

## DOCUMENT RESUME

00525 - [A1051904]

Implementation of the Professional Standards Review Organization Program. April 4, 1977. 19 pp.

Testimony before the House Committee on Ways and Means: Oversight Subcommittee; by Gregory J. Ahart, Director, Human Resources Div.

Issue Area: Health Programs (1200).

Contact: Human Resources Div.

Budget Function: Health: Health Care Services (551).

Organization Concerned: Department of Health, Education, and Welfare.

Congressional Relevance: House Committee on Ways and Means: Oversight Subcommittee.

Authority: Social Security Act, as amended (P.L. 92-603).

GAO reviewed activities at 15 Professional Standards Review Organizations (PSRO) in 11 States and at the Department of Health, Education, and Welfare (HEW). To date, 37 areas, including the entire States of Texas, Georgia, and Nebraska, have no PSROs. Of the 58 current planning PSROs, 47 were not established until February or March 1977. A number of the 108 conditional PSROs are not performing concurrent reviews at all the hospitals in their areas and have done few or no profile analyses. Some PSROs are or were in the planning stage for what appears to be unnecessarily long periods. Several interrelated factors have impeded implementation of the PSRO program: deficiencies in HEW's program administration; physician opposition; and internal PSRO problems in organizing, developing program plans, converting to conditional status, developing working relationships with State Medicaid and Maternal and Child Health agencies, obtaining support from some hospitals, developing long-term care facility review programs, and coordinating with Health Systems Agencies. HEW failed to promptly effectively organize and adequately staff the PSRO program and obtain or direct cohesive, vigorous efforts among participating branch agencies. (OH)

00525  
United States General Accounting Office  
Washington, D.C. 20548

FOR RELEASE ON DELIVERY  
Expected at 9:00 a.m. EST  
Monday, April 4, 1977

Statement of  
Gregory J. Ahart, Director  
Human Resources Division  
Before the  
Subcommittee on Oversight  
Committee on Ways and Means  
U.S. House of Representatives  
on the  
Implementation of the Professional  
Standards Review Organization Program

Mr. Chairman and Members of this Subcommittee, I am pleased to appear here today to discuss some of the problems we identified in the implementation of the Professional Standards Review Organization (PSRO) program. My testimony today is based on the results of our review to date, which includes field work at 15 PSROs in 11 States and at the Department of Health, Education, and Welfare (HEW). We expect to complete our field work at these locations and two additional PSROs by the end of May. Also, by that time we will have the results of questionnaires we sent to 103 additional PSROs.

Because our review is not yet complete, the observations we are presenting must be considered as tentative. We have not fully developed the causes of the problems nor have we developed recommendations for resolving them.

BACKGROUND

The PSRO program was established by the 1972 amendments to the Social Security Act (Public Law 92-603, approved

October 30, 1972) and is administered by the Bureau of Quality Assurance (BQA) in HEW. The program objectives are to reduce costs and improve quality of health care by involving local practicing physicians in the on-going review and evaluation of the necessity and quality of medical care provided under the Medicare (Title XVIII), Medicaid (Title XIX), and Maternal and Child Health (Title V) programs.

PSROs are to determine, for purposes of reimbursement under these programs, whether services provided to patients in hospitals and long-term care facilities are (1) medically necessary, (2) provided in accordance with professional standards, and (3) provided in the appropriate setting. PSROs can, but are not required to, review ambulatory care. PSRO review processes include (1) concurrent reviews of the medical necessity and appropriateness of inpatient admissions and the length of continued stays, (2) medical care evaluation studies to identify problems in the quality or administration of health care, and (3) profile analyses of the utilization patterns of providers, physicians, and patients. PSROs must delegate responsibility for concurrent review and/or certain facility-based medical care evaluation studies to qualified hospitals that are willing to assume such functions.

PSROs are generally developed in three stages--planning, conditional, and fully designated. PSROs in the planning stage are expected to establish an acceptable organization structure, recruit physician members, and formulate a plan for acquiring resources and conducting and evaluating review activities. Responsibilities of PSROs in the conditional stage include developing criteria and standards, implementing review plans, delegating certain review functions to qualified hospitals and monitoring their progress to assure that identified problems are corrected. Once a conditional PSRO has met its organizational requirements and is effectively discharging its responsibilities, including long-term care review, it can become a fully designated PSRO.

PSRO program funding has grown from \$4.5 million in fiscal year 1973 to an estimated \$103 million in fiscal year 1977. PSROs operate under contract with HEW and are entirely federally financed. Funds are derived from general appropriations and the Medicare trust fund.

Notwithstanding the strong opposition to the PSRO program at the time it was established by legislation, progress has been made in implementing the program. As of April 1, 1977, 166 PSROs--108 conditional and 58 planning--have been established. As of June 1976 PSRO review activity involved about 1.2 million Medicare, Medicaid, or Maternal and Child Health discharges from 1,291 hospitals. Between July 1975 and

December 1976, PSROs reported doing about 3,300 medical care evaluation studies. Some profile analyses were also done. Despite these accomplishments, development of the program has been constrained by several factors.

#### PROBLEMS IN IMPLEMENTING THE PROGRAM

PSRO enabling legislation requires HEW to designate PSROs as conditional at the earliest practicable date after PSRO areas are designated. In March 1974, HEW designated 203 PSRO areas. Areas ranged in size from single counties to entire States. To date, 37 areas--including the entire States of Texas (9 areas), Georgia (1 area), and Nebraska (1 area)--have no PSROs. BOA expects to establish 3 more planning PSROs in April 1977, and the number of areas in Texas may change as a result of litigation.

The legislation also requires that PSROs assume their review responsibilities at the earliest date practicable. Of the 58 current planning PSROs, 47 were not established until February or March 1977. A number of the 108 conditional PSROs are not performing concurrent reviews at all the hospitals in their areas and have done few or no profile analyses. PSRO review of care provided to patients in hospitals under the Maternal and Child Health program has been limited. There are no fully designated PSROs because, among other reasons, there has been only limited involvement in reviewing care provided to patients in long-term care facilities.

Some PSROs are or were in the planning stage for what appears to be unnecessarily long periods. Of the 15 PSROs visited, four remained in the planning stage for 24 to 27 months; six remained for 11 to 18 months; one has not yet achieved conditional status after 33 months; and another is not conditional after 21 months. Several of the 13 PSROs that converted to conditional status have been delayed in initiating or fully implementing hospital review activities. Care provided to Medicare and Medicaid patients was being reviewed in only about 64 percent of the 625 hospitals in these areas. Only 4 of the 13 PSROs had done profile analyses; 3 had reviewed long-term care; and 3 were reviewing care to Maternal and Child Health patients.

#### FACTORS IMPEDING PROGRAM IMPLEMENTATION

Several interrelated factors have impeded implementation of the PSRO program. Some are discussed here, and we are exploring others. Factors which we identified include: deficiencies in HEW's program administration, physician opposition, and internal PSRO problems. These factors could continue to impede program implementation if they are not resolved.

#### HEW program administration

HEW was slow in establishing an effective, adequately staffed organization to operate the program. It did not

promptly gain the necessary support and cooperation of the Social and Rehabilitation Service, the Social Security Administration, or the Bureau of Community Health Services, which administered the Medicaid, Medicare, and Maternal and Child Health programs, respectively. (HEW recently put the administration of the Medicare and Medicaid programs under the newly established Health Care Financing Administration.) It has been slow in providing needed program regulations, instructions, and guidance for PSROs.

#### Organization and staffing

Between November 1972 and July 1974, HEW established a number of organizational arrangements to implement the PSRO program. However, these did not prove totally effective, because of such problems as fragmented responsibility, insufficient staffing, and internal struggles for program control. In July 1974, BQA was given primary responsibility for the daily operation of the program, but these problems were not completely resolved. For example, during 1975, BQA did not have enough staff to provide PSROs with technical assistance and to promptly review PSRO plans for conversion to conditional status. As a result, BQA had to provide more than \$1.8 million to maintain 61 planning PSROs while their plans were being reviewed.

Interagency support  
and cooperation

The Social and Rehabilitation Service and the Bureau of Community Health Services have a direct influence over State agencies administering their programs, and they, as well as the Social Security Administration, can directly influence hospital activities because they provide funds for patient care. BQA, on the other hand, provides no funds for patient care and thus has limited or no such influence. Therefore, BQA needs the full support and cooperation of the HEW agencies to implement the PSRO program. Disagreements among these agencies have sometimes hampered PSRO review of care provided to hospital patients.

HEW has been slow in fully defining the roles and responsibilities of the Social Security Administration, the Social and Rehabilitation Service, and the Bureau of Community Health Services, and in requiring their full support and cooperation in implementing the program. In April 1974, about a year and a half after passage of the act, the Assistant Secretary for Health and the heads of the Social Security Administration and the Social and Rehabilitation Service agreed on their respective responsibilities under the PSRO program. According to BQA, significant improvements have been made since the agreement, but the lack of full support and cooperation from these agencies continues to impede program implementation.



### Uncooperative hospitals

Several hospitals in a number of States have refused to permit PSRO review. For example, in May 1976, between 60 and 70 hospitals in Tennessee were expected to refuse to permit PSRO review. Our field work in Tennessee showed that 15 hospitals still refused to permit PSRO review.

In October 1975, BQA asked the Social Security Administration to issue general instructions to hospitals and fiscal intermediaries regarding the statutory obligation of hospitals participating in the Medicare program to cooperate with PSROs. The instructions were not issued and in April 1976 BQA repeated its request. Although the Social Security Administration has dealt with this problem on a hospital by hospital basis, it has not yet issued the requested instructions. It is, however, developing them.

### Working agreements with State agencies

BQA requires PSROs to develop administrative arrangements (preferably memoranda of understanding) with Medicare fiscal intermediaries and State Medicaid and Maternal and Child Health agencies before initiating PSRO review activities. Most PSROs had few problems negotiating memoranda of understanding with Medicare fiscal intermediaries. However, a number of State Medicaid agencies

have been reluctant to develop such memoranda, and as a result, PSRO review of care provided to Medicaid patients has been delayed or precluded. For example:

--Three Massachusetts PSROs were delayed in implementing review of care of Medicaid patients for an average of 6 months because of problems in reaching agreement with the State Medicaid agency.

--The San Francisco PSRO began reviewing care provided to Medicare patients in November 1976 but has been unable to review care provided to Medicaid patients because of problems in reaching agreement with the State Medicaid agency.

The Social and Rehabilitation Service did not take prompt, aggressive action to help resolve disagreements between PSROs and State Medicaid agencies. The problem stems, in part, from the Social and Rehabilitation Service's reluctance to implement a decision made by the Secretary of HEW in February 1975 and reaffirmed in January 1976. The decision provided for conditional PSROs to make binding decisions on the necessity of hospital care for Medicare and Medicaid hospital patients for reimbursement purposes.

In June 1975, the Social and Rehabilitation Service informed State Medicaid agencies of the Secretary's decision. However, instructions implementing the decision were not issued until September 1976. According to BQA,

the Social and Rehabilitation Service has not applied the sanctions provided for in the instructions against State Medicaid agencies hindering PSRO review.

PSROs have had difficulty negotiating agreements with State Maternal and Child Health agencies because for some time BQA and the Bureau of Community Health Services were unable to agree on PSRO-State agency relationships for PSRO review activities. In July 1976, BQA issued to PSROs instructions developed jointly with the Bureau on this subject, and further stated that they were jointly developing additional guidance in this area. This guidance is still being developed.

Long-term care  
coordination

PSROs and State Medicaid agencies have overlapping responsibilities in the review of long-term care patients. HEW, however, has not clearly defined the procedures to be followed to avoid duplication and ensure effective and efficient review of long-term care activities. As a result, efforts in the long-term care area have not been fully coordinated.

Although most PSROs are not yet involved in the long-term care area, they are responsible for developing criteria for the review of care to long-term care patients. In 1975, the Social and Rehabilitation Service awarded a \$1.4 million grant to the Massachusetts Medicaid agency to develop and implement

medical criteria for the review of selected ambulatory and long-term care services provided under the Massachusetts Medicaid Program. The Social and Rehabilitation Service awarded the grant (1) before the State Medicaid agency had coordinated with the Massachusetts PSROs and (2) before the scope of work was clearly defined and agreed upon. Although the Social and Rehabilitation Service stated it would not release all the project funds until the objections of the PSROs and BQA were resolved, several hundred thousand dollars were subsequently released even though the issues were unresolved. Agreement has not yet been reached.

Delays in issuing regulations, instructions, and guidance

HEW has been slow in issuing program regulations and providing needed instructions and guidance to PSROs. As a result, planning PSROs have been delayed in converting to conditional status; conditional PSROs have been delayed in reviewing care provided to Medicare and Medicaid hospital patients; and the potential exists for duplication of effort between PSROs and Health Systems Agencies established pursuant to the National Health Planning and Resources Development Act of 1974.

Regulations

The PSRO program cannot be fully implemented until HEW publishes regulations. Thirteen regulations or interrelated

sets of regulations were required by the enabling legislation or deemed necessary by HEW officials. As of March 1977, only two complete regulations and part of another had been published in final form. Parts of two other regulations were issued on an interim basis pending publication of final regulations.

In a few cases, States and hospitals have hindered program implementation because of the lack of final regulations. For example, regulations specifying the authority of PSROs to conduct binding review of Medicare and Medicaid hospital patients are needed but not yet published. Some States refused to accept the Secretary's February 1975 decision and impeded PSRO review of care to Medicaid hospital patients.

Final regulations are also needed on the confidentiality of PSRO data. Three Massachusetts PSROs we reviewed were delayed several months in reviewing care to Medicaid patients because of disputes with the State Medicaid agency over the release of PSRO data which identified hospitals and physicians. Although HEW published an interim confidentiality regulation in December 1976, these PSROs are still reluctant to release data to the State in the absence of a final regulation on confidentiality. They want to be assured that they are not violating legislative restrictions on data release.

Coordination between Health Systems Agencies and PSROs could also be adversely affected if final confidentiality

regulations are not published promptly. Health Systems Agencies were established to (1) increase the accessibility, acceptability, continuity, and quality of health services, (2) restrain increases in the cost of providing health services, and (3) prevent unnecessary duplication of health services. They are expected to do this by identifying the health status and needs of residents in their areas and by developing and helping to implement plans to meet these needs.

To carry out their health planning responsibilities, Health Systems Agencies must obtain data on the need for and use of health resources. PSROs collect some of this data in performing their duties, but some have been reluctant to share it with Health Systems Agencies until HEW publishes final regulations specifying what data they can provide.

Legislation requires Health Systems Agencies to coordinate with PSROs and to make data they have available to the public. PSRO legislation, on the other hand, restricts the release of data by PSROs and requires the imposition of penalties for improper release. Despite BQA's encouragement of PSROs to cooperate with the Health Systems Agencies, PSROs are reluctant to do so because of conflicts between the programs' enabling legislation. If the issue is not resolved soon, Health Systems Agencies could be forced to independently collect data that has already been obtained by PSROs.

Program guidelines  
and instructions

BQA was not timely in issuing complete guidelines and instructions needed by planning PSROs to convert to conditional status. Several PSROs received needed instructions shortly before or after they had submitted their conversion plans to HEW. As a result, several planning PSROs were delayed converting to conditional status. Delays were further extended because of HEW funding problems.

Ten of the 15 PSROs we visited had submitted conversion plans to BQA before it issued complete guidelines and instructions. Seven PSROs indicated that they could have prepared better plans if they had had complete instructions earlier. Four of these seven PSROs experienced significant delays in converting to conditional status because of the time needed for revision and approval of their plans and/or because of HEW funding problems.

For example, the South Dakota PSRO was awarded a planning contract in June 1974 and was to submit a plan for conversion to conditional status within 6 months. The PSRO, however, could not complete its plan on time because it did not receive needed guidelines and instructions on delegating review responsibilities to hospitals until late November 1974. In January 1975 the PSRO submitted its conversion plan to BQA.

In February 1975, BQA sent the PSRO a set of guidelines and instructions on preparing a conversion plan and told the PSRO to revise its plan accordingly. The PSRO required about 3 months to reorganize the information to conform to the new format specified and provide additional information. Some of this information was not required by guidelines and instructions available to the PSRO before it submitted its plan. In May 1975, the PSRO submitted its revised plan to BQA, and BQA gave the PSRO additional tasks to keep it operating until it could further refine its plan and be converted to conditional status. In September 1975, BQA approved the PSRO's plan, but the PSRO was not converted to conditional status until June 1976 because BQA was uncertain that future funding levels would sustain expanded program activities. Time was also needed to complete contracting procedures after fiscal year 1976 appropriations were enacted in January 1976. Officials at this PSRO and at two others in similar situations indicated that they could have used the funds they received for additional tasks more productively had they been designated conditional PSROs.

Several factors have hindered BQAs ability to develop and provide regulations, instructions, and guidance earlier. These include fragmented responsibilities, staffing shortages, the complexity and sensitivity of the issues, complex inter-relationships with other agencies, changes in HEW's regulation development procedures, and changes in PSRO legislation.



## LACK OF PHYSICIAN SUPPORT

Legislation requires that physician organizations be given preference in establishing PSROs. Moreover, adequate physician involvement in PSRO activity is critical to the overall success of the program. Initially, a substantial number of physicians opposed the PSRO program. Although HEW has helped to dissipate much of this opposition, lack of physician support has continued to impede PSRO development in some areas.

Lack of physician support has been a factor in delaying PSRO establishment in at least 17 of the 37 areas without PSROs. Also, it has been a problem in converting some PSROs from the planning to the conditional stage.

For example, physicians in Nebraska have shown no interest to date in establishing a PSRO. Although Georgia physicians have formally opposed the program, they have submitted an application for a planning PSRO to HEW with a request that it not be considered until December 15, 1977. This is 15 days before expiration of a requirement that HEW give physician organizations preferential consideration.

In addition, a planning PSRO in San Mateo, California, could not convert to a conditional PSRO and had to terminate operations because more than half the area physicians polled opposed the PSRO's conditional designation. Physicians opposed the PSRO's conditional designation primarily

because they were against the PSRO concept, believing it represented too much Government involvement in medicine. An HEW PSRO project officer reported that the intensity of opposition in some sections of California was so great that practicing physicians in one area ostracized, both professionally and socially, the physicians openly associated with the PSRO.

Legislation allows HEW to designate a non-physician organization as a PSRO prior to January 1, 1978, when (1) the major physician organization in an area formally opposes or adopts a noncooperation policy toward the PSRO program or (2) physicians in an area reject HEW's proposed designation of a conditional PSRO through polling.

HEW, however, has not issued regulations required for the designation of non-physician organizations as PSROs. Although HEW is developing such regulations, BQA officials said that they would probably not take action to designate a non-physician organization as a PSRO until January 1978 to give physician organizations every opportunity to participate.

#### INTERNAL PSRO PROBLEMS

Some PSROs had internal problems that delayed program implementation. For example, a California PSRO still remains in the planning phase 33 months after it was awarded a planning contract. During this period the PSRO had only a

part-time executive director; for 25 months, it had filled only one other position, and three different persons held it. A Florida PSRO delayed converting to conditional status because its physicians were reluctant to accept the rate of payment allowed for physician review activities.

#### SUMMARY

In summary, Mr. Chairman, 166 of 203 areas in the Nation are covered by PSROs in various stages of development. Thirty-seven areas, 11 of which encompass three entire States, do not have a PSRO. There are no fully designated PSROs. Of the 58 PSROs with planning contracts, 47 were only recently awarded; some of the 11 others have remained in planning for lengthy periods. Several of the 108 conditional PSROs were delayed in converting from the planning stage and beginning review of care provided to hospital patients for lengthy periods. Many have still not fully implemented hospital review activities and only a few are involved in reviewing care to patients in long-term care facilities.

PSROs experienced problems in organizing, developing program plans, converting to conditional status, developing working relationships with State Medicaid and Maternal and Child Health agencies, obtaining support from some hospitals, developing long-term care facility review programs, and coordinating with Health Systems Agencies. Some of these problems are attributable to problems in HEW's administration

of the program. But physician opposition, much of which HEW has helped to dissipate, and other problems, such as funding difficulties and internal PSRO problems, have also impeded the program's implementation. Consequently, Federal funds have not always been used efficiently and effectively and benefits anticipated under the authorizing legislation have not fully materialized.

HEW failed to promptly (1) effectively organize and adequately staff the PSRO program and (2) obtain or direct cohesive, vigorous efforts among BQA, the Social Security Administration, the Social and Rehabilitation Service, and the Bureau of Community Health Services. These problems, in turn, contributed to HEW's inability to provide timely PSRO program regulations, instructions, and guidance. The establishment of the Health Care Financing Administration recently announced by HEW could help resolve many of the management problems identified.

- - - -

Mr. Chairman this concludes our statement. We shall be happy to answer any questions that you or other Members of the Subcommittee might have.