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Report to Rep. Sam M. Gibbons, Chairman, House Committee on Ways and Means: Oversight Subcommittee; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs: Reimbursement Policies and Utilization Controls (1208).
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Professional Standards Review Organizations (PSROs) were established in order to assure that health care services provided under medicare and medicaid conform to appropriate professional standards and are delivered in the most effective, efficient, and economical manner possible. On November 14, 1977, the Department of Health, Education, and Welfare (HEW) announced that it was increasing the maximum allowable compensation for PSRO Executive Directors and Medical Directors.
Findings/Conclusions: The salary schedules established for executive directors appeared to be inflated, and criteria and data on which they were based were not consistent with the backgrounds of most executive directors. The salary increases are about 8% to 10% higher than they would be if they were based on rates for similar positions in nonprofit organizations, and the levels are equal to, or higher than, those in similar positions in the medicare/medicaid administration complex. Also, there are similarities in the administrative hierarchy within each organization and opportunities in States with more than one PSRO to consolidate similar administrative functions which could result in cost savings. The 164 PSROs in the 21 States with more than one PSRO area will spend over $40 million for administrative staffs. Consolidation can best be achieved when nonperforming organizations are identified and removed from the program. Recommendations: The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to: rescind the executive director salary levels published in November 1977 and establish new levels based on salaries paid comparable positions in nonprofit organizations; and identify PSRO areas where administrative staff and functions can be

combined, paying particular attention to situations where nonperforming PSROs are replaced, and encourage the sharing of support services. (HTW)

REPORT BY THE

8005

Comptroller General

OF THE UNITED STATES

Opportunities To Reduce Administrative Costs Of Professional Standards Review Organizations

New salary guidelines established by the Department of Health, Education, and Welfare in November 1977 for Professional Standards Review Organizations Executive Directors are too high and should be revised. Also, the administrative hierarchies of the organizations are similar regardless of workload and there are 164 of them in the 21 States with more than one organization area. Savings could be accomplished through consolidation of administrative functions or sharing of support services.

HRD-78-168
OCTOBER 12, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Sam M. Gibbons
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Your December 2, 1977, letter requested that we review Professional Standards Review Organization staffing levels, staff salaries and fringe benefits, and travel policies for staff members. This report discusses the reasonableness of proposed salary increases for Professional Standards Review Organization executives, and identifies opportunities to reduce costs by combining administrative functions or sharing administrative support services, such as data processing.

We did not take the additional time to obtain written agency comments because the major issues discussed in this report were presented in testimony before your Subcommittee on June 15, 1978. Department of Health, Education, and Welfare comments on these issues are a part of the record relating to that testimony and are recognized in this report.

This report contains recommendations to the Secretary of Health, Education, and Welfare. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

As arranged with your office, unless you publicly announce its contents earlier we plan no further distribution of this report until 7 days from the date of the report. At that time we will send copies to interested parties and make copies available to others on request.

Sincerely yours,

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT
TO THE SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

OPPORTUNITIES TO REDUCE ADMINISTRATIVE COSTS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

D I G E S T

Professional Standards Review Organizations are designed to assure that health care services provided under Medicare and Medicaid are delivered in the most effective, efficient, and economical manner possible. GAO reviewed recent increases in the salary schedules established for Executive and Medical Directors, the top administrators of these organizations, and compared their current salaries with salaries of similar positions in the Medicare/Medicaid administrative complex.

Salary schedules issued by the Department of Health, Education, and Welfare (HEW) in November 1977, to guide Professional Standards Review Organizations in establishing Executive Director salaries, appeared inflated. Criteria and data on which the salary schedules were based do not appear to be consistent with the experience and backgrounds of most Executive Directors.

These positions seem to relate more closely to similar positions in nonprofit organizations. Salary increases based on rates paid to similar positions in nonprofit organizations would be about 8 to 10 percent less than the current HEW salary schedules. HEW said it would discuss GAO's findings with its consultant to determine more appropriate criteria for establishing the salary levels of Executive Directors.

Current salary levels for Professional Standards Review Organization Executive Directors generally are equal to, or higher than, salaries of similar positions in the Medicare/Medicaid administration complex. (See p. 6.)

GAO also noted similarities in the administrative hierarchy within each organization structure and concludes that opportunities

exist in States with more than one organization to consolidate similar administrative functions which could result in cost savings.

Total of average salaries paid to administrative staffs at 13 organizations was over $256,000. Because there are 164 organizations in the 21 States with more than one organization area, HEW will spend over $40 million for administrative staffs when these 164 organizations are fully operational. (See p. 13.)

Not all organization areas can or should be consolidated into a one per State situation, but it would seem that the potential for eliminating duplication and realizing the resulting savings could be significant if the total number of organizations can be consolidated even on a limited basis, or if sharing of basic administrative support services such as data processing and data management could be accomplished. HEW believes that consolidation could best be achieved when nonperforming organizations are identified and removed from the program.

The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to

--rescind the Executive Director salary levels published by the Health Standards and Quality Bureau in November 1977, and establish new salary levels based on salaries paid comparable positions in nonprofit organizations and

--identify organization areas where administrative staff and functions can be combined, paying particular attention to situations where nonperforming Professional Standards Review Organizations are replaced, and encourage the sharing of support services.

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ABBREVIATIONS

HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
HSQB	Health Standards and Quality Bureau
PSRO	Professional Standards Review Organization

CHAPTER 1

INTRODUCTION

Establishment of Professional Standards Review Organizations (PSROs) was mandated by the Congress in the 1972 Amendments to the Social Security Act (Public Law 92-603). The purpose of the PSRO program is to assure that health care services and items for which payment may be made in whole or in part under titles V (Maternal and Child Health and Crippled Children's Services), XVIII (Medicare), and XIX (Medicaid) of the Social Security Act conform to appropriate professional standards and are delivered in the most effective, efficient, and economical manner possible. PSROs are currently required to review services that are provided in hospitals and nursing homes. Review of ambulatory health care provided by physicians may be required in the future.

To meet their responsibilities, PSROs review admissions, certify the need for continuing treatment, review extended or costly treatment, conduct medical care evaluation studies, and review profiles of the medical care provided. PSRO review systems are being implemented first in hospitals, since the amount of Federal expenditures is largest for this category of service.

On November 14, 1977, the Department of Health, Education, and Welfare (HEW) announced that it was increasing the maximum allowable compensation for PSRO Executive Directors from $35,000 to $56,500 and for PSRO Medical Directors from $50,000 to $62,500. On December 2, 1977, the Chairman, Subcommittee on Oversight, House Committee on Ways and Means, wrote the Comptroller General about his concern regarding the increases in these salary levels. He said that the PSRO program had cost about $103 million in fiscal year 1977 and was expected to cost $150 million in fiscal year 1978, with most of these costs associated with personnel. The Chairman requested us to review PSRO (1) staffing levels, (2) staff salaries and fringe benefits, and (3) travel policies for staff members. (See app. I.)

SCOPE OF REVIEW

We reviewed staffing levels, employee compensation, and travel policies at the 14 PSROs listed in appendix II. At each PSRO, we interviewed Executive and Medical Directors to determine the nature of their duties and responsibilities. We

also gathered information on salaries, duties, and responsibilities for similar positions in the Medicare/Medicaid administrative complex in each PSRO geographic area included in the review. Discussions were held with key officials of Hay Associates, whose study of PSRO Executive and Medical Directors salaries formed the basis of HEW's increase in maximum compensation. Also, because of Subcommittee interest in the area of data management, we obtained information on how the 14 PSROs were handling their data requirements.

CHAPTER 2

DEVELOPMENT OF NEW SALARY LEVELS FOR PSRO EXECUTIVE AND MEDICAL DIRECTORS

In November 1977 the Health Standards and Quality Bureau (HSQB), a component of the Health Care Financing Administration (HCFA), published revised PSRO Executive and Medical Director salary levels. These levels were established based on a study by a private contractor. We believe that the criteria and the data on which the increased salary schedules were based were not consistent with the experience and backgrounds of the Executive Directors in the 14 PSROs included in our review. The use of other criteria and data, more directly related to the activities of the Executive Directors and more consistent with HSQB original criteria, could avoid unwarranted future salary increases.

USE OF PRIVATE CONTRACTOR TO DEVELOP CRITERIA

In January 1977 HSQB contracted with Hay Associates--a private consulting firm specializing in conducting analyses of compensation schedules among a variety of public and private organizations--to develop guidelines and criteria to evaluate employment compensation, including salaries of PSRO Executive and Medical Directors and fringe benefits.

Hay Associates was selected by HSQB to do this evaluation because of its experience in job evaluation techniques, particularly in conducting comparative analyses of compensation schedules among a variety of public and private organizations. Also, according to HSQB, Hay Associates possessed the most comprehensive data base for analyses and comparison of compensation schedules offered by hundreds of different organizations, representing every conceivable occupational category. For these reasons, HSQB decided that a sole source contract was necessary to meet its requirements.

One of the major requirements identified in HSQB's sole source justification was:

> "The Bureau of Quality Assurance intends to ensure that all PSROs personnel practices, specifically compensation policies, are adequate, appropriate, and comparable to other organizations which are geographically located in the same PSRO areas, nonprofit in nature, service oriented and relatively small in size."

The contract was awarded on January 26, 1977. The initial study was completed on August 31, 1977, at a cost of about $57,000.

NEED TO REEVALUATE EXECUTIVE DIRECTORS' SALARIES

The scope of the study covered the evaluation of the Executive and Medical Directors' salaries at conditional PSROs. 1/ Because of the varying complexity and size of PSROs, as well as differing organizational structures and reporting relationships, the study identified four position levels for each of the two director positions. Position level A represents the most complex position in terms of job content, with position levels B, C, and D following in descending order of relative difficulty, importance, and job content complexity. With respect to the Executive Director position, the study concluded that the demands made upon the Executive Director placed the job in a rather unique category because it was similar to certain aspects of hospital administration, and it resembled fiscal management common to banking or insurance companies.

The job also had overtones of the management of an association/service organization. For the most part, however, the study concluded that the Executive Director position was one that requires managerial skills matching many executive positions on the American business scene. Hay subsequently compared the salary data for Executive Directors with data of a cross section of American business based on the belief that the Executive Director's job must be business oriented. The cross section of American business includes nearly 500 companies in the insurance, banking, and manufacturing industries.

Prior experience of Executive Directors suggests different criteria

As mentioned previously, the criteria for comparisons provided for in HSQB's sole source procurement justification were for small nonprofit service-oriented organizations. At the 14 PSROs included in our review, the majority of Executive Directors came from service-type, nonprofit medical organizations. Nine of the 14 were previously administrators

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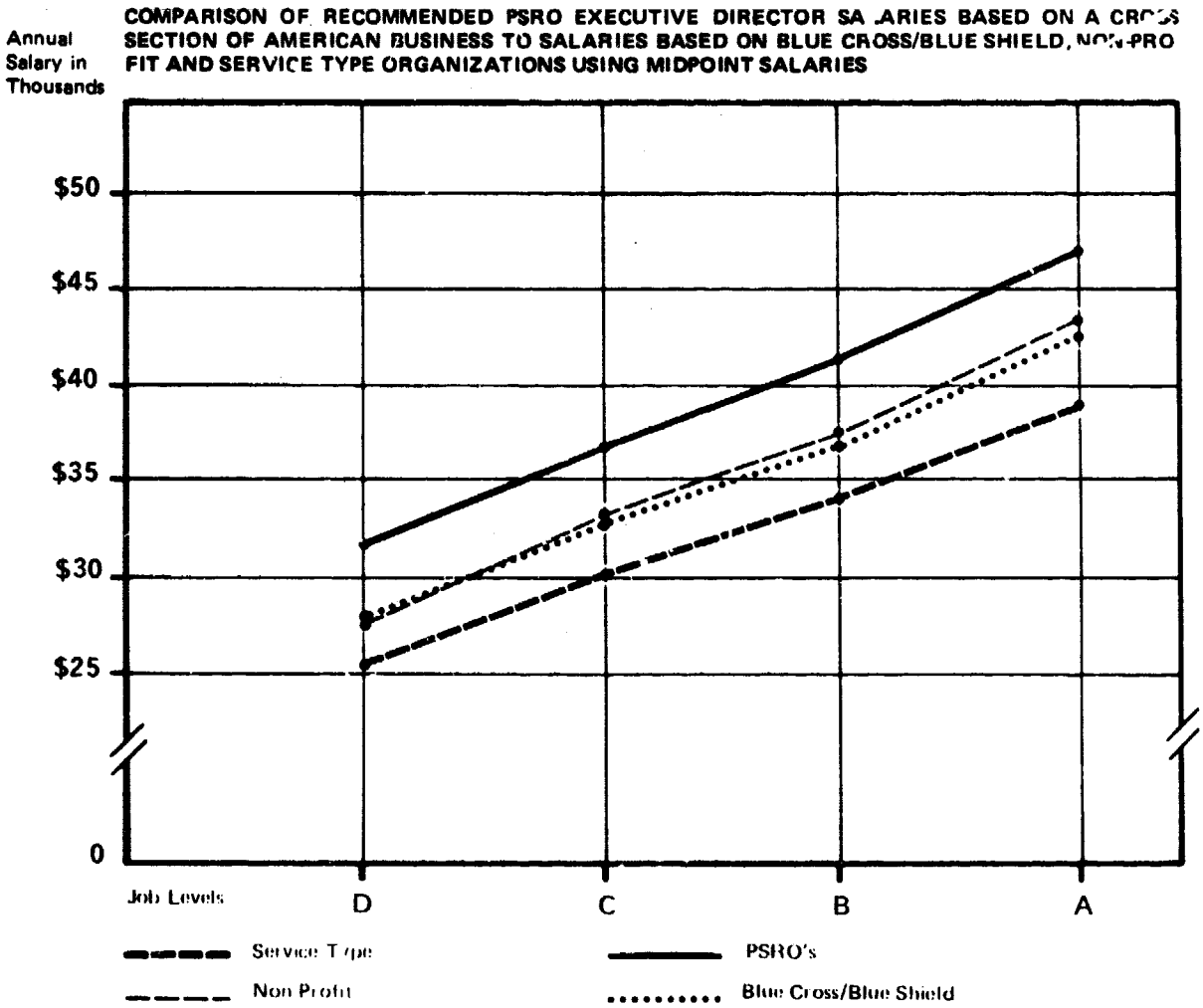
1/These are organizations designated as PSROs for a trial period based on approved plans for the orderly assumption and implementation of their responsibilities under the law.

of medically oriented organizations, such as hospitals, foundations for medical care, medical institutes, and medical divisions of insurance companies. Three of the 14 were hired directly from college graduate schools and had health-care-type educational backgrounds. One Executive Director was formerly on a nonprofit planning council, and one was a director of human service studies.

Since the personnel actually filling these positions are mainly from nonprofit service-type medically oriented organizations, and since service-type nonprofit organizations were specified by HSQB in its sole source justification, we requested Hay Associates to compute a range of salaries based on service type, Blue Cross/Blue Shield, and nonprofit organizations. The results of this computation and the comparison to the HSQB-recommended midpoint salary levels based on a cross section of American business, as adopted by HSQB in November 1977, are illustrated in the following graph.



Comparison of Executive Director salaries to similar positions in the Medicare/Medicaid administrative complex

We compared current Executive Director salaries and responsibilities to upper management positions in the local Medicare/Medicaid administrative complex in each geographic area. For Medicare, we used the local Blue Cross fiscal intermediary positions, such as Vice-President for Provider Relations; Director of Government Programs; and Coordinator, Medicare Part A. For Medicaid, for the most part, we used the individual directly responsible for the administration of the State Medicaid program. The similarity of positions was established through discussions with Blue Cross and State Medicaid officials, as well as PSRO Executive Directors. In addition, we compared the salaries of the PSRO Executive Director to those of the Executive Director of the local Health Systems Agency that provides health planning in local areas to promote and develop health services, manpower, and facilities. This comparison is shown in appendix IV.

Overall, excluding the three Los Angeles County PSROs, four of the Executive Directors' salaries were higher than the salaries paid by Medicare intermediaries and Health Systems Agencies for comparable positions. Five Executive Directors' salaries were about equal to comparable positions in the intermediaries and/or Health Systems Agencies, and two Executive Directors' salaries were lower than the intermediaries and the Health Systems Agencies.

We reviewed three of the eight PSROs in Los Angeles County. Because of the dispersion of responsibility, we had difficulty comparing these positions to other organizations in the Medicare/Medicaid administrative complex and in the health planning program because (1) the Health Systems Agency covered the whole county, (2) the fiscal intermediary in the area was responsible for the southern half of California, and (3) the State Medicaid official was responsible for institutional utilization review for the whole State. However, we feel that the Executive Directors' salaries for these PSROs, which ranged from $30,475 to $34,500, appear high considering the higher workload and larger responsibilities of the other organizations.

The fiscal intermediary positions, when compared generally, involved supervising more people and dealing with more hospitals than the corresponding PSROs. Also, except where the PSRO covered a county or part of a county, the PSRO Executive Directors' salaries are higher than comparable State Medicaid positions.

The Hay Associates study included specific salary recommendations for individual PSROs in addition to the salary ranges. The study included specific salary recommendations of all but 1 (Charlotte, North Carolina) of the 14 PSRO areas included in our review. The Executive Directors' salaries were not immediately raised to the Hay-recommended levels in all cases. However, in future contract or grant years, it is probable that Executive Director salaries will be negotiated upward within the November 1977 guidelines. A comparison of current Executive Director salaries with the salary levels contained in the November 1977 guidelines, and with salary levels based on the criteria for nonprofit service organizations, is shown in the following table.

Comparison of Current PSRO Executive Director Salaries to Nonprofit Organization Salary Scale and to Salary Scale Adopted by HSQB

PSRO area	Current salary	Nonprofit salary scale Midpoint	Nonprofit salary scale Maximum	HSQB salary scale Midpoint	HSQB salary scale Maximum
Norfolk, Va. (E)	$32,000	$33,100	$39,550	$36,900	$44,300
Winston-Salem, N.C. (H)	31,920	33,100	39,550	36,900	44,300
South Carolina (H)	35,650	37,260	44,700	41,400	49,700
Cincinnati, Ohio (L)	29,160	33,100	39,550	36,900	44,300
Columbus, Ohio (E)	30,240	37,260	44,700	41,400	49,700
Kentucky (H)	35,000	37,260	44,700	41,400	49,700
Montgomery Co., Md. (E)	27,327	27,600	33,100	31,600	37,900
Prince Georges Co., Md. (E)	25,875	27,600	33,100	31,600	37,900
Colorado (L)	34,000	43,425	52,070	47,100	56,500
California Area 22 (H)	31,320	33,100	39,550	36,900	44,300
California Area 23 (H)	30,475	33,100	39,550	36,900	44,300
California Area 24 (H)	34,500	37,260	44,700	41,400	49,700
California Area 27 (E)	32,036	33,100	39,550	36,900	44,300

Key: L = Current salary is lower in comparison to local Medicare/ Medicaid administrative positions.

H = Current salary is higher in comparison to local Medicare/ Medicaid administrative positions.

E = Current salary is equal in comparison to local Medicare/ Medicaid administrative positions.

ESTABLISHMENT OF MEDICAL DIRECTOR SALARY RANGES

Hay Associates used hospital-based practitioners' salary data to establish salary ranges for PSRO Medical Directors and we had no particular problem with this criteria. We compared 11 Medical Directors' salaries to similar positions in the Medicare/Medicaid administrative complex in the PSRO areas. Three PSROs were excluded because they had no Medical Director.

This comparison, shown in appendix V, indicated that in three PSRO areas the Medical Director is paid a higher salary than his peers in the Medicare/Medicaid administrative complex whereas in seven areas the PSRO salaries were lower than or within the range of other Medicare/Medicaid salaries. In one area (Columbus, Ohio), there was insufficient information to make a comparison.

HCFA COMMENTS

HCFA stated it planned to discuss our findings with Hay Associates to determine if there is a more appropriate index for determining the salary levels for Executive Directors.

CONCLUSIONS

HSQB's original justification when contracting for the Hay study was to insure that HSQB's compensation policies were comparable to nonprofit, service-oriented organizations. Current Executive Directors' salaries which relate closely to the minimum salary levels adopted by HSQB are in most cases already equal to or higher than salaries of comparable positions in the Medicare/Medicaid administration complex. We believe that if HSQB were to adopt the salary levels for Executive Directors based on the Blue Cross/Blue Shield and nonprofit organization criteria as originally planned, future unwarranted salary increases for Executive Directors could be avoided and the disparities between PSRO salaries and those of comparable positions in the Medicare/Medicaid and health planning administrative complex could be minimized--thus counteracting a source of pressure to raise these salaries also.

RECOMMENDATION

We recommend that the Secretary of HEW direct the Administrator of HCFA to rescind the Executive Director salary levels published by HSQB in November 1977 and establish new salary levels based on salaries paid comparable positions in nonprofit organizations.

CHAPTER 3

PSRO FRINGE BENEFITS AND TRAVEL POLICIES

Hay Associates developed a set of guidelines for HSQB's use in reviewing certain PSRO policies. These guidelines covered (1) fringe benefits, such as death benefits, health insurance plans, and retirement plans, (2) personnel policies which included vacation and paid holidays, and (3) business expenses which included travel policies. The guidelines, which were for internal HSQB use, suggested maximum fringe benefits of 21 percent of salaries, excluding the statutory benefits of social security, unemployment, and workmen's compensation. The fringe benefits of the PSROs included in our review ranged in total from 17 to 23.9 percent of salaries. After deducting statutory benefits, they ranged from 10 to 15.1 percent, which is 11 to 6 percent below the maximum.

Summary of Fringe Benefit Percentages

PSRO area	Fringe benefits as percent of total salaries	Fringe benefits, excluding statutory benefits, as percent of total salaries (note a)
Norfolk, Va.	20.0	12.4
Charlotte, N.C.	20.0	14.1
Winston-Salem, N.C.	19.0	12.7
South Carolina	17.0	10.0
Cincinnati, Ohio	22.0	14.0
Columbus, Ohio	20.0	14.2
Kentucky	21.6	14.2
Montgomery Co., Md.	23.3	14.2
Prince Georges Co., Md.	23.9	13.0
Colorado Area	22.0	15.1
California Area 22	20.1	13.0
California Area 23	23.0	15.1
California Area 24	21.9	12.6
California Area 27	17.2	10.5

a/Statutory benefits include social security, unemployment, and workmen's compensation. The benefits include health and life insurance and pensions but exclude annual and sick leave.

We observed that, overall, PSRO noncash benefits do not materially exceed the standards developed by Hay Associates. Some individual benefits were more liberal and others were more restrictive. Examples of more liberal benefits follow:

--Several PSROs pay the entire cost of health care coverage for both the employee and his or her dependents. While paying for the employee is acceptable, the Hay standard suggests that the employee should provide at least 20 percent to 35 percent of the cost of dependent coverage.

--At least 9 of the 14 PSROs have retirement plans which permit the employee to become fully vested in less time than the Hay-recommended 5 years. For example, employees of the Prince Georges Foundation for Medical Care are fully vested immediately, and the other eight PSROs allow 100 percent vesting in 1 to 4 years.

One official told us that because of the tenuous nature of the PSRO program, a rapid vesting in a retirement plan was one of the few sure benefits the PSRO could offer its employees.

--Vacation policies at 12 of the PSROs deviated slightly from the Hay guidelines. Where Hay recommended 2 weeks paid vacation for service of from 1 to 5 years, the PSRO might allow 2 weeks before 3 years and 3 weeks for 3 to 5 years. Additionally, several PSROs provided administrative leave days and an allowance for funeral leave.

--We found lenient deductible provisions in several PSRO medical plans. The suggested deductible for PSRO medical plans is $100 per person per year. However, several PSROs we reviewed had plans which included a deductible amount of only $50.

On the other hand, more restrictive noncash benefits include:

--Generally PSRO allowances for sick leave are 1 day or less per month versus the standard's guideline of 1.25 days per month. The PSROs also limit accumulation of sick leave, while the standard places no maximum on leave accumulated.

--Six PSROs have life insurance policies which fall below the suggested standard of two times the employee's base salary. These PSROs either stipulate maximum amounts depending on position level, or allot a certain amount of coverage for all employees regardless of position.

TRAVEL POLICIES

PSRO travel policies are generally within the standard developed by Hay Associates and are governed by the Federal principles for determining costs applicable to grants and contracts with nonprofit institutions (45 CFR 74, app. F, G-46). Allowable costs for travel are described in the PSRO Program Manual and included in each individual PSRO contract. PSROs can be relieved of specific travel cost limitations if (1) the PSRO develops a complete set of travel policies for its own organization and (2) these policies have been approved by the HEW Project Officer and Contracting Officer.

Although we did not observe any major deviation from the Hay standard or the Federal principles, we noted the following practices which appear excessive:

--HSQB approved a policy at one PSRO which allowed payments for per diem of up to $50 in cities other than those designated as high cost in the guidelines. In the high-cost areas, the maximum per diem was $65 in lieu of the suggested maximum of $50.

--A second PSRO submitted a proposed travel policy to HSQB which provides for reimbursement of actual lodging expense not to exceed $35 per day plus $15 for meals and tips. The ceiling would be $50 per day regardless of whether the travel is to a designated high-cost area. This policy, if approved by HSQB, would not be consistent with the limits placed on other PSROs described above.

--At a third PSRO, employees attending an annual meeting for PSRO physicians, executives, and review directors were reimbursed actual expenses exceeding allowable per diem for the location. One employee was reimbursed $72 per day and two were reimbursed $76 per day as opposed to the $50 standard suggested for high-cost areas.

CONCLUSIONS

PSRO fringe benefits were generally lower than the maximum developed by Hay and used by HSQB to evaluate these items. PSRO travel policies and practices are in line with the standards. Although we noted some deviations from the standards, these were few in number and insignificant.

CHAPTER 4

POTENTIAL CONSOLIDATION OF PSRO ADMINISTRATIVE FUNCTIONS

Of the 14 conditional PSROs reviewed, there were similarities in the administrative hierarchy within each organization structure. We believe opportunities exist in States with more than one PSRO to consolidate similar administrative functions. These consolidations of administrative functions could result in cost savings. Also, if properly undertaken, they should not result in a reduction of the local medical input which was intended by the Congress.

CONGRESSIONAL INTENT ON AREA DESIGNATIONS

The Report of the Senate Committee on Finance, accompanying the 1972 Amendments of the Social Security Act which established the PSRO program, gives priority in establishing PSRO areas to organizations "at the local level." 1/ The intent was that local sponsorship and operations would "help engender confidence in the familiarity of the review group with norms of medical practice in the area." However, neither the statutory language nor the legislative history precludes statewide designation of populous States. A subsequent Finance Committee report, 2/ on an amendment which was not enacted during the 93d Congress, stated that while local areas were preferred, "authority to designate Statewide areas was implied" in the original legislation. Although the proposed amendment, which would have required the Secretary to give priority to local PSRO areas, was not enacted, the report on the proposed amendment explains that it was not intended to "preclude designation of a statewide area or statewide PSRO."

In addition, the Congress intended that area designations take into consideration "the need to assure a reasonably coordinated administrative arrangement among PSROs and the various medicare and medicaid administrative mechanisms in a State or area."

1/S. Rept. 92-1230, pp. 254 to 269, Sept. 26, 1972.

2/S. Rept. 93-553, p. 67, 1973.

It seems that the Congress intended that area designations consider

--local operation to assure medical input consistent with norms of practice in local medical service areas and

--centralized administrative management to assure coordination between PSROs and statewide organizations.

As a result of the actual area designation process, which featured input from local practicing physicians, there were 32 statewide PSROs (including the District of Columbia, Puerto Rico, and the Virgin Islands) and 21 States with 164 area PSROs which ranged from 2 (Arizona, Minnesota, Oregon, Tennessee and Wisconsin) to 17 and 28 in New York and California, respectively.

One single State PSRO included in our review, the Colorado Foundation for Medical Care, retained the local medical input, and at the same time retained centralized administrative management. Since Colorado had a large physician population and several medical service areas, an organizational structure was developed in which program administration was centralized in Denver while the review of medical care requiring local physician input was decentralized into regions which comprise various medical service areas in the State. The Executive Director of this PSRO stated that the advantages of this centralized administrative management were the:

--Elimination of the need for duplicative administrative functions of Executive Director, Medical Director, Finance Manager, Long Term Care Manager, Ambulatory Care Manager, and data and clerical personnel found in separate PSROs.

--Ability of one PSRO to deal more effectively with statewide agencies and fiscal intermediaries.

--Ability of one PSRO to deal more effectively with large private insurers in developing private review contracts.

--Consolidation of data services, because larger data systems are contractually more cost effective.

--Consolidation of personnel functions (in such area as personnel management, fringe benefits, and training, which is also cost effective.

ADMINISTRATIVE STAFF COSTS

Each PSRO has an administrative cadre to support PSRO program operations, such as the review of hospital admissions and patient care, the collection and analysis of statistical data, and the studies of patterns of medical care. A list of typical PSRO program administrative positions is as follows:

Management	Technical	Support
Executive Director	Administrative Supervisor	Data Manager
Assistant Director	Secretaries	Data Analyst
Finance/Business Manager	Clerical staff	Data Clerk
Director of Acute Care	Bookkeeper	Medical Records Analyst
Director of Long-Term Care		
Medical Director		

These administrative positions are not level-of-effort positions but exist to support program operations whether or not that program reviews a low or high number of Federal patients. The total of average salaries paid to the cadre of administrative staffs at the PSROs included in our review was over $256,000. Since each administrative staff costs about $250,000 per year for salaries alone, and since there are 164 PSROs in the 21 States with more than 1 PSRO, HEW could spend over $40 million for administrative staffs when these 164 PSROs are fully operational.

NO RELATIONSHIP BETWEEN ADMINISTRATIVE COST AND WORKLOAD

We compared the size and cost of 13 administrative staffs of the 14 PSROs included in our review and concluded that there was no relationship between the cost of administering the PSRO program and the workload. (One PSRO, Charlotte, N.C. had no staff at the time of our review.) The following table lists the comparative data.

Comparison of PSRO Administrative Staff Costs and Workload

PSRO area	Hospitals	Fiscal year 1977 discharges reviewed	Program administration staff persons	Year 1978 budgeted payroll
Norfolk, Va.	25	31,794	21	$ 280,585
Winston-Salem, N.C.	20	5,391	14	182,261
South Carolina (note a)	87	124,161	18	236,922
Cincinnati, Ohio	24	78,924	12	183,825
Columbus, Ohio	21	44,177	20	268,083
Kentucky (note a)	110	112,485	23	321,140
Montgomery Co., Md.	4	13,490	15	166,520
Prince Georges Co., Md.	5	12,080	13	151,480
Colorado (note a)	95	98,341	26	595,224
California Area 22	12	10,605	15	237,064
California Area 23	33	17,056	17	284,542
California Area 24	30	10,981	13	193,781
California Area 27	15	30,710	17	231,295
Total				$3,337,722
Average				$256,748

a/Single State PSRO.

Examples of the relationships between administrative staff and workload are as follows:

--Kentucky and Columbus, Ohio, have an almost equal number of administrative staff. Yet, Kentucky is a statewide PSRO with 110 hospitals and a 1977 workload of 112,000 discharges while Columbus covers 21 hospitals in a 9-county area with a 1977 workload of 44,000 discharges. The single county PSRO in Montgomery County, Maryland, which reviews only four hospitals, has three less administrative staff than South Carolina at an annual cost of $166,520 as compared to South Carolina's $236,922.

--The statewide PSRO in South Carolina administers its program in 87 hospitals and had a 1977 workload of 124,000 discharges. The program administrative

salary budget for the Norfolk, Virginia, PSRO exceeds South Carolina's by $43,663, yet the Norfolk PSRO covers only 25 hospitals and reviewed 32,000 discharges.

--Three of the eight PSROs located in Los Angeles County, and included in our review, have budgets for administrative personnel costs ranging from $193,781 to $284,542 annually for fiscal year 1978. The administrative salaries are not directly related to the workload. The PSRO with the $193,781 budget covers 30 hospitals whereas another Los Angeles County PSRO with 12 hospitals in its area budgeted administrative salaries at $237,064. These two PSROs both reviewed nearly 11,000 discharges in fiscal year 1977.

--Each PSRO generally has a data manager and technical support staff to manage its data systems regardless of size. (See ch. 5.) It would seem that the consolidation of administrative staff would also decrease the total number of technical support staff required. For example, Kentucky, which reviewed about 112,000 discharges in fiscal year 1977 and projects an annual workload of 225,000 when all hospitals are implemented, has the same number of technical staff as Columbus, Ohio, which had 44,177 discharges in 1977.

HCFA COMMENTS

HCFA pointed out that the consolidation issue is related directly to the PSRO area designation process and that each PSRO is a separate corporate entity responsible for all PSRO activities within a designated area. Therefore, HCFA believes requiring the consolidation of administrative functions without actual area redesignation would be of questionable legality.

HCFA officials also said that PSRO areas vary significantly in size as a result of the Federal guidelines for designating PSRO areas, and that they do not have sufficient experience to know what the most efficient and effective size is for a PSRO. Also they recognized some apparent inefficiencies when there are a number of small areas in a State, citing the function of data processing as one that usually lends itself to efficiencies of scale. They added that they are now reexamining these issues to determine which functions could be performed more

effectively and efficiently on a larger than single-area basis and what would be the proper method of achieving such combinations. In addition, area redesignation is one factor that will be considered when they identify for termination and replacement a PSRO that does not perform. According to HCFA, 15 PSROs have been notified of deficiencies that may prevent their continued funding. Of these, 14 are multi-state PSROs and one is a single-State PSRO.

CONCLUSIONS

The matters discussed in this chapter are a direct result of the PSRO area designation process. All PSRO areas cannot and should not be consolidated into a one per State situation; however, it would seem that the potential for eliminating duplication and realizing the resulting savings could be significant if the total number of PSROs can be consolidated even on a limited basis, or if sharing of basic administrative support services, such as data processing and data management, could be accomplished. HCFA has recognized some of the inefficiencies involved in small multi-State PSRO areas, and indicated that it will consider area redesignation when a PSRO is to be terminated due to nonperformance. We believe that it is likely that those PSROs with relatively small workloads and high fixed-administrative costs will have the most difficulty demonstrating their cost effectiveness. Therefore, we believe that area redesignation and consolidation should be given priority when HCFA considers terminating an ineffective PSRO.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator of HCFA to (1) identify PSRO areas where administrative staff and functions could be combined paying particular attention to situations where PSROs have been identified as poor performers and (2) encourage the sharing of basic technical and support services.

CHAPTER 5

PSRO DATA MANAGEMENT

The Social Security Act provides that a PSRO collect data for internal use and for the Federal Government to use in monitoring PSRO performance. To date, PSROs have met with limited success in accomplishing this task. Data subcontract negotiations are complex and time consuming, resulting in slow progress in establishing systems. The PSROs have subcontracted with a variety of independent data processors at a wide range of prices. Individual PSRO data systems may not only be operating inefficiently, but each PSRO has the same type technical personnel that could be consolidated and result in personnel savings. Some PSROs are experiencing difficulty when attempting to use existing hospital data systems. We observed little exchange of data with other health administrative organizations.

DATA REQUIREMENTS

Two HSQB reporting requirements necessitate the collection and processing of data by the PSROs, the quarterly summaries of the number and types of patient reviews conducted, and quarterly submission of a magnetic tape containing a data record for each hospital discharge reviewed. HSQB specifies the data elements and the edit checks. PSROs may collect more data elements for internal purposes.

PSROs may obligate funds and enter into subcontracts for automated data processing services to include data input, routine processing, data delivery, and any nonroutine services that may be negotiated. The PSROs may select their own data processor; the only limitations are the subcontract price may not exceed 75 cents per discharge, and the proposal must be technically acceptable to HSQB. In developing and implementing a data system, PSROs are encouraged to make use of existing data collection systems to the extent that such systems can be adapted to meet PSRO requirements. PSROs are also encouraged to share statistical information on the volume, nature, and frequency of the medical services reviewed by them with State, Federal, and other health administrative organizations, and with other PSROs to avoid duplication of effort.

OBSERVATIONS ON PSRO DATA SYSTEMS

We gathered some basic information on the data systems of the 14 PSROs included in our review. We obtained general

information on the costs of the systems, the methods used to obtain the data, the subcontractors who were supplying the data services, and the types of PSRO personnel who analyze and schedule the data. The following table presents an overview of the information obtained.

Table of PSRO Data Systems Reviewed

PSRO area	Discharges reviewed in fiscal year 1977	Contracted price per discharge (in cents)	Subcontractor	PSRO data management personnel
Norfolk, Va.	31,794	74.6--hard copy 66--tape	Blue Cross of Va.	Data Manager Data Analysts (3)
Winston-Salem, N.C.	5,391	75	Commonwealth Clinical Systems	None
South Carolina	124,161	70	South Carolina Medical Building, Inc.	Data Manager Data Clerk Statistician
Cincinnati, Ohio	78,924	65	Medical Dimensions	Data Specialist
Columbus, Ohio	44,177	54.8--hard copy 41.5--tape	Dikewood	Data Manager Data Analyst Data Clerks (2)
Kentucky	112,485	74	Medical Research Foundation	Data Manager Data Analysts (3)
Montgomery Co., Md.	13,490	61	Applied Management Sciences	Data Manager
Prince Georges Co., Md.	12,080	70--hard copy 50--tape	Maryland Resource Center	Data Manager Health Data Analyst
Colorado	98,341	37.5--hard copy 32.3--tape	American Health Systems	Data Manager Data Analysts (3) Data Clerks (3) Data Auditor
California 22	10,605	63	Optimum Systems, Inc.	Data Manager Data Clerk Quality Assurance Technician
California 23	17,056	70.1--hard copy 46.5--tape	Dikewood	Data Coordinator Data Clerks (2)
California 24	10,981	57	Optimum Systems, Inc.	Data Liaison Data Clerks (2)
California 27	30,710	56	Statistical Records, Inc.	Operations Manager Data Analysts (2) Data Clerks (2)

Note: The Charlotte, N.C., PSRO has not awarded a data contract.

Our analysis of the PSRO data contracts showed that the price per discharge for the data services varies for a number of reasons. PSROs are not required to accept the lowest bidder for data services. At least five PSROs included in our review did not take the lowest bid, and one negotiated a sole source contract. In addition to cost per discharge, PSROs told us they consider the quality of the data, technical expertise of the processor, and services provided by the processor when obtaining data services. For example, the Cincinnati PSRO received five proposals ranging in price from 36.4 cents per discharge to 84 cents per discharge. It selected a proposal of 65 cents per discharge based on the types and quality of the services provided.

Use of existing hospital data collection systems

The integration of existing systems has met with limited success at some PSROs. HEW has encouraged PSROs to use existing hospital data collection systems in order to

--avoid duplicative recording and collecting of data,

--recognize the experience and capabilities of existing data systems, and

--quickly provide the PSRO with basic data requirements.

At the PSRO in Columbus, Ohio, this concept was working because the hospital data systems were designed according to PSRO needs and guidelines. However, two other PSROs had problems when attempting to use existing data collection systems. For example, the use of magnetic tape produced by outside abstracting systems can result in a higher cost per discharge to the PSRO. The California Area 24 PSRO has negotiated agreements with hospital abstracting services in the area. The PSRO must pay these outside organizations from 9 cents to 30 cents per discharge to have the existing tapes sent to the PSRO data processor.

Using existing abstracting services also adds a time-consuming additional level of processing which has affected data turnaround time. The PSRO in Cincinnati, Ohio, has had problems receiving data in time to meet HSQB reporting requirements. One abstracting service, used by Cincinnati area hospitals, quoted a time frame of 45 days for sending tapes to the PSRO's processor after the close of a period.

The processor requires an additional 30 days to get the reports back to the PSRO. The turnaround time is therefore 75 days, which exceeds HSQB's allowable 60-day limit for receipt of reports.

Not only is turnaround time affected, but the actual receipt of data can suffer. We noted one case where the hospital's existing system could not be modified to incorporate edit routines required by HSQB, so the hospital had not sent any 1977 data to the PSRO's processor. Other PSROs were experiencing similar problems with hospitals' existing systems.

Sharing collected data

Once the data is collected, the PSRO is encouraged to share it with the State Medicaid Agency, Medicare fiscal intermediaries, PSROs, and other health regulatory organizations. Most of the systems we observed were either not yet functioning or just beginning to generate output, therefore the potential for data exchange was limited. We noted the following proposals for future sharing of data:

--The Montgomery County, Maryland, PSRO was considering merging its tapes with the neighboring National Capital PSRO because Montgomery County's data base is too small to establish standards and norms for patterns of care.

--The Prince Georges County, Maryland, PSRO is a member of a data consortium in Maryland. The intent is to pool all hospital data into one data base so that users may extract reports according to their needs. At the time of our review, the consortium had not furnished the PSRO any data due to technical problems.

--The South Carolina PSRO provides quarterly summary information on distribution of services and resources and on appeals to the State Medicaid Agency and Medicare fiscal intermediary. The PSRO will soon begin to receive ambulatory care data from the Medicaid agency and Medicare fiscal intermediary.

--The Kentucky PSRO's proposed profile analysis includes a health planning profile to be shared with the Health Systems Agencies in the State. Kentucky

is also making arrangements to receive a computer tape from the Medicare fiscal intermediary for use in review of ancillary services.

CONCLUSIONS

The cost of PSRO data subcontracts varies considerably depending on the subcontractor and the type and quality of services obtained. We believe the consolidation of smaller data systems could result in a savings of personnel costs.

Based on the problems observed with PSROs trying to use existing data collection systems, it may be impractical to encourage PSROs to accept magnetic tapes from hospitals unless the hospital's system has been designed to accommodate PSRO needs and has demonstrated acceptable output and turn-around time.

APPENDIX I

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C. 20515

SUBCOMMITTEE ON OVERSIGHT

December 2, 1977

Honorable Elmer B. Staats
Comptroller General of the
United States
General Accounting Office
Washington, D.C. 20548

Dear Mr. Staats:

In fiscal year 1977, the Professional Standards Review Organization program cost $103 million to operate and it is estimated that the program will cost about $150 million in fiscal year 1978. A substantial portion of these costs relate to personnel.

We have been informed that significant differences exist throughout the PSRO program in the compensation of PSRO employees. We have also learned that HEW has approved significant pay increases for principal officials; for example, the maximum compensation levels for Executive Directors and Medical Directors have been increased from $35,000 to $56,000 and from $50,000 to $62,500 respectively. As a result of our concerns in this area, we have asked the Secretary of HEW to discontinue further action pending your review.

The Subcommittee would therefore like the General Accounting Office to review Professional Standard Review Organizations in regard to:

--staffing levels,
--staff salaries and fringe benefits, and
--travel policies for staff members.

We would appreciate your reporting to us on this matter by October, 1978 with the possibility of participating in hearings in June, 1978. As always, my Subcommittee would be happy to elaborate on this request. Thank you for your attention to this important matter.

Sincerely,

Sam M. Gibbons, Chairman
Subcommittee on Oversight

SMG:PP:vs

APPENDIX II

PSROs INCLUDED IN REVIEW

California PSRO Area 22
12301 Wilshire Boulevard,
Suite 203
Los Angeles, California 90025

California PSRO Area 23
23840 Hawthorne Boulevard
Suite 100
Torrance, California 90505

California PSRO Area 24
3200 Wilshire Boulevard
Suite 906
Los Angeles, California 90010

California PSRO Area 27
6833 Indiana Avenue
Riverside, California 92506

Colorado Foundation for
Medical Care
1601 East 19th Avenue
Denver, Colorado 80218

Kentucky Peer Review
Organization
Professional Towers Building
4010 Dupont Circle, Suite 480
Louisville, Kentucky 40207

Montgomery County, Maryland
Medical Care Foundation
11141 Georgia Avenue
Suite 202
Wheaton, Maryland 20902

Prince George's Foundation
For Medical Care
6801 Kenilworth Avenue
Berkshire Building, Suite 310
Riverdale, Maryland 20840

Piedmont Medical Foundation
325 Stratford Oaks, Suite 330
514 South Stratford Road
Winston-Salem, North Carolina
27103

Metrolina Medical Peer Review
Foundation
One Charlottetown Center,
Suite 150
Charlotte, North Carolina
28024

Medco Peer Review
204 Lytle Towers, 405 Broadway
Cincinnati, Ohio 45202

Region X Peer Review Systems
3720-J Olentangy River Road
Columbus, Ohio 43215

South Carolina Medical Care
Foundation
3325 Medical Park Road
P.O. Box 21667
Columbia, South Carolina
29221

Colonial Virginia Foundation
For Medical Care
5 Koger Executive Center,
Suite 220
Norfolk, Virginia 23502

APPENDIX III

COMPARISON OF EXECUTIVE DIRECTOR SALARY RANGE TO OTHER COMPARABLE RANGES

Salary ranges currently in use	Minimum	Midpoint	Maximum
Level A	$37,700	$47,100	$56,500
B	33,100	41,400	49,700
C	29,500	36,900	44,300
D	25,300	31,600	37,900
Salary range based on service-type organizations			
Level A	$31,200	$39,000	$46,825
B	27,050	33,855	40,570
C	24,200	30,270	36,250
D	20,425	25,575	30,635
Salary range based on Blue Cross/Blue Shield organizations			
Level A	$34,200	$42,700	$51,200
B	29,500	36,900	44,300
C	26,300	32,900	39,500
D	22,200	27,700	33,300
Salary range based on non-profit organizations			
Level A	$34,775	$43,425	$52,070
B	29,800	37,250	44,700
C	26,500	33,100	39,550
D	22,100	27,600	33,100

APPENDIX IV

COMPARISON OF PSRO EXECUTIVE DIRECTOR SALARIES TO SALARIES PAID BY FISCAL INTERMEDIARIES, STATE MEDICAID AGENCIES, AND HEALTH SYSTEMS AGENCIES (note a)

Salary	Norfolk, Va.	Charlotte, N.C.	Winston-Salem, N.C.	South Carolina	Cincinnati, Ohio	Columbus, Ohio
PSRO	$32,000	$29,000	$31,920	$35,650	$29,160	$30,240
Fiscal Intermediary	32,500	27,245	27,245	b/28,200	36,264	b/22,740
State Medicaid	21,400	28,092	28,092	32,000	23,982	23,982
Health Systems Agency	27,394	26,300	29,917	28,355	42,500	39,055
Employees						
PSRO	30	13	20	76	12	29
Fiscal Intermediary	37	100	100	135	37	32
State Medicaid	128	110	110	96	76	76
Hospitals						
PSRO	25	22	20	87	24	21
Fiscal Intermediary	74	163	163	72	49	42
State Medicaid	170	150	150	87	215	215

Salary	Kentucky	Montgomery County, Md.	Prince Georges County, Md.	Colorado	California 22	California 23	California 24	California 27
PSRO	$35,000	$27,327	$25,875	$34,000	$31,320	$30,475	$34,500	$32,036
Fiscal Intermediary	b/30,540	b/26,350	b/26,350	45,772	34,824	34,824	34,824	34,824
State Medicaid	21,500	29,733	29,733	27,528	33,600	33,600	33,600	33,600
Health Systems Agency	33,000	36,750	24,000	35,819	45,000	45,000	45,000	31,000
Employees								
PSRO	69	18	23	104	17	31	11	19
Fiscal Intermediary	130	30	30	583	137	137	137	137
State Medicaid	315	70	70	32	606	606	606	606
Hospitals								
PSRO	110	4	5	95	12	33	30	15
Fiscal Intermediary	112	50	50	95	290	290	290	290
State Medicaid	122	60	60	95	612	612	612	612

a/Employees supervised and hospitals reviewed are also shown.

b/These salaries are the midpoint of the salary range for these positions. Actual salary of the incumbent was not available.

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COMPARISON OF PSRO MEDICAL DIRECTOR SALARIES TO FISCAL INTERMEDIARIES AND MEDICAID AGENCIES

Salary	PSRO AREA: Norfolk, Va.	South Carolina	Cincinnati, Ohio	Columbus, Ohio	Kentucky	Prince Georges County, Md.
PSRO	$45,280	$45,200	$48,400	$50,000	$46,000	$45,000
Fiscal Intermediary	50,000	50,000	40,749	a/N/A	b/42,500	b/38,000
State Medicaid Agency	a/37,400	N/A	c/31,200	c/31,200	b/52,000	b/35,229

Salary	PSRO AREA: Colorado	California 22	California 23	California 24	California 27
PSRO	$62,400	$42,000	$48,600	$45,200	$45,780
Fiscal Intermediary	56,000	56,268	56,268	56,268	56,268
State Medicaid Agency	36,876	40,632	40,632	40,632	40,632

a/Not available.

b/This figure represents the midpoint of the salary range for the position; actual salary figures were not available.

c/Annual figure based on hourly rate the State pays its physicians.

APPENDIX V