

REPORT BY THE U.S.

# General Accounting Office

## Need To Better Use The Professional Standards Review Organization Post-Payment Monitoring Program

Professional Standards Review Organizations are designed to assure that health care services provided under Medicaid and Medicare are delivered as effectively, efficiently, and economically as possible. The Department of Health, Education, and Welfare's intermediary post-payment monitoring program is intended to assist (1) these organizations in fulfilling their responsibilities and (2) HEW in evaluating how effective these organizations are functioning.

The post-payment monitoring program was not working as intended primarily because HEW has not issued guidelines or instructions on how the program should work.

HEW should issue such instructions specifically emphasizing how the program should be used

- to identify the causes of and eliminate, to the extent practicable, unnecessary days of hospitalization, and thus, improve the cost effectiveness of individual Professional Standards Review Organizations;
- to educate personnel of such organizations and hospitals on new and proper techniques for reviewing the appropriateness of patient care; and
- by HEW as a potential indicator of the effectiveness of the patient care reviews made by these organizations.



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UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

HUMAN RESOURCES  
DIVISION

B-164031(3)

The Honorable Patricia Roberts Harris  
The Secretary of Health, Education,  
and Welfare

*AGC 00022 ✓*

Dear Mrs. Harris:

This report discusses the need to better utilize the Professional Standards Review Organization post-payment monitoring program. The report contains recommendations to you on pages 19 and 20 for improving the usefulness of this program.

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 House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and 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.

We are sending copies of this report to the above-mentioned Committees; the House Committee on Ways and Means; the Senate Committee on Finance; the Director, Office of Management and Budget; the Inspector General; the HEW Audit Agency; and the Administrator of the Health Care Financing Administration.

Sincerely yours,

*Philip A. Bernstein*  
Philip A. Bernstein  
Acting Director

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GENERAL ACCOUNTING OFFICE  
REPORT TO THE SECRETARY  
OF HEALTH, EDUCATION, AND  
WELFARE

NEED TO BETTER USE  
THE PROFESSIONAL STANDARDS  
REVIEW ORGANIZATION POST-  
PAYMENT MONITORING PROGRAM

D I G E S T

Professional Standards Review Organizations (PSROs) are designed to assure that health care services provided under Medicaid and Medicare are delivered as effectively, efficiently, and economically as possible. Recently, considerable emphasis has been placed on their ability to function as a cost containment mechanism. (See p. 1.)

This is accomplished, in part, by reviewing the medical necessity and appropriateness of inpatient admissions and length of patient stays. These reviews are performed when the patient is admitted and periodically thereafter, and are generally referred to as "concurrent review." (See p. 2.) Prior to PSROs, fiscal intermediaries, such as Blue Cross and Aetna Life and Casualty, reviewed Medicare hospital claims for medical necessity. (See p. 3.) Under the intermediary post-payment monitoring program, intermediaries still sample and review 20 percent of Medicare claims.

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GAO believes that intermediary post-payment monitoring could be a useful tool to improve the cost effectiveness of the PSRO program. However, post-payment monitoring has not met its objectives of (1) being an educational tool and (2) helping the Department of Health, Education, and Welfare (HEW) assess the effectiveness of patient reviews (concurrent review) performed by individual PSROs.

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Under the post-payment monitoring program, fiscal intermediaries randomly sample and review 20 percent of claims related to the inpatient admissions reviewed by a PSRO. Claims questioned by fiscal intermediary

physicians are brought to the attention of the PSRO, which is expected to comment on the intermediary's findings. (See p. 3.)

At four PSROs GAO visited where intermediary findings could be related to total Medicare inpatient hospital days, the intermediaries questioned the necessity of 1 to 5 percent of the days approved by the PSRO because (1) patients were admitted for diagnostic work which could have been performed on an outpatient basis or (2) patients were kept in the hospital longer than necessary. Officials at two of the four PSROs agreed that they had certified 2.6 and 4.2 percent of the total days of care as necessary when in fact these days were not necessary. (See p. 6.) GAO was informed of several factors that contributed to these unnecessary days of care. (See p. 10.)

GAO believes that these amounts are significant. A recent analysis by HEW estimates that active PSROs were cost effective as a result of reducing Medicare hospital utilization by 1.5 percent. On the other hand, a Congressional Budget Office official informed GAO that their analysis shows that these PSROs must reduce utilization by 2.9 percent in order to become cost effective. In either event, a 1- or 2-percent reduction in Medicare hospital utilization is an important factor. (See p. 9.)

The intermediary post-payment monitoring program is not uniformly effective as an educational tool or vehicle for exchanging information because HEW has not issued guidelines or instructions on how the reports are to be used to meet these objectives. At three of the six PSROs GAO visited, it learned that fiscal intermediary results were not being discussed with physician advisers, appropriate hospital personnel, or the attending or admitting physicians in the questioned cases. (See p. 14.)

GAO also noted that (1) HEW instructions to intermediaries do not call for reporting the most appropriate data and (2) intermediaries do not always randomly select claims for review. (See p. 15.)

#### RECOMMENDATIONS

2. The Secretary of HEW should direct the Administrator of the Health Care Financing Administration to issue guidelines and instructions outlining how the post-payment monitoring system should work. These instructions should emphasize how the program should be used 624

--to identify the causes of and eliminate, to the extent practicable, unnecessary days of hospitalization and, thus, improve the cost effectiveness of individual PSROs;

--to educate PSRO and hospital personnel on new and proper techniques for reviewing the appropriateness of patient care; and

--by HEW as a potential indicator of the effectiveness of the patient care reviews made by PSROs.

The Secretary should also direct the Administrator to

--revise the instructions to intermediaries to require the reporting of total days of care sampled and

--remind the intermediaries of the importance of existing instructions requiring the use of random sampling methods. (See p. 19.)



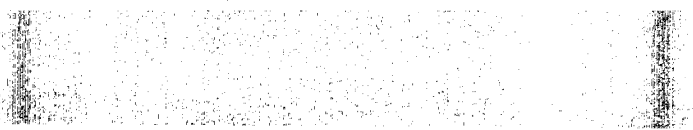


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### ABBREVIATIONS

CBO	Congressional Budget Office
GAO	General Accounting Office
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

The 1972 amendments to the Social Security Act mandated the establishment of Professional Standards Review Organizations (PSROs). PSROs are groups of local practicing physicians who organize and operate peer review mechanisms to assure that health care services provided under three Federal health care programs--Medicare, Medicaid, and Maternal and Child Health--conform to appropriate standards and are delivered efficiently, effectively, and economically.

Medicare provides health insurance benefits to the aged, disabled, and certain others with kidney disease. During fiscal year 1978, this program cost about \$25.2 billion. Medicaid--a Federal-State program--pays for health services for those whose income and resources are insufficient to meet the cost of necessary medical services. During fiscal year 1978, this program cost about \$18.9 billion, of which the States' share amounted to about \$8.3 billion. Maternal and Child Health provides Federal grants to States to help them reduce infant mortality and promote the health of mothers and children, especially those in rural and poverty areas. During fiscal year 1978, this program cost about \$400 million.

PSROs operate under either a contract or a grant with the Department of Health, Education, and Welfare (HEW). PSRO contracts and grants are administered by the Health Standards and Quality Bureau (HSQB) of the Health Care Financing Administration (HCFA).

### PURPOSE OF THE PSRO PROGRAM

Recently, considerable emphasis has been placed on PSROs' ability to perform as a cost-effective mechanism for containing health care costs. For example, during June 1978 hearings, the Chairman, Subcommittee on Oversight, House Committee on Ways and Means, stated that the PSRO program was created by the Congress in 1972 with the intent that PSROs could be a mechanism for containing health care costs and, to some extent, could improve the quality of care. He added that it is incumbent on the PSROs and HEW to demonstrate the program's value. Also, during hearings held in June 1979, the Chairman again indicated that the PSRO program was intended as a mechanism for containing health care costs.

PSROs work to minimize unnecessary hospitalizations and unnecessary lengths of stay among Medicare and Medicaid patients by reviewing the care they receive in short-stay general hospitals and long-term facilities. In short-stay hospitals a PSRO is responsible for:

1. Concurrent reviews--Reviews of the medical necessity and appropriateness of inpatient admissions and length of patient stays. Typically, concurrent reviews involve having a PSRO review coordinator (such as a nurse) screen all Medicare and Medicaid patient admissions and patient lengths of stay. Any case which does not appear appropriate is referred to a PSRO physician (physician adviser) who reviews it and determines the medical necessity of the patient's admission or the patient's remaining in the hospital. If the PSRO physician believes that a patient does not need to be hospitalized, or remain in the hospital, the physician will discuss the case with the attending or admitting physician. If the PSRO physician still believes that future hospitalization is not necessary, the patient, patient's physician, and hospital are notified and have the right to appeal the decision. Medicare patients are given an additional 1 to 3 days--known as grace days--to arrange for their post-discharge care. Each State prescribes whether grace days may be paid for Medicaid patients.
2. Medical care evaluation studies--Retrospective in-depth reviews of care or medical management practices to assess the quality or utilization of health services. Completed medical care evaluation studies identify potential or actual problems, are used to initiate action plans, and assess the impact of action plans initiated during prior evaluations.
3. Profile analyses--Retrospective reviews through which aggregate patient care data are compiled to analyze the patterns of health care services and lengths of stay. Such reviews give the PSRO and the hospitals information for determining needed medical care evaluation studies and are intended to be a means of monitoring concurrent review activities.

The concurrent reviews and medical care evaluation studies may be delegated by PSROs to qualified hospitals that are willing and able to assume these functions (delegated hospitals). As of May 1979, there were 195 PSRO areas, and concurrent reviews were being performed--by either the PSRO or delegated hospitals--in 188 of those areas.

#### MONITORING PSRO PERFORMANCE

HCFA uses its contract intermediaries, such as Blue Cross and Aetna Life and Casualty, under the Medicare program and if the States so desire, the State Medicaid agencies to help monitor PSRO performance.

#### Intermediary monitoring

HEW's January 1977 instructions to Medicare intermediaries state that the objectives of this program (post-payment monitoring) are to (1) facilitate the flow of information between intermediaries and PSROs with respect to new techniques of concurrent review, medical management, and quality assurance and (2) develop information to help the Secretary of HEW determine the efficiency, effectiveness, and progress of each conditional PSRO. A "conditional PSRO" is an organization designated as a PSRO on a trial basis. After an organization has satisfactorily performed as a conditional PSRO, it can become a fully designated PSRO. As of October 1979, there were no fully designated PSROs.

HCFA officials told us that the idea behind intermediary post-payment monitoring is to have PSROs benefit from the experience intermediaries accumulated in their role as reviewers of the necessity of admissions and lengths of stay under the Medicare program. Prior to the PSRO program, the role of intermediaries included the review of Medicare hospital claims for medical necessity. This role continues for hospitals where PSRO review has not yet been implemented.

Under the post-payment monitoring program, intermediaries are required to review a 20-percent sample of claims related to the inpatient admissions reviewed by a PSRO. The selection of claims must be through the use of an acceptable random sampling technique. In examining the claims, the intermediaries are supposed to subject the PSRO-related claims to the same review procedures they use for hospitals that are not under PSRO review. For reporting purposes, an intermediary questioned case, by definition, does not exist until a physician questions the PSRO determination. Questioned claims

are those where the intermediary's determination would have differed from the PSRO's, including whether the intermediary would have denied what the PSRO approved or vice-versa.

Those cases on which the PSRO and intermediary continue to disagree after the case has been brought to the attention of the PSRO are documented individually and summarized in a report. This report also contains summary information on cases where the PSRO agrees that days of care should have been denied. The individually documented cases and summary report are shared with the PSRO and the regional HSQB office to identify potential problem areas with PSRO review and the need for the regional office to provide the PSRO technical assistance.

According to the Office of Planning, Evaluation, and Legislation of HEW's Health Services Administration, the cost of a fully implemented nationwide post-payment monitoring system for Medicare claims is about \$9 million annually.

#### State Medicaid agency monitoring

A HCFA official informed us that State monitoring of PSROs is intended to provide assurance to States that their Medicaid funds are not being misused. The States are not required to follow HEW instructions with respect to how many claims they should review, how the claims are to be selected, or how the review should be performed. HEW instructions do, however, require that State reviews not duplicate the intent and purpose of the PSRO concurrent review process--the States should be checking on the effectiveness of PSRO review, and not attempting to identify and deny payment for unnecessary medical care. States that desire to monitor PSROs must develop and submit a monitoring plan to HEW for approval. Before submitting the plan to HEW, the State agencies should provide the PSROs and hospitals with an opportunity to comment on the plan.

HEW guidelines provide that State monitoring can be (1) performed onsite in the hospitals, (2) performed retrospectively, using utilization review techniques in place before implementing PSRO review, (3) a comparison of statistics on such things as trends in hospital utilization or physicians' patterns of practice, and (4) other monitoring techniques as long as they do not duplicate the PSRO concurrent review process or other responsibilities of the PSRO.

SCOPE OF REVIEW

Our review was made at HEW headquarters in Washington, D.C.; HSQB headquarters, which the time of our review was located in Rockville, Maryland; and HEW regional offices in Boston (Region I), Chicago (Region V), and San Francisco (Region IX). We also talked to officials in HEW's seven other regional offices and reviewed the activities of six PSROs. In addition, we visited seven hospitals in Massachusetts and two in California.

We reviewed applicable regulations, program instructions, and HEW project and correspondence files and interviewed officials at State agencies, six PSROs, and nine hospitals.

The six PSROs visited and the periods covered by the fiscal intermediary reports included in our review are as follows.

<u>PSRO</u>	<u>Period covered by fiscal intermediary reports</u>
1. Bay State PSRO, Inc., Boston, Mass.	Jan. to Dec. 1977
2. Charles River Health Care Foundation, Wellesley Hills, Mass.	Jan. to Nov. 1977
3. South Carolina Medical Care Foundation, Columbia, S.C.	July 1976 to Dec. 1977
4. Nevada Professional Standards Review Organization, Reno, Nev.	Jan. to June 1978
5. California PSRO Area XXIII Torrance, Calif.	July 1977 to June 1978
6. Medco Peer Review, Inc., Cincinnati, Ohio	Jan. to Dec. 1977

We also reviewed State Medicaid monitoring reports for Massachusetts, South Carolina, and California.

## CHAPTER 2

### POST-PAYMENT MONITORING FINDINGS INDICATE

#### THAT PSROs COULD BE MORE COST EFFECTIVE

Intermediary post-payment monitoring reports show that a significant number of Medicare hospital patient days are unnecessary. If effectively used, the monitoring program could be a helpful tool to HEW and PSRO management in reducing these unnecessary days by identifying areas where concurrent review activities and the PSRO program's cost effectiveness can be improved. At four PSROs visited where intermediary findings could be projected to total Medicare inpatient hospital days, intermediaries questioned the necessity of 1 to 5 percent of the days as unnecessary because (1) patients were admitted for diagnostic work which could have been performed on an outpatient basis or (2) patients were kept in the hospital longer than necessary. The days questioned were days that the PSRO had certified as necessary. Further, officials at two of the four PSROs agreed that they had inappropriately certified about 2.6 and 4.2 percent of the total days.

We believe these findings are significant because recent analyses by HEW and the Congressional Budget Office (CBO) indicate that reducing Medicare hospital utilization by 1.5 or 2.9 percent, respectively, results in PSRO concurrent review being cost effective.

The Medicaid monitoring systems in effect at four of the PSROs identified few unnecessary days of hospital utilization.

#### MEDICARE INTERMEDIARY REPORTS AND QUESTIONED INPATIENT HOSPITAL DAYS

Intermediary monitoring reports applicable to four PSROs visited were based on random sampling methods, whereas the reports for two PSROs were not, and thus could not be projected. Based on the intermediary data applicable to the four PSROs, we estimated the total number of days the intermediaries might have questioned had they reviewed all claims (rather than just 20 percent of the claims) and the total number of questioned days the PSROs might have agreed to. We did this by multiplying the actual sampling results--both for total days questioned and the number of days with which the PSROs agreed--by five. Our projections are summarized in the following table.



PSRO	Total Medicare days subject to sample	Fiscal intermediary questioned days		Questioned days that PSRO agreed with	
		Number	Percent of days subject to sample	Number	Percent of days subject to sample
Bay State, Mass.	573,080	6,370	1.1	1,230	a/.2
Charles River, Mass.	55,350	3,060	5.5	1,460	2.6
South Carolina	292,040	5,385	1.8	1,795	.6
Nevada	b/105,122	5,485	5.2	4,415	4.2
Total	<u>1,025,592</u>	<u>20,300</u>	2.0	<u>8,900</u>	.9

a/This PSRO did not indicate the extent to which it agreed with the intermediary's determinations. We had PSRO physician advisers review a 20-percent sample of the days questioned by the fiscal intermediary to project this number.

b/The intermediary for the Nevada PSRO did not have information readily available on the number of days in the sample; therefore, rather than projecting the number of Medicare days subject to being sampled, we used the number of days certified by the PSRO as the size of the universe.

If prepared according to instructions, the intermediaries' reports show the name of the hospital, the beneficiary identification number, the number of Medicare claims processed, the number of claims sampled, and the number of claims and inpatient days questioned. The reports also indicate the reasons intermediary physicians concluded the days were unnecessary and a record of PSRO concurrence or nonconcurrence.

Questioned cases in these reports fall into one of four categories--(1) improper documentation of the medical record, (2) improper level of care, (3) unnecessary diagnostic admission, and (4) other (including delayed discharge).

Our analysis covered only unnecessary diagnostic admissions and delayed discharges. Improper documentation of the medical record could indicate incomplete or poor recordkeeping and does not necessarily mean that an admission or length of stay was not justified. Improper level of care often results from such complex problems as the lack of alternative facilities or services (such as nursing home beds or home

health care) that are beyond the control of the PSRO; therefore, for these cases, continued hospitalization might be unavoidable.

#### Unnecessary days of care

Unnecessary diagnostic admissions and delayed discharges can generally be described as follows: (1) unnecessary diagnostic admission--the patient, although not in acute distress, is admitted for diagnostic treatment--and (2) delayed discharge--generally the patient, having recovered from his/her illness, is retained in the hospital longer than medically necessary. An example of each is discussed below.

Unnecessary diagnostic admission--A 65-year-old male was admitted to the hospital for 2 days with a diagnosis of chronic chest problems and given a series of laboratory tests. Blue Cross physicians (the fiscal intermediary), upon examining the patient's record, stated that the patient was obviously not acutely ill and appeared to be admitted for laboratory tests which could easily have been handled on an outpatient basis. The hospital's utilization review committee and PSRO officials agreed with Blue Cross.

Delayed discharge--A 73-year-old man was admitted to the hospital for 5 days with a diagnosis of acute gastritis (inflammation of the stomach) and complaints of severe abdominal pains during the previous week. After reviewing the patient's chart, Blue Cross physicians stated that the patient was eating and had no abdominal pain 1 day after admission. The intermediary physicians concluded that the first 2 days were necessary for observation, but the remaining 3 days were questioned as a delayed discharge. The PSRO physician agreed.

#### Intermediary reports not projected

We were unable to determine the extent to which unnecessary admissions and delays in discharge existed at two PSROs visited because intermediaries did not use random sampling techniques. HEW instructions state that intermediaries will select for review a sample representing 20 percent of all PSRO-processed claims and that the selection must be made through an acceptable sampling technique.

Intermediaries for two PSROs were first screening all claims and selecting their 20-percent sample from those

claims that appeared to have the greatest potential for over-utilization. Because the sample and questioned claims were not representative of the universe, they could not be projected to determine the total number of days that would have been questioned if the intermediary had reviewed all claims. Therefore, even though the reports indicate that unnecessary days of care are being incurred, they can not be used to determine the extent of the problem.

Although we were unable to determine the extent that unnecessary diagnostic admissions and delayed discharges exist at these two PSROs, we were able to confirm that they do occur. For example, at one of the PSROs a fiscal intermediary sampled 14,589 patient days during 1977. It reported, and PSRO officials and physicians agreed, that 371 of the 14,589 patient days (or about 2.5 percent) were unnecessary diagnostic admission or delayed discharge days. At the other PSRO, two fiscal intermediaries questioned 657 patient days between July 1977 and June 1978 as unnecessary diagnostic admissions and delayed discharges. The PSRO agreed that 129 of the patient days were unnecessary.

#### POTENTIAL FOR PSROs TO BECOME MORE COST EFFECTIVE

A 1- or 2-percent reduction in hospital utilization can be an important factor. A January 1979 HEW evaluation of the PSRO program estimates that the program reduced Medicare hospital utilization for aged enrollees by 1.5 percent in 96 areas where there were active PSROs, as compared to 93 areas where there were no active PSROs. This reduction in utilization resulted in estimated Medicare savings of \$50.5 million. The estimated cost of performing concurrent review in these areas was \$45 million, resulting in net savings of \$5.5 million. On the other hand, a CBO official stated that a CBO analysis showed that these 96 PSRO areas would not become cost effective until hospital utilization is reduced by 2.9 percent.

As the chart on page 7 shows, intermediaries questioned 1.1 to 5.5 percent of the days of care that the PSROs had certified as necessary. Moreover, the PSROs agreed that between 0.2 and 4.2 percent of the days that they certified as necessary were unnecessary.

HEW and the PSROs should use the post-payment monitoring system to identify and eliminate, to the extent practicable, the causes for unnecessary days of care. In our opinion, this could improve the cost effectiveness of the PSRO program.

## FACTORS CONTRIBUTING TO THE PROBLEM AMONG MEDICARE PATIENTS

Several factors appear to have contributed to the unnecessary diagnostic admission and delay in discharge problem among Medicare patients including: (1) inadequate PSRO monitoring, (2) reluctance of PSROs to enforce guidelines, (3) inappropriate length-of-stay criteria, and (4) prior third-party reimbursement practices.

### Inadequate PSRO monitoring

One factor in the unnecessary admissions and retentions was the PSROs' failure to adequately monitor the review activities of coordinators and physician advisers. Five of the six PSROs had, in most instances, delegated their admission certification and continued-stay review authority to the hospitals in their respective areas. The executive directors of three of the five PSROs indicated that coordinators and physician advisers had not been adequately monitored. For example, one PSRO did not regularly visit the hospitals. Another PSRO believed hospital utilization review committees were responsible for the unnecessary admissions and delayed discharges; however, it took no corrective action.

### Reluctance of PSROs to enforce guidelines

Officials at six PSROs indicated that coordinators and physician advisers are sometimes reluctant to challenge an admitting or attending physician's judgment on medical necessity. One PSRO director of acute care review said some coordinators feared dismissal if they seriously challenged the physician's judgment. Consequently, patients may be unnecessarily admitted and/or retained. Further, PSRO physicians and officials from three PSROs said that some physician advisers did not accept the PSROs' admission and length-of-stay guidelines and were unfamiliar with Medicare regulations and instructions.

### Inappropriate length-of- stay review criteria

Under the PSRO review system, the appropriateness of hospital admissions for Medicare and Medicaid patients is generally reviewed by a PSRO coordinator, usually a nurse, and, if necessary, a physician adviser. If the admission is certified as necessary, the coordinator assigns the patient

a length of stay, i.e., the number of hospital days that patients generally need to satisfactorily recover from the illness. In addition to the initial review, the patient is reviewed at the 50th percentile of the assigned length of stay and periodically thereafter.

Officials at two PSROs said that many of the unnecessary days certified as necessary were between the initial review and the 50th percentile checkpoint, i.e., some people get well before the 50th percentile review takes place and are not discharged until the coordinator reviews the case. This indicates that PSRO assigned lengths of stay may be longer than necessary.

#### Prior third-party reimbursement practices

Several PSRO officials and physicians said some patients are admitted or retained unnecessarily because many patients and physicians adhere to payment policies established by fiscal intermediaries 30 years ago and reinforced by the original Medicare program. Under those policies Blue Shield and Medicare would not permit payment for treatment or diagnostic tests provided on an outpatient basis but would pay for those services on an inpatient basis. Currently, a person must be hospitalized before Medicare will pay for care in a skilled nursing home.

#### MEDICAID PATIENTS

State Medicaid agencies that submit plans acceptable to HEW can monitor PSRO performance. As of November 1979, 19 States had approved plans. Four of the five States visited have approved plans--Massachusetts, Ohio, California, and South Carolina.

The monitoring systems in Massachusetts, South Carolina, and California identified only a few unnecessary diagnostic admissions and delayed discharges. The system in Ohio had just recently been approved. According to a State Medicaid agency and PSRO officials, Medicaid patients generally are younger than Medicare patients, and physicians are more willing to treat them in an outpatient, nonhospital setting.

### Massachusetts post-payment monitoring reports

We reviewed 53 Massachusetts post-payment monitoring reports for July 1976 through December 1977. The reports identified only three instances of unnecessary diagnostic admission or delayed discharge, which represented less than 1 percent of the sampled cases. As a result, the program director did not believe the program had an unnecessary diagnostic admission or delayed discharge problem.

### South Carolina post-payment monitoring reports

In 1977, South Carolina's Department of Social Services issued post-payment monitoring reports on 61 of its 70 hospitals. The reports did not identify any unnecessary diagnostic admission or delay in discharge cases.

### California post-payment monitoring reports

California's Department of Public Health has monitored PSRO-certified claims in hospitals in 5 of the State's 28 PSROs. The three reports that were issued showed few unnecessary diagnostic admissions or delayed discharges. Department officials said they review only claims that appear to have excessive hospital lengths of stay. Such claims are not reviewed on a random basis.

### HCFA COMMENTS AND OUR EVALUATION

During congressional hearings held in June 1979, a HCFA official stated that, when two groups of individuals review cases, some disagreement is inevitable. HCFA estimates this inevitable disagreement rate to be about 1 to 2 percent of patient days.

The official added that some unnecessary days are simply not worth the cost necessary to find them. HCFA knows that unnecessary days occur between admission and the first "checkpoint" on which length of stay is reviewed. Review checkpoints are chosen to miss as few days as possible while avoiding unnecessary review.

With respect to disagreements, the table on page 7 shows that, after eliminating these disagreements, two PSROs agreed that they had inappropriately certified about 2.6 and

4.2 percent of the total days. We believe these are significant amounts which, if reduced, could improve the cost effectiveness of the PSRO program.

A patient's first checkpoint is usually the 50th percentile of the number of days that patients generally need to recover from the illness. Some patients probably would be ready for discharge before the checkpoint and some after. We believe that PSROs should examine intermediary questioned cases more closely to see whether there is any rationale and cost-effective basis for identifying the shorter stay patients at the time of admission. It may be appropriate to review these patients before they reach the 50th percentile. For example, the review coordinator may be able to identify, at the time of admission, patients whose severity of illness might not warrant their hospitalization until the 50th percentile.

### CHAPTER 3

#### HCFA'S USE OF INTERMEDIARY POST-PAYMENT

##### MONITORING PROGRAM COULD BE IMPROVED

The intermediary post-payment monitoring program has not met its objectives (1) as an educational tool for PSRO personnel and attending physicians, (2) as a vehicle for exchanging information between intermediaries and PSROs, and (3) in helping HEW assess the effectiveness of individual PSRO concurrent review activity. We believe the overall effectiveness of the program could be enhanced if HCFA

- provided specific guidance and instructions regarding the actions PSROs are to take on the intermediary reports and
- insured that the data collected and included in the intermediary reports were appropriate to meet program needs.

Further, the intermediary post-payment monitoring program is the closest thing to a quality control system for the PSRO concurrent review activity and thus is a potentially valid indicator for comparing PSRO performance.

##### PSRO ACTIONS ON INTERMEDIARY REPORTS

The intermediary post-payment monitoring program has not been uniformly effective as an educational tool or vehicle for exchanging information. HCFA has prepared instructions on how intermediaries are to develop and prepare their post-payment monitoring reports. However, no guidelines or instructions have been issued regarding how the reports are to be used in meeting the educational and informational objectives of the program. HSQB officials stated that no formal guidelines or instructions were issued because they believed oral instructions were sufficient.

HCFA officials said that they have not issued instructions requiring that PSROs respond to the fiscal intermediaries' reports. They did, however, expect that the PSROs would respond. During the early stages of our review, many PSROs were not responding to these reports. In May 1978 we contacted HEW's 10 regional Medicare offices and learned that 46 of the then 154 PSROs conducting concurrent reviews were



not responding to intermediary reports. During the past year, many of these 46 PSROs have started to respond. In May 1979 we again contacted HEW's regional Medicare offices and were informed that only 6 of the 183 PSROs conducting concurrent reviews were not responding to the intermediary reports.

At three of the six PSROs visited--Bay State, Medco Peer Review, and Nevada--PSRO physicians were not routinely using fiscal intermediary post-payment monitoring reports as a means of sharing concurrent review techniques and experiences. These three PSROs did not routinely discuss fiscal intermediary monitoring results with their physician advisers, with the delegated hospital utilization review committees, or with the attending or admitting physicians in the questioned cases. Also, few PSRO physician advisers in five of the six PSROs regularly met with fiscal intermediary physicians to discuss questioned cases.

DATA COLLECTED AND REPORTED  
DO NOT FACILITATE ASSESSMENT  
OF PSRO EFFECTIVENESS

Medicare officials told us that the system for collecting and reporting post-payment monitoring data was designed before it was fully known what type of data could be produced or how the data would be used. As a result, certain data which are needed by the program in order to meet its objectives of assessing PSRO effectiveness are not being collected, and certain data are being collected which are not being used by HSQB.

Post-payment monitoring reports deal primarily with claims data. For example, the reports indicate the number of Medicare claims a hospital submitted in a month, the number of claims sampled and questioned, and the number of patient days in the questioned claims. However, the guidelines for preparing the reports do not indicate that the total number of patient days in the sample should be reported. Thus, the data are sufficient to indicate if a problem exists, but are insufficient to define the magnitude of the problem or to make meaningful comparisons among PSROs. To establish the relative extent of the problem at two of the four PSROs shown in the table on page 7, in one case we had to obtain information on the number of patient days sampled from the fiscal intermediary, and in a second case, we had to use the number of days certified by the PSRO as being the size of the universe. The intermediaries for the other two PSROs reported the number of days in the sample even though this information was not required by the guidelines.

We also identified certain cases where data were being collected but not used. For example, PSRO and fiscal intermediary physicians often disagreed on the need for certain Medicare patients to be in the hospital. In South Carolina, PSRO physicians disagreed with fiscal intermediary physicians on 67 percent of the patient days questioned for diagnostic admission or delayed discharge. Under the post-payment monitoring system, statistics on these disagreements and synopses of the medical records are collected and provided to HSQB. HSQB officials said that they have yet to determine how to use this information.

POST-PAYMENT MONITORING  
AS A PERFORMANCE INDICATOR

Although intermediary post-payment reviews do not change a PSRO decision for payment purposes, the post-payment monitoring program is the only program that actually looks at the medical necessity determinations made by individual PSROs on a national basis. Therefore, this is the closest activity to being a quality control function for PSRO concurrent review.

Other components of Medicare and Medicaid which are involved in administering the delivery of health care-- such as State Medicaid agencies and fiscal intermediaries-- are subject to formal quality control procedures.

Under Medicaid, the claims payment functions of the States and/or their contractors are subject to review as part of the Medicaid quality control system. Under this system, States are required to examine statistical samples of Medicaid cases and claims to quantify the dollar losses resulting from errors in determining patient eligibility, claims processing errors, and errors in determining third-party liability. <sup>1/</sup> The objective of the system is to enable States to identify the causes of errors and attempt to correct them to reduce losses to the Medicaid program. In addition, the results of the quality control samples are used to compare the relative effectiveness of the States.

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<sup>1/</sup>Under the law, Medicaid is the payer of last resort in that, if a beneficiary has private health insurance or is the victim of an accident where a third party is liable, these sources of payment take precedence over Medicaid.

Under Medicare, private contractors (carriers such as Blue Shield) that pay for doctors' services provided to Medicare beneficiaries are subject to a quality control program which features reviewing a statistical sample of paid claims to quantify underpayments and overpayments. One purpose of the system is to provide a performance indicator to compare carrier performance.

Recently, congressional and HEW attention has been directed toward the problem of assessing and comparing PSRO performance, which would require developing valid performance indicators. In our view, the intermediary post-payment monitoring program could provide such an indicator provided the intermediaries follow HCFA instructions and use bona fide random sampling methods. As discussed in the previous chapter, intermediaries for two of the six PSROs biased their samples to increase the probability of identifying probable cases of overutilization. Under these circumstances, we did not project the results of the reviews, nor would it have been fair to compare the results to the four PSROs where random sampling methods were used.

#### HCFA COMMENTS AND OUR EVALUATION

During hearings on June 29, 1979, a HCFA official stated that, in the interest of cost efficiency, HSQB was planning to discontinue the post-payment monitoring program with respect to those PSROs where, over a period of time, the levels of intermediary disagreement with PSRO determinations are relatively low. The official added that, in cases where disagreement levels are low, other approaches to monitoring PSRO performance would be more effective--such as monitoring by State Medicaid agencies, day-to-day oversight by regional offices, financial audits, and comparative analysis based on local and national evaluations.

In our view, none of the above would replace intermediary post-payment monitoring programs as a quality control mechanism or a performance indicator for comparison purposes.

Only 19 States have approved monitoring plans, and as discussed on page 4, each State determines how many claims to review and how the claims are to be selected and reviewed. Therefore, meaningful comparisons of PSRO performance cannot be made between States. Also, to the best of our knowledge, the other approaches do not feature a systematic review of the actual medical necessity determination made by PSROs.

We believe that, if HEW wants to reduce the cost of the program, it should reduce the size of the sample, rather than abandoning the program at individual PSROs. In our opinion, the post-payment monitoring program should be used as one indicator of the effectiveness of the PSRO program until a better or more uniform quality control system can be developed.

## CHAPTER 4

### CONCLUSIONS AND RECOMMENDATIONS

The intermediary post-payment monitoring program could be a more useful tool to PSRO and HEW management to improve the cost effectiveness of the PSRO program if HEW (1) provided the PSROs with specific guidance and instructions on the actions to be taken regarding the intermediaries' reports and (2) assured that the data collected and evaluated in the reports are appropriate to meet program objectives.

At two of the four PSROs visited, where projections could be made, intermediaries questioned the necessity of over 5 percent of the days sampled, and the PSROs agreed with the intermediaries' determinations for 2.6 and 4.2 percent of the total days sampled. We believe that this is significant because recent studies have indicated that reductions in hospital utilization of 1.5 or 2.9 percent can make the PSRO concurrent review function cost effective.

Further, we believe that HEW should continue the post-payment monitoring program and use it as a quality control system for the PSRO concurrent review activity until a better or more uniform quality control system can be developed. In our opinion, the post-payment monitoring program can be used as a quality control system to assess and compare PSRO concurrent review performance. We believe that HCFA should reconsider its plans to cut back on the program when PSRO and intermediary disagreement rates are relatively low. If HEW wants to reduce the cost of the program, we believe that it should reduce the size of the sample, rather than eliminating the program at individual PSROs.

### RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Administrator of HCFA to issue guidelines and instructions outlining how the post-payment monitoring system should work. These instructions should emphasize how the program should be used

- to identify the causes of and eliminate, to the extent practicable, unnecessary days of hospitalization, and, thus, improve the cost effectiveness of individual PSROs;

--to educate PSRO and hospital personnel on new and proper techniques for reviewing the appropriateness of patient care; and

--by HEW as a potential indicator of the effectiveness of the patient care reviews made by PSROs.

We also recommend that the Secretary direct the Administrator of HCFA to

--revise the instructions to intermediaries to require the reporting of total days of care sampled in order to provide a common denominator for measuring the extent of the questioned cases and facilitate comparisons between PSROs and

--remind the intermediaries of the importance of existing instructions requiring random sampling methods so that the results of the monitoring efforts are not biased.

In addition, we recommend that, if HEW wants to reduce the cost of the intermediary post-payment monitoring program, it reduce the size of the sample, rather than eliminating the program at individual PSROs.

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