95415

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:30 a.m., EST
Thursday, June 15, 1978

STATEMENT OF

GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ON

GAO REVIEWS OF THE PROFESSIONAL STANDARDS REVIEW PROGRAM

Mr. Chairman and Members of the Subcommittee,

We are pleased to be here today to discuss the status of two on-going reviews of the PSRO program. These reviews are being performed in response to your requests of December 2, 1977. Specifically, we were asked to

(1) Review, on a sample basis, the validity of the claims being made by individual PSROs with respect to cost savings and attempt to determine the causes for any significant increases or decreases in Medicare utilization observed in the study made by the Office of Planning Evaluation and Legislation (OPEL) of HEW's Health Services Administration, and

(2) Review the staffing levels, staff salaries and fringe benefits, and travel policies for staff members of selected PSROs.

BACKGROUND

The PSRO program was established by the 1972 amendments to the Social Security Act (Public Law 92-603, approved October 31, 1972) and is administered by the Health Standards and Quality Bureau (HSQB) in the Health Care Financing Administration of HEW. The program objectives are to reduce costs and improve quality of health care by involving local practicing physicians in the on-going review and evaluation of the necessity and quality of medical care provided under the Medicare, Medicaid, and Maternal and Child Health programs.

PSROs are to determine, for purposes of reimbursement under these programs, whether services provided to patients in hospitals and long-term care facilities are (1) medically necessary, (2) provided in accordance with professional standards, and (3) provided in the appropriate setting. Eventually, it is intended that PSROs will review services provided on an ambulatory basis. PSRO review processes include (1) reviews of the medical necessity and appropriateness of inpatient admissions and the length of patient stays, (2) medical care evaluation studies to identify problems in the quality of administration of health care, and (3) profile analyses of the utilization patterns of providers, physicians, and patients. PSROs must delegate responsibility for concurrent review and/or certain facility-based medical care evaluation studies to qualified hospitals that are deemed by the PSRO capable and willing to assume such functions.

PSRO program funding has grown from $4.5 million in 1973 to an estimated $147 million for fiscal year 1978.

REVIEW OF HOSPITAL MEDICARE UTILIZATION CHANGES AND CLAIMED COST SAVINGS OF SELECTED PSROs

The first review that I would like to discuss is our review of hospital Medicare utilization changes and claimed cost savings of selected PSROs. Your request pointed out that many individual PSROs have been making claims of cost savings and you asked that we review, on a sample basis, the validity of these claims.

Also, the OPEL study which I referred to previously, stated that some PSROs were associated with a reduction in hospital utilization

while others were associated with increases in hospital utilization and concluded that 6 of the 18 PSROs included in the study were found to be cost-beneficial. However, the study did not determine the causes for the variations in utilization rates. Therefore, you requested us to attempt to determine the causes for any significant increases or decreases in the utilization rates observed at the 18 PSROs included in the OPEL study.

VALIDATION OF COST SAVINGS CLAIMS

With respect to the validation of claims of cost savings, we have initiated reviews of nine estimates of PSRO cost savings, and completed our fieldwork with respect to seven of these claims. Eight of the nine estimated savings that we selected indicate savings of over $22 million. The ninth claim estimated that 61,049 patient days had been saved but at the time did not translate this into dollar savings.

Methodologies Used

A wide variety of methods were used to compute these savings which basically fall into four categories:

--Five claims were based on comparing total Medicaid and/or Medicare days of care for one period to another and generally taking credit for any reductions.

--Two claims of savings were computed by determining the reductions in the length-of-stay for Medicare and Medicaid patients from one period to another, and multiplying this reduction times the number of hospital admissions. The claims indicate that if it were not for the PSRO, these additional days of care would have been incurred.

--One claim represents the number of days of inappropriate care that the PSRO was able to identify.

--One claim represents the PSRO's estimate of the impact of PSRO concurrent review interventions.

After computing the number of days of care saved by one of the above methods, all but two claims converted these days of care into dollar amounts by multiplying the days saved times actual or estimated hospital per diem rates for routine services or times the per diem rate plus an amount for ancillary services such as operating rooms, laboratory service, and X-rays. One PSRO study did not convert the days saved into dollar amounts, and another study by the Social Security Administration multiplied the days saved times 40 percent of the per diem rate and indicated that the other 60 percent represented fixed costs which are incurred whether or not the hospital bed is occupied.

Problems With Estimates of Cost Savings

During our review of the seven studies on which we have completed fieldwork, we noted several significant deficiencies with respect to the data used in the estimates. We also noted several computation errors.

The seven studies reported total estimated dollar savings of $19,339,762, and an additional 61,049 days of care saved which were not converted into dollar savings. However, as a part of our review we adjusted the data used by the PSROs in order to make it as current, complete, and accurate as possible.[1] Using this adjusted data and applying the same methods as used by the PSROs, (except in one case where the PSRO used alternative methods because of a lack of data), we recomputed the estimated savings to be $2,506,208, and the days of care saved to be 36,115.

CHART 1

PSRO	PSRO Estimate	GAO Adjustment	Adjusted Estimate
Dollar Savings			
Wyoming	$ 2,709,951	$ (2,256,307)	$ 453,644
New York County (1975-1976)	3,060,000	(7,622,064)	(4,562,064)
Southeastern, Mass.	2,042,011	(2,307,658)	(265,647)
Charles River, Mass.	3,000,000	(2,765,625)	234,375
Multnomah, Ore.	7,327,800	(1,881,900)	5,445,900
San Joaquin, Calif.	1,200,000	note a	1,200,000
Totals	$19,339,762	$(16,833,554)	$2,506,208 (note b)
Medicare/Medicaid Days of Utilization Reduced			
New York County (1976-1977)	61,049	(24,934)	36,115

Note a: Methodology was not susceptible to verification.
Note b: As discussed later, this figure is, in our view, highly questionable because of deficiencies in the methodologies.

Incomplete Utilization Data

The most significant problem we noted was the use of incomplete data. This problem existed in six of the seven studies reviewed, and accounts for the entire amount of the adjustments that were made to the Wyoming study and to the 1976-1977 New York County study.

To obtain 1975 utilization data, the Wyoming PSRO used Medicare utilization data obtained from the Social Security Administration in March 1976, only three months after the end of 1975. SSA officials informed us that its files do not reflect total utilization data until 18 to 24 months after the close of the year. We recomputed the savings using more recent and complete SSA utilization data and concluded that PSRO claimed savings was overstated by more than $2 million. It should also be noted that when the Wyoming PSRO reported its savings to HEW,

it qualified the amount by stating it was not taking credit for the entire savings. The qualifying statement was deleted in HEW's report to OMB.

New York County's 1976-1977 study generally obtained 1976 utilization data from Uniform Statistical Reports, which are submitted by the hospitals to the New York Blue Cross as a basis for reimbursement negotiations. However, at the time the study was made this data was not available for 1977. As a result, 1977 data was generally obtained from data provided by the hospitals to the PSRO. Officials at all hospitals included in the study informed us that the best source of utilization data is the Uniform Statistical Reports. We recomputed the savings based on 1976 and 1977 utilization data obtained from the Uniform Statistical Reports and concluded that New York County overstated its claimed savings by about 25,000 days.

Another example of the use of incomplete data is the comparison of total days of care for one period to just days of care that the PSRO certified for payment in a subsequent period and then attributing the differences to PSRO review. We noted this problem with respect to two claimed savings. An example is the Southeastern, Massachusetts' PSRO. In computing the cost savings, total days of care paid by Medicare and Medicaid for one period were compared to the number of days certified by the PSRO in a later period. However, because Medicare and Medicaid also pay for certain days that are not certified by the PSRO, such as administratively necessary days and days allowed by law beyond those determined to be necessary (so-called grace days), this is an improper comparison and resulted in the PSRO overstating its claim by about $.5 million.

Problems With Methodologies Used In Developing Savings Estimates

In addition to deficiencies with respect to the data used and in the computations made, we noted several problems with the methodologies used in developing the estimated savings.

For the most part, savings were based on reductions in patient days of care or length-of-stay from one period of time to another. These reductions were then multiplied by hospital cost reimbursement rates to obtain estimated savings. The general implication is that the savings are totally attributable to the PSRO. This is questionable in view of the conclusion in the OPEL study that,in the aggregate,PSRO review did not explain utilization changes at the 18 PSROs included in that study. In addition, these claimed savings generally did not consider that:

--Most hospital costs are fixed and that in the short turn the elimination of a day of care by the PSRO only results in partial savings of the cost of a day of care. As previously indicated, this factor was recognized in connection with one of the nine claimed savings we reviewed (Sacramento, California PSRO).

--The Federal Government incurs costs that partially offset hospital savings when patients receive alternate care in nursing homes.

We are considering recommending to HEW that if it is considered necessary for PSROs to make claims of savings, that HEW:

--develop a standard methodology that can be used by all PSROs to measure their effectiveness, and

--provide technical assistance to help PSROs prepare future assessments, particularly in the area of validating the data to be used.

DETERMINATION OF FACTORS INFLUENCING MEDICARE UTILIZATION CHANGES

Our determination of factors influencing Medicare utilization changes began with the selection of five PSROs which showed significant changes in the rate of Medicare utilization per 1,000 enrollees as reported by OPEL--that is changes of five percent or more. The PSROs selected were Wyoming; Quad River, Illinois; Multnomah, Oregon;--which showed decreased utilization--and San Joaquin, California; and Baltimore City, Maryland--which showed increased utilization.

Using the Medicare data provided to OPEL by the Social Security Administration, we identified the hospitals in the PSRO areas and their non-active PSRO comparison areas that contributed to more than 70 percent of the gross Medicare utilization change in their areas. Visits were made to these hospitals and opinions were obtained from hospital officials as to what factors may have influenced the Medicare utilization change. To the extent possible, we obtained documentation supporting the opinions. We also discussed these changes with officials of the Health Systems Agencies and PSROs.

Problems with Data Used by OPEL

Our analysis of the data used by OPEL disclosed several problems which, in one instance, had the problems been known would have altered an OPEL conclusion with respect to the cost effectiveness of one PSRO. We found that the data provided to OPEL by the Social Security Administration included seven hospitals which were inappropriately classified as

short-term acute hospitals, four hospitals not within the PSRO or comparison areas, and nine hospitals not the responsibility of the PSRO program such as military hospitals. The data also did not include three other hospitals which should have been included.

The most significant impact of these problems was in connection with the Medicare utilization changes in the Quad River PSRO and its comparison area. The OPEL evaluation concluded that the Quad River PSRO was associated with a substantial reduction in Medicare utilization and was one of the six PSROs found to be cost beneficial. Our analysis of the OPEL data revealed that utilization statistics for two long-term State psychiatric institutions had been included, when in fact, the PSRO had no review responsibility for these institutions. Exclusion of these hospitals and other minor adjustments results in a reduction of the Medicare utilization decrease to a point where the Quad River PSRO can no longer be considered cost beneficial using the OPEL methodology.

Another problem noted with the data used by OPEL was the fact that the data limited the identification of the Medicare eligibility rates (i.e., utilization per 1,000 enrollees), to residents in the confines of the PSRO and comparison areas when in fact many hospitals reported that their Medicare patients reside outside of these areas.

HEW officials informed us that for the analysis being done as a follow-on to the OPEL study, steps are being taken to assure that these problems are resolved prior to the use of Social Security Administration data.

Factors Influencing Medicare Utilization Changes

We were informed that the Medicare utilization changes for the five PSROs we selected could be attributable to a variety of influencing factors such as changes in

--medical services,

--medical practices,

--number and availability of physicians, and

--impact of nursing home bed availability.

Also, PSRO review was cited as a factor influencing Medicare utilization in the two PSRO areas where there was clearly lower utilization based on corrected data.

Changes in Medical Services

New or expanded hospital units providing coronary care, 24-hour emergency service, physical medicine and rehabilitation, and cancer treatment are among the changes in medical services where were cited as factors influencing the increased Medicare utilization in San Joaquin and Baltimore City.

Changes in Medical Practices

Decreases in Medicare utilization at the Multnomah and Quad River PSROs were said to be partially influenced by changes in medical practices. These changes included greater use of out-patient services, such as home-care nursing, and the admittance of surgery patients on the same day as their scheduled surgery instead of the day before.

Changes in Number and Availability of Physicians

Many hospital officials cited changes in the number and availability of physicians as one of the influencing factors. Specifically, increases

were noted in the number of physicians emphasizing specialties generally associated with Medicare patients. For example, increased orthopedic physicians in a Quad River PSRO hospital led to an increase of ~~726~~ 736 patient days. Also, the physician population in Nevada increased ~~31~~ 21 percent from 1974 to 1976--the time period of the OPEL study.

Impact of Nursing Home Bed Availability

Shortages of nursing home beds were noted as influencing Medicare hospital utilization increases in Baltimore, its comparison area, Philadelphia, and San Joaquin. Also, hospital officials in these areas explained that the problem becomes more acute because existing nursing homes participating in Medicare are very selective as to the type of patient to be admitted. In most cases, a private patient is preferred by the nursing homes because Medicare patients often become Medicaid patients after their Medicare benefits have expired and Medicaid reimbursement is considered by many nursing homes to be insufficient to cover the cost of care.

PSRO Review

PSRO review was cited as a factor in reducing Medicare utilization in the Multnomah PSRO area and the Wyoming area. Hospital officials in Multnomah agreed that the PSRO contributed to reducing length-of-stay and said that the PSRO review process forced physicians to stay current with the progress of their patients and made physicians more aware of the need to be cost conscious. Similar views were expressed by hospital officials in Wyoming.

In conclusion, our review demonstrates that Medicare utilization was influenced by numerous factors.

Furthermore, we have identified several problems with the Social Security Administration data used by OPEL in its evaluation of the PSRO program. Most of the problems noted could only have been identified through on-site visits and an extensive validation process.

We are considering recommending to HEW that, in the future, before Social Security Administration data is used to evaluate PSRO effectiveness, an extensive validation process, including site visits, be undertaken to assure that data is complete and accurate and truly comparable.

PSRO STAFFING, EMPLOYEE COMPENSATION AND TRAVEL POLICIES

In connection with our work to date in response to the Committee's interests in the area of PSRO staffing, employee compensation, and travel policies, we have completed our fieldwork at 14 PSROs and believe that two issues have emerged where there are potentials for savings. One deals with the establishment of PSRO Executive Director salary ranges in HSQB's November 1977 guideline at levels higher than we believe are appropriate based on available comparable data and more appropriate comparison criteria, and the second issue involves the potential for the consolidation of PSRO administrative functions including technical personnel to support the PSRO data systems.

Establishment of Executive Director salary ranges

In January 1977, HSQB contracted with Hay Associates--a private consulting firm specializing in conducting comparative 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.

The scope of the study covered the evaluation of the Executive and Medical Directors' salaries at conditional PSROs. 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.

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

foundations for medical care, medical institutes, and medical divisions of insurance companies. Three of the fourteen 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.

As a result of an analysis of the Executive Directors' prior experience, we concluded that the personnel actually filling these positions are mainly from nonprofit service-type medically oriented organizations. Accordingly, 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 PSRO-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 identified as Chart 2.

COMPARISON OF RECOMMENDED P&O EXC. DIRECTOR SALARIES BASED ON A CROSS SECTION OF AMERICAN BUSINESS TO SALARIES BASED ON BLUE C./DUES., NON-PRO. FIT, SERVICE TYPE ORGANIZATIONS USING MIDPOINT SALARIES

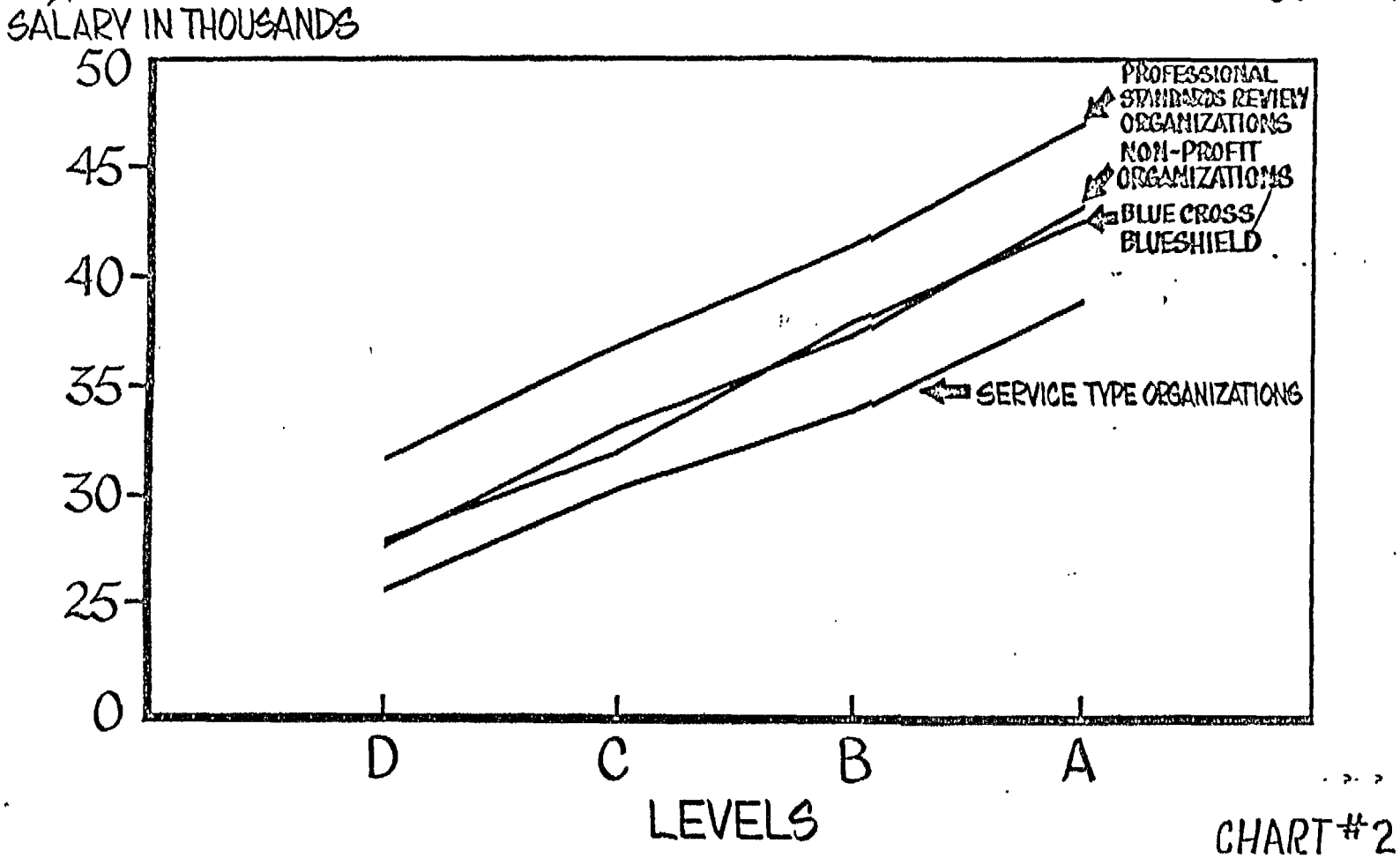

CHART #2

We compared current Executive Director salaries and responsibilities to comparable positions in the local Medicare/Medicaid administrative complex in each geographic area. For Medicare, we used the local Blue Cross fiscal intermediary and for Medicaid for the most part, we used the individual directly responsible for the utilization review portion of the State Medicaid program. In addition, we compared the salaries of the PSRO Executive Director to those of the Executive Directors of the local Health Systems Agency. This comparison is included as Attachment I to this statement.

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 Director's salaries were lower than the intermediaries and the Health Systems Agencies. There were eight PSROs in Los Angeles County and we reviewed three of them. 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 Director's 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.

We found that the fiscal intermediaries generally supervise more people and deal with more hospitals than the comparable 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. All but one (Charlotte, N.C.) of the fourteen PSRO areas included in our review were included in the initial or follow-on Hay study. In the PSRO areas that were included, the Executive Director's 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 Blue Cross/Blue Shield, a nonprofit organization, is shown in the following graph identified as Chart 3. The designations L, E, and H on the chart indicated whether the current salaries are lower, equal to, or higher than the salaries paid by fiscal intermediaries and Health Systems Agencies.

COMPARISON OF CURRENT PSRO EXECUTIVE DIRECTOR SALARIES TO MIDPOINT & MAXIMUM SALARIES OF HEALTH STANDARDS & QUALITY BUREAU (HSQB) SALARY SCHEDULE

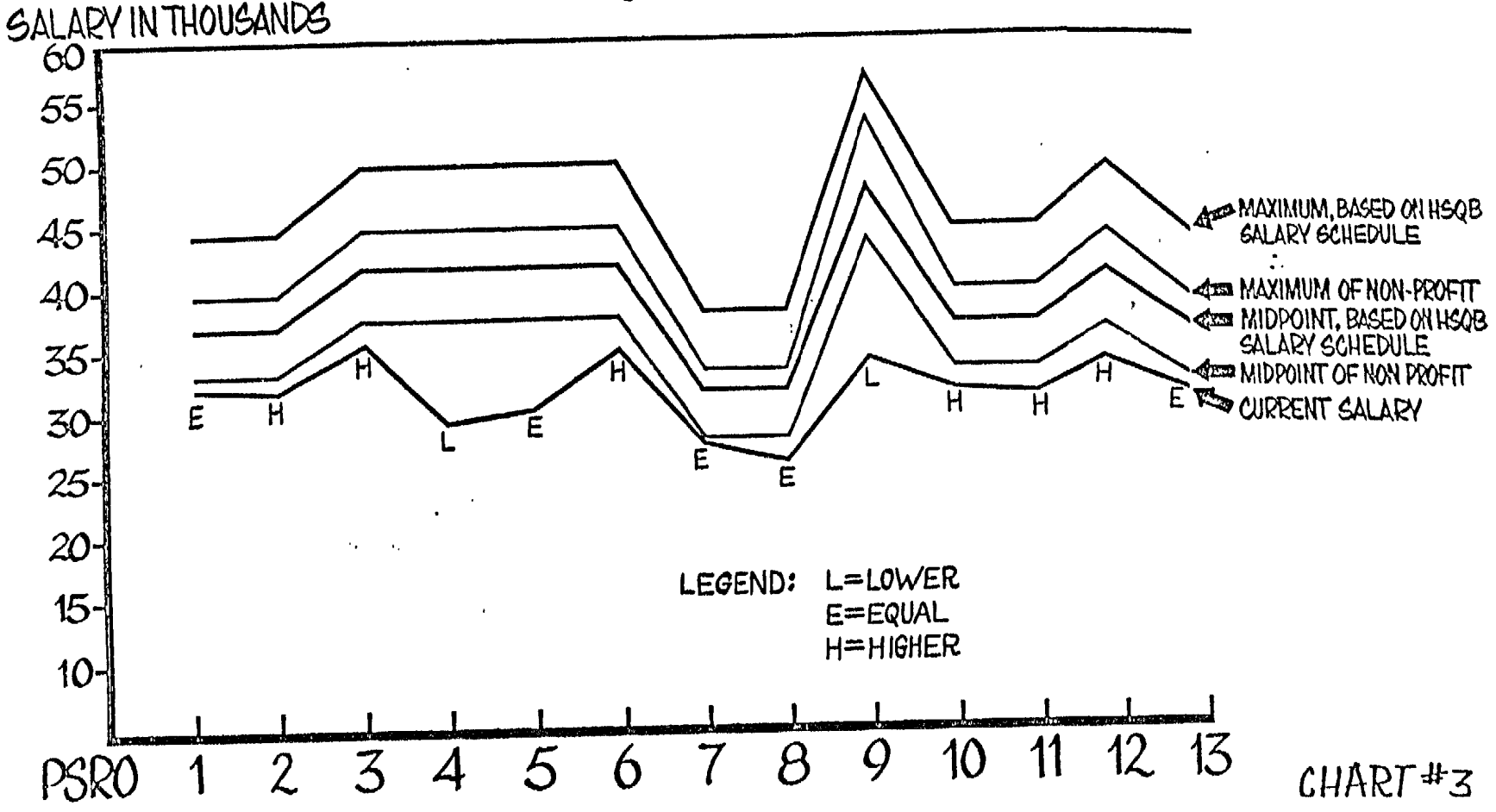

CHART #3

We believe that if HSQB were to adopt the salary levels based on the Blue Cross/Blue Shield and nonprofit organization criteria as originally planned, future unwarranted salary increases 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.

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 eleven 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.

The comparison is included as Attachment II to this statement. The comparison 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.

POTENTIAL CONSOLIDATION OF PSRO ADMINISTRATIVE FUNCTIONS

Of the fourteen conditional PSROs reviewed, we noted 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 Committee on Finance, United States Senate, 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". 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, on an amendment which was not enacted during the 93rd 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 mechanism in a State or area".

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.

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 medical aspects needing local physician input were decentralized into regions which comprise various medical service areas in the State.

Administrative Staff Costs

Each PSRO has an administrative cadre to support PSRO program operations such as concurrent hospital review, data collection, profile analysis, and medical care evaluation studies. The 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 average salaries paid to the cadre of administrative staffs at the PSROs included in our review was over $251,000. In fiscal year 1977, salaries for administrative staffs totaled over $14 million for the 108 operational PSROs. Total expenditures for these organizations for fiscal year 1977 were about $95 million. Thus, administrative support made up about 15 percent of total PSRO expenditures. Since each administrative staff costs about $250,000 per year

for salaries alone, and since there are 164 PSROs in States with more than one PSRO, HEW will spend over $40 million for administrative staffs when these 164 PSROs are fully operational.

Opportunities for Reducing Administrative Costs

We compared the size and cost of the 14 administrative staffs for the PSROs included in our review and concluded that the cost of administering the PSRO program is nearly the same regardless of the workload. For example,

--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 and 27,000 discharges 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 as the PSRO with the $193,781 budget covers 30 hospitals. 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. It would seem that the consolidation of administrative staffs 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 on 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.

Obviously, all PSRO areas cannot 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 PSROs can be consolidated even on a limited basis, or if sharing of basic administrative support services could be accomplished.

Mr. Chairman, this concludes our statement. We would be pleased to answer any questions you or other members of the Subcommittee may have.

ATTACHMENT I

COMPARISON OF PSRO EXECUTIVE DIRECTOR SALARIES TO SALARIES PAID BY FISCAL INTERMEDIARIES, STATE MEDICAID AGENCIES, AND HEALTH SERVICE AGENCIES. EMPLOYEES SUPERVISED AND HOSPITALS REVIEWED ARE ALSO SHOWN.

	Norfolk VA.	Charlotte N.C.	Winston Salem N.C.	South Carolina	Cincinnati Ohio	Columbus Ohio	Kentucky	Montgomery County Md.	Prince Georges Md:	Colorado	California 22	California 23	California 24	California 27
SALARY														
PSRO	$32,000	$29,000	$31,920	$35,650	$29,160	$30,240	$35,000	$27,327	$25,875	$34,000	$31,320	$30,475	$34,500	$32,036
Fiscal Intermediary	32,500	27,245	27,245	1/28,200	36,264	1/22,740	1/30,540	1/26,350	1/26,350	45,772	34,824	34,824	34,824	34,824
State Medicaid	21,400	28,092	28,092	32,000	23,982	23,982	21,500	29,733	29,733	27,528	33,600	33,600	33,600	33,600
Health Agency	27,394	26,300	29,917	28,355	42,500	39,055	33,000	36,750	24,000	35,819	45,000	45,000	45,000	31,000 ~~45,000~~
EMPLOYEES														
PSRO	30	13	20	76	12	29	69	18	23	104	17	31	11	19
Fiscal Intermediary	37	100	100	135	37	32	130	330	30	583	137	137	137	137
State Medicaid	128	110	110	96	76	76	315	70	70	32	606	606	606	606
HOSPITALS														
PSRO	25	22	20	87	24	24	21	110	5	95	12	33	30	15
Fiscal Intermediary	74	163	163	72	49	42	112	50	50	95	290	290	290	290
State Medicaid	170	150	150	87	215	215	122	60	60	95	612	612	612	612

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

ATTACHMENT II

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

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

	PSRO AREA				
	Colorado	California 22	California 23	California 24	California 27
Salary					
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

N/A - Not Available
(a) - This figure represents the midpoint of the salary range for the position; actual salary figures were not available.
(b) - Annual figure based on hourly rate the state pays its physicians.