

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE EVALUATION OF MEDICAID
MANDATORY SECOND SURGICAL
OPINION PROGRAMS**



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INSPECTOR GENERAL**

OEI-03-89-01530

EXECUTIVE SUMMARY

PURPOSE

This report provides information on recent State evaluations of Medicaid mandatory Second Surgical Opinion Programs (SSOPs) and their implications for the Health Care Financing Administration's (HCFA) proposed regulation requiring such programs. A companion report summarizes common elements of States' mandatory SSOPs (OEI-03-89-01531).

BACKGROUND

Section 1902(a)(30)(A) of the Social Security Act requires that Medicaid State plans contain safeguards against unnecessary utilization of services and assure that payments are consistent with efficiency, economy, and quality care.

States currently use second surgical opinion programs (SSOPs) as a utilization safeguard. These programs require clients to obtain independent medical opinions prior to elective surgery. The SSOPs encourage patients to be more informed and involved in their medical treatment. It is believed that this education enables patients to make better decisions and thus lead to improved care and cost savings from foregone surgeries.

SSOPs in the Medicaid Program

The earliest Medicaid mandatory SSOPs were established in 1976. In 1983, the Office of Inspector General (OIG) advised HCFA to establish mandatory SSOPs for Medicaid and Medicare. The OIG estimated HCFA could save \$157 million annually by adopting mandatory SSOPs for both programs. The HCFA rejected the OIG's recommendation, calling for further analysis.

In 1986, HCFA proposed a regulation requiring a mandatory SSOP in each State's Medicaid program. The proposed regulation would permit a State not to implement a mandatory SSOP if its current review program achieved the objectives of being cost effective and preventing unnecessary surgery. In 1990, HCFA tentatively decided not to implement the proposed regulation. At that time, 14 State Medicaid programs were using mandatory SSOPs.

As part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), HCFA must complete by January 1, 1993, a report to Congress on States' utilization review systems for certain Medicaid services. Section 4755(b)(2) of OBRA requires the report to address the effects of such services on patient access to necessary care, quality of care, and cost of care.

METHODOLOGY

During 1990 we gathered information from all 50 States and the District of Columbia to determine whether they had mandatory SSOPs or a precertification review program. We obtained detailed information from the 14 States with mandatory SSOPs, including site visits to 4 States (Colorado, Massachusetts, Michigan, and Pennsylvania).

FINDINGS

- ▶ Current SSOP evaluative data is limited and inconclusive.
- ▶ All but two States have review programs other than mandatory SSOPs. Most use precertification review.
- ▶ Current data is insufficient to support mandating SSOPs.

RECOMMENDATION

We support HCFA's intention to withdraw the proposed regulation mandating SSOPs in the Medicaid program.

We recommend that HCFA, upon completion of its report to Congress, assess what additional information is necessary to determine if States are successfully guarding against unnecessary utilization.

HCFA COMMENTS AND OIG RESPONSE

The HCFA agreed with our recommendation to withdraw the proposed regulation mandating SSOPs in the Medicaid program. However, they did not agree to require States to submit utilization data and analysis which would permit HCFA to evaluate the effectiveness of the various approaches, at least until January 1, 1993, when a report analyzing State utilization review is due to Congress.

While we agree that it is not necessary for States to submit data until the report is submitted to Congress, we continue to believe in the appropriateness of determining the effectiveness of States' utilization review programs. We have modified our recommendation to take the report to Congress into account.

The full text of comments from HCFA are included in Appendix B.

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INTRODUCTION

PURPOSE

This report provides information on recent State evaluations of Medicaid mandatory Second Surgical Opinion Programs (SSOPs) and their implications for the Health Care Financing Administration's (HCFA) proposed regulation requiring such programs. A companion report summarizes common elements of States' mandatory SSOPs (OEI-03-89-01531).

BACKGROUND

Section 1902(a)(30)(A) of the Social Security Act requires that Medicaid State plans contain safeguards against unnecessary utilization of care and services and assure that payments are consistent with efficiency, economy, and quality care.

States currently use SSOPs as a utilization safeguard. These programs require clients to obtain independent medical opinions prior to elective surgery. A second opinion either confirms or refutes the necessity of the proposed surgery. The SSOPs encourage patients to be more informed and involved in their medical treatment. It is thought that this education will enable patients to make better decisions which will lead to improved quality of care and cost savings from foregone surgeries.

Initial SSOPs

The first national SSOP was established in New York in 1972 as a joint venture between Cornell-New York University and a Taft-Hartley benefit fund. Dr. Eugene McCarthy established and administered the SSOP.

In 1974, Dr. McCarthy reported a 18.7 percent rate for nonconfirming second opinions. This resulted in program savings of \$2.63 for every dollar spent. The report generated interest in Congress, which was considering ways to contain Medicaid and Medicare costs.

The earliest Medicaid mandatory SSOP was established in Massachusetts in 1976. Michigan also established its SSOP in 1976.

HCFA Implements Voluntary SSOP for Medicare

During 1976 and 1977, the House of Representatives' Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce (known as the Moss Committee) conducted hearings on unnecessary surgery and its effect on spiraling health care costs. The Moss Committee recommended that the then Department of Health, Education, and Welfare promptly institute a program of

independent professional second opinions to confirm the need for elective surgery underwritten by Medicare and Medicaid. To comply with this request, HCFA implemented a national Medicare voluntary SSOP in September 1978. Prior to this, HCFA had initiated several second opinion demonstration projects in 1977.

1981/1982 Abt Evaluation of SSOPs

Under a HCFA contract, Abt Associates, Inc., evaluated the voluntary Medicare demonstration second opinion program and a mandatory Medicaid SSOP in Massachusetts. The Abt report concluded that only mandatory programs could achieve cost savings because of the low participation rate in voluntary SSOPs. The report noted substantial savings for the mandatory SSOP in Massachusetts, where the SSOP reduced the volume of surgical procedures by 20 percent, thereby saving an estimated \$1 million annually.

Mandatory SSOPs are effective because of a phenomenon known as the sentinel effect. The sentinel effect operates by creating an environment in which physicians recommend fewer surgeries because they know their decisions will be reviewed by second surgical opinion consultants. However, voluntary SSOPs have not benefitted from the sentinel effect because most beneficiaries do not seek a second opinion.

Office of Inspector General (OIG) Recommends Mandatory SSOPs

In a 1983 report, the OIG advised HCFA to establish a mandatory SSOP for both Medicaid and Medicare. At that time, seven States had implemented mandatory SSOPs; three of these States claimed substantial savings. The OIG estimated HCFA would save \$157 million annually by adopting a mandatory SSOP for both programs.

The HCFA rejected the OIG's recommendation, citing limited experience with mandatory SSOPs in the private and public sectors. The HCFA called for further analysis of existing second opinion programs before proceeding with any proposal to establish a mandatory SSOP for either Medicaid or Medicare.

Mandatory SSOPs Proposed by HCFA

In 1986, HCFA proposed a regulation requiring mandatory SSOPs in State Medicaid programs. The proposed regulations required, at a minimum, that a mandatory SSOP be applied to 10 common elective surgical procedures. The regulation was designed to promote mandatory SSOPs nationally. However, HCFA would permit a State not to implement a mandatory SSOP if it currently operated a review program that achieved the objectives of being cost effective and preventing unnecessary surgery.

Current Status of Regulation

The proposed mandatory SSOP regulation has never been finalized. The 1986 Omnibus Budget Reconciliation Act (OBRA 86) precludes HCFA from issuing regulations in final form until 180 days after releasing a report on the matter.

In June 1989, HCFA reported on high volume and high payment procedures in the Medicaid population. The report contained information on States' SSOPs. It contained no recommendations.

In 1990, HCFA made a tentative decision not to finalize the proposed mandatory SSOP regulation. At that time, 14 State Medicaid programs were using mandatory SSOPs.

As part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), HCFA must complete by January 1, 1993, a report to Congress on States' utilization review systems for certain Medicaid services. Section 4755(b)(2) of OBRA requires the report to address the effects of such services on patient access to necessary care, quality of care, and cost of care.

SSOPs in the Private Sector

Currently, commercial insurers and Blue Cross and Blue Shield plans insuring more than 47 million people do not actively market SSOPs as a stand-alone product. They continue to provide it as one component of a complete quality assurance and utilization review package. According to these insurers, the substantial savings documented when SSOPs were first introduced are no longer possible because recommendations for elective surgery are usually confirmed.

Managed Care Organizations have also moved away from stand-alone SSOPs. They do not market SSOPs as a tool to achieve cost savings. However, some employers still purchase the program as part of a larger utilization review package to educate employees and enable them to participate more fully in health care decisions.

METHODOLOGY

During 1990, we gathered information from all 50 States and the District of Columbia. We contacted all Medicaid agencies to determine how many currently have mandatory SSOPs or have considered one in the past. We also asked if they were using a preadmission, precertification, or prior approval program.

We contacted the 14 States with mandatory SSOPs and requested detailed information. We visited Colorado, Massachusetts, Michigan, and Pennsylvania to learn first-hand about their programs. We conducted structured telephone interviews with the remaining States. The information requested included: year established, length of

the program, program administrator, objectives, procedures covered, reimbursement mechanism, nonconfirmation rate, and evaluation of the program.

We reviewed pertinent reports by HCFA's Office of Research and Demonstrations. We also analyzed published reports on SSOPs in private sector literature.

FINDINGS

CURRENT SSOP EVALUATIVE DATA IS LIMITED AND INCONCLUSIVE.

Few States have evaluated their mandatory SSOPs and evaluations were limited.

Three States (Michigan, Wisconsin, and Colorado) evaluated their SSOPs in 1990. Eleven States have not evaluated their SSOPs within the last 2 years. Fourteen States had mandatory SSOPs in calendar year 1990. (See Appendix A for a list of these States.)

The Michigan and Colorado evaluations were limited in scope while Wisconsin's evaluation was much broader and is ongoing.

Michigan. The Michigan Medicaid agency used data on the total number of requests for second opinion, the total number of second opinions given, the total number of surgeries confirmed, the total number of surgeries not confirmed, and the total number of surgeries actually performed. The evaluation also included information on the costs of the second opinion program and the hospital admission and utilization program. Additionally, a routine retrospective review was performed, under the hospital admission and utilization program, on a limited number of actual surgeries.

Colorado. The Foundation for Medical Care, a provider of medical review for both Medicare and Medicaid, evaluated data for two surgical procedures. The Foundation compared Medicaid utilization rates with a non-Medicaid group which had similar demographics.

Wisconsin. The University of Wisconsin-Madison, Center for Health Systems Research and Analysis, Medicaid Evaluation Program, is under contract to perform an evaluation of the State mandatory SSOP. The evaluation is focused on two program outcomes: the estimated change in the number of surgeries performed as a result of the program and the resultant cost implications. Using fiscal year 1987-88 data for two procedures, researchers compared for selected individuals, the medical cost per case for those electing surgery with those deciding to forego surgery. They estimated the number of individuals that would forego surgery as a result of the program. In addition, the Medicaid Evaluation Program compared program savings to program costs, including administrative and second opinion consultation costs. The remaining eight procedures are scheduled to be reviewed in a similar manner.

A recent HCFA study reported that few States had evaluated their SSOPs for cost savings. The 1989 mandated HCFA report to Congress, entitled *High Volume and High Payment Procedures in the Medicaid Population*, provided detailed information on 11 of the 13 mandatory Medicaid programs in operation at that time. (Two of the 13 States did not provide information.)

The report listed only three States -- Oregon, Virginia, and Washington -- that calculated the savings they believed accrued to their program as a result of the mandatory SSOP. The State evaluations were performed in 1987 or earlier. Oregon reported savings of \$394,982 for the period July 1, 1986 to June 30, 1987; Virginia reported savings of \$961,521 for calendar year 1986; and Washington reported savings of \$656,000 for the period January 1, 1982 to December 31, 1982.

Recent evaluation results are inconsistent.

Current evaluations reveal that SSOPs are not producing consistent results. This is in contrast to the earlier evaluations that demonstrated that mandatory SSOPs were cost effective and were reducing unnecessary surgeries.

Michigan discontinued its 11-year-old SSOP in 1990. They provided us with a number of reasons for discontinuing their program.

- ▶ **First**, half of the clients receiving a nonconfirming second opinion had the surgery anyway. (Michigan's program allowed clients to decide whether to have surgery, even if they received nonconfirming second opinions.)
- ▶ **Second**, about three percent of the surgeries reviewed under the hospital admission and utilization program were found to be medically unnecessary.
- ▶ **Third**, folding the mandatory SSOP into the hospital admission and utilization review program would reduce provider and recipient confusion and be just as effective at holding down the incidence of elective surgeries. In fact, their analysis indicated that Medicaid would save \$600,000 by folding the mandatory SSOP into the hospital admission and utilization review program.

They also felt that the hospital admission would enable the State to keep abreast of the latest treatment alternatives and review criteria for elective surgeries. Rather than relying on individual physicians, the State would assume the job of ensuring that the most current treatment alternatives and criteria are used.

- ▶ **Fourth**, physician practice patterns had changed since implementation of the SSOP. It was thought that the drop in the incidence of elective surgeries is partly attributable to the fact that the physician community is much more used to the whole concept of utilization and peer review. Michigan concluded that while a second opinion was an appropriate and effective response 11 years ago, it is not today.

Colorado's evaluation found the program worthwhile. The rate per 1000 non-Medicaid members for the two surgical procedures reviewed was lower for the populations having the second opinion program. The rate was even lower per 1000 Medicaid members under the second opinion program.

Wisconsin's SSOP is currently being evaluated,¹ and thus far, two procedures have been reviewed. The evaluation indicates the SSOP is meeting the stated objective of reducing the number of surgeries performed. Medicaid expenditures have been reduced as a result of individuals electing to forego surgery after having the second opinion. However, only one of the procedures had a favorable savings-to-cost ratio. This is in contrast to the first evaluation in 1981 which documented cost savings and the second evaluation in 1985 which documented a break-even point.

ALL BUT TWO STATES HAVE REVIEW PROGRAMS OTHER THAN MANDATORY SSOP. MOST USE PRECERTIFICATION REVIEW.

Most States have chosen review programs other than mandatory SSOPs. Of the States without a mandatory SSOP, 34 States and the District of Columbia use a precertification or preadmission review process to avoid unnecessary surgeries and hospital admissions. The precertification process requires that the State's review agent be informed prior to treatment as a condition for full benefit coverage. A determination is then made as to the appropriateness of treatment and proposed site of service.

Of the 34 States with precertification programs, 22 considered a mandatory SSOP. However, 14 of the 22 have no plans for implementation. Only 2 of the 22 have future plans for implementation. Five did not know and one had already discontinued its second opinion program. Almost half of those that had no future plans for implementation concluded that a SSOP was not cost effective. Some indicated that a SSOP would not save them money or that it had become an obsolete cost containment tool.

Only two States (Oklahoma and South Dakota) have neither a mandatory SSOP nor a precertification or preadmission review process.

CURRENT DATA IS INSUFFICIENT TO SUPPORT MANDATING SSOPs.

The proposed HCFA regulation would require State Medicaid plans to include SSOPs for certain surgical procedures. Its objectives are cost effectiveness and the prevention of unnecessary surgery. States using other review programs which HCFA determines will achieve these objectives are not required to establish SSOPs.

The proposed regulation would base approval of a State's current program on whether its outcome is, at a minimum, equal to the outcome of an SSOP. However, our review has demonstrated a lack of outcome data for current SSOPs. This lack of data raises doubts as to whether SSOPs should be required.

¹The results of this review were reported in early 1991.

Additionally, without data HCFA would be unable to enforce the proposed regulation because HCFA would have no performance indicators that could be used to exempt States having an alternative program. This is significant since most States have a review program other than a mandatory SSOP.

RECOMMENDATION

We support HCFA's intention to withdraw the proposed regulation mandating SSOPs in the Medicaid program.

We continue to support HCFA's efforts to ensure that States have methods to safeguard against unnecessary utilization of care and services. When the regulation was first proposed in 1986, there was clear evidence of program savings and prevention of unnecessary surgery resulting from mandatory SSOPs. At that time it would have been appropriate to require all States to implement a mandatory SSOP.

However, at this point little evaluative data is available for mandatory SSOPs. Few States have performed evaluations of their existing mandatory SSOPs. Even when evaluations have been done, the results do not conclusively indicate that mandatory SSOPs are cost effective and successful in reducing unnecessary surgeries. Without this data, mandatory SSOPs should not be required. Additionally, HCFA cannot use mandatory SSOPs as a standard to judge the effectiveness of other review programs if data on mandatory SSOPs' effectiveness is inconclusive.

In order for HCFA to carry out its responsibilities under section 1902, it should assess the adequacy of State programs designed to guard against unnecessary utilization. There is room for considerable flexibility and experimentation in the approach to such programs. These programs might use SSOPs but could use other methods as well, such as managed care or precertification review.

Evaluation of the efficacy of these various approaches is one goal of HCFA's report to Congress on utilization review. After completion of its report to Congress, HCFA will be in a better position to determine what additional information, or routine reporting of data, is necessary for it to assess State compliance with section 1902(a)(30)(A).

We therefore recommend that HCFA, at the completion of its report to Congress, assess what additional information is necessary to determine if States are successfully guarding against unnecessary utilization.

HCFA COMMENTS AND OIG RESPONSE

The HCFA agreed with our recommendation to withdraw the proposed regulation mandating SSOPs in the Medicaid program. However, they disagreed that they should require States to submit utilization data and analysis so they can evaluate the efficacy of the various approaches.

The disagreement is based on the fact that HCFA does not want to require States to submit data at least until they complete their report to Congress on State utilization review systems. The report will include an analysis of State utilization review procedures for ambulatory surgery, preadmission testing, and same-day surgery in order to ensure these programs are appropriate for Medicaid patients. The report will address the effects of such programs on access, quality, and costs of care.

The HCFA has indicated it will ensure that required information on utilization review programs is included in the Medicaid State plans. This could be helpful if States provide enough information to enable HCFA to make determinations on the efficacy of various utilization review programs.

We agree that it is not necessary for States to submit utilization data until the required report is submitted to Congress, since the report should provide insights on the impact broader data collection requirements will have on providers and States, as well as the HCFA staff. However, we still believe that it is appropriate to determine the effectiveness of States' utilization review programs. We have modified our recommendation to take the report to Congress into account.

The full text of comments from HCFA are included in Appendix B.

APPENDIX A

STATES WITH MANDATORY SSOPS IN 1990

COLORADO

INDIANA

MARYLAND

MASSACHUSETTS

*MICHIGAN

MINNESOTA

MISSOURI

NEW JERSEY

OREGON

PENNSYLVANIA

TENNESSEE

VIRGINIA

WASHINGTON

WISCONSIN

* DISCONTINUED IN 1990

APPENDIX B

COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

APR 27 1992

Date *William Toby, Jr.*
From William Toby, Jr.
Acting Administrator

IG
PDIG
DIG-AS
DIG-EI
DIG-OI
AIG-MP
OGC/IG
EX SEC
DATE SENT 4/29

Memorandum

Subject: OIG Draft Reports - "State Evaluation of Medicaid Mandatory Second Surgical Opinion Programs (SSOPs)," OEI-03-89-01530, and "Medicaid Mandatory SSOPs: Summaries of State Programs," OEI-03-89-01531

To: Inspector General
Office of the Secretary

We have reviewed the subject companion reports. The first-referenced draft report discusses the lack of current outcome data for mandatory SSOPs and the effect this has on the 1986 proposed regulation mandating SSOPs for Medicaid. The second-referenced report describes and summarizes the common elements of the 14 States' Medicaid SSOPs that were in existence in 1990. This latter report was issued as a final since it does not contain any recommendations.

OIG found that 34 States and the District of Columbia use a precertification or preadmission review process instead of SSOPs to reduce instances of unnecessary surgeries and hospital admissions. OIG also found that while past studies demonstrated that mandatory private sector SSOPs curtailed unnecessary surgeries and produced savings, the few evaluations available of current Medicaid SSOPs could not conclusively determine that these programs were cost-effective or reduced unnecessary surgeries for Medicaid. OIG maintains that the lack of current outcome data raises doubt as to whether SSOPs should be required. Therefore, OIG concludes that the Health Care Financing Administration (HCFA) should withdraw the current proposed regulation which would mandate SSOPs. OIG did, however, recommend that HCFA ensure that each State establish the requisite utilization review program and require States to submit such data and analyses to enable HCFA to evaluate the efficacy of the various approaches.

We agree with OIG's findings and are currently considering whether to withdraw the regulation mandating SSOPs in Medicaid. However, we disagree with the aspect of OIG's recommendation requiring States to submit utilization data. Our specific comments on the report's recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

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Comments of the Health Care Financing Administration (HCFA)
on the OIG Draft Reports: "State Evaluation of Medicaid
Mandatory Second Surgical Opinion Programs (SSOPs)."
OEI-03-89-01530, and "Medicaid Mandatory SSOPs:
Summaries of State Programs." OEI-03-89-01531

Recommendation

That HCFA should ensure that each State establish the requisite utilization review program and require States to submit such data and analyses to enable HCFA to evaluate the efficacy of the various approaches.

HCFA Response

HCFA concurs with the first part of this recommendation. We are pleased that OIG recognizes that there are several viable options for utilization review and we are currently considering whether to withdraw the proposed regulation mandating SSOPs. However, we disagree with the part of this recommendation that requires States to submit data.

As noted by OIG in this report, section 1902(a)(30)(A) of the Social Security Act already requires States to include safeguards against unnecessary utilization of medical care in their State plans. To satisfy this requirement, States are employing several different programs, including: precertification, preadmission review, coordinated care and SSOPs. We believe coordinated care systems represent the best mechanism for reducing hospital costs, admissions and lengths of stays prior to surgery. Therefore, while we will continue to encourage States to choose coordinated care, we are reluctant to impose new mandates when States are already meeting the existing requirement.

With regard to the second part of this recommendation, we would not want to require that States submit data at least until HCFA completes its report to Congress on the State utilization review systems. This report, required by section 4755(b)(2) of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), is due to Congress on January 1, 1993. OBRA 90 requires that the report include an analysis of State utilization review procedures for ambulatory surgery, preadmission testing, and same-day surgery in order to ensure these programs are appropriate for Medicaid patients. The report will address the effects of such programs on access, quality, and costs of care. This study will give us valuable insights on the impact broader data collection requirements will have on providers and States, as well as HCFA staff.

We also believe this requirement may be unnecessarily burdensome given the current austerity of many State budgets. While we are not in favor of requiring States to submit utilization review data at this time, we will ensure that required information on utilization review programs is included in Medicaid State plans.