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Mr. Chairman, I am pleased to be here today to testify about the effectiveness of the Professional Standards Review Organization (PSRO) program.

The Congress has recently considered two principal questions about this program: what level of funding is appropriate, and whether changes in the program's operations are needed. The interest in these questions has been widespread, in part because the PSRO program is only the latest of a long-standing effort to restrain the use--and the costs--of federally financed health services through utilization review. This effort, which dates from the inception of the Medicare program, is likely to continue, as evidenced in the many recent health bills that have incorporated PSROs or other utilization review mechanisms.

At the request of the Subcommittee on Oversight of this Committee, CBO has twice evaluated the performance of the PSRO program. My testimony today summarizes the more recent CBO evaluation and addresses the following three issues:

- Do PSROs reduce inpatient use of short-stay hospital facilities by Medicare beneficiaries?
- Do the reductions in health-care expenditures attributable to PSROs exceed the costs of the program?
- Does the PSRO program have the potential to reduce health-care costs significantly?

THE GOALS AND ACTIVITIES OF THE PSRO PROGRAM

The PSRO program was established by the Social Security Amendments of 1972 to "promote the effective, efficient, and economical delivery of health-care services of proper quality for which payment may be made under the [Social Security] Act." The amendments call for the creation of local or statewide organizations of physicians to monitor services to ensure that such services:

- Conform to appropriate professional standards,
- Are provided only when medically necessary, and
- Are provided in the most economical but medically appropriate settings.

Although the statute specifies that PSROs should assure quality of care as well as restrain utilization, control of utilization and costs has in some ways been the program's primary focus. Activities aimed at utilization control were implemented more rapidly and still account for most of the program's budget. Moreover, most of the recent controversy about PSROs has centered on their effectiveness as a means of controlling utilization and costs.

The principal means by which PSROs attempt to control costs is concurrent review, which involves two activities: admissions reviews, in which cases are reviewed shortly after a patient's admission to determine if admission was needed, and periodic

continued-stay reviews, in which cases are re-evaluated to determine if continued inpatient care is warranted. A negative determination can result in denial of reimbursement by Medicare or Medicaid. Sanctions against providers and practitioners are also established in the statute, but regulations allowing their imposition have only recently been issued by the Department of Health and Human Services (HHS).

The two CBO evaluations of the program--which differed only in that the second used more recent data and somewhat better estimating methods--assessed only the impact of the program on utilization and costs under Medicare. Quality assurance efforts and their costs were not considered, mainly because of inadequate data. Similarly, the lack of reliable data precluded an analysis of the program's impact on Medicaid use, and the costs of Medicaid review activities, therefore, were also excluded.

DO PSROs REDUCE SHORT-STAY HOSPITAL USE?

CBO estimates that a PSRO program in which all Medicare patients are reviewed reduces Medicare days of hospitalization by about 1.5 percent. (The difference between this and Health Care Financing Administration's (HCFA) current estimate of 1.7 percent is so small that it has no statistical or practical importance.)

This conclusion, however, is subject to a few important qualifications:

- Some patterns in the data are hard to explain and throw the results into doubt. For example, PSROs in the South are associated with an increase in hospital use.
- The result is based on PSRO activities in 1978, when all Medicare cases were reviewed. Today, in response to tight budgets, PSROs "focus" their activities, reviewing on average fewer than half of all Medicare cases. Shifting to focused review probably has reduced both the cost of the program and its impact on utilization, but there is no information indicating which has been reduced more.
- As I noted, there is still no reliable information about the program's effect on Medicaid use. Since the Medicaid and Medicare patient populations are so markedly different, it is inappropriate to assume that the program works equally well with both groups. Because review of Medicaid patients absorbs about one-third of the program's budget, a large part of the program's utilization-control efforts remains unevaluated.

While PSROs have been successful in reducing Medicare hospital use, they apparently do not become more effective as they gain experience. The average PSRO's impact on Medicare use of

short-stay hospitals did not change appreciably between 1977 and 1978--the last years for which data are available--even though the average duration of PSRO activity increased from 16 to 25 months during that period.

DO PSROs SAVE MONEY?

Although PSROs have measurably reduced Medicare hospital use, they have not been comparably effective in reducing costs. The program's impact on federal outlays has been minimal; moreover, it actually has increased slightly the resources spent on health-care by society as a whole.

Before I present more specific figures, let me explain two different ways of calculating the cost of the program, both of which are used in our estimates. The cost figures that appear in the federal budget, as well as in HCFA's evaluation of the program, reflect the total cost of operating the program. The cost of running the program, however, is substantially greater than the incremental cost of first putting it into operation. The reason for this difference is that the PSRO program replaced an earlier form of utilization review. Medicare and Medicaid have required hospitals to perform utilization review since the 1960s. When a PSRO begins review, those pre-existing utilization review activities stop, and the resulting savings offset some of the cost of

PSRO operations. To calculate the incremental cost of PSRO review, then, the cost of pre-PSRO review is substracted from the cost of PSRO review.

Whether total or incremental cost is the appropriate measure depends on the options being considered. If the Congress is considering abolishing the PSRO program without removing the utilization review requirements in the Medicare and Medicaid statutes, incremental cost would be germane, because pre-PSRO utilization review would again be required. If the Congress is considering eliminating the utilization review requirements as well, total cost would be relevant. If the Congress is considering only changes in the level of PSRO funding, either could be appropriate, depending on whether the number of hospitals under PSRO review would change.

Do PSROs Reduce Federal Outlays for Medicare?

Does the estimated 1.5 percent reduction in Medicare hospitalization translate into a net budgetary savings? That is, do the savings of Medicare reimbursements exceed the costs of running the program? This question can be answered by calculating the ratio of reimbursement savings to program cost.

CBO estimates that reimbursement savings fall short of total program cost by about 10 percent. That is, the savings-to-cost ratio is 0.9 to 1. On the other hand, we estimate reimbursement

savings to be twenty percent larger than the incremental cost of the program--a savings-to-cost ratio of 1.2 to 1. In either case, the net impact of PSRO review of Medicare patients is small: a small net loss when total cost is considered, and *a* small net gain when only incremental cost is relevant.

Do PSROs Reduce the Amount Society Spends on Health Care?

The impact of PSROs appears less favorable if one considers their effect on the resources spent on health care by society as a whole. Societal resource savings from PSRO review of Medicare patients fall far short of program cost. CBO estimates that every dollar in program expenditures yields only 40 cents in resource savings, for a net loss of 60 cents on the dollar. Even when only incremental cost is considered, the program still saves society less than it costs, producing a net loss of 20 cents on the dollar. Since the cost of operating the PSRO program is itself a part of society's total health care costs, this finding indicates that by spending resources on PSROs, society as a whole actually ends up paying more for health care then it otherwise would.

The discrepancy between the program's effects on federal outlays and expenditures by society as a whole stems from the way the Medicare reimbursement system works. A large portion of the cost of a day's stay in a hospital--perhaps 60 percent--is attributable to fixed costs such as mortgage debt. When PSROs reduce Medicare

days of care, these fixed costs remain and must be absorbed by someone. The Medicare reimbursement system apportions those fixed costs among remaining patients, with private patients absorbing most of the additional burden. In the short term, PSROs--and indeed any successful federal utilization review program--bring about federal savings in part by transferring some costs to private patients.

It should be stressed that extending PSRO review to private patients would not solve the problem of costs being transferred to them. The fixed costs would remain, and private patients, who would still comprise about two-thirds of the patient population, would still absorb about two-thirds of them. Successful review of private patients would, however, drive federal reimbursement savings down, since Medicare would absorb about a third of the additional fixed costs from the saved days of private hospitalization.

Over a period of several years, however, hospitals might reduce those initially fixed costs by reducing capacity. To the extent that this occurred, the transfer of costs would decrease, and the resource savings to society as a whole would increase, gradually approaching the level of reimbursement savings. If all fixed costs were eventually removed (for example, all facilities either worn out or converted to alternative use), the resource savings would roughly equal the total cost of the program.

In summary, CBO estimates that PSROs produce reimbursement savings about 20 percent greater than the incremental cost of the program, but this savings is achieved at the cost of a net increase of about the same amount in the resources spent for health care by society as whole. Moreover, the outlay savings are small relative to the expenditures that the program was designed to control. In 1978, for example, the budgetary savings from PSRO review amounted to less than two-tenths of one percent of Medicare Part A outlays. Finally, in cases where the total cost of the program are the relevant comparison, the program's net effect is actually to increase budgetary outlays.

How Would the Numbers Change if Medicaid Were Included?

The above estimates exclude the costs and benefits of the program's Medicaid portion because of the lack of reliable data. Including Medicaid review, however, would probably produce a more pessimistic estimate of the program's impact on federal outlays. Even if PSROs were equally effective in reducing Medicaid days of care--which is unlikely, given the nature of the Medicaid patient population--federal reimbursement savings per day would be lower, since states would receive about 44 percent of the reimbursement savings.

The various comparisons of program costs and savings are presented in Figure 1.

FIGURE 1. IMPACT OF PSROs ON COSTS: FOUR WAYS TO CALCULATE THE RATIO OF SAVINGS TO COSTS

		Savings Considered	
		Resource Savings	Federal Reimbursement Savings
Costs Considered	Total	0.4 to 1[a]	0.9 to 1[b]
	Incremental	0.8 to 1	1.2 to 1[c]

NOTE: Numbers include only Medicare portion of the program because of data limitations. See footnotes b and c.

a. CBO's best estimate.

b. If Medicaid were included and if PSROs are as effective with Medicaid as with Medicare, this would be 0.75 to 1. If Medicaid were included and if PSROs are ineffective with Medicaid, this would be 0.6 to 1.

c. If Medicaid were included and if PSROs are as effective with Medicaid as with Medicare, this would be 1.1 to 1. If Medicaid were included and if PSROs are ineffective with Medicaid, this would be 0.8 to 1.

Are There Other Justifications for Continuing PSRO Review?

In light of these pessimistic findings are other reasons to continue PSRO review? This question has to be answered in the context of the program's dual mandate to assure quality as well as to contain costs. PSROs, however, engage in different activities to achieve these two goals. Concurrent review activities (which are the activities that CBO has evaluated) are aimed primarily at

the control of use and costs. Other, less expensive activities are aimed primarily at quality assurance. Either one of these components could be expanded, cut back, or otherwise changed without changing the other.

A second, more difficult issue is whether PSRO concurrent review activities that were designed to restrain use affect quality as well. If they do, then these effects on quality should be considered in evaluating the effectiveness of concurrent review.

Concurrent review does sometimes affect quality, but it is not clear whether this effect is, on balance, positive or negative. Preventing unnecessary surgery would often be seen as improving quality of care. Earlier discharges of elderly, infirm patients, on the other hand, may reflect a decline in quality.

To answer this question, basic descriptive studies of PSRO denials are needed. Although we have estimates of the aggregate impact of the PSRO program, representative data on the program's effects on individual patients are not available. In order to evaluate the program's impact more fully, we would need information on the health status of patients whose stays are shortened, the alternative care available to them, their subsequent placements, and so on.

PROSPECTS FOR THE FUTURE

The failure of the PSRO program to produce substantial savings raises the question of whether the program's performance can

be improved. Certainly there are many ways the PSRO program could be changed. Alternative methods of review and alternative management strategies might be tried. Different sanctions--such as the Department's current efforts to involve PSROs in waiver-of-liability determinations--might also alter the program's performance.

Unfortunately, it is not now clear what specific changes would be beneficial. While HHS has proposed changes and individual PSROs have tried alternative procedures, there has been little planned experimentation designed to find out which alternatives are best. Moreover, evaluation of the relative effectiveness of various procedures now in effect has been hampered by a lack of systematic data on the practices of individual PSROs. For example, little information is yet available about how PSROs select cases for review or about different management and review practices of various PSROs. Without information of this sort, systematic improvement in the program can only come slowly.

In sum, Mr. Chairman, a great deal is still not known about the total impact of PSRO concurrent review. Nonetheless, it is clear from both the CBO and HCFA evaluations--which used identical data and similar methods--that the program has not generated the substantial savings many had hoped for. Moreover, it has not yet shown signs of major improvement in that respect.