whether or not the quality is to be a significant factor. Similarly, professional input in analyzing either new services within a hospital (i.e., pediatric, radiographic) or new facilities (i.e., ambulatory surgery) can and should be looked at by PSRO. (These activities can and do take place at our PSRO.)

Essentially, while the long-range plans of HSA take hold, the short-term requires that excess demand be eliminated. It is not unrealistic to believe that the closing of 2 hospitals in Queens was directly related to either the pending initiation of PSRO review or shortly after PSRO review began. It is no coincidence that some hospitals are having difficulty keeping census up.

Consideration must be given to creating alternative uses for the excess beds in the system. It simply will not suffice to close institutions, especially in the urban environment, since in many communities the hospital is one of the few stabilizing forces in an otherwise decaying environment (the shoe maker, grocery store, cleaners, luncheonette, local bank, etc., all depend upon the hospital). If long term beds are what is needed or at least holding areas until a long term bed opens up, then incentive must be given to close the acute care bed and redesignate the bed as something else. The staff would naturally need to be retrained and union support solicited (if the choice is no job or a retrained job, there is a chance that unions will cooperate).

5. Delegation of hospitals—The initial creation of the delegation model whereby a facility merely needs to request and meet minimum criteria to receive delegation must be changed. Legislative amendments need to be considered which would make delegation an option and not a requirement which the PSRO must pursue if the hospital desires such an arrangement.

There is no question that utilization reductions and LOS outcome are more favorable in non-delegated versus delegated hospitals. This becomes even more obvious when you consider the amount of money being offered to a hospital to perform delegated review. If you are paying $4 per admission for concurrent review you will buy $4 worth of review. Since most PSRO's have had to reduce hospital budgets by as much as 50 percent, you can expect to buy 50 percent less work. There is no efficiency in dividing a very small budget between the PSRO and its constituent hospitals.

By providing for an option and not a requirement to delegate, those PSRO's who feel the delegation arrangement is workable because of size and location of hospital, etc., may continue to do so.

Nursing Home Placement—As previously noted, the PSRO has identified 7 percent of the patients who enter the hospital go on to nursing homes. Some 6 percent of the total hospital days are spent waiting to go to a nursing home.

From a cost containment perspective, a solution to this problem would save millions of dollars.

To begin with, mechanisms to allow hospitals to have swing beds, i.e., acute and/or long term care holding beds with commensurate reimbursement. Second, entire facilities could be converted to long term facilities. Waivers and huge bureaucratic regulations would need to be overcome, but at least Congressional intent should be attempted. Incentive should be granted to hospitals willing to reconvert to lesser levels.

State Medicaid Agencies must be pursuaded to establish immediate presumptive Medicaid eligibility so that nursing home placement and reimbursement can be assured. While the eligibility is firmly established, at least the home is receiving funds. While there may be some Medicaid dollars expended for persons above Medicaid levels, by and large, the dollars saved from unused hospital days will more than compensate for this. The Federal government must participate in this with the State and share in the financing of this endeavor.

7. Knowledge and information deficit—The amount of data currently being amassed, profiled, reviewed, analyzed and distributed to hospitals exceeds anything the hospitals may have had before. The PSRO serves as the fulcrum for the dialogue and suggested actions based upon this information. As an outside agency reviewing hospital performance on an almost day-by-day basic results are obtainable. Part of the impact described in the next section resulted from a coherent, effective data collection and processing system.

This system does not come cheap nor can it create a data base either for the past or for the private sector. It is, however, a very real information set.

The PSRO is the essential communicator of government concerns, aspirations, objectives and other information which HEW may wish the profession to know about. For example, the dissemination and subsequent implementation of the 11 (eleven) surgical procedures identified as potential problems went very quickly from HEW to the PSRO and out to the Provider community. Similarly, provider concerns, expectations and aspirations are quickly communicated to HEW and as this paper indicates, to Congressional Committees when appropriate.

The dissemination of new medical information, whether it be concerning the results of an areawide study, antibiotic therapy, anticoagulant therapy, etc., is sent to the Provider and practitioner specifically involved with the information at hand. The accusation that the health care community is ill-informed about its responsibilities, and therefore unable to comply, is no longer applicable.

It is only with knowledge gathered in a systematic and organized manner, that you can reach the health care community. No organization is better equipped to handle such a function.

Contained within this section and in the attachments are some of the more important accomplishments and impact which this PSRO has demonstrated. After exploring the utilization data, a concluding section on quality will be addressed.

With respect to length of stay, admission rates and days of care rates, all indices indicate that the presence of PSRO has continued to assist in the decrease of these utilization parameters (Attachment 1). While the data is for "Medicare patients only, it does suggest both positive impact and suggestions for future actions. The PSRO recognizes that its experience when compared to the region and nation is high, therefore, the hospital reduction goals previously described were derived (Attachment 2).

Similarly, in an effort to identify inefficiencies due to preventable delays, whether they be physician or hospital induced, a carve-out policy was initiated which requires that the days of delay be segregated from the total length of stay. When a pattern of days is identified, which is attributable to a particular reason, specific hospital action is required (Attachment 3).

After extensive review of specific surgical procedures, the PSRO has determined that cataract surgery, dilitation and curettage, and hysterectomies are performed only when necessary with appropriate documentation provided (Attachment 4).

A common area of concern to all PSRO's is the area of unjustified weekend admissions when no active treatment of services are provided to the patient. This is an area, as part of our objectives, that has been focused in on during this year. In an effort to curtail these types of admissions, a PSRO policy was promulgated (Attachment 5). By analyzing our year-to date data, we have seen our pre-operative LOS decrease by 0.9 day for Friday admissions. Length of stay as measured by admission day of the week has decreased in 5 of the 7 days (Attachment 6).

In order to avoid unnecessary pre-operative delays for elective procedures, a pre-admission scheduling procedure was established (Attachment 7).

Overall pre-operative LOS continues to be a length of stay problem when comparatively profiled. The PSRO has established a list of procedures (Attachment 8) which it is currently focusing attention on in an effort to reduce the length of stay. Some preliminary results are shown in Attachment 9.

The above descriptions are not meant to include all PSRO utilization accomplishments, but they do represent a broad-based perspective on the parameters which are intensively reviewed.They represent the best effort currently at our disposal. Perhaps the most exciting part of these analyses is the realization that through the sorting of information, the establishement of administrative procedures, and the direct assault upon the administrative management of a hospital as it relates to the delivery of patient care (Refer back to the reasons for carve-out), a direct and positive impact can be made upon the utilization of health care resources.

Any description of the PSRO program would not be complete without the identification of quality issues and how they are directly impacted upon by PSRO. It is, of course, difficult to amass a series of statistics to document, in the quality arena, in a

similar fashion to utilization. However, the anecdotal evidence is persuasive and overwhelming.

Perhaps, the greatest achievement of this PSRO is in contributing to the closing of a hospital long known for its poor quality and inappropriate utilization. At the time the PSRO began to assess this institution, no fewer than 3 agencies (Office of Program Integrity, State Dept. of Health, Welfare General's Office) were reviewing on-site in an attempt to curtail unusual practices.

The absence of a quality assurance program, the complete lack of delineation of privileges, the unsubstantiated medical records, the lack of meaningful treatment protocols even for the most basic conditions (i.e., M.I. admissions), the unusual and certainly unsubstantiated cancer treatment programs, the total lack of supervision of the medical staff, etc., led the PSRO to the decision of non-delegation.

After initiating a pre-admission policy for the active physicians, requiring treatment protocols to be submitted in advance of admission, refusing to certify to pay for experimental procedures, refusing to certify to pay for patients at less than acute levels, the census dropped from around 80% in 1977 to 20% in 1978. The hospital closed its doors in mid 1978—a bankrupt institution. If left to the administrative processes of the State and the Court delays, due process requirements, etc., this hospital might still be open.

This scenerio is described not because we take great pride in closing a hospital, but rather, because it indicates the express and implied power of PSRO and how when confronted with the issue, the Board of Directors took swift and definitive action.

Perhaps another anecdote can illustrate how cooperative steps between a hospital or group of hospitals and PSRO can result in more favorable patient outcomes. In 2 hospitals, a congestive heart failure study indicated that deviations from established protocols had occurred, and in fact, the overall mortality was to some degree influenced by these deviations.

The PSRO, after investigating the problem, discussed the findings with the hospital and required a number of actions, including, amongst other things, the initiation of standing orders for nurses, and the requirement that concurrent physician intervention take place when protocols are not met.

In the first study, 16 of 100 (16%) patients died with 7 (7%) questioned as to whether or not the mortalities were preventable. Upon restudy, 2 of 52 (3.8%) patients died. Neither mortality was preventable according to PSRO analysis. We do not attach statistical significance to these results, nor do we discount that other factors may be influencing the outcome. However, at PSRO we consider this to be a success story (See Attachment 10).

The assortment of practitioner quality issues are numerous and not worth repeating in detail. From antibiotic use to anticoagulant therapy. From questioned surgical procedures to questioned consultations. When PSRO review indicates that quality questions have arisen, a meeting is arranged; the results of which are summarized and followed up. Examples are provided as Attachment 11.

The entire area of quality assurance and evaluation of health care is still very much in its infancy and new ideas, methodologies, theories, etc., are constantly being updated in the literature. The PSRO constantly reviews the literature and is always attempting to incorporate new approaches into its quality review activities. There probably is no single answer either in how to evaluate or in how to decide which indices defines the important quality questions. As the learning process continues, the rigorous notion of peer review and one-to-one encounters will continue to be one of the mainstays of our process.

There is no other profession or industry currently scrutinized to the extent that the health industry is today. The value of this scrutiny and the duplicity of this scrutiny is an open question. From the Congressional perspective, the choice is who can reasonably do the job of accomplishing accountability for federal expenditures. It is our belief that PSRO continues to be the best effort mounted to date to accomplish this objective, recognizing that PSRO is reactive to the environment and that changes to the overall environment are in order.

Respectfully submitted,

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PSRO of Queens County, Inc.

ATTACHMENT 1

MEDICARE UTILIZATION DATA FOR QUEENS COUNTY

	Days of care rate per 1,000				Percent change		
	1974	1975	1976	1977	1974–75	1975–76	1976–77
Queens PSRO	4378.6	4311.4	4553.1	4346.6	−1.5	5.6	−4.5
Region 2	4156.0	4260.0	4377.3	4265.9	2.5	2.8	−2.5
National	3776.9	3760.8	3817.3	3767.4	−0.4	1.5	−1.3

	Discharge rate per 1,000				Percent change		
	1974	1975	1976	1977	1974–75	1975–76	1976–77
Queens PSRO	254.6	255.1	269.4	273.4	0.2	5.6	1.5
Region 2	271.6	278.4	289.9	296.2	2.5	4.1	2.2
National	325.6	329.9	340.8	345.6	1.3	3.3	1.4

	Average length of stay				Percent change		
	1974	1975	1976	1977	1974–75	1975–76	1976–77
Queens PSRO	17.2	16.9	16.9	15.9	1.7	0.0	−5.9
Region 2	15.3	15.3	15.1	14.4	0.0	−1.3	−4.6
National	11.6	11.4	11.2	10.9	−1.7	−1.8	−2.7

CHARACTERISTICS OF PATIENT POPULATION BY DIAGNOSIS GROUP

Diagnosis Group	*Patient Population Analyzed*
Malignant neoplasm of large intestine	Multiple diagnosis/operative greater than 64 years old
Malignant neoplasm of ill-defined and secondary sites	All patients over 64 with Multiple Diagnosis
Diabetes Mellitus without complications	Multiple diagnosis/non-operative greater than 50
Acute Myocardial Infarction	Multiple diagnosis/non-operative greater than 64
Miscellaneous ischemic heart disease	Multiple diagnosis/non-operative greater than 50
Arrythmia and slowed conduction	All patients over 64 with multiple diagnosis
Heart failure	All patients over 64 with multiple diagnosis
Miscellaneous cerebrovascular lesion with paralysis	All patients over 64 with multiple diagnosis
Miscellaneous cerebrovascular disease	Multiple diagnosis/non-operative greater than 64
Pneumonia	Multiple diagnosis/non-operative greater than 64
Miscellaneous diseases of intestine and peritoneum	All patients over 64 with multiple diagnosis
Diseases of gallbladder	All patients over 64 with multiple diagnosis
Fracture of upper end of femur	All operative patients over 64
Benign prostatic hypertrophy	All operative patients over 64
Arterial embolism and thrombosis, gangrene	Multiple diagnosis/operative greater than 64

1979 PROJECTED LENGTH OF STAY BY SPECIFIC DIAGNOSIS GROUPS FOR QUEENS HOSPITALS

Diagnosis Group	Hospital #	1	2	3	4	5	6	7	8	10	11	12	13	14	15	16	17	18	19	20
Malignant Neoplasm of Large Intestine	Target LOS 1979	28.4	29.5	21.6	21.0	28.5	24.2	22.1	26.0	25.7	22.7	-	23.8	-	24.2	19.9	28.5	22.5	-	22.5
	% Reduction 1978-1979	83%	6%	0%	0%	NA	14.7	0%	4%	0%	0%	-	0%	-	15%	0%	NA	0%	-	-
Malignant Neoplasm of ill defined and secondary sites		18.6	16.7	10.3	14.3	21.9	-	16.7	-	15.5	19.9	-	18.4	18.8	20.3	14.4	21.9	-	16.7	-
		15.7%	2%	0%	0%	NA	-	0%	-	0%	8.7%	-	4.3%	6.7%	15%	0%	NA	-	0%	-
Diabetes Mellitus without complication		15.9	17.3	-	12.4	19	15.3	16.5	18.1	-	-	13.5	-	17.2	15.1	-	19	-	16.0	17.7
		0%	8%	-	0%	NA	8%	6.7%	11.3%	-	-	0%	-	2%	11.7%	-	NA	-	0%	0%
Acute Myocardial Infarction		16.1	16.3	13.7	15.2	20	16.3	16.2	15.9	15.2	16.3	16.2	14.9	15.2	16.5	13.9	20	17.1	13.7	22.6
		6.5%	0%	0%	0%	NA	10%	0%	5%	0%	10%	0%	0%	0%	18%	0%	NA	0%	0%	0%
Misc. Ischemic Heart Disease		12.7	13.0	10.5	12.5	15.2	13.7	13.2	13.0	9.2	13.5	11.7	10.2	13.8	15.1	12.0	15.2	10.3	14.2	10.9
		3%	0%	0%	0%	NA	6.5%	2.5%	0%	0%	5.5%	0%	0%	13%	6%	0%	NA	0%	0%	0%
Arrythmia and slow conduction		14.4	13.2	8.6	11.3	14.3	-	13.3	11.6	11.3	12.8	14.0	9.6	-	13.8	8.9	14.3	12.4	14.6	15.2
		14%	0%	0%	0%	NA	-	3%	0%	0%	3%	5%	0%	-	8.7%	0%	NA	3%	5%	0%
Heart Failure		13.7	14.0	12.9	13.2	15.2	17.1	15.3	16.2	13.0	15.9	16.2	12.9	13.2	15.8	15.1	15.2	14.9	15.2	10.6
		0%	0%	0%	0%	NA	14%	2%	5%	0%	8.3%	0%	0%	0%	13%	2%	NA	5%	0%	0%
Misc. Cerebrovascular Lesion with Paralysis		-	26.6	22.8	20.1	29.5	26.3	-	24.2	22.2	-	-	18.1	-	-	22.4	29.5	21.6	26.3	22.5
		-	16.3	2.5%	0%	NA	7.3%	-	0%	0%	-	-	0%	-	-	2.5%	NA	5.2%	0%	-
Misc. Cerebrovascular Diseases		18.8	-	15.1	13.4	22.8	21.6	19.5	18.5	-	-	18.5	12.7	18.7	20.8	17.4	22.8	16.2	15.7	14.6
		4.3%	-	0%	0%	NA	10%	5.3%	3%	-	-	0%	0%	2%	17.3%	0%	NA	4.8%	0%	0%
Pneumonia		17.1	16.1	13.5	11.2	16.2	18.1	15.8	15.0	-	11.0	10.7	12.3	14.1	15.1	16.2	16.2	13.1	14.8	15.6
		2%	0%	0%	0%	NA	10.3%	2.5%	12%	-	0%	0%	0%	0%	8%	9.3%	NA	3.3%	0%	0%
Misc. Diseases of Intestine & Peritoneum		13.9	19.5	12.9	15.1	18.1	18.1	14.4	19.8	16.2	14.3	15.7	10.6	14.8	16.9	-	18.1	-	19.0	-
		0%	6.5%	0%	0%	NA	7%	0%	2%	0%	0%	0%	0%	0%	11.3%	-	NA	-	8.3%	-
Diseases of Gallbladder		17.2	-	16.1	12.8	18.1	15.9	16.5	-	14.6	-	15.9	14.2	17.1	15.2	14.5	18.1	17.0	-	17.6
		9%	-	0%	0%	NA	0%	5.3%	-	0%	-	0%	0%	10.7%	7%	0%	NA	2.5%	-	5%
Fracture at Upper End of Femur		27.7	31.0	26.1	25.4	33.3	30.6	28.8	30.4	29.1	25.0	30.0	20.9	24.3	29.3	32.3	33.3	28.4	30.8	22.1
		0%	16%	0%	0%	NA	11.7%	0%	3.3%	3.5%	0%	0%	0%	0%	12%	0%	NA	6%	6%	-
Benign Prostatic Hypertrophy		15.8	-	-	-	17.1	-	16.3	-	-	13.6	15.8	13.2	15.9	15.0	-	17.1	14.8	-	-
		14.5%	-	-	-	NA	-	2%	-	-	0%	2%	0%	2%	0%	-	NA	2%	-	-
Arterial Embolism and Thrombosis, Gangrene		-	24.4	31.6	24.7	32.3	23.9	-	-	31.0	27.8	21.5	-	22.5	28.2	21.6	32.3	-	33.0	-
		-	0%	7.6%	0%	NA	0%	-	-	0%	0%	0%	-	11.4	11.2	0%	NA	-	13.4%	-

Procedure Group	Hospital #	1979 PROJECTED LENGTH OF STAY BY SPECIFIC PROCEDURE GROUPS FOR QUEENS HOSPITALS																		PSRO Target LOS
		1	2	3	4	5	6	7	8	10	11	12	13	14	15	16	17	18	19	20	
Intracapsular Lens Extraction	Target LOS 1979	4.8	4.3	5.5	4.8	4.8	4.4	4.7	4.7	4.5	4.6	4.3	4.5	6.2	6.2	4.8	4.8	4.1	5.0	4.6	4.8 Days
	% Reduction 1978 - 1979	5%	0%	6.8%	5%	N.A.	0%	0%	5%	0%	0%	0%	0%	11.4%	10.1%	5.9%	N.A.	0%	5%	5%	
Pacemaker Implant		17.8	13.2	11.4	14.6	19.9	19.0	16.0	14.6	14.9	13.4	14.3	10.1	20.0	14.6	---	19.9	14.8	15.5	---	14.6
		7%	0%	0%	5.8%	N.A.	9.5%	7.2%	7.1%	5%	0%	5%	0%	9.5%	5%	---	N.A.	5%	7.2%	---	
Colectomy		34.0	29.0	20.8	22.9	34.2	33.0	29.5	28.0	28.0	24.8	27.3	28.0	21.2	30.0	---	34.2	27.4	36.0	26.2	28.0
		6.8%	5%	0%	0%	N.A.	8.1%	6%	6%	5.1%	0%	5%	0%	0%	8.3%	---	N.A.	0%	10.2%	0%	
Cholecystectomy		21.0	18.3	16.5	15.5	17.1	17.1	20.6	17.3	21.0	19.5	19.0	19.3	21.0	26.0	20.0	20.9	19.5	25.0	18.3	19.2
		6.6%	0%	0%	0%	N.A.	0%	5%	0%	9.5%	5.3%	4%	0%	6.7%	10.0%	8.3%	N.A.	6.7%	9.1%	0%	
Unilateral Repair-Inguinal or Femoral Hernia		8.9	7.2	9.5	7.3	6.7	9.0	9.5	11.5	9.5	7.9	7.8	9.5	11.8	10.8	8.7	6.7	7.8	11.5	7.9	9.1
		5%	0%	9.5%	0%	N.A.	0%	5%	12.2%	5%	0%	0%	6.9%	5%	7.7%	0%	N.A.	0%	10.2%	0%	
Incisions, Excisions of Abdominal Wall and Peritoneum		22.6	17.0	---	15.7	27.6	22.0	26.0	25.0	34.0	22.5	23.5	15.5	17.5	24.0	---	27.6	20.5	---	18.9	22.4
		0%	0%	---	0%	N.A.	6%	8.4%	7.7%	9.8%	0%	6%	0%	0%	5.9%	---	N.A.	0%	---	0%	
Transurethral Excision of Bladder Lesion		11.0	12.0	8.3	7.1	13.1	13.5	12.0	13.0	11.6	9.0	10.0	10.9	---	8.2	14.5	13.1	12.0	11.6	13.5	11.0
		5%	6.3%	0%	0%	N.A.	8.2%	7%	7.8%	5%	0%	0%	0%	---	0%	8.2%	N.A.	5.5%	5%	5%	
TURP		16.5	17.0	14.4	12.2	17.1	16.5	17.3	16.0	14.7	12.6	13.7	14.3	16.5	18.5	---	17.1	13.4	21.0	12.7	14.8
		7.8%	9.1%	0%	0%	N.A.	8.3%	5%	8.1%	5%	0%	0%	5%	9.3%	10.2%	---	N.A.	0%	10.3%	0%	
Other Prostatectomy		21.0	17.0	15.4	18.0	19.0	19.0	16.3	16.4	16.9	14.7	18.5	16.5	---	15.6	---	19.0	16.7	14.4	---	16.9
		11%	5.5%	0%	7.4%	N.A.	9.5%	0%	5%	5.6%	0%	8.0%	0%	---	0%	---	N.A	0%	0%	---	
D & C		4.7	3.4	2.6	---	3.8	3.3	2.7	4.5	3.5	3.1	4.5	5.5	---	---	---	3.8	3.8	2.5	---	3.7
		9.6%	0%	0%	---	N.A.	0%	0%	10%	0%	0%	8.2%	12.7%	---	---	---	N.A.	0%	0%	---	
Closed Reduction of Fracture Except Maxillofacial		12.2	18.5	6.9	12.7	17.1	25.0	11.4	15.5	17.5	---	18.5	14.0	12.3	11.2	6.7	17.1	14.5	13.9	---	14.3
		0%	8.4%	0%	0%	N.A.	10.1%	0%	6%	7.4%	---	8.0%	5%	0%	0%	0%	N.A.	5.8	0%	---	
Open Reduction of Fracture Except Maxillofacial		21.8	28.5	29.0	17.7	32.1	33.0	26.5	27.2	29.5	25.0	27.0	20.7	25.3	15.0	15.0	32.1	26.5	26.6	20.0	26.2
		0%	6.9%	7%	0%	N.A.	9.1%	5%	5%	7.5%	0%	6%	0%	0%	0%	0%	N.A.	5%	5%	0%	
Other Incisions, Excisions of Skin		10.3	13.1	11.9	12.2	14.3	13.7	14.2	16.0	10.7	17.0	14.5	9.1	11.9	14.0	7.0	14.3	10.6	19.5	12.4	13.8
		0%	0%	0%	0%	N.A.	0%	5%	8.6%	0%	6.6%	6.4%	0%	0%	5.4%	0%	N.A.	0%	10.1%	0%	

N.B.-All goals are for over 64 population, except D&C which is based on all ages

[Attachment 3]

PROFESSIONAL STANDARDS REVIEW
ORGANIZATION OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., November 20, 1978.

To: Hospital Advisory Committee.
From: Mark Rosenblatt, M.P.H.
Subject: Criteria and guidelines for carve-outs—Action necessary.

As discussed at the Hospital Advisory Committee Meeting of November 14, 1978, attached are the criteria and guidelines for carve outs. These criteria are to be implemented immediately since each hospital is required to identify separately medically necessary vs. unnecessary days on the Medicare and Medicaid bill. These criteria are to be utilized by the review staff to accomplish this end.

The Board of Directors has provisionally approved this policy.

Please contact your PSRO Senior Review Coordinator for details about billing logs and carve-out letters.

MARK ROSENBLATT.

PSRO OF QUEENS COUNTY, INC.—CARVE-OUT CRITERIA

Background

Public Law 92-603 clearly mandates local physicians, through their PSRO review systems, to make determinations as to whether hospital days of stay are or were medically necessary and appropriate before certification can be made for payment purposes under the Medicare/Medicaid programs. Medically unnecessary hospital days may occur at any point during an otherwise necessary hospitalization. Although a PSRO certifies the necessity for admission to a hospital, such admission (and continued stay) certifications assume that the period of the stay assigned by the PSRO will only cover days of stay which are medically necessary and appropriate at the acute level of care. PSROs, therefore, may not certify one or more days of stay during an otherwise certified period, if the(se) day(s) were not medically necessary and could reasonably have been avoided.

In the past year, PSRO of Queens County identified problems in various hospitals relating to medically unnecessary avoidable days which were being certified during the concurrent review process. The extent of this problem has been confirmed by the Medicare Fiscal Intermediaries (Blue Cross and Travelers Ins.) in their monitoring of PSRO performance during the past year and Queens County hospitals have been informed regarding these findings.

Carve-out review procedure

In the course of the concurrent review process, a nurse review coordinator may identify a specific day or group of days within a previously assigned length of stay period which appears to have been medically unnecessary and avoidable. The nurse review coordinator must refer this case to a Physician Adviser (PA). If the PA determines, based upon a review of the clinical record, that the day(s) in question were medically unnecessary and the avoidance of the(se) day(s) could reasonably be expected to have been within the control of the responsible physician of record and/or the hospital, an adverse determination should be rendered. In essence, the specific day(s) are "carved-out" from the patient's hospital stay. Such a denial should not be construed as affecting the entire hospitalization nor as a disapproval of an extension of the current stay.

Notification of "carve-out" instituted for medically unnecessary and avoidable days must be sent to the physician, hospital, and fiscal agent or intermediary. Since medically unnecessary and avoidable days fall within the responsibility of the physician or the hospital, the patient cannot be held financially liable for these days. Carve-out days must be documented on the appropriate Medicare billing sticker or Medicaid billing form. A copy of the "carve-out" letter should also be attached to the billing form(s), in the event there is insufficient space on forms for explanation of carve-outs.

Carve-out guidelines for physician advisers

In reviewing any questioned day or group of days, the Physician adviser (PA) must determine whether the period of time referred was medically necessary and appropriate and whether the delay was avoidable. To evaluate this type of situation, implicit rather than explicit criteria must be utilized. Existing criteria sets address

indications for admission and extension of the initial stay. Intervening circumstances are not reflected and therefore professional judgement is necessary.

When determining medical necessity and avoidability, the PA will evaluate the following in each case:

1. The overall status and condition of the individual patient.
2. The feasibility of having certain procedures or workups performed on an outpatient basis.
3. The extent and basis of any delays.
4. The appropriateness in scheduling the admission, diagnostic and/or therapeutic procedures.
5. The time period expended in obtaining test results, consultation, etc.
6. Documentation reflecting attempts to expedite the administration of items or services.
7. The need for an acute level of care during the specified time period.
8. The medical necessity for hospitalization for all days within referred periods.

The Physician Adviser (PA) must weigh all the attendant circumstances in arriving at a medical judgement that (1) the days in question are or were medically unnecessary or have a direct bearing on the quality of care rendered to the patient, and (2) the avoidance of these days could reasonably be expected to be within the control of the responsible physician of record and/or the hospital.

SCREENING CRITERIA FOR REVIEW COORDINATOR REFERRALS TO PHYSICIAN ADVISERS FOR POSSIBLE CARVE-OUTS WHEN LENGTH OF STAY IS INFLUENCED

(1) *Necessity for inpatient stay*

(a) Part of work-up could have been done as an out-patient.
(b) Part of treatment could have been done as an out-patient.

(2) *Inadequate preadmission scheduling*

(a) Delay in completing diagnostic work-up.
(b) Delay in booking operating room.
(c) Delay where surgeon in an elective case was not consulted by attending physician prior to admission, resulting in delays pre-op.

(3) *Physician management deficiencies*

(a) Delay in ordering tests.
(b) Delay in initiating active treatment in the presence of obvious signs and symptoms.
(c) Delay in obtaining medical clearance for surgery.
(d) Delay in M.D. responding to a request for consultation. (A response is expected within 24 hours unless unusual circumstances at time of request are documented).
(e) Lack of documentation by attending physician within 24 hours of admission.
(f) Lack of physician documentation during acute care stage.
(g) Delay in placing patient on alternate level of care.
(h) Placing patient at an inappropriate level of care, i.e.,—Medicare SNF when patient requires HRF.
(i) Delay in ordering discharge.

(4) *Hospital deficiencies*

(a) Delay in performing tests.
(1) It is expected that the following tests are performed within 24 hours of the physician's order. Routine blood work, Urinalysis, EKG, Chest x-ray, Type and X Match.
(2) Blood for Culture and Sensitivity and Blood Gases as per *specific* physicians' orders.
(3) Tests within 48 hours—EEG, EMG. Nuclear Medicine and Radiology except for emergency cases which are "state" ordered.
(b) Delay in providing other ancillary services, i.e., P.T. respiratory therapy. Start of therapy expected within one working day or less.
(c) Delay in obtaining test results.
(1) Definition of delay is left to physician adviser's judgment. Receipt of results is identified by results actually on chart or incorporation of results in M.D. progress notes.
(d) Delay in obtaining patient's or family's consent for surgery. (Consent should be obtained within 24 hours of scheduling of surgery.)
(e) Elective weekend admission with no commensurate services provided.

(5) *Social Service deficiencies*

(a) Delay in arranging transfer to post-hospital facility.

(b) Delay in arranging other post-hospital care i.e.,—home care, medical equipment.

(c) Lack of weekly documentation of adequate and aggressive placement attempts. No waiver regardless of waiver status.

[Attachment 4]

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., August 10, 1978.

To the Directors of Surgery:

GENTLEMEN: During the past few months the PSRO upon the advice of the National PSR Council and the concurrence of the Board of Directors, began to explore the possibilities of initiating a procedure justification process for specified elective surgical procedures.

Both the Hospital Review Committee (Queens Hospitals' UR Chairpersons) and the Hospital Advisory Committee (Queen's Hospital Administrators) requested that PSRO perform a retrospective study to investigate the *real* as opposed to *perceived* need for prior-to-admission surgical justification.

The Surgical Criteria Committee under the direction of Paul Spear, M.D., PSRO Medical Director, adopted 9 surgical criteria sets which are attached for your information (Attachment I).

Each hospital was instructed to go back retrospectively and review 25 charts for each of the procedures specified and review the admitting note, admitting history and physical and compare these notes against the stated criteria.

The results of this study as submitted by our hospital administrators are summarized below:

Procedure	Number	Percent meeting criteria	Number	Percent without criteria
Tonsillectomy and/or adenoidectomy	52	13	221	57
Abdominal hysterectomy	381	88	54	12
Hiatal hernia	6	40	9	60
Cholecystectomy	384	90	45	10
Menisectomy	119	42	163	58
Cataract removal	219	51	214	49
Vaginal hysterectomy	222	97	7	3
Lumbar disc excision	133	89	16	11
Dilatation and curettage	448	99	4	1

It was decided that any procedure which had a rate of 10% or greater without criteria would be considered for prior-to-admission documentation.

Based upon this study, vaginal hysterectomy and D&C would be exempt from pre-admission certification.

The sample size was too small to discern patterns of individual physicians. This will only come with time.

You may ask yourself why not utilize the existing admission certification process. There are many reasons, some of which are listed below:

1. Current criteria for elective surgery contain the criterion "schedule for operation." When a review is performed it is obvious that a procedure is scheduled hence the necessity for the surgery is affirmed by merely scheduling the procedure.

2. By removing the above criterion and reviewing the case after admission 2 possibilities may occur.

a. The pre-operative stay, allowable for one day without medical necessity for more time, would never allow the review process enough time.

b. After admission a patient is prepared to have the surgery. To inform the patient that the proposed procedure is unnecessary based upon physician documentation may lead to a very awkward encounter between patient and physician.

3. 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.

4. New York has continually blocked the successful implementation of full PSRO review. You are all familiar with the duplicative review system which hospitals have been subjected to.

In order for HEW to get New York State to agree to a binding memorandum of understanding with the PSRO a demonstration project will take place. Queens County is one of the targeted areas.

During the next 2 years the State and PSRO will compete with each other. The results will determine the future for physician peer review.

The initiation of this type of review should help us when the final evaluation is made.

We are of the belief that as experience is generated, large numbers of physicians will become exempt from prior-to-admission documentation. The State and HEW are committed along with PSRO to focusing attention on problem areas.

We ask for your cooperation and support during the implementation of this program.

Attachment II lists the proposed definitions for Emergency/Urgent Surgery and Elective Surgery. Your comments and suggestions are solicited. We are planning an implementation date of October 1, 1978.

We will be holding a meeting on Tuesday, September 12 at 2:30 P.M. at the PSRO office to discuss this very important matter. Your attendance is appreciated. Please return the attached reply sheet and indicate whether you will be attending this meeting (envelope provided).

Sincerely,

MARK ROSENBLATT, M.P.H.,
Executive Director.

PAUL W. SPEAR, M.D.,
Medical Director.

ATTACHMENT G

Subsequent to the initiation of pre-admission review for cataract surgery, the following results were obtained:

PREADMISSION CERTIFICATIONS RECEIVED AT PSRO

(Type: Cataract Extraction)

	Number approved	Number requiring P.A. referral	Number with more than 1 pre-op day
Hospital			
A	20	0	0
B	80	1	2
C	35	1	1
D	47	[1] 2	1
E	8	0	0
F	50	1	1
G	19	2	3
H	13	[2] 13	0
I	30	0	0
J	73	0	0
K	8	0	0
L	45	0	0
M	44	1	1
N	14	1	0
O	25	1	0
P	29	7	0
Q	16	2	1
R	24	1	2
S	7	2	0
Total	[3] 587	35	12

[1] Others referred because R.C. was on vacation.
[2] Most met criteria as written.
[3] Total approved; none denied. All met criteria.

[Attachment 5]

PROFESSIONAL STANDARDS REVIEW ORGANIZATION OF QUEENS COUNTY, INC.,
Forest Hills, N.Y. February 13, 1979.

Memo: PSROQC 79-16.
To: The Hospital Advisory Committee.
From: Mark Rosenblatt, M.P.H.
Subject: Weekend Elective Admissions.

The signed Medicaid MOU recently sent as a part of PSRO memo 79-9 provides for a weekend admission policy.

In order for elective admissions to be certified on Friday or Saturday the hospital must submit a list of the proposed conditions and commensurate services which are to be made available during the weekend for stated conditions.

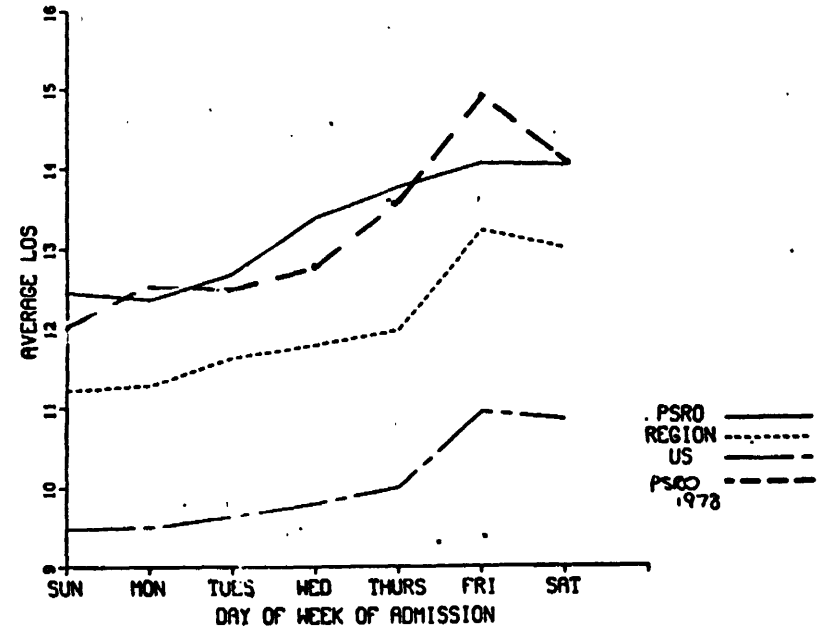
The State has a 30-day comment period after PSRO review of your proposed list.

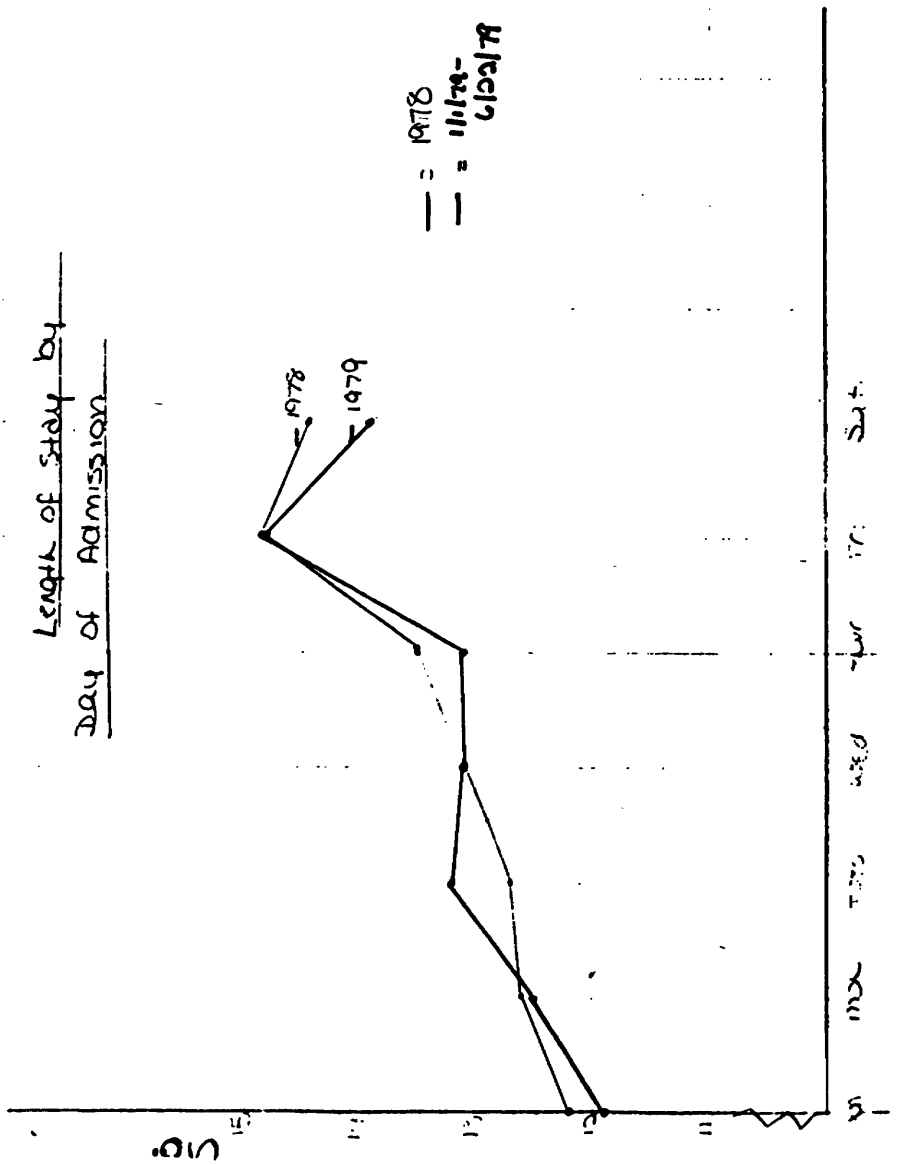
You are urged to submit such lists to the PSRO. In as much as formal notice is given by the inclusion of this provision in the MOU, no waiver or grace period can be extended for those cases electively admitted without an approved weekend policy.

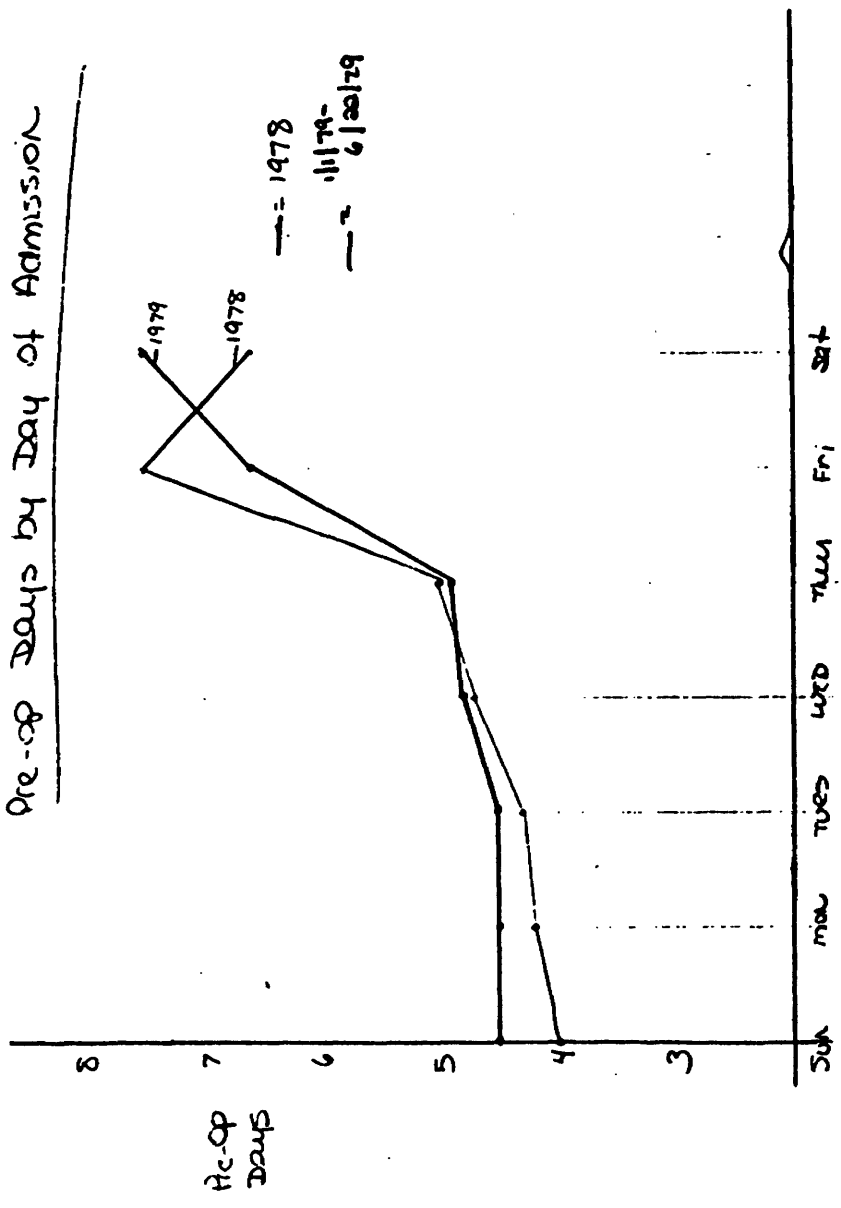
1976

FIGURE 3

Average Length of Stay by Day of the Week
of Admission for US, Region 02, and PSRO 33014







[Attachment 7]

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., May 18, 1979.

Memo: PSROQC 79-38.
To: Hospital Advisory Committee.
From: Mark Rosenblatt, M.P.H.
Subject: Alteration in Pre-Admission Surgical Review.

Pursuant to the request of the Hospital Advisory Committee, the Board resolution stated below was reviewed by a task force of the HAC.

(A) Elimination of cataract surgical review.

(B) Initiation of pre-admission notification for all elective surgical cases—

(1) If elective case is to be admitted without an O.R. booking for the next day, a pre-admission form is to be completed justifying the need for additional pre-op days.

(2) If case is to be admitted and surgery is confirmed for the next day, no forms must be filled out.

Exception:

(a) Physicians specifically placed on pre-admission review either by hospital or PSRO.

(b) The six elective procedures remaining from the original list: 1. Hiatal hernia; 2. Abdominal hysterectomy; 3. T.&A.; 4. Lumbar disc; 5. Meniscectomy; 6. Choloecystectomy.

After review, the task force approved the implementation of the above resolution. It was suggested that these changes be made for elective surgical admissions on or after July 1, 1979.

This leadtime will allow you to communicate with your surgical staff, Admitting and O.R. Departments. Your review depatments should take the lead in coordinating this effort.

The elimination of cataract review which represents the predominant share of pre-admission surgical review (80 percent) and the elimination of review for all elective surgery with one pre-op day will more than reduce the increases required to review additional pre-op days for elective surgery.

Attachment 8

Procedure Codes for Pre-operative Days for Selected Procedures

Procedure	ICD-9CM Procedure Code
Cataract Extraction	
intracapsular	13.11, 13.19
extracapsular	13.2, 13.3, 13.41, 13.42, 13.43, 15.51, 15.59
other cataract extraction	13.61, 13.62, 13.63, 13.64, 13.65, 13.66, 13.69
Tonsillectomy	28.2
Tonsillectomy with Adenoidectomy	28.3
Adenoidectomy	28.6
Vein Stripping	38.50 - .59
Hemorrhoidectomy	49.46
Cholecystectomy	51.21, 51.22
Inguinal Herniorraphy	
unilateral without prosthesis	53.00, 53.01, 53.02
unilateral with prosthesis	53.03, 53.04, 53.05
bilateral without prosthesis	53.10, 53.11, 53.12, 53.13
bilateral with prosthesis	53.14, 53.15, 53.16, 53.17
Hiatal Hernia Repair	
abdominal approach	53.7
thoracic approach	53.80, 53.81, 53.82
Prostatectomy, transurethral	60.2
Prostatectomy, suprapubic	60.3
Prostatectomy, retropubic	60.4
Abdominal Hysterectomy	
subtotal	68.3
total	68.4
radical	68.6
Vaginal Hysterectomy	68.5
radical	68.7
D & C	69.01, 69.02, 69.09
Dunionectomy	77.51, 77.52, 77.53, 77.54, 77.59
Lumbar Disc Excision	80.5
Meniscectomy	80.6
Cardiac Catheterization	37.21, 37.22, 37.23

Attachment 9
Attachment B

1/1/79 - 7/27/79
Procedure Goal Groups
LOS - Pre-op Analysis Areawide

Group Description	Group # 1979	Group # 1978	1979 to Date Cases	Ave LOS/Pre-op 1979	Ave LOS/Pre-op 1978	% Change LOS	% Change Pre-op LOS
Intracapsular Lens Extr.	525	424	401	4.6/1.3	5.0/1.4	-8.0%	-7.1%
Pacemaker Implant.	574	464	264	15.1/5.0	15.3/5.1	-1.3%	-2.0%
Colectomy	599	483	180	26.6/7.1	29.5/9.1	-9.8%	-22.0%
Cholecystectomy	616	497	193	18.9/5.5	19.0/6.3	-0.5%	-12.7%
Unilateral Hernia Repair	620	500	287	7.5/1.6	8.9/2.1	-8.0%	-23.8%
Incision, Excision Abdominal Wall	626, 627	505	82 no data	19.1/4.5	22.8/6.3	-16.2%	-28.6%
TUR Bladder	637	512	149	11.1/3.3	11.5/3.4	-3.5%	-2.9%
TURP	648	522	351	14.7/5.2	15.5/5.4	-5.2%	-3.7%
Other Prostatectomy	649	523	104	17.0/4.9	17.7/5.2	-4.0%	-5.8%
D & C	675	546	267	3.6/1.3	4.0/1.5	-10.0%	-13.3%
Closed Reduction of Fx	708, 711, 713	575	no data no data 119	10.4/1.6	13.9/1.9	N.A.	N.A.
Open Reduction of Fx	709, 710, 712	576	215 no data no data	33.6/4.7	27.5/4.2	N.A.	N.A.
Other Incision, Excision of Skin	747, 748	609	322 no data	13.9/4.0	13.3/4.2	-4.5%	-4.8%

1/1/79 - 7/27/79
Diagnosis Goal Groups
LOS Analysis Areawide

Group Description	Group No. 1979	Group No. 1978	1979 to Date Cases	1979 to Date Pt. Days	Ave. LOS 1979 LOS/Acute	Ave. LOS 1978	% Change
Heart Failure	149	135	1164	17,414	14.9/13.5	14.9	0%
Acute MI	140	130	810	12,665	15.6/15.1	16.2	-4.7%
Fx of Femur	351	306	399	11,267	28.2/22.7	28.9	-2.4%
Misc. CV Lesion w/Paralysis	155		200	4,160			
	159	140	42	751	21.5	23.8	-9.7%
	162		489	10,797			
Pneumonia	179	157	700	9,963	14.2/12.8	15.0	-5.3%
Misc. IHD	143		430	5,768	12.0/11.4	12.8	-6.2%
	142	132	417	4,438			
BPH	235	205	412	5,300	12.8/12.2	14.8	-13.5%
Ca III-Defined Sites	045	042	290	5,085	17.5/15.6	17.5	0%
Arrhythmia & Slowed Conduction	146		19	206			
	147	133	168	1,847	13.1/11.9	12.1	+8.3%
	148		343	4,884			
Ca of Colon	023	020	198	4,787	24.1/22.0	24.1	0%
Arterial Embolism	167	146	73	1,256	26.9	26.3	+2.2%
Gangrene	334		133	4,282			
Diabetes, Uncompl.	071	067	275	3,381	12.2/11.3	15.6	-21.8%
Misc. Disease of Intestine	207	188	154	2,306	14.2/12.8	15.7	-9.6%
	211		245	3,373			
Gallbladder Disease	215	191	208	3,147	14.5	15.1	-4.0%
	216		102	1,359			
Misc. CVD	163	141	116	2,177	18.8	18.4	+2.1%
(154, 158, 161 no cases)							

Additional Diagnoses That Relate To Procedure Goal Groups

Group Description	Group No. 1979	Group No. 1978	1979 to Date Cases	1979 to Date Pt. Days
Senile Cataract	124	116	454	2,902
Inguinal Hernia	200	183	289	1,867
Ca of Prostate	037	034	163	2,407
Total			8,293	127,789
% of Data to Date			34.1%	39.5%

[Attachment 10]

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., July 31, 1979.

To: Mark Rosenblatt, M.P.H.
From: Eileen Rothman, R.R.A.
Subject: Results of the concurrent monitoring for patients admitted with congestive heart failure to ———— Hospital.

A retrospective MCE study was performed at ———— Hospital by PSRO personnel and analyzed by PSRO physicians. The audit topic was Congestive Heart Failure. Analysis of the compliance to criteria indicates significant deviations without explanation. The large percentage of non-compliance with critical criteria resulted in an action plan which included, amongst other actions, a concurrent monitoring of criteria with physician intervention.

The criteria are Attached.

———— Hospital recently completed concurrent monitoring of all patients admitted with Congestive Heart Failure to assure that all physicians follow proper protocols. Twenty-five admissions from February 21, 1979 through May 8, 1979, with a total of thirteen attending physicians, were included in the monitoring process.

Overall, there is a pronounced improvement in the quality of care, as the results show. The following table details the comparison of results between the original audit and the follow-up study. (See Attached).

ELEMENTS	STANDARD	EXCEPTION	INSTRUCTIONS FOR DATA RETRIEVAL
1. Justification for Diagnosis (one or more of the following)	100%	None	
a) Positive chest x-ray			a) Positive chest x-ray = pulmonary venous congestion, pulmonary edema or congestiv failure
OR			
b) Positive physical findings of gallop rhythm, or venous hypertension or edema or enlarged heart.			
c) Clinical improvement following digitalis or diuretics.			c) Must be in association with a or b.
2. Justification for Admission (one or more of the following)	100%	None	2. See history, physical exam, or admittin note
a) Diagnosis or suspicion of pulmonary edema			
b) Patient unresponsive to out-patient therapy			b) See history for documentation of persistent or recurrent symptoms of dyspnea, weakness, edema
3. Justification for Special Procedure			3. Rapid single dose of digoxin (or equivalent) ≥ 0.5mg I.V.
3a. Rapid intravenous digitalization	0%	3a) Acute pulmonary edema in patient not taking digitalis within the previous week	3a. See history, physical exam, progress notes, or orders
Critical Processes:			
4. Complete history & physical examination within 24 hours of admission	100%	Acute pulmonary edema - no rectal or pelvic exam	4. Should include a comprehensive description of all findings including those that are negative.

ELEMENTS	STANDARD	EXCEPTION	INSTRUCTIONS FOR DATA RETRIEVAL
6.			
4. EKG within 24 hours of admission	100%	None	
5. Chest x-ray within 24 hours of admission	100%	None	
7. Serum electrolytes within 24 hours of admission	100%	None	
8. BUN within 24 hours of admission	100%	None	
9. Daily weight ordered and recorded	100%	None	9. See order sheet, progress or nurses notes
10. Daily record of fluid balance	100%	None	
11. Low salt diet	100%	None	11. See order sheet
12. Diuretics	100%	None	12. Diuretics: Lasix, furosimide order sheet, medication record
13. Digitalis	100%	13a) digitalis toxicity b) acute M.I.	13. See order sheet, medication record
14. Morphine	0%	14a) patients with acute pulmonary edema	14. See order sheet, medication record
15. Patient or SO demonstrates knowledge of: a) Diet b) Discharge medication c) Symptoms requiring medical attention d) Medical follow-up	100%	None	15. Documentation in progress notes, nurses' notes or discharge summary.
16. Mortality	0%	None	16. Committee to review all deaths

No.	ELEMENTS	STANDARD	EXCEPTION	INSTRUCTIONS FOR DATA RETRIEVAL
	Generic Criteria			
17.	Prior admission to this hospital within 6 months for cardiac-related problems	0%	None	17. Report dates, record numbers, final diagnosis, procedures performed
18.	Subsequent admission to this hospital for cardiac-related problems or complications of procedures	0%	None	18. Report dates, record numbers, diagnoses, procedures
	Complications			Committee to review all complications
19.	Pulmonary embolism	0%		19. X-ray or lung scan consistent with pulmonary embolism
20.	Renal failure	0%		20. Serum creatinine $\geq$ 1.6mg%
21.	Electrolyte disturbance	0%		21. Refer to lab sheets for abnormal values
22.	Digitalis intoxication	0%		22. Intoxication: EKG report of digitalis intoxication or toxicity or digoxin level $\geq$ 2.5mg% (not digitalis effect)
23.	Other complications	0%		

PSRO of Q.C.
7/78

53-461 O - 79 - 28

Concurrent Monitoring
_____ Hospital

Criteria #	Original Study # of Charts Meeting Criteria	%	Follow-up Study # of Charts Meeting Criteria	%
1	50	100	25	100
2	49	98	25	100
3	50	100	25	100
*4	12	24	25	100
*5	40	80	24	96
*6	36	72	24	96
*7	44	88	25	100
*8	40	80	24	100
*9	6	12	23	92
*10	32	64	23	92
11	48	96	22	88
12	50	100	24	96
13	49	98	25	100
14	49	98	25	100
*15	16	32	25	100
*16	10 Deaths 4 of which were questionable		No Deaths	

17 & 18 - Eliminated from study

Complications

Criteria #	Original Study # Complications	%	# Not Meeting Critical Mgmt.	Follow-up Study # Complications	%	# Not Meeting Critical Mgmt.
19	5	10	1	1	4	0
20	15	30	3	4	16	0
2.	15	30	5	5	20	0
**	33	66	3	0	0	0
				4	16	0

*Indicates a marked improvement in compliance with the criteria.

A retrospective restudy will be conducted in four months.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., September 7, 1979.

To: Mark Rosenblatt, M.P.H.
From: Lawrence Adler, R.R.A.
Subject: Results of concurrent monitoring for patients admitted with congestive heart failure to hospital.

Hospital recently completed their required concurrent monitoring to ensure compliance with proper protocols for the treatment of Congestive Heart Failure. Between the period from 2/1/79 to 5/31/79, 27 cases with an admission diagnosis or secondary diagnosis of Congestive Heart Failure were reviewed against the predetermined criterion used in the orginal audit. Five hospital physician advisors analyzed the attached results.

The overall results indicate a pronounced improvement in every facet of Congestive Heart Failure treatment, although some problems remain. The following table provides a comparison of compliance rates per criterion between the original audit and follow-up study. (See Attachment I).

This is followed by the hospital's case by cases deficiency analysis and further plans for corrective action concerning lingering problems.

Attachments.

Attachment 1

Comparative Criterion Compliance Display
Between Original Study and Reaudit

Criterion	Original Study (n = 50) # Charts Meeting	%	Follow-up (n = 27) # Charts Meeting	%	Net % Improvement (+) Regression (-)
1. Dx Justification	46	92	27	100	+8
2. Adm. Justification	44	88	27	100	+12
3. Rapid Intravenous Dig.	48	96	27	100	+4
4. Complete H & P	9	18	22	81	+63
5. EKG	49	98	27	100	+2
6. Chest x-ray	43	86	27	100	+14
7. Electrolytes	45	90	27	100	+10
8. BUN	45	90	27	100	+10
9. Daily wts.	2	4	16	59	+55
10. Fluid balance record	16	32	16	59	+27
11. Low salt diet	44	88	26	96	+8
12. Diuretics	47	94	26	96	+2
13. Digitalis	42	84	25	93	+9
14. Morphine	48	96	27	100	+4
15. Patient knowledge	10	20	27	100	+80
16. Justified Mortality	3/6	50	2/2	100	+50
17, 18 - Eliminated from study Complications appropriately managed over total no. occurring.					
19. Pulmonary Embolism	1/1	100	4/4	100	0
20. Renal Failure	8/15	53	9/9	100	+47
21. Electrolyte Disturbance	3/11	27	10/10	100	+63
22. Digitalis Intoxication	11/11	100	3/3	100	0
23. Other Complications	20/34	59	17/23	74	+15

[Attachment 11]

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., February 15, 1979.

DEAR DR. ———: I am transmitting to you a copy of a recent review of some of your cases conducted by Dr. ———, Chief of the Division of Cardiology at ——— Medical Center.

Because of what our review coordinator and I have considered excessive lengths of stay in some of your cases, we wished to have an opinion from a recognized specialist in Cardiology.

I think you will agree that Dr. ——— fills this bill very adequately. He is a Diplomate of the American Board of Internal Medicine, as well as being certified in the sub-specialty of Cardiology and has a considerable reputation as a Cardiologist.

We hope you will recognize the need to monitor length of stay in your patients, as well as those referred to you by other members of your staff. In addition, the quality of care issues raised in the report need to be responded to.

We expect to continue to monitor your cases carefully and see a definitive improvement within 30 days. Unless there is evidence of adherence to accepted norms of stay or justification for exceeding these norms, we will proceed to carve out days and withdraw your hospital's Waiver of Liability so that the hospital will not be paid.

If you have any questions about this, I will be pleased to discuss them with you. The PSRO of Queens County is willing and anxious to offer you any assistance it can in resolving these problems.

Sincerely yours,

PAUL W. SPEAR, M.D.,
Medical Director.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., April 4, 1979.

DEAR DR. ———: This letter is intended to put on record our conversation of April 3, 1979.

In response to a number of chart reviews by our Senior Utilization Review Coordinators at both ——— Hospital and ——— Hospital, questions arose about: (1) the quality of care rendered by you (2) inappropriate lengths of stay and, (3) inappropriate hospital admissions. You are given the opportunity to review all the charts in question.

As a result of our meeting together, we agreed that: (1) you would undertake to carefully document the need for hospital admission by providing a thorough history and physical examination, (where this has not been done by a "house" physician), (2) you would write daily (where indicated meaningful progress notes which will describe the status of the patient, including your thinking, diagnostic problems and therapeutic plans, and (3) timely discharge of patients or where appropriate, assigning patients to a lesser level of care so that social service may find an appropriate bed.

I hope you will institute these steps promptly. We will, within the next two months, contine to monitor your records. If the hope for improvement occurs, it will not be necessary to involve sanctions provided by the Department of HEW which would result in your not receiving payment from the Federal Government for Medicare and Medicaid patients.

Sincerely,

PAUL W. SPEAR, M.D.,
Medical Director.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., August 9, 1979.

DEAR DR. ———: This will confirm our meeting of today at which we discussed the problems resulting from prior reviews of your case records at ——— Hospital.

It now appears that the chief problem is failure to document in sufficient detail the reasons for admitting patients to the hospital. Had this been done in all the instances we cited, there would have been no reason to question the admissions.

There were no serious disagreements about the quality of care rendered by you and recorded in the chart. We agreed that blood transfusions should not be given to patients whose hematocrits are above 30% unless careful monitoring shows evidence

of rapid blood loss, (tachycardia, hypotension, syncope) prior to the time required for hemodilution with a fall in the hematocrit to occur.

Your progress notes should document the reasons for doing diagnostic studies as well as documenting the day-to-day status of the patient.

Thank you for your cooperative attitude.

Sincerely yours,

PAUL W. SPEAR, M.D.,
Medical Director.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., August 9, 1979.

DEAR DR. ———: Dr. ——— has recently referred a chart on your patient, ———, to me because she questioned the necessity for admitting this patient to ——— Hospital for a diagnostic work-up. She also tells me she has had other similar problems involving your patients.

It is not sufficient to write as you did, "L.U.Q. pains and nausea too severe for out-patient work-up". You must document in more detail why she could not have the necessary tests done outside the hospital. For example, inability to walk, or extreme weakness or continuous pain requiring drug therapy, none of which is evident in your patient.

It will be necessary to require preadmission review of your elective admissions to the hospital if this pattern continues. I hope you understand the constrictions we are now under which mandate containment of medical costs and which make it unacceptable to use hospitalization merely because it is more convenient for the doctor and/or the patient.

Sincerely yours,

PAUL W. SPEAR, M.D.,
Medical Director.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.,
Forest Hills, N.Y., May 10, 1979.

DEAR DR. ———: I have reviewed a number of records of patients you have treated at ——— Hospital. As a result of this inquiry, some questions have arisen regarding utilization of hospital facilities and the quality of care rendered.

I would like to discuss these problems with you. If you call my office, we can arrange a time that is mutually agreeable.

Meanwhile, the following is a list of the charts I have reviewed with my comments:

Chart No. —— A 67 year old female admitted with pancreatitis. This record presents little difficulty except for non-informative progress notes.

Chart No. —— A 70 year old female admitted with gallbladder disease. The work-up took eight days, which seems excessive. Erythromycin was given without any explanation for its use.

No second opinion was requested regarding elective cholecystectomy (surgery not performed).

Chart No. —— A 39 year old woman admitted for D & C. This procedure warrants a one day stay, not two.

Chart No. —— A 61 year old man admitted with a left testicular mass. It took five pre-operative days to do work-up, which could have been done as an out-patient. The presence of a nodule on the chart was never explained. Hernia repair done without consent.

There is no clear discussion of the diagnostic problem and the therapeutic plan.

Chart No. —— A 68 year old man with a tumor of the left breast. There was no pre-operative effort to rule out metastatic, so two day pre-op stay was not justified. He received a transfusion when his hematocrit was 43 percent. This is inappropriate.

Chart No. —— A 70 year old woman with a seizure disorder. It took five days to get a neurosurgical consultation. Actually, a neurologist should have seen patient. E.E.G. requested on February 24, 1979 but not reported and no evidence of it was ever done. Length of stay with excessive.

Chart No. —— A 75 year old woman with a pelvic mass and rectal bleeding. Notes are illegible. The admission note is inadequate. If bleeding occurred, why is the hematocrit 41 and 45 percent.

Stools not examined for occult blood. Hypovolemic shock does not result from preparation for barium enema.

Chart No. —— A 78 year old woman admitted for removal of a nodule (metastatic) from chest wall. I don't understand why it was necessary to remove this nodule in a woman with known metastatic disease.

Chart No. —— A 49 year old woman with thrombophlebitis. Why was she on prednisone? Not a treatment for thrombophlebitis or emphysema. Admission to hospital may not be justified.

Chart No. —— A 83 year old woman with metastatic cancer. After March 5, 1979, she should have been placed on alternate level of care.

Chart No. —— A 66 year old woman admitted with vaginal bleeding. There are two progress notes, and an O.R. note. Both are scanty and illegible. No post discharge plan indicated.

Chart No. —— A 75 year old woman admitted for D & C. There is no documentation of the reason for admission. Previous Pap smear not reported.

Chart No. —— A 80 year old woman with a strangulated hernia. Progress notes are poor. Patient should have been placed on alternate level of care on February 4, 1979.

Chart No. —— A 72 year old male admitted for closure of colostomy. Three days of the pre-op stay were unjustified. Progress notes are inadequate.

In summary, it seems your admission notes are much too brief and fail to give plans of diagnosis, treatment and follow-up.

Your progress notes are not informative and there are unnecessary delays in discharge.

Sincerely,

PAUL W. SPEAR, M.D.,
Medical Director.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION
OF QUEENS COUNTY, INC.
Forest Hills, N.Y., May 31, 1979.

DEAR DR. ———: This is to confirm our conversation of May 29, 1979, relative to the problems raised in the review of your case records.

1. Where there is any question of appropriateness of hospital admission, you should consult the specific criteria published by the Queens County PSRO and available in the U.R. office at ——— Hospital. Also, Dr. ———, our physician advisor, will be glad to advise you. In general, it is not appropriate to hospitalize patients for work-ups which can be accomplished on an out-patient basis.

2. You should document in the hospital record the reasons for performing various tests, (laboratory, x-ray, etc.), which are not obvious. Unnecessary tests must be eliminated.

3. The initial history and physical examination, whether done by you or a house physician, should be complete and daily progress notes should make it perfectly clear what is happening to the patient. Information of relevance which is contained in your office records should be incorporated in the hospital record.

If you have any questions involving your Medicare and Medicaid patients, please feel free to consult with Dr. ———. She is thoroughly informed concerning all our policies, as well as being a very competent practitioner.

It is our responsibility under Federal mandate to contain the costs of medical care, as well as to guarantee that the quality of care is maintained at a satisfactory level.

We are anxious to help you in any way we can to meet these goals in your own practice. We will review your records again after a suitable interval.

I appreciate your cooperation.

Sincerely yours,

PAUL W. SPEAR, M.D.,
Medical Director.

———

FORTUNA, CALIF., *September 12, 1979.*

Re PSRO Program and Financing.

Mr. MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: As a physician committed to the PSRO Program, I would like to make some pertinent comments, about the Program and its future. By way of introduction I am the past president of the Redwood Coast PSRO, current vice president and chairman of the data committee. We have an active aggressive board of directors, and one of the finest staff support systems in the PSRO Program. We are just beginning the job intended for us. My comments follow:

Currently it is argued that PSRO's are not cost effective. This may be true for many PSRO's, however even including those PSRO's in the total picture, the PSRO Program is at least a cost trade-off, with supplemental attributes. I list these for you:

1. With time and "persuation by performance", the PSRO Program will be a potent, effective, professional tool. It will exceed its current value to both the medical profession and society. The PSRO Program will require careful planning, nourishment, longevity and persistence by those of us willing to perform the needed transition.

2. PSRO's are currently learing to "crawl", and will require many expensive and incorrect attempts to define and execute its proper functions during its maturation. It is a "new science" worth preserving.

3. PSRO's are not of proven value to either the medical profession or its financial benefactor. It will take perseverance to scientifically establish the value to both. Then there will be no problem in gaining professional and financial support in our society.

4. PSRO's are collecting data (some very high in quality). This data is collected by observation, experience and experiment. This data must be organized, reproducible, and verifiable withstanding the rigors of the scientific method. Such data will lead to the new laws of the science of PSRO's. These new guidelines will help define that intangible but always sought after, elusive "OPTIMUM MEDICAL CARE". Optimum medical care is defined as "high quality of medical care at a reasonable cost" to society.

5. Professional acceptance will come through understanding the value of the tools provided by PSRO's. Proper experience, experiment and observation will win over the critics and devisive forces in medical practice. However mismanagement and improper funding could jepardize the entire PSRO objective. Dehumanizing and avoiding the educational approach will further hinder its natural evolution, acceptance, and full value.

In summary, multiple factors will be responsible for the success of the PSRO concept. Adequate funding is an obvious requisite, however the means by which PSRO's operate is equally important to whether PSRO's are right or wrong philosophically. The value to society will ultimately be demonstrated!

Sincerely,

GEORGE A. JUTILA, M.D.

TESTIMONY OF THE UNION OF AMERICAN PHYSICIANS AND DENTISTS

The Union of American Physicians and Dentists is a labor organization of over 23,000 doctors of medicine and dentistry, that is dedicated to preserving the highest standards of health care through representing the interests, not only of doctors, but of their patients.

We are familiar with the letter and the intent of the enabling legislation that created the PSRO's, and with much of their intervening history. We have had an ongoing regret that many of the difficulties encountered in the operation of these organizations might have been avoided, had two basic modifications been included at the onset.

First of all, it was my original proposal to Congress that these organizations be named "Cost Control Review Organizations"; as any pretense that they had anything to do with professional excellence is a denial of the original purpose for which they were created. Ample safeguards exist within the licensing and regulatory functions of the individual states to cull out the small percentage of inadequate, incompetent, or inappropriate treatment.

From that starting point of intellectual honesty it becomes infinitely simpler for all parties to direct their efforts; either to making the PSRO's (now to be named CCRO's), perform in the manner for which they were intended, or to oppose them frontally as a matter of conscience.

As it now stands, the PSRO's create a hodge-podge of misunderstanding, misdirected effort, and outright deception; mainly because of their title, which wraps their real purpose in a sanctimonious cloak of "improving professional standards". This is analogous to concealing the substantive nature of an issue by hiding it behind motherhood, the flag, and compassion for the downtrodden. Let these organizations, then, henceforth be known as "Cost Control Review Organizations".

Second, we believe that the inclusion of physicians on these CCRO's forces the doctors into a hopeless dilemma, at least; and into a moral conflict of interest that doubly negates their effectiveness, both as healers of the sick and as cost-controllers. We propose, therefore, that all physicians be excluded from the panels of these CCRO's, as the increasing compromises they will be forced to make will rob the

program of its real intent—to provide the cheapest possible health care commensurate with acceptance by the electorate.

It is a violation of a doctor's oath to ask him to choose his therapy on the basis of cheapness, rather than on the basis of his conscience and expertise. If it pleases Congress to assume that all doctors are tainted and self-serving, you may henceforth assume that doctors will always choose the most expensive procedures and therapy, rather than exercising their good judgment, in cases where reasonable options exist.

It is a prior and over-riding obligation of a doctor of medicine to serve his patient first. In these times of runaway inflation and of exploding technology, however, it is manifestly unfair to ask the doctor to be the gate-keeper or rationer of health care. You should simply assume that he will over-diagnose, over-prescribe, and over-treat—and it is my fervent wish that each member of this committee may have such a doctor as his personal physician!

It is one thing to be a taxpayer, insurance premium payer, or just a concerned citizen. But all of these, at one time or another, are converted involuntarily into being patients. It is at such a time that it becomes totally clear to the sick patient that healthy people can never make decisions regarding limitation of medical care to the sick.

In conclusion, we appreciate and stand in awe of the task you are undertaking. Our recommendations are only two in number, and they are simple and free of cost or need for supplemental appropriation:

1. That the designation of "Professional Standards Review Organizations" be changed forthwith to "Cost Control Review Organizations".
2. That physicians be excluded from participation in such organizations.

We envision, as a Union of doctors; the development of an interface of collective bargaining, between the CCRO's on the one hand, and a Physician-Patient Union on the other. The CCRO would perform properly if it lived up to its charter to reduce health care costs, commensurate with the avoidance of malpractice-through-omission, or rebellion by the citizenry. The Doctors' Union, representing also the patients whose lives, health, and peace of mind were concerned, would fight for "damn-the-expense" health care in every case.

It is our hope when you or I or our loved ones get sick, that the doctors shall prevail in the bargaining.

Respectfully submitted,

SANFORD A. MARCUS, M.D.,
President.

NATIONAL LUTHERAN HOME FOR THE AGED,
Washington, D.C., October 1, 1979.

Mr. DENNIS SEIBERT,
Director, Office of Professional Standards Review Organizations,
Baltimore, Md.

DEAR MR. SEIBERT: In January, 1978, six elderly women at The National Lutheran Home were denied intermediate care Medicaid benefits by the National Capital Medical Foundation (NCMF) acting in its capacity as the Professional Standards Review Organization (PSRO) for the District of Columbia. To the best of my knowledge these six cases have been the first intermediate denials nationally that have been appealed through the PSRO reconsideration process. As such, it is important for you to know how this time-consuming, expensive process has functioned.

1. On January 11, 1978, it was determined by the PSRO that the six patients did not have a medical need for intermediate care. According to PSRO guidelines, the patients' attending physician should have had an opportunity to discuss the six cases with the physician advisor who denied them benefits. This was not done.
2. The six denials were appealed to the NCMF/PSRO for reconsideration immediately. The three physician reconsideration team upheld all six denials. One of the physicians on the reconsideration team was the President of the NCMF.
3. The Home then appealed the six cases to the Secretary of the Department of Health, Education and Welfare, as instructed in the NCMF/PSRO guidelines. This reconsideration hearing was not held until August 23, 1978. On that date an Administrative Law Judge (ALJ) heard the hearings.
4. In January, 1979, the Home received the ALJ's decisions. The ALJ ordered three of the patients to be reinstated as intermediate Medicaid patients because their conditions medically warranted intermediate care. The ALJ ordered the other three patients to be reinstated because the NCMF/PSRO did not follow its own procedures in denying them Medicaid benefits.
5. The ALJ's decisions were reviewed by the Social Security Administration (SSA) before becoming final. On March 23, 1979, the SSA ordered the three residents who

the ALJ identified as medically requiring intermediate care to be reinstated as intermediate Medicaid patients. The SSA overturned the ALJ's decision regarding the three patients who were denied when NCMF/PSRO neglected to follow its own procedures.

6. The SSA's decision regarding the three women who medically required intermediate care stated that the Home was to "do nothing" and the SSA would see to it that their beneifts were reinstated. (Meanwhile the Home has been without Medicaid reimbursement for all six patients for over fourteen months.)

It was not until August 1979 that a directive finally came to the NCMF/PSRO from the Office of PSRO to retroactively reinstate the three women back to January 11, 1978. This directive came solely on the Home's initiative. The PSRO had no system by which to enact the SSA's decision. It was only after countless phone calls and letters from the Home that a directive was finally provided.

In September, 1979, one month after the directive was sent, the NCMF/PSRO finally acted by denying the three patients intermediate care again, effective the date of the SSA decision. As it turned out, the PSRO had been certifying one of the three women as needing intermediate care since February 1979, so that particular denial had to be withdrawn. The Home appealed to other two denials and is still awaiting a decision from the NCMF/PSRO reconsideration team as of this date.

7. The SSA's decision regarding the denial of reinstatement to three patients even though the NCMF/PSRO did not follow its own procedures in denying them benefits, has been appealed to the next level of the reconsideration ladder, U.S. District Court. It will probably be months, if not years, before their decision is concluded. Meanwhile the Home continues to be without Medicaid reimbursement for these three patients since January 1978.

The purpose of this letter is to point out the problems with PSRO reconsideration procedures. I do appreciate the fact that a reconsideration process is available.

In summation, my greatest areas of concern regarding the PSRO reconsideration process are:

1. "Medical necessity" is too narrowly defined with regard to intermediate care Medicare patients. In the opinion of many professionals in long-term care, medical necessity implies not only purely physical needs, but also psychological, emotional and social needs.

2. The reconsideration process is too lengthy. The Home waited nineteen months before the ALJ's decision was reached and enacted.

3. There is no procedure whereby the SSA's decision is directed to the PSRO and thus enacted.

4. Due to the lengthy reconsideration process, three indigent, elderly patients had to wait nineteen months to learn whether or not their stay at the Home would be reimbursed by Medicaid. The other three residents will have to wait a minimum of two years to learn whether or not their care will be reimbursed.

I offer this analysis of my experience with the PSRO reconsideration process in the hope that constructive efforts can be made to make the system work for indigent Medicaid patients and not against them. The reconsideration process is set up in such a manner that an elderly, indigent person could never go through the appeal process without expensive legal assistance or the emotional and financial support of a facility, such as The Lutheran Home.

Sincerely,

TIMOTHY V. COTZ,
Assistant Director/Administrator.

STATEMENT OF JOANNE E. FINELY, M.D., M.P.H., COMMISSIONER OF HEALTH, NEW JERSEY STATE DEPARTMENT OF HEALTH

HOSPITAL RATESETTING AND QUALITY ASSURANCE IN NEW JERSEY

In New Jersey we are deep into a 57-month HCFA Contract to implement A Prospective Reimbursement System Based on Patient Case-Mix for New Jersey Hospitals 1976-1983. The New Jersey State Department of Health is applying an innovative reimbursement rate-setting system which:

(a) recognizes the need for appropriate financial support of hospital care if of demonstrably good quality, and

(b) promotes an essential dialogue between medical staff and administration so important for the creative management of services and resources in the best interests of the patient-consumer.

The most unique characteristic of this rate-setting system is the reimbursement of costs on a per case basis as opposed to the traditional per diem method. Such an approach is achieved through the use of Diagnosis Related Groups (medically mean-

ingful and statistically defined groups of admitted patients displaying consistent patterns of hospital resources use). Payment is based upon "cost standards" established on a Diagnosis Related Group basis for comparable kinds of hospitals. Hence, hospitals whose patient care costs fall below cost standards will derive the benefit of retaining a portion of the difference as an incentive. This serves as an innovative response to administration and industry criticism that hospitals are often left to struggle with rate-setting policies which lack incentive-based payment.

However, the New Jersey Department of Health is also concerned that industry responses to the incentive system not encouraged diminished quality in the care provided. For example, hospitals could reduce costs in order to capture greater portions of the incentive payment, or even increase the number of admissions if they provide "efficient" services. Given the potential for such mismanagement, the system we are beginning must possess not only the means of measuring and assessing quality, but the capacity to integrate these measurements into ongoing assurance and peer review programs such as the PSROs.

To this end, the Commissioner of Health with the aid of the State's PSROs, Professional Societies, and the College of Medicine and Dentistry of New Jersey, established a Physician Advisory Committee. This is a panel of experts including PSRO active physicians and representing those medical disciplines responsible for the care of a majority of admissions to New Jersey hospitals. This group was convened during 1977 and 1978 to recommend minimal quality criteria and standards for 30 high-volume (as to numbers of admission) Diagnosis Related Groups which account for approximately 50 percent of all admissions to New Jersey hospitals. These quality criteria were largely available in the data base established to derive the Diagnosis Related Group payment rates.[1] The measures are designed to provide a means of assessing institutional performance, thereby furnishing a crucial link between appropriate care processes and service resource consumption. Hence, the reimbursement system possesses the capacity to provide reasonable financial support for quality care.

The Department of Health and its allied Hospital Rate-Setting Commission advocate the partnership of PSROs and physicians into the development and use of a reimbursement system that does make it possible to measure quality as well as legitimate costs incurred by hospitals. The integrated process of PSRO quality assurance and Diagnosis Related Group based institutional quality assessment assures that incentives payments are made to achieve high quality and reasonable cost.

The Department of Health operates a reimbursement system which also furnishes a powerful financial management information system with a capacity to profile institutional case-mix, volume, quality, and costs related to the actual kinds of care needed by the patients being served. Given this system's capability, the Hospital Rate-Setting Commission will be in a position to interpret the integrity of any institution's performance against a standard for a given Diagnosis Related Group or any set of Diagnosis Related Groups.

The integration of statewide PSRO activities with Diagnosis Related Group payment will considerably enhance the ability of the Rate-Setting Commission to address matters of quality, efficiency and effectiveness. PSROs maintain first-hand knowledge of the practice setting through routine utilization reviewed. For example, PSRO admission certification provides a critical mechanism for screening unnecessary admissions, thereby furnishing a "volume check." PSRO concurrent review can serve to maintain appropriate lengths of stay for inpatients, but also identify the patients whose longer stays may reflect delays due to such social problems as finding placement in long-term care facilities. PSROs are capable of providing the important certification of principal and major diagnoses and procedures so necessary for the correct assignment of patients into Diagnosis Related Groups.

In addition to these on-going review and certification activities, PSROs will serve an essential advisory role to the Hospital Rate-Setting Commission sitting in its capacity as a hearer of appeals of rate bases. For example, PSRO monitoring systems allow the identification of medical practices which could significantly affect lengths of stay and patient outcomes. If a given institution's costs exceed standards, but its program of care promotes high quality, then the PSRO could review these assertions and recommend modifications to the schedule of rates.

In short, a unique opportunity exists in New Jersey to develop a truly powerful hospital rate-setting system which promotes high quality at reasonable cost, and which has forged a partnership with the process of physician peer review and PSRO quality assurance activities. PSRO effectiveness in performing the aforementioned

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[1] New Jersey has required all hospitals to submit their patient discharge abstracts on all admissions, since January 1976.

activities cannot be assessed at the present. However, the New Jersey Department of Health sincerely believes that such an integration will assure the success of a reimbursement system which both relies upon and promotes real physician involvement in influencing the management of hospital resources and costs.

STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists is a medical specialty society representing approximately 20,000 physicians and 15,000 nurses who provide specialty care in gynecology and obstetrics. One of the ten continuing goals of this organization is "the assurance that adequate obstetrical-gynecological care is available to all women, through, (a) solutions to the problems of maldistribution of personnel and facilities, and (b) reductions in health care costs by the more efficient utilization of personnel and facilities."

Consistent with the organization's concern for efficient utilization of health care resources, the ACOG Maternal Health Policy stresses that "The quality of care, its availability and its cost-benefit effectiveness should be continually assessed. The active ongoing evaluation of a program is the best assurance that the health care resources are utilized wisely." The American College of Obstetricians and Gynecologists has consistently supported the concept and activities of the Professional Standards Review Organizations throughout the United States; in the past decade, ACOG committees have produced and published several documents to assist in peer review activities.

In 1972, the Senate Finance Committee reported the Professional Standards Review section of the Social Security Act amendments with the following language:

> A PSRO would have the responsibility of determining—for purposes of eligibility for medicare and medicaid reimbursement—whether care and services provided were: first, medically necessary, and second, provided in accordance with professional standards. Additionally, the PSRO where medically appropriate, would encourage the attending physician to utilize less costly alternative sites and modes of treatment. The PSRO would not be involved with questions concerning the reasonableness of charges or costs or methods of payment nor would it be concerned with internal questions relating to matters of managerial efficiency in hospitals or nursing homes except to the extent that such questions substantially affect patterns of utilization. The PSRO's responsibilities are confined to evaluating the appropriateness of medical determinations so that medicare and medicaid payments will be made only for medically necessary services which are provided in accordance with professional standards of care.

Peer review is essential to the assurance of quality medical care in measuring efficiency of particular modalities and settings for care. It is that element of the PSRO program which attracts the support of ACOG. Only through professional review of resource utilization can we assure that medical determinations are appropriate to the patient and his or her unique needs.

The primary consideration offered by the American College of Obstetricians and Gynecologists in this statement is that Professional Standards Review Organizations must be viewed not only in the context of a program designed to reduce cost of medical care, but also as a quality assurance mechanism. To place considerations of economy ahead of standards for quality care would be an alternative which this organization considers professionally inconceivable and publicly irresponsible.

The ACOG urges the Subcommittee to bear in mind the significance of a formal, professional program to monitor expenditures of federal funds. It is important to measure all factors bearing upon decisions to utilize limited and/or high cost health care resources. Because cost is but one of many medical considerations involved in directing one or another manner of treatment, the American College of Obstetricians and Gynecologists wishes to emphasize the physician must not only have a participatory role in the PSRO program but also must support its aims and objectives.

Professional Standards Review Organizations can and will enjoy such support, cooperation, and participation of physicians when it is demonstrated by the Congress and the Department of Health, Education & Welfare that the purpose of PSRO's remains as originally described by the Finance Committee: "determining . . . whether care and services provided were: first, medically necessary, and second, provided in accordance with professional standards." The ACOG is optimistic that this Subcommittee will endorse that original statement by its actions in the future.

The PSRO program-designed in part to encourage effectiveness and better utilization of limited resources—must set an example in its performance. If the PSRO program cannot carry out its charge efficiently, it should be revised to accomplish

that end; if it is determined that peer review of professional activities cannot be performed effectively then the peer review process should revert to those who have the first professional obligation and reason to assure that all care rendered is appropriate: the medical profession. As an organization which continually develops and improves its guidelines for standards of care, the ACOG asserts its professional duty to the public—that the best possible care will be available and that its utilization will be economically responsible. This duty is neither politically nor economically motivated; it is an element of the highest code of practice in the healing arts, and serves only the interests of the patient.

A recent development worthy of note at this time is the ruling by United States District Court Judge Gerhard Gesell, that medical data collected by Professional Standards Review Organizations is subject to public access under the Freedom of Information Act. While the personal rights of the patient continue to be protected by confidentiality assurance, the attending physician may be subjected to public judgement and professional criticism based upon medical records which do not fully reflect the physician's reasons for directing a certain modality of care. Despite Judge Gesell's expressed opinion, this organization anticipates that some physicians will decline federally reimbursed services rather than subject themselves to public review of their medical practice through FOIA access to PSRO records. We hope that the Subcommittee will give appropriate consideration to preserving the confidentiality due physicians in any peer review program.

The American College of Obstetricians and Gynecologists stands ready to contribute manpower and materials toward measuring the appropriateness of care and the effectiveness of the PSRO program. We urge the Subcommittee to review the original purpose of PSRO, to consider its performance consistent with that purpose, and to direct its future toward preserving the perspective of appropriateness in health care: quality in a quantity proper to the need when judged in the context of individual medical circumstances.

CENTRAL MARYLAND PROFESSIONAL STANDARDS
REVIEW ORGANIZATION, INC.,
OFFICE OF THE EXECUTIVE DIRECTOR,
Towson, Md., September 26, 1979.

Mr. MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: The PSRO of Central Maryland requests that the following comments be included in the record of Senator Talmadge's Subcommittee on Health hearing on PSROs:

1.0—*General comments on performance measurement*

1.1—Evaluation measures of PSRO performance to date have been purely quantitative output measures with little or no emphasis on PSRO organizational inputs, processes, outcomes, or comparative organizational observations. Measurements of "efficiency" and "effectiveness" are mutually exclusive. That is, a PSRO may be efficient but not effective or vice versa, and yet a measurement of only one indicator—i.e., efficiency—may not be an accurate measurement of the program's effectiveness. The point is further obscured by what the exact nature of the mandate is, in practice. What can be measured; how can it be measured; how can it be measured accurately; what do these measurements mean; and to what are they being compared? These are the difficult questions to be answered in evaluating PSROs, and at this stage of development no one actually knows what is considered a "good" PSRO. Because the PSRO "program" is administered in different Regions, by different organizational and management methodologies—all of which produce varying results—program variables are produced that are so diverse that no "average" PSRO exists!

1.2—PSRO evaluation and assessment data are subject to the same validity and reliability problems as all statistical inferences. These are:

A single index (such as Medicare dollars saved), by itself, is sufficient to represent PSRO performance. PSRO activity is not simple and requires multidimensional treatment.

Quantitative elements (such as LOS and costs) tend to be more easily measured and thus overly represented in the analysis of PSRO performance.

Reinterpretation of data collected for other (agency) purposes is seldom satisfactory.

Health data is particularly difficult to obtain in a comprehensive and accurate form.

Patterns discerned in data change from one unit of analysis or analytic detail to another in response to different underlying patterns of expectation and identification may be quite high for the region, and insignificant at the national level, etc.

1.3—For these reasons, it will be extremely difficult to "sort" those good PSROs from those that are not.

2.0—*Cost control and the nature of PSRO*

2.1—One will probably not get much of an argument if he stated that PSRO has not controlled the costs of Medicare. PSROs should be the first to admit this. The reason is fairly simple—PSROs, alone, cannot control "hospital" costs.

2.2—In a similar manner, PSROs can only affect Medicare admissions per thousand and length of stay (LOS) in a superficial manner. Many variables affect the Medicare admission rate, of which PSRO is but one small variable. Likewise, length of stay (LOS) is a function of many variables, one of which may be the influence of PSRO. In the areas of LOS and Adm/1000, PSRO will be a proportionately stronger variable in affecting these areas if the following conditions exist:

There is over-utilization to begin with,

The area is at or under acute bed capacity,

Non-medically necessary admissions are occurring, and

Health care delivery professionals are committed to change.

2.3—If these conditions exist, then there is the potential for marginal change and even at this juncture impact may only be demonstrated initially. That is, assuming the four former conditions are met, after the non-medically necessary admissions are eliminated, there will be a significant drop in Adm/1000 in year one; little change in year two, and no change from year two to year three. Eliminating non-medically necessary admissions will then have a limited, marginal impact on Medicare expenditure. Correspondingly, however, assuming non-medically admissions constituted the low LOS patient in the past, after Adm/1000 is controlled, "sicker" patients who remain longer will then begin driving up the LOS. Therefore, assuming there is over-utilization (i.e., days extending hospitalization) cutting off days on the end of the stay may impact total LOS but then in diminishing returns.

2.4—Thus, utilizing Adm/1000 or LOS indicators, alone, will provide an unreliable picture of PSRO performance.

2.5—Further complicating the evaluation picture is the nature of the Medicare reimbursement system. It has already been addressed, that if a utilization problem does exist, PSRO will have marginal impact, diminishing in return over time. Correspondingly, PSRO activity in admission and continued stay "denials" does not translate into Medicare cost savings. These denials are merely paperwork denials. That is why where LOS and/or Adm/1000 statistics seem to support positive PSRO activity, Medicare cost savings do not. Because of Medicare's various grace periods, waivers and end-of-year cost supplements—days denied by PSRO—are reimbursed to the hospital by Medicare as part of the reimbursement formula. Usually, this formula is based upon actual, or a percentage of actual costs incurred by the hospital. As addressed in 2; PSRO has no control over these costs. Therefore, when OPEL and GAO reports say the PSRO program has not controlled Medicare costs, they are absolutely correct, because the Medicare program continues to pay for everything—even days denied for benefit by PSRO, under waiver. Thus, it appears Congress and the Secretary must rethink the relationship between DHEW/HCFA/HSQB and DHEW/BHI. The Medicare program reimburses (per formula) the hospital(s) for "actual" costs; thus, there are no incentives to cut costs. The more one spends, the higher (percentage of) reimbursement. Therefore, given the limited PSRO impact areas (i.e., length of stay, admissions per 1000, admission and need for continued stay reviews and quality assurance—for Federal beneficiaries only)—the PSRO is not designed to impact total hospital costs and, in fact, cannot, in its present structure. If there were a direct relationship between PSRO activity and Medicare reimbursement, that is, PSRO denial equals per diem denial, cost savings to the Medicare program would still be minimal. This is true for several reasons:

1. Hospital costs are subject to many inflationary variables, least of which can be controlled by controlling the costs of the Federal benefit programs.

2. The non-profit (or "not-for-profit") status of the majority of hospitals' "Profits" must be reinvested, usually in the form of bed and/or other expansions, or, the purchasing of sophisticated equipment, etc.

3. The "mercurial" nature of hospital costs. That is, once one puts their finger on one cost center, these costs seem to "bead" away and appear as new or in combination with other, cost centers, remaining or increasing with overall hospital costs.

As a rule of thumb, PSROs have always calculated, theoretically, that if a day of Medicare benefit were denied, in fact, the cost savings to the Program would only be half a day because even though a patient no longer occupied the bed, the bed still

remained as part of the overall hospital costs for overhead, housekeeping, electricity, etc. Other groups and agencies have documented these observations through a more succinct (and perhaps more accurate) ratio—that is, to save the Medicare program the cost of one hospital day and account for these other hospital cost variables, the PSRO must deny fifteen (15) days! 15:1

It is safe to say that the PSRO program cannot impact Medicare costs in a significant manner. Therefore, with this fact in mind, the success of the (any) PSRO program(s) should not be evaluated utilizing cost savings to Medicare as the sole benefit criterion.

2.6—On the other hand, the Maryland Medicaid agency does not obscure its reimbursement mechanism with the various waiver vagaries inherent in the Medicare program. Therefore, utilizing Medicaid data may balance out Medicare washouts in the assessment process. However, Medicaid data is subject to the same type data variations and constraints outlined in Section 2.3.

3.0—*The role of PSRO*

3.1—As addressed earlier, PSRO has little or no effect on controlling overall costs, marginal effect on admissions per 1000, and a short-term potential effect on lengths of stay (LOS) and then with an early threshold, and diminishing returns over the long run. What then is the need for the PSRO program? Why have the Program at all if it can't control costs? The answer is twofold:

1. The PSRO provides a comprehensive approach to monitoring the utilization, and the appropriateness of the Federal health benefit programs. This oversight function by an impartial third party provides for a mutually acceptable (i.e., by the fiscal intermediaries, hospitals, and physicians) professional group to assure that Federal health benefits are being appropriately utilized. The role of "watchdog" cannot be lightly dismissed.

2. In the areas of quality assurance (especially in the Long-Term Care areas) and patterns of practice of health care delivery, the PSRO can show its strongest impact, although neither area can be concisely quantified in terms of cost/benefit. Quietly, patterns of practice are being changed, not because PSROs have singled out physicians for not being cost effective, but because the various indices that do not support PSRO program cost/benefits, do support pattern of practice and can be instrumental in change. Patterns can also be identified through quality of care or quality assurance reviews. Quality of care provided in accordance with accepted professional standards is a keystone in changing patterns of practice and utilization. The role of the PSRO as a change agent cannot be overlooked.

4.0—*Role ambiguity and conflicting signals from DHEW*

4.1—On one hand the PSROs are told to "cut costs," on the other to "be more effective." Cost cutting thus far seems to be a one-way street. Congress cuts the DHEW appropriation. DHEW cuts the PSRO's allocation. The PSRO's cut back effort(s) and programs, and jeopardize potentially effective personnel and programs. This all points to the compromise position of consolidation. Consolidation implies, if not intends, "centralization" of PSRO program initiatives and would destroy local initiatives and prerogatives. If the PSRO is successful at all, and in some cases it is extremely effective, it is because for the most part the initiative is held at the local level.

4.2—At the same time, as more mature PSROs become cognizant of the fact that their real worth lies in the areas of quality assurance, utilization, education and pattern of practice effectiveness—not (cost) efficiency—revisions to PL 93-641 (Public Health Service-Health Systems Agencies) appear to have created an expensive and duplicative system in quality of care areas. This is particularly disturbing to those of us in the PSRO program for several reasons: One, the above-mentioned areas of expansion (i.e., HSA "appropriateness and quality assurance reviews") fall clearly under the professional purview of the PSRO. Secondly, if Congress is concerned with controlling (Federal) expenditures in the health care delivery oversight agencies, then why is one branch of DHEW (i.e., HCFA/HSQB/OPSRO) being critically assessed, with budget cuts, and another branch of DHEW (i.e., Public Health Service/HSA) being given the mandate to duplicate PSRO activities in quality of care areas? In fact, the HSAs, through their planning efforts, have not been able to substantiate cost/benefit gains in "planning" as a mechanism for controlled and less expensive change in the health care delivery system. In essence, DHEW is creating role ambiguity for the two health programs. PSROs are being encouraged to "get a handle" on the rising costs of the Federal benefit programs, which they can't do because of the effect of extraneous variables over which they have no control. On the other hand, HSAs are being encouraged to get a handle on the appropriateness of services and quality of care, which they can't do because they lack the profession-

al expertise and broad-based physician support of the PSROs. In conclusion, it appears that PSRO evaluation is being based on a false premise, that is, that somehow a program created to monitor only a percentage (i.e., the Federal portion) of the patient population, will have the ability to impact total health care delivery costs. Secondly, there is the commonly held probalistic notion that there is a direct relationship between PSRO activity and the Medicare reimbursement program. There is not. This gap was never bridged, and HSQB and BHI apparently continue to pass one another like ships in a fog. In fact, all the Federally-funded health care projects under the various DHEW agencies fog up the HCFA picture. Health Maintenance Organizations (HMOs) have become yet another form of (partially) Federally funded health insurance, which will surely and ultimately be subject to the same inflationary forces affecting Medicare and private insurers. HSAs are funded to duplicate in part PSRO functions, etc., and yet there appears to be no logical or coherent control from DHEW.

5.0—*Criteria for assessment*

5.1—Knowing, then, all of the above limitations imposed upon the Program, how can PSROs be evaluated fairly as to their performance?

5.2—Did the PSRO pay for itself? Given the pitfalls of data interpretation, and the failure to translate PSRO paperwork savings into real Medicare dollars, using the gross indicators of LOS and Adm/1000 and ascribing a mutually agreeable dollar value to these days, did the PSRO break even? This could be one criteria, although not perhaps the most important.

5.3—Quality of care, which does not easily lend itself to quantifiable measurement, should be another. Was the quality of care of quality of patient life impacted by the presence of PSRO?

5.4—Degree of satisfaction on the part of the Medicare and Medicaid intermediaries, with the PSRO performance, could be another criterion.

5.5—Budgetary controls (internal) of the PSRO should be another area. Was the individual PSRO able to manage its budget without over-running the DHEW contract or grant award? Certainly, a PSRO with elevating LOS's and Adm/1000, in conjunction with budget over-runs, should be carefully scrutinized.

5.6—Was the PSRO instrumental in bringing about documentable and positive change in utilization, audit, or physician practice patterns?

5.7—Do Federal beneficiary patients feel any better knowing that their hospital stays are being monitored by a physician group to assure high quality of care, than their private counterparts?

5.8—Degree of physician support—How do physicians feel about the PSRO program? Has there been a change, if not in practice, then in attitude?

5.9—Finally, organizational effectiveness and development should be considered in any evaluation.

But, once again, organizational effectiveness is open to subjective criticism on a "standard" basis. What works in Iowa may not work in Oregon or vice versa. The point, of course, is the question of "effectiveness" at the local level. Is what the PSRO doing at the local level effective? Does it work? And, if it does work, why? The given answer, of course, is what works effectively in one PSRO cannot necessarily be generalized effectively to other areas.

Thank you in advance for including our comments in the hearing record. It is hoped that they will assist in the development of rational and reasonable methodologies to assess PSRO performance in the milieu of the existing health care system of this country.

Sincerely,

FREDERICK J. MENOSKY,
Executive Director.

THE PSRO PROGRAM—STATEMENT ON PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The American Health Care Association (AHCA), a non-profit membership association whose membership numbers approximately 7,000 long term care facilities in 47 states, is pleased to submit comments on the operation of the PSRO program in long term care review.

In the context of the review, AHCA would like to note the ways in which long term care facilities differ from acute care facilities. The most outstanding differences include (1) less day to day involvement of physicians in long term care, (2) physicians generally having limited working knowledge of the long term care field, and (3) a mix of patients in the facilities with health and related care problems which are, by definition, less responsive to treatment. We believe these differences

mean that PSRO long term care review should receive separate and distinct consideration. Our members have identified several areas of concern which we believe require special attention by the Subcommittee.

Currently, long term care facilities are under some form of utilization for Medicaid and Medicare recipients. In some cases, PSRO review has been more effective and efficient than previous systems of state and/or facility review. In others it has been more costly and less effective.

Because of the inherent differences between long term care and acute care, the following recommendations should be considered in developing national policy for long term care review.

1. *Data collection.*—Determination of the amount and kinds of data needed and the way in which it is to be collected should be made cooperatively between PSROs and long term care providers. Duplication of effort results in a waste of time and money. Whenever possible, existing forms should be used, or forms should be developed cooperatively. The responsibility for data collection should be clearly allocated as a PSRO responsibility in non-delegated facilities.

2. *Development of procedures, standards, etc.*—Long term care providers should be involved at all levels of the PSRO process so that procedures, criteria, standards, and norms which are developed are appropriate to long term care review. The long term care providers' knowledge of the unique problems of long term care must be utilized fully. In addition, this mechanism increases the opportunity for sharing of ideas and solutions to problems.

3. *Determinations procedures.*—These procedures should be developed by PSROs so that adequate opportunity for interchange between reviewing and attending physicians is ensured before an adverse determination is made.

In some early PSRO long term care review projects, the attending physician was not consulted during the determination process. Frequently, the primary, or admitting diagnosis of a long term care patient is no longer the major problem, but other conditions mandate his continued stay. Face to face contact with the attending physician is often needed for the PSRO to make appropriate continued stay decisions.

4. *Relocation and discharge.*—The time period for relocation after and adverse determination should be lengthened to seven days. A specific change in statute is required from the present maximum of three days.

Often the patient and his family are not ready for discharge, and the facility may not have expected an adverse determination. Discharge planning, because of multiple problems, is often more difficult for the long term care patient, especially if he is to be sent home and multiple services must be arranged.

5. *Mandatory review.*—Long term care review should be optional for the individual PSRO until more is known about long term care review. This includes information about the effectiveness of the varied types of review.

Because, this lack of knowledge is combined with the potential for development of effective and economical PSRO long term care, we support the administration's proposal that performance of long term care review should not, at this point, be required for full PSRO designation.

6. *Delegation.*—While we recognize the inherent problems in delegated review, we believe a free standing skilled nursing facility which can meet PSRO standards for delegation should be permitted to apply to perform delegated review.

Many SNFs have the capacity, and are performing high calibre utilization reviews. Not permitting such facilities to show they have this capacity appears discriminating. In addition, we would like to commend HEW's use of qualified outside organizations to perform assessment of PSRO activities. We were favorably impressed by the Rand Corporation's assessment of the PSRO Long Term Care demonstration projects and refer their recommendations, particularly those regarding the need for additional research and improved communications and information-sharing among PSROs, to the subcommittee.

Statement of the American Hospital Association

The American Hospital Association represents over 6,100 hospitals, long-term care facilities, mental health institutions, hospital schools of nursing, and over 30,000 personal members. We appreciate this opportunity to present our views and recommendations on the administration and operation of the Professional Standards Review Organization (PSRO) program.

The AHA believes that utilization review and medical audit programs should serve to assure the American public that hospital care is of high quality and rendered in an appropriate setting. Quality assurance programs are an essential function of the hospital; they are important for all patients and purchasers of care

because such programs institutionalize the peer review process and help to assure that scarce health dollars are appropriately spent. In addition to recognizing that hospitals are required by law to conduct utilization review and medical audit programs with respect to patents whose care is financed by Medicare or Medicaid funds, the AHA supports the principle that hospitals should conduct these programs for all patients, without regard to the source of payment, as part of their corporate responsibility to insure high quality health care in their communities.

We believe that all purchasers of care, including government, should pay their appropriate share of the full cost of conducting such programs. We would like to note here our serious concern with recent changes in the payment policies of the PSRO program that create difficulties for many hospitals seeking to discharge their legal responsibilities to conduct quality assurance programs and to finance the costs of such activities. In addition, recent regulatory actions have raised concerns regarding the process through which PSROs will continue to discharge their statutory obligations. Our statement will examine these issues as they relate to (1) the delegated status of hospitals, (2) "focused" review activities, (3) reimbursement for delegated review activities, and (4) the confidentiality and disclosure requirements pertaining to PSRO information.

DELEGATED REVIEW

It is our belief that a quality assurance program is most effective when the review activities are conducted as closely as possible to the site of the actual provision of health care services. Medical professionals who practice in hospitals as members of organized hospital medical staffs should have the primary responsibility for this review process. As noted by several witnesses who testified previously before this Subcommittee, effective utilization review and medical audit programs are enhanced when program findings are used primarily to improve the quality of medical care through medical staff educational programs.

Hence, division of the basic responsibilities for the review of professional activities within the health care institution or between internal and external mechanisms could work to the disadvantage of physicians, other health care practitioners, and the patients they serve. The commitment to, and implementation of, quality assurance activities in the health care institution represent the best way for the hospital and its medical staff to serve all patents and to facilitate achievement of the goals of the PSRO program. Those responsible for decisions affecting the care of patients in the hospital also should be responsible for evaluating the medical necessity for, and the quality of, that care. Placement of the responsibility for conducting quality assurance activities with the hospital and its medical staff is integral to the acceptance by professionals of the results or outcomes of such activities, thus helping to ensure their success.

Congress recognized this general principle during its debates on the Social Security Amendments of 1972 (Public Law 92-603). The legislative history of the PSRO program clearly states that self-regulation of professional activities is preferable to direct, external regulation by the government. As a result, existing law requires each PSRO to delegate to individual health care institutions those institutional review activities related to the concurrent and retrospective review of patient care that the PSRO determines are being performed efficiently and effectively. Under this delegated status, the medical staff and other hospital professionals perform the review functions in lieu of the area-wide PSRO. Where review activities are delegated to the institution, the local PSRO remains responsible for insuring that the institution continues to perform these delegated activities to its satisfaction. Fully functioning institutional quality assurance activities will enable the governing board of the health care institution to establish accountability for, and insure the quality of, hospital services and will preserve, to the maximum extent, self-regulation at the institutional level.

While we realize that fully delegated status may not be appropriate for every hospital, the AHA encourages health care institutions to achieve delegated status if it is feasible. We believe that PSRO monitoring of delegated hospitals should be educational and supportive of such delegation.

Several of the witnesses who testified before this Subcommittee stated that, because of funding limitations, delegated reviews should be terminated in favor of non-delegated review. The AHA disagrees strongly with this position. Delegation of professional standards review activities places the review process where it most appropriately belongs: within the health care institution. The framers of the PSRO legislation recognized this fact by their decision to allow termination of delegated status only for unsatisfactory performance of review activities and not for purely economic reasons.

The original intention of Congress in this regard is further clarified by the following excerpt from the report of the Senate Finance Committee (Report No. 94-459, 1975, p. 11), which affirms that the delegation decision should be based upon the competence and performance of the hospital rather than upon the cost of operating the required review activities: The committee anticipates that in order to completely eliminate any financial incentive either for or against the delegation of review responsibilities and authority by PSRO to a hospital, existing Medicare policies of the Bureau of Health Insurance will be modified to provide that a separate cost center will be established by a hospital to clearly identify the reasonable costs of required review activities. It is expected that for Medicare and Medicaid reimbursement purposes (whether such review be conducted under a delegation by a PSRO to a hospital review committee, or directly by the PSRO), 100% of the reasonable costs incurred in the reasonable review of Medicare and Medicaid, . . . patients admitted to the hospitals concerned shall be recognized as a direct cost of such programs without requirement of any apportionment of the review costs among patients of the institution for whom such costs had not been incurred.

The American Hospital Association hopes that the Subcommittee will continue to recognize that delegated review is important to the vitality of the concept of voluntary self-regulation of professional activities.

FINANCIAL CONSTRAINTS ON THE PSRO PROGRAM

Due to an evaluation of the PSRO program by HEW's Office of Planning, Evaluation, and Legislation in 1977 and to congressional concern over the cost-effectiveness of the PSRO program, funding for the PSRO program has been significantly reduced. The Administration's budgeted per-case cost has been reduced from $13 in fiscal year 1978 to $8.70 in fiscal year 1980, with a total request of $152 million. This figure has been reduced in the Labor/HEW fiscal year 1980 appropriations bill to $144 million, limiting further the budgeted per-case cost. In order to operate within the budget constraints, PSROs have been encouraged to "focus" or target their review on problem areas only. In addition, proposed regulations would significantly alter the current reimbursement mechanism and would give the PSRO complete control over the budgets of delegated hospitals.

Focused review

AHA has always supported the concept of focused review as the most effective way to carry out the functions of the PSRO program. However, in order to clarify the review requirements to hospitals, we have recommended to HEW that hospitals' role in reducing costs through focused review be more explicitly specified.

Focused reviews must be worked out in partnership with the delegated hospital, and not mandated by the PSRO. It has come to the attention of the AHA that PSROs have attempted to impose their own concept of focused review without any hospital input whatsoever. We believe the year-end PSRO financial approval requirement proposed in the draft PSRO transmittal, "Reduction of PSRO Hospital Review Costs," encourages such unreasonable behavior on the part of PSROs. We believe that any requirement that PSROs approve year-end payments made to delegated hospitals by fiscal intermediaries is contrary to the letter of the Social Security Act (which reflects congressional concern that federal health care programs should be fully paid for by the government) and is not an appropriate function for PSROs since they generally lack expertise in evaluating reimbursement matters.

It should be pointed out that reducing costs by limiting review activities is not fully consistent with expanded PSRO requirements for review of hospital emergency room and outpatient services. We believe that requirements for such new areas of review activities should not be imposed until pilot projects have demonstrated cost-effective ways to implement them.

Changes in the reimbursement mechanism

Reductions in funding of the PSRO program have led the Health Care Financing Administration (HCFA) to propose a new method of reimbursement for delegated hospital review activities conducted under the authority of PSROs. As proposed, reimbursement for such review activity would no longer be made on the basis of total reasonable costs incurred for delegated review. Rather, the PSRO would operate under a fixed budget established by HCFA. The PSRO, in turn, would be responsible for establishing a budget ceiling for each delegated hospital in its area on a per-case basis. This budget, and therefore the payment rate, would be based on specific review objectives negotiated with the PSRO. This rate would reflect all

activities that the hospital had been delegated to perform, such as pre-admission and concurrent reviews and medical care evaluations. Although the rate could be revised in consonance with the area-wide PSRO budget as the result of "substantial changes" in the review process, no retroactive adjustments would be permitted.

Although the AHA recognizes that the PSROs must work within budgetary constraints, we believe the arbitrary provisions of this proposed regulation are not appropriate. The ultimate effect of this proposal on delegated hospitals would be to contain costs by denying full reasonable cost recovery by these hospitals. Delegated hospitals faced with inadequate payments will be forced to either relinquish their delegated status or subsidize the losses through increased charges to other hospital patients. This violates both the original intent of delegated status and the applicable provisions of the Social Security Act. Delegated status, as we have stated above, is related to ability and performance, and not to financial considerations.

Further, the prohibition against retroactive adjustments also violates the requirements of the statute, which state that the regulations shall "provide for the making of suitable retroactive corrective adjustments where, for any provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

In addition, it is not clear to what extent negotiations between the PSRO and the hospital will be used in determining the budget ceiling. Obviously, targeting or focusing review on specific areas will help reduce costs. However, as currently proposed, it is possible that the budgetary limits may be set without adequate consideration of the resources necessary to accomplish even focused review objectives. The proposed regulations further permit the PSRO to modify the budget ceiling "on its own initiative or at the request of the hospital" if a "substantial change in the review process occurs." Because the term, "substantial change in the review process," is not defined in the proposal, there is a significant potential for arbitrary action by the PSRO.

CONFIDENTIALITY AND DISCLOSURE OF PSRO INFORMATION

An issue of continuing concern to those work with the PSRO program on a day-to-day basis is the need for proper assurances that information obtained and held by PSROs be kept confidential and protected against unauthorized disclosure to third parties. Although some groups have advocated public disclosure of information concerning the utilization and medical care profiles of individual practitioners and institutional providers, we believe that the concept of self-regulation of the quality and necessity of hospital services can only be sustained through clear assurances of confidentiality.

As we previously noted, the legislative history of the PSRO statute states that "it is preferable and appropriate that organizations of professionals undertake review of members of the profession rather than for the government to assume that role." PSROs rely on voluntary services by local physicians. Should data acquired by PSROs be disclosed without necessary safeguards, participation of physicians in PSRO activities will be in jeopardy. Confidential professional discussions separating appropriate concerns from unfounded allegations are essential ingredients of the PSRO process, and personally identified opinions and judgments must be protected from disclosure. Unless the continued confidentiality of professional review activities is preserved, the PSRO program will suffer from a lack of professional support and increased administrative and legal costs. Indeed these concerns were echoed by the framers of the PSRO statute, who provided that "any data or information acquired by any (PSRO) shall be held in confidence."

Earlier this year, HEW, pursuant to its statutory mandate, proposed rules dealing with confidentiality and disclosure of PSRO information. The AHA at that time raised both legal and practical concerns related to these proposed rules. While the proposed regulations recognize the need and the statutory mandate to keep patient information confidential, the AHA is specifically concerned about the failure of the regulations to recognize that health care institutions, along with patients and practitioners, are entitled to the protection of their privacy. With only narrow exceptions, the PSRO statute requires such protection. AHA is seriously concerned about HEW's apparent failure to recognize this statutory requirement.

Underlying the regulations is the faulty assumption that Congress intended HEW to balance conflicting interests, and in doing so to decide what PSRO information is to be kept confidential and what is to be made public. The statute contemplates no such balancing: it is unequivocal—PSRO information is to be kept confidential. The statute contains no elements describing a balancing test, but four specific, narrowly drawn exceptions. These regulations, in our opinion, deny an institution's right to privacy.

The AHA is aware that the denial of health care institutions' right to privacy was intentional. As HEW stated in the preamble to the proposed regulations: We are aware of some objections to treating statistical information on institutions as nonconfidential information. However, organizations are not generally accorded the same right to privacy as individuals and we believe that the benefits to be gained by sharing this information outweigh the potential disadvantages.

The statute, however, does not give HEW the power to set such a policy. Title XI of the Social Security Act requires any regulations governing release of data or information required by a PSRO (other than that necessary for the functioning of the PSRO program) "to assure adequate protection of the rights and interests of . . . providers of health care."

An example of the manner in which the denial of institutional privacy rights manifests itself in these regulations can be seen in rules governing the release of information to agencies charged with investigating Medicare/Medicaid fraud and abuse. The proposed rule would require PSROs to disclose, upon the request of such agencies identifying information, including PSRO medical necessity determinations, that describe or display incidents or patterns of practice or performance of a particular practitioner or institution. This rule is inconsistent with Title XI, which provides for release by a PSRO of information to an investigating agency at the discretion of the PSRO. The basis of this discretion is specifically limited to findings with respect to evidence of fraud or abuse. By requiring PSROs to disclose such information upon request, HEW has usurped the decision-making power that Congress conferred upon PSROs and has totally ignored the requirement that there must be some evidence of fraud or abuse to justify release of the information. We believe these interpretations are a serious deterrent to continued institutional support of the PSRO program.

In addition, the proposed regulatory approach to the confidentiality of PSRO information raises serious practical problems for hospitals. For example, the proposed regulations would authorize PSRO access to medical records and information concerning patients whose care is not being paid for through federal programs, without any requirement for the patient's consent to such disclosure. Not only is such an invasion of privacy wrong in principle, but also compliance with this requirement could expose hospitals to civil or criminal liability under state law. The regulations would give PSROs access to medical records and information of non federal patients "if authorized by the institution or practitioner." While AHA appreciates this recognition of hospital autonomy, we are concerned that if a hospital relies on this provision to release non federal patient information to a PSRO without first obtaining the patient's consent, the institution may find itself subject to a suit by the patient for invasion of privacy, or perhaps liable. Further, the hospital could be second-guessed by the courts as to whether the disclosure of nonfederal patient information was related to the performance of the duties and functions of the PSRO and, hence, protected from liability by the provisions of the PSRO statute.

Another example of the practical problems posed by current confidentiality regulations is the proposal to permit a PSRO or state-wide council to disclose sanction reports to licensure, accreditation, and fraud investigating agencies prior to the actual imposition of any sanction by the Secretary of HEW. Since a PSRO sanction report is only an interim determination, such disclosure is inappropriate, as it does not afford hospitals or individual practitioners any fo the due process protections otherwise guaranteed by the law.

Finally, proposed regulations would require PSROs to utilize the Medicare provider number on all submissions of information to HEW.

This section would reverse the present practice, which allows a PSRO to assign its own, confidential number in order to compile provider profiles. This procedure is fully adequate for all PSRO review purposes, and has long been supported by the health care community. Utilization of Medicare provider numbers in the fashion proposed would have one major effect: it would create a means for the federal government to establish a national record on many health care providers and patients. AHA has long opposed the use of Medicare provider numbers for this purpose and continues to do so.

Legal and practical concerns, such as those outlined above, seriously undermine the continued confidence of patients and providers in the PSRO program. As noted, a basic tenant of professional standards review is that, except to the extent necessary to carry out the purposes of the program, information on patients and providers will be treated in confidence. Without such assurances, the professional support necessary for the effective operation of the program is likely to diminish substan-

tially. This position has been supported by a number of PSRO directors, in testimony before this Subcommittee.

PSROS AND THE FREEDOM OF INFORMATION ACT (FOIA)

Legislation (H.R. 934) approved by this Subcommittee further protects PSRO information which identifies a specific patient, physician, provider, supplier, or reviewer from public disclosure under the Freedom of Information Act (FOIA), the Privacy Act, and related provisions of the law. We strongly endorse this provision. A recent decision by the U.S. District Court for the District of Columbia, holding that PSROs are agencies of the federal government and thus subject to the FOIA, is clearly inconsistent with the intent of Congress as expressed in the 1972 PSRO legislation. We believe the decision is also contrary to the directive to HEW, contained in Title XI of the Social Security Act, to develop specific regulations governing the disclosure of information acquired by PSROs.

Subjecting PSROs to sweeping provisions of the FOIA would seriously and detrimentally affect continued development of an effective peer review program, changing its focus from cooperation and professional education to regulation.

CONCLUSION

Mr. Chairman, we appreciate this opportunity to present our views and recommendations regarding the PSRO program. We will be happy to respond to any further questions you or any members of the Subcommittee may have on this issue.

CHARLES RIVER HEALTH CARE FOUNDATION,
Wellesley Hills, Mass., September 28, 1979.

To: U.S. Senate Committee on Finance, Subcommittee on Health.
From: Charles River PSRO.
Subject: Statement Covering Functions of PSRO Program in Massachusetts.

In 1975 the Boston Globe published on its editorial page a declaration that "the PSRO is working in Massachusetts".

In 1979 the same declaration holds true: The PRSO Program is continuing to work effectively in Massachusetts with increasing impact on the cost and quality of medical care provided in hospitals and nursing homes.

In a recent PSRO Impact Survey (August, 1979), the Charles River PSRO summarized the impact of the Massachusetts PSRO Program on Community Health Care as follows: "The PSRO has integrated into a single concurrently operated and uniformly monitored review system the local hospital and physician control activities required to assure that Federal and State subsidized patients receive medically necessary and appropriate quality care in local hospitals." This was the mandate of the Congressional PSRO legislation passed in 1972, and it is being well carried out by the Massachusetts PSRO program.

Members of Congress and the Federal agencies which carry out Congressional directives obviously have a strong interest and a mandated responsibility to question whether the purposes of Congressional legislation and the costs of programs set up by such legislation are being justified by the performance and accomplishments of that program.

We are aware that the OPEL studies of 1976 and 1977, and the GAO reports of 1976–1977, based upon compilation of derivative data, have questioned the cost effectiveness of the early PSRO program activities. On the other hand, firsthand, on-site information obtained by organizations such as the Charles River Health Care Foundation of Massachusetts (which has been operating one of the original conditoinal PSRO programs for over five years), throws a different light on some of the questions raised by these reports. Studies of aggregate statistics of actual Federal cost outcome figures did not emphasize sufficiently the fact that, during 1976 and 1977, the cost effectiveness impact of the PSRO review program was almost entirely blunted by failure of Medicare fiscal agencies to utilize the review findings of the PSRO program as mandated by the provisions of PL 92-603 that the SSA should make payment for Medicare and Medicaid services "only when and to the extent medically necessary as determined in the exercise of reasonable limits of professional discretion", by a Federally designated PSRO.

In assessing the cost and quality effectiveness of the PSRO program, it would appear that two key questions need to be asked:

1. To what extent is the PSRO program influencing effectively the cost and quality control visualized by Congressional legislation; and

2. To what extent are instances of failure to live up to Congressional expectation the fault of the PSRO program or the fault of other Federal agencies which have not implemented the recommendations of the PSRO program.

OBJECTIVES OF THE PSRO PROGRAM

The stated purpose of PL 92-603 was to provide "effective, efficient and economical delivery of health care services of proper quality" which would "conform to appropriate professional standards for the provision of health care." (Section 1151). This has usually been interpreted as meaning to reduce and control health care costs without impairing health care quality.

Congress proposed to accomplish this by establishing qualified, non-profit, administrative review organizations (PSROs) composed of practicing area physicians who would determine "through the application of suitable peer review procedures" and "the exercise of reasonable limits of professional discretion" what health care services provided by institutional and individual providers of health care were medically necessary and appropriate.

The law further provides that:

1. It shall be the obligation of any health care practitioner or organization to accept the authority and the review determinations of the area PSRO subject to appeal to the Secretary through specified appeal procedures. Any violations of such obligation shall be reported by the PSRO to the Secretary who may impose sanctions including denial of Federal reimbursement for health care services. (Sections 1160 and 1157.)

2. "No Federal funds appropriated under any title of this Act shall be used for the payment of any claim for provision of services if the provisions of such services is subject to review by any PSRO, and such organizaton has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim". (Section 1158a.) Whenever any PSRO so disapproves of any health care services, the PSRO "shall promptly notify the agency having responsibility for acting upon claims for payment for or on account of such services." (Section 1158b.)

The general objectives of PSRO review have commonly been stated to be to assure effective cost and quality of hospital and nursing home medical care. We have not found that these two objectives are—as some contend—in conflict with each other. We feel that the PSRO responsibility is to asure that the best use is made of the Federal money available—i.e. to work toward the single goal of providing to Medicare and Medicaid patients the best quality of medical care that the national community economy can afford.

CURRENT IMPACT OF PSRO

Although the PSRO has certain potential control functions (through the mechanism of submitting recommendations to the Secretary of HEW) it must be regarded primarily as a service organization to assist Federal and State authorities in health care review and to review and evaluate the effectiveness of utilization and appropriate quality of hospital and nursing home medical care and to assist health care institutions, physicians and other health care providers in implementing the PSRO responsibilities for establishing effective patterns of medical practice and patient care in local hospitals and equally effective continuing care in local nursing homes. The PSRO impact was designed to be and is primarily local.

We have found that an important PSRO responsibility has been to maintain continuing close communications and mutually supportive relations with and between area hospitals and nursing homes, soliciting input from administration, from physician and nursing staff, and from trustees and other representatives of community "consumers", and, in turn, keeping them advised of PSRO utilization and quality objectives and requirements. The PSRO has also filled an important and much needed role as a communication link and buffer between hospitals and nursing homes and responsible Federal, State, and community health care agencies. The basic impact of the PSRO has been to set up a "mechanism for talking together" through which the PSRO has been able to assess community medical care needs and resources, to recommend ways of sharing limited resources and providing needed care at reasonable cost, and to stimulate organized provider and community interest in accomplishing these community objectives with the cooperation and support of the PSRO.

In the Charles River PSRO, in order to emphasize the importance of full physician and hospital participation in this program, each of the seven community hospitals in the Charles River area has been delegated full authority for performing

binding (authoritative) PSRO review for all Medicare and Medicaid patients admitted to its hospitals, subject to monthly monitoring by the PSRO medical review staff nurses and physicians. This review includes conducting preadmission assessment and certification of the care needs of patients requiring transfer to a nursing home—an important patient care activity which the Charles River PSRO found hospital staffs had in most cases not been effectively performing prior to implementation of the PSRO program. In addition, the PSRO nurse and physician reviewers have introduced into the area hospitals and twenty-two area nursing homes an entirely new review procedure of on-site concurrent monitoring of the appropriate quality and utilization of institutional patient care. In the nursing homes, this procedure is carried out by PSRO staff nurses and physicicans instead of being delegated to the limited nursing home staff.

As we wrote in June, 1978 to Dr. Smits, HEW's Director of the Bureau of Health Standards and Quality (HSQB), the Charles River PSRO was "amazed" to find how many of the proposed health care control measures recommended by the Secretary of HEW in his April 12 news release had already been initiated by Charles River area physicians, hospitals, and nursing homes under the direction and guidance of the PSRO. (See copy enclosed.) The effective impact of these PSRO review procedures on health care practices in the Charles River PSRO area has been gratifying. The details of the impact of these Charles River PSRO activities have recently been compiled by the PSRO in an "Impact Survey" prepared for AAPSRO in August, 1979, copies of which have been forwarded to HSQB.

An important example of the impact of the Charles River PSRO program was its effectiveness in identifying and correcting unnecessary and inappropriate utilization of days spent in acute care community hospitals by Medicare beneficiaries. One set of indices used to measure this effect has been the average length of hospital stay (ALOS) of Medicare patients in each area hospital. Another is the total days of hospital stay utilized by 1000 Medicare enrollees.

Baseline statistics used were those for the calendar year 1974, the year immediately prior to implementation of the Charles River PSRO review program. In 1976, after one year of advisory PSRO hospital training and guidance, the ALOS of Medicare patients in Charles River hospitals had decreased slightly (2.3%). This was significant in that it indicated an abrupt interruption in a 10 year trend of yearly increase in Medicare hospital ALOS utilization in our area. In 1977, 1978 and 1979, this reverse in the previous 10 year trend continued with a progressive 3.2, 3.3, and 5% decrease respectively in the medically necessary Medicare ALOS utilization in Charles River hospitals. A special study by the Boston University Evans Foundation of changes effected in inappropriate utilization of Medicare services in Charles River hospitals between 1973 (pre PSRO) and 1978, confirmed these statistics by indicating an 8.7 percent decrease in inappropriate hospital stay utilization in 1978 as compared with 1973.

Overall, during the 3 year period from January, 1976 to January, 1979, the PSRO identified and certified as non-payable by SSA 38,296 medically unnecessary or inappropriate hospital days which had been utilized by Medicare beneficiaries during that period. At the average hospital cost of $200/day, the cost to the community of these unnecessary days of hospital stay totalled $7,659,200. Since these days were certified by the PSRO as non-payable by the Federal government, Federal payor agencies should not have paid any of the total cost. Actually, however, in spite of the Congressional requirement (PL 92-603, Section 1151) that SSA payment for Medicare services "will be made only when and to the extent medically necessary" (as determined by the PSRO), our information indicates that the costs of 15,651 of those unnecessary days (over $3 million) were paid by Medicare.

In connection with this comment about cost, it should be noted that the GAO accountants who last year audited several PSRO reports of cost effective performance during 1976 and 1977 have recently reminded Congress that these PSRO reports should not be interpreted as documenting actual cash savings for the Federal taxpayer. HEW has agreed that the PSROs were not equipped or intended to evaluate or control the actual cost savings of their activities, but only to identify for the Federal government "within the limits of reasonable professional discretion" which health care services provided by hospitals and other health care institutions and providers were medically necessary, appropriate, and of a quality consistent with professionally recognized standards to the extent that Federal payment should be made for them.

An example of the impact of the PSRO on identifying and correcting inappropriate quality of care is demonstrated by the methodology and results of PSRO conducted areawide Medical Care Evaluation Audits. During 1977, 1978 and 1979, 15 areawide Medical Care Evaluation audits (12 audits in each of seven hospitals and 3

audits in each of 22 nursing homes), were conducted by the PSRO plus supervision of over 100 audits in individual hospitals. 2 to 12 variations from agreed upon quality criteria were identified in each audit and appropriate action taken by the PSRO to assure that similar variations would be avoided in the future. Quality of Care Criteria published by national physician specialty organizations were usually used in evaluation hospital audits. Quality of Care Criteria for nursing home care (non-existent before the advent of PSRO) were developed by the PSRO and published in a 27 page manual which was updated in June, 1978, November, 1978 and May, 1979. PSRO nurse reviewers conducted teaching sessions for nursing home personnel, stressing the use of these criteria and urging them to seek the cooperation of the attending physicians to order the recommended procedures outlined in the criteria. Using these nursing home criteria, between October, 1977 and October, 1978 a total of 1312 recommendations regarding Quality of Care issues were made by PSRO nurse reviewers to nursing home staff and physicians. These covered the categories of recommended lab test and physical examinations, medication regimes, improvement of patient's care plan and daily activities (ADL), and updating patient records and physician orders and progress notes. The response of both nursing staff and physicians has been impressive in that, in general, PSRO recommendations are being accepted, or, if not, a reasonable written explanation being given by physicians and nursing staff.

CONCLUSION

We would hope that the above condensed summary of the five year experience of the Charles River PSRO program in Massachusetts will demonstrate the unique capability of this physician peer review program to review and control the proper utilization and appropriate quality of medical care in community hospitals and nursing homes. The PSRO has identified and answered the need for developing more effective criteria and standards for utilizing only the elements of quality of care which are necessary and appropriate to provide the best medical care result. Under the influence of the PSRO such standards have been and are continuing to be developed and applied by local hospitals and nursing homes, impacting on institutional and physician patterns of practice and encouraging increased utilization of outpatient and physician office facilities and improving the quality and efficiency of care provided in the hospital or nursing home inpatient setting.

The physicians of Massachusetts remain convinced, as they were in 1975, that the practice of medicine has become so complex, and that the personal relationship between patient and physician is such a vitally needed part of quality medical care, that only practicing physicians can properly monitor the necessity, appropriateness and quality of the medical services provided by their colleagues, and properly assess the medical needs of their patients. Attempts at review and control by non-physician Federal or State agencies and intermediaries or by distant physician organizations such as the AMA and other National or State medical organizations have in the past been ineffective in monitoring the activities of individual physicians. The members of Congress in their wisdom were well aware of this in 1972 and assuredly must be equally aware of it today when medical costs and needs are even more obviously demanding of review and control.

LEWIS S. PILCHER, M.D.,
Medical Review Director.

STATEMENT OF DENNIS J. DUFFY, EXECUTIVE VICE PRESIDENT, PROFESSIONAL STANDARDS REVIEW ORGANIZATION OF UNION COUNTY, N.J.

The Professional Standards Review Organization of Union County, New Jersey, has some very serious concerns regarding the future funding and effectiveness of the PSRO Program.

It is our feeling that if the program were funded at an appropriate level for a given period of time, the Senate and the House of Representatives would be able to assess the effectiveness more rationally than if we continue under the present system, which does not allow individual PSROs the freedom to implement as they see fit.

The physicians in Union County, New Jersey, incorporated this organization in 1974, with the expectation that they would receive a planning contract that same year. However, it was decided that, since funds were tight, larger, more-established organizations would be funded first. Even though there was great disappointment, those interested physicians continued to hold meetings of the Board of Trustees on a quarterly basis for two years without ever having the aforementioned contract with DHEW. Finally, in April 1977, the organization signed a twelve-month contract with

DHEW. At that time, the necessary staff was hired and the program began growing in Union County, New Jersey. In April 1978, the PSRO of Union County signed its first Conditional Contract with DHEW, which, as I am sure you are aware, meant the beginning of the DHEW-approved review system in this area. In the following year, the PSRO of Union County implemented review in its seven acute general hospitals. These hospitals serve a community of approximately 500,000 people, with approximately 30,000 Federal-program admissions. This same area is serviced by over 1,000 physicians.

We considered the implementation process effectively carried out with a rather efficient review process going on within those acute facilities. Our next goals were to implement review within our three specialized hospitals and over twenty nursing homes. This has not occurred, due mainly to the aforesaid funding problems and, therefore, creates a break in a review process that should follow a patient through all facilities.

The organization and its physician members are committed to assuring the appropriateness and quality of the health care delivered in the area. To this end, three cost-effective goals which are currently being pursued within the system (and which we foresee as being met by the close of this grant year) are:

1. The reduction of the Medicare length of stay in Union County from 13.5 days to 13 days.
2. The reduction of the Medicare admission rate from 300.8 admissions per 1,000 enrollees, to 295.
3. The reduction of the Medicare utilization rate from 3,910 to 3,850 days per 1,000, by April 1, 1980.

These goals, along with many others, involve the quality and appropriateness of the care rendered in Union County and should prove our commitment and effectiveness.

We consider ourselves a fairly young organization, but we would respectfully request that we be allowed to follow through with our goals and commitments toward achieving an effective review system within this area of New Jersey. At that time, we feel, it would be fair to be judged as to whether or not we were fulfilling our end of the bargain.

We trust that the physicians involved in peer review have not been written off by our legislative bodies. This is a particularly strange phenomenon in a rather conservative profession. If the program could be viewed in toto, it would seem that, except for a few inept organizations, it is a success as seen by all parties.

The PSRO of Union County will do the job we are committed to, but a more efficient manner of funding would certainly reap a reward to all involved, particularly the Medicare and Medicaid programs and their beneficiaries.

NORTH LOUISIANA MEDICAL REVIEW ASSOCIATION,
Shreveport, La., September 11, 1979.

Mr. MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: The North Louisiana Medical Review Association, the Conditional PSRO for Area I of Louisiana, submits this statement for inclusion in the record for the hearings on Professional Standards Review Organizations (PSROs).

1. In regard to funding levels for conditional and fully delegated (if any) PSROs, the Association recommends that funding for Parts II, III and IV of the PSRO budget be in the range of $8.70 for each discharge for which the PSRO has completed review. Incentives for the PSRO to focus out acute care concurrent review should be included in the amendments in the form to allow a PSRO to divert funds from focused out review activities to other review areas, such as ancillary services review, skilled nursing facilities (SNF) review in both common facilities review and under separate facilities review, and ambulatory review. The section of the social Security Act to which this amendment can be applied is Section 1155(f)(1) by adding a new paragraph C.

2. In order to provide an orderly transition of a PSRO from one fiscal year funding period to another fiscal year funding period, and in order to prevent the marked disruptions in funding procedures that is being experienced now by PSROs because the government is waiting until one, two or three days before the expiration period of a contract or grant before notifying that PSRO of its subsequent amount of funds, Section 1155(f)(2) should be amended to provide that the Secretary notify a PSRO ninety (90) days prior to the date funds are to be made available for that PSRO. With a 90 day notification the Secretary would be making to a PSRO concerning the amount of funds that PSRO is to receive, the PSRO will have ample

time to plan for the succeeding fund period, thereby eliminating the very disruptive and costly delays that are existent today.

3. In regard to Section 1158 of the Social Security Act, without fault determinations and waiver of liability should be left under the authority of the PSRO in the event the Secretary refuses to or does not publish regulations concerning waiver of liability and without fault determinations. Section 1158(a) should be amended to reflect that a PSRO has the authority to make without fault determinations and waiver of liability determinations for Medicare and Medicaid whenever the Secretary has not published final regulations.

With the adoption of the above amendments, the Association has a firm belief that the PSRO Program will be efficient and effective in reviewing the health care services and items under Titles XVIII and XIX for which payment may be made under the Social Security Act and in determining the medical necessity, appropriateness of care, and level of care.

Sincerely,

STEVE G. KIRKIKIS, M.D.,
President.

STATEMENT OF THE GREATER SOUTHERN ARIZONA PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The Greater Southern Arizona PSRO welcomes the opportunity to submit a statement to the Committee on Finance, Subcommittee on Health, concerning the PSRO program. We are particularly pleased with the comments of Senator Talmadge, concerning the PSRO program and its reponsibilities. We believe the basic mandate is still unclear regarding quality versus cost.

Assessments of this program thus far have highlighted their attention on the issue of cost reduction. Little emphasis has been placed on the quality of medical care and the impact PSROs are having in this most important area. Those PSROs who have attempted to document cost savings have seen their claims negated to a great extent by the GAO.

The present structure of both the Medicare and Medicaid Programs severely restrict the program's ability to demonstrate actual cost savings. As pointed out by the GAO, the mere fact that a PSRO may deny institutional services as being medically inappropriate does not necessarily equate to savings of program dollars since these costs are inevitably picked up by the program either through the waiver of liability provision or the grace days mechanism. The only true method of financial savings is cost avoidance. This, of course, is extremely difficult to document.

In the evaluation of PSROs, the Health Care Financing Administration places great weight on denial statistics, sanctions, etc. It is our contention that a truly effective PSRO would have a minimal number of denials and only on rare occasions would sanctions be appropriate. Through educational activities and careful scrutiny of the practice of medicine in a given area, improper or over-utilization should be all but eliminated. Consequently, denials and sanctions would also be greatly reduced.

We believe much greater emphasis must be placed on the re-structuring of the Medicare and Medicaid programs before they can be truly cost effective. There are presently no incentives in either program for a physician or an acute facility to operate efficiently. As these programs are presently constituted, the more services provided, the greater the reimbursement. This, of course, applies to all patients, not only those covered by Medicare and Medicaid.

PSROs have little control over existing or new services. While cooperation with local HSAs will impact on this situation in the future, this will be a long term activity.

Obviously, the infusion of additional tax dollars into these programs, is not the answer. The costs of both programs have increased dramatically while at the same time, the ratio of benefits to costs for the recipients of these programs, has grown ever larger. This alarming increase in the out-of-pocket costs under these programs has created yet another monster. The profusion of organizations offering supplemental policies to plug the gaps in the federal programs, has added additional financial burdens, particularly to the elderly who foolishly purchase, in many cases, a variety of supplemental contracts, in their futile attempts to ward off financial ruin in the event of illness.

It has been well documented that thousands of acute care days are being utilized, particularly by Medicare beneficiaries since there is no appropriate alternate source of care availabe such as a skilled nursing facility. These days are covered under the existing Medicare regulations so long as the patient continues to require the skilled nursing level of care. This obviously represents a gross mis-utilization of health care resources. Many skilled nursing facilities have adopted very stringent guidelines

concerning admission, particularly for Medicare and Medicaid patients, primarily due to the uncertainty concerning reimbursement. While, in many cases, this in violation of the Conditions of Participation, nonetheless, the situation is fairly prevalent. In the early days of the Medicare program, few if any restrictions were applied to the skilled nursing portion of the benefit package. Presumably, this was done to encourage physicians and patients to look upon skilled nursing facilities as a viable part of the recovery process. In the late 1960s and early 1970s, this trend was dramatically reversed and very stringent controls were instituted over skilled nursing facilities. Consequently, the degree of participation in federal programs by skilled nursing facilities markedly decreased. This same philosophy has also greatly impeded the participation by home health agencies in federal programs.

We cannot over emphasize the critical need for a sweeping restructuring of both the Medicare and Medicaid programs. The necessity for a three day qualifying stay should be revised. The swing bed concept must be enlarged upon. Incentive reimbursement must be addressed. The overall administration of the program must be re-structured. A recent study by HEW strongly recommends a reduction in the number of intermediaries in order to provide improved controls over utilization of facilities and expenditures. Ideally, providers of all types in a geographic area would be serviced by one intermediary/carrier. This would provide economies of scale and would also enable the intermediary to more effectively analyze utilization and resource allocations.

For example, at the present time, in any given area of the country, there is one organization responsible for acute hospitals, another responsible for skilled nursing facilities and yet a third, responsible for home health agencies. This fragmentation of activities does little to ensure effective coordination of patient care among these groups of providers. Additionally, the duplication of administrative expense is significant.

Hospital Administrators are under intense pressure from their Boards of Trustees to maintain adequate occupancy levels and to provide the ultimate in services and technology in order to attract a qualified staff. New technology such as organ transplants, joint replacement, the development of the CAT Scanner, and innumerable other scientific and technological advancements have contributed to the ever increasing costs of medical care. Inflation alone, has a very negative impact since the costs of all goods and services provided continue to escalate. Obviously, these costs are passed on to the third party payors and/or the patients. Defensive medicine has increased alarmingly as a result of the malpractice crisis.

In the face of these hurdles, the PSRO program is being asked to reduce the costs of medical care. We submit that effective PSROs can and do have a positive impact on utilization of services, however, this in and of itself, cannot reduce the costs of medical care. Fixed institutional costs continue whether or not a bed is occupied. Until a reasonable balance is struck between availability and necessity for expensive medical resources, significant cost reduction will remain a problem of tremendous magnitude.

Patients feel they are entitled to the ultimate in medical care. They look to their personal physician to ensure receipt of such care. The average American remains woefully uninformed about medical economics. In the vast majority of cases, they place their confidence in their physician and follow his advice without question. The lack of success of the Second Opinion Program for elective surgery is a case in point.

We strongly believe the PSRO program is a valuable link in the chain of medical care. It is however, only a link. Its effectiveness will be determined in large measure by other affirmative actions necessary to deal with the significant problems surrounding the health care delivery system. Several steps must be taken without delay if any truly meaningful progress is to be made in our attempts to realistically address the problems of health care. We believe the following steps must be taken:

1. A basic restructuring of the Medicare and Medicaid programs to provide incentives for cost effective delivery of health care.
2. Medical schools should be required to provide courses on medical economics.
3. Physicians should receive itemized copies of their patient's hospital bills.
4. The administration of the Medicare program should be restructured with consolidation of intermediary/carrier service areas.
5. PSROs must receive adequate funding if they are to fulfill their mandates.

In conclusion, we believe the PSRO program represents the best and perhaps the last opportunity for government and the medical profession to work together to bring about much needed reforms in the financing and delivery of health care. If this partnership is to be successful, the program urgently needs much greater support both financial and moral. The program must be evaluated realistically bearing in mind the severe constraints under which it operates.

We very much appreciate the opportunity to comment and we hope that our observations will be of assistance to you with the tremendous problems we are all coping with.

AREA-22 PROFESSIONAL STANDARDS REVIEW ORGANIZATION
Los Angeles, Calif., September 24, 1979.

MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: I am writing in response to press release No. H-53, regarding hearings scheduled by Senator Herman Talmadge to review the administration and operation of the PSRO program.

As per the press release, Area 22 PSRO is submitting a position paper for inclusion in the record of the hearings. Enclosed please find five copies for your distribution.

Area 22 believes that there are several important criteria for evaluating PSRO performance and effectiveness. These include improvement in the quality of medical care afforded beneficiaries of the Medicare program, as well as quantitative documentation of the cost effectiveness of program administration. Based on its performance as a conditional PSRO, Area 22 believes it has been successful in both these spheres.

While we applaud the efforts of Senator Talmadge in evaluating the program, we also feel that there may be negative side effects to consolidation—especially if small but effective PSRO's like our own are constrained from fulfilling program mandates. Please keep me informed as to the outcome of these hearings.

Thank you for your assistance.

Sincerely,

FRANK M. CROWLEY,
Acting Executive Director.

Enclosure.

STATEMENT OF AREA-22 PROFESSIONAL STANDARDS REVIEW ORGANIZATION

In response to the hearings of the Senate Subcommittee on Health of the Committee on Finance, as well as the increasingly imminent question of PSRO consolidation, Area 22 PSRO wishes to submit the following documentation of its activities and accomplishments. It is our belief that the effectiveness of a specific PSRO, as well as the program as a whole, must be measured by both qualitative and quantitative change in health care delivery patterns. It is important to consider the implications of administrative reorganization in the program in terms of its effect on quality of medical care and responsiveness of local physicians, as well as the more obvious cost issues. Area 22 PSRO believes that the amount of administrative overhead expenditures in maintaining small but effective PSROs is far outweighed by the larger cost savings to the Medicare program through monitored quality patient care with local physician peer support.

The process underlying an effective peer review system is a complex series of feedback loops between the PSRO, the hospitals in its area, and the practitioner members. Evaluation of the effectiveness of a PSRO must focus on three issues: changing patterns of medical utilization, and improvement in quality of care (as mandated by the 1972 Social Security Amendments), and the cost-benefit ratio of accomplishing these performance objectives. Monitoring and measuring program effectiveness over time is a direct function of the PSRO's ability to accomplish two tasks: (1) creating a viable physician membership in a PSRO with high local credibility, and (2) identifying and resolving problems in its area by giving input and direction to hospitals and practitioners through the feedback mechanisms.

A key issue in the implementation of a successful and effective PSRO is that of time. A PSRO must earn the support and cooperation of the hospitals and practitioners in its area, an achievement testified to by the now 70% membership rate in Area 22. Such loyalty is difficult to mandate by administrative acts, or geographic reorganization. The PSRO must also establish appropriate norms and standards for measuring patterns of care and concommitant changes in those practices resulting from administration of the PSRO program.

The three major operational areas of a PSRO—data, utilization review, and medical care evaluation—are the basis for effective program management and intervention in behavioral patterns of patient care. Clearly, the sophisticated utilization of the PSRO data system is of great importance in these efforts. Through profile analysis of area trends, and of hospital and practitioner specific patterns of care, the PSRO can correctly identify areas of priority action, focus program activities, and

correctly set objectives to change and improve performance to meet and maximize program goals. Once the PSRO has established valid measures of hospital and practitioner performance for baseline standards, it must actively intervene to set and enforce new performance standards through objective setting and focusing. It must also continually monitor its own performance through review of the effectiveness of its own objectives and hospital and practitioner compliance.

Assessment of program impact can come only after all participants in the PSRO process have actively responded to the performance guidelines and objectives set by the PSRO, and by the changing federal requirements for maintaining the program nationally. The results of PSRO intervention in the patterns of care must be documented by corrective action on the part of the hospital, and cost impact on the part of the PSRO. Thus, the two areas of qualitative and quantitative measurement can be addressed to evaluate the effectiveness of the PSRO.

Area 22 PSRO believes it is doing a "good job," possibly even an excellent job, in administering the program mandates. Our major accomplishments and achievements are outlined below as documentation of our efforts:

DATA MANAGEMENT AND PROFILE ANALYSIS

During 1979 Area 22 has become a leader in the analysis of utilization data. Through the capabilities of an in-house on-line terminal, we have created an active and operational data base and performed stratified analyses of Medicare discharges for the six quarters after July 1, 1977. Examples of these analyses include:

Analysis of length of stay by zip code origin of Medicare patient;
Analysis of length of stay by admission day of week; and
Analysis of length of stay by diagnostic category.

Most importantly, the Area 22 data base has been used to generate three major analyses with statistically significant cost-benefit implications for the program implementation:

1. Impact analysis: July 1, 1977 to December 31, 1978

A pre-post analysis of area utilization trends was conducted to compare data from 4th quarter 1977 and 4th quarter 1978. In July, 1978, Area 22 PSRO actively and forcefully intervened in the delegated hospital review system. The analysis demonstrated statistically significant impact, and documented decreases in number of patients discharged, number of patient days utilized, and ALOS.

2. Physician profile analysis

Area 22 has conducted a pattern of practice utilization profile for each of its member physicians. Based on comparisons between physicians ALOS for PAS patient groupings with and without surgery to hospital and areawide ALOS norms for these same groups, physicians who overutilize hospital services over their case mix have been identified.

3. Objective setting baseline data

Area 22 PSRO has established baseline norms for all area hospitals from analysis of the 7/1/77-12/31/78 data. The areawide norms were used to establish impact objectives for the budget year 7/79-6/80. Objectives were hospital specific and designed to correct identified patterns of aberrant care. These objectives form the basis of the focused-in monitoring conducted by the Utilization Review Department.

The Area 22 data department has initiated the exchange of comparative data among Southern California PSROs in order to determine the geographic service area of Area 22. Such projects, as well as continued profile analyses of the type outlined above, enable the program to be implemented with maximum effectiveness.

UTILIZATION REVIEW DEPARTMENT

The Area 22 Utilization Review Department has instituted several innovative approaches to the monitoring of hospital utilization. These are designed to (1) follow-up on the already identified aberrant patterns of care developed by the Data Department, (2) to identify potential new problems and corrective actions for them, and (3) to identify issues of quality of care for Medicare patients.

The most important difference between Area 22 PSRO and most other PSROs is the use of concurrent monitoring rather than retrospective monitoring. This allows identification of problems on-site and in the most expeditious manner. Problems which might take months to resolve on a retrospective basis are identified and dealt with interactively before they can cause negative dollar impact. Area 22 has been extremely effective in identifying and resolving problems of delays in service, ques-

tioning necessity of admission and treatment, and successfully identifying physicians whose behavior is in potential violation of program mandates.

Additionally, Area 22 PSRO is in the process of pilot testing and implementing new and more stringent criteria for admission and monitoring of treatment of Medicare patients. We believe that the Interqual pilot project will demonstrate a decrease in ALOS and an even greater ability to identify quality issues.

The most important aspect to the Utilization Review sector is the interactive relationship with the area hospitals. Concurrent monitoring places shared responsibility for identified problems on both the PSRO and the hospital. While it is the responsibility of the PSRO to identify and seek the resolution of problems, it is that of the hospital to enforce the corrective action procedures which will result in changing patterns of care. Through a close working relationship with the hospitals, the utilization review sector can provide the necessary information to the PSRO management about possible need and use of sanction procedures to insure the efficacy of the PSRO program.

MEDICAL CARE EVALUATION DEPARTMENT

The Area 22 PSRO MCE Department has conducted a rigorous application of program mandates in area hospitals to insure compliance with both regulations regarding the performance of MCE studies and standards of quality medical care.

For the delegated hospitals, the PSRO has conducted validity checks on audit data, and performed individual evaluations of audits submitted to the PSRO. Criteria for evaluating all hospital audits have been established, and staff and physicians have reviewed all 1977 and 1978 audits for design, criteria, data analysis, relevance, and corrective actions. Additionally, the PSRO has provided technical assistance to hospitals to improve the quality of the audits, as well as to insure that corrective actions deemed necessary by the PSRO have been undertaken. Three non-delegated MCEs have been conducted, with an additional five ready for implementation.

Area 22 PSRO has completed four areawide surgical audits addressing the necessity of surgery issue. Five additional areawide audits are in process. Area 22 has followed up these areawide audits with corrective actions in each hospital where deficiencies were identified.

Finally, Area 22 has been extremely active in the cost-effectiveness area of MCEs. A comprehensive cost analysis study of MCEs was conducted to determine base costs for the hospitals. The PSRO Quality Assurance Committee has adopted a decentralized format with sub-task forces, each responsible for audit criteria development, review of audit variation analysis, and corrective actions. In addition to reinforcing continuity for each audit, cost savings on overhead will be apparent.

PROGRAM MANAGEMENT

The primary attribute of Area 22 PSRO is persistance in the pursuit of program goals. This stance has provided the impetus for the accomplishments outlined in the preceeding pages. Such staff endeavors have allowed the PSRO to actively pursue identified aberrancies of practice and seek resolution through corrective action.

Area 22 PSRO has demonstrated the following impact since achieving its status as a conditional PSRO:

1. A cost-benefit ratio of 1:1.39 for the budget year 1978-1979. This is documented in the Impact Analysis submitted with the budget materials for the grant year 1979-1980. Analysis is based on $1.4 million saved due to decrease in utilization.
2. Identification of 86 physicians in the area who account for 80 percent of the overutilized days (in comparison with area norms for the same diagnoses and procedures). These physicians are being validated by area hospitals. Potential savings to the Medicare program is estimated at $3.5 million if behavior change can be effected.
3. Improvement in quality issues through physician chart review of peers identified by concurrent review as potentially aberrant. Results from this review process include imposition of such actions as mandatory consultation for specific procedures, recommendations to the Statewide Council for further action, withdrawal of waiver status for specific physicians and procedures, and investigations into the medical necessity of certain surgical procedures. Additionally, the PSRO has removed the waiver of a hospital for lack of compliance with PSRO and program policies, and done the same to a speciality unit in another hospital.

SUMMARY

Area 22 PSRO has performed its mandated program functions effectively and efficiently. In its four years as a conditional PSRO, it has used a 70 percent

physician membership as the support base for promoting behavioral change in area hospital patterns of care. The results of these changes are quantitatively documented by dollar savings in a 1:39:1 ratio to PSRO operating and review costs, as well as potentially greater savings from PSRO interventions currently in process. In the quality sector the PSRO has maintained stringent criteria for patient care, and through innovative review procedures has enforced these criteria. Area 22 PSRO believes that the basis for even greater impact has been laid, and that disruption of its activities by consolidation will prove to be counter-productive to the goals of the program.

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