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REPORT TO THE CONGRESS



BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

Management Of The Civilian Health And Medical Program Of The Uniformed Services Needs Improvement

Department of Defense

In 1970 and 1971, GAO issued five reports containing 31 recommendations to improve program management and pointing out opportunities to reduce costs. GAO's followup review showed that 19 recommendations have been acted on to some extent, although slowly, and 20 recommendations still require action.

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WASHINGTON, D.C. 20548

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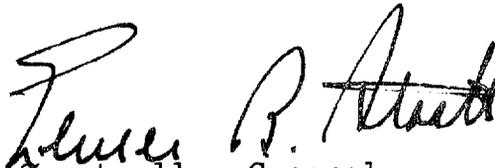
To the President of the Senate and the
Speaker of the House of Representatives

This is our report on the need to improve the management of the Civilian Health and Medical Program of the Uniformed Services.

In 1970 and 1971, we issued 5 reports containing 31 recommendations to improve program management and pointing out opportunities to reduce costs. Because of congressional concern over the escalating costs of the program--from \$91 million in fiscal year 1958, the first full year of operation, to about \$550 million in fiscal year 1975--we reviewed the Department of Defense's progress in following these recommendations. This report describes the Defense Department's corrective actions and the areas still needing improvement.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Defense.


Comptroller General
of the United States

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ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DCAA	Defense Contract Audit Agency
DOD	Department of Defense
GAO	General Accounting Office
HEWAA	Department of Health, Education, and Welfare Audit Agency
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

MANAGEMENT OF THE CIVILIAN
HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES
NEEDS IMPROVEMENT
Department of Defense

D I G E S T

The Congress has expressed concern over the escalating costs of the Civilian Health and Medical Program of the Uniformed Services--from \$91 million in fiscal year 1958, the first full year of operation, to about \$550 million in fiscal year 1975.

In 1970 and 1971, GAO issued 5 reports containing 31 recommendations to improve program management and pointing out opportunities for the Department of Defense to reduce benefit and administrative costs.

The Department took some action--although slowly--which has reduced costs and improved management.

No action was taken, however, on 12 of GAO's recommendations, and more action is needed on 8 other recommendations.

Some of the more important actions the Defense Department still needs to take to improve the management of the program include:

- Adopting more comprehensive and specific standards for evaluating severity of handicaps. (See pp. 6 to 7.)
- Acting faster on proposals for program changes and requests for guidance from its operations office. (See pp. 7 to 9.)
- Discontinuing a duplicate claims-review operation, unless it can be substantiated that benefits exceed costs. (See pp. 21 to 22.)
- Increasing the scope of audits to evaluate the necessity and effectiveness of administrative services performed by fiscal agents. (See pp. 22 to 23.)

- Improving fiscal agents' performance in determining reasonableness of charges. (See pp. 26 to 28.)
- Increasing the use of available Government facilities or lower cost civilian facilities for psychiatric care. (See pp. 30 to 31.)
- Improving utilization reviews performed by fiscal agents. (See pp. 31 to 33.)
- Prohibiting payment under the program for services paid by other health insurance. (See p. 34.)
- Strengthening procedures for issuing and recovering identification cards or implement other controls to assure benefits are provided only to those eligible. (See pp. 37 to 38.)

Other actions which the Department still needs to take are listed on pages 13 to 14, 23, 35 to 36, and 39. The Defense Department expressed general agreement with GAO's recommendations and indicated that actions had been initiated or planned to improve program management. (See app. I.)

CHAPTER 1

INTRODUCTION

We issued the following five reports in 1970 and 1971 on the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in response to an October 20, 1969, request from the Chairman, House Committee on Appropriations, to make a comprehensive review of the program:

- "The Civilian Health and Medical Program of the Uniformed Services" (interim report), May 19, 1970 (B-133142).
- "Improved Management Needed in the Program Providing Benefits to Handicapped Dependents of Servicemen," March 16, 1971 (B-133142).
- "Potential for Reducing Hospital and Administrative Costs Under the Civilian Health and Medical Program of the Uniformed Services." April 16, 1971 (B-133142).
- "Costs of Physician and Psychiatric Care--Civilian Health and Medical Program of the Uniformed Services," July 9, 1971 (B-133142).
- "Potential for Improvements in the Civilian Health and Medical Program of the Uniformed Services," July 19, 1971 (B-133142).

These reports contained 31 recommendations directed at improving CHAMPUS management and reducing health care and administrative costs. We made a followup review to determine whether corrective actions had been taken.

PURPOSE OF THE PROGRAM

CHAMPUS helps dependents of active duty members, retirees and their dependents, and dependents of deceased members to pay for health care obtained from civilian sources. The program originated with the Dependents' Medical Care Act of 1956 (Public Law 84-569). The purpose of this act was to create and maintain high morale throughout the uniformed services by providing an improved program of medical care for members and their dependents. Before the act was passed considerable disparity existed among the branches of the uniformed services in (1) the categories of dependents eligible for care at service medical facilities and (2) the type of care provided.

Also, those dependents who resided at locations where no medical facilities of the uniformed services were available or where facilities were in full use had to pay the total cost of care received from civilian sources.

The Military Medical Benefits Amendments of 1966 (Public Law 89-614) added retirees and their dependents and dependents of deceased members as eligible beneficiaries, expanded benefits, and provided for special handicap care for dependents of active duty personnel.

CHAMPUS benefits are divided into two categories--basic and handicap. Basic benefits cover medical services provided on both an inpatient and outpatient basis, such as medical treatment and surgery, drugs, X-rays, and clinical laboratory tests. These benefits are available for dependents of active duty and deceased members and for retired members and their dependents. Handicap benefits cover moderately or severely retarded or seriously physically handicapped spouses and children of active duty members only.

Costs of medical care are shared by the Government and the beneficiary. For inpatient care, dependents of active duty members pay a total of \$25 or \$3.70 a day, whichever is greater; retired members and their dependents and the dependents of deceased members pay 25 percent of total charges. For outpatient care, every beneficiary has a \$50 deductible (\$100 maximum deductible for each family) each fiscal year. After the deductible has been paid, dependents of active duty members pay 20 percent and other beneficiaries pay 25 percent of remaining charges. Under the special handicap benefits, the dependent of an active duty member pays a share based on the member's pay grade; the Government pays the remainder, to a maximum of \$350 a month.

PROGRAM ADMINISTRATION

The Secretary of Defense--who administers the program for the Army, Navy, Air Force, Marine Corps, and the Coast Guard when operating as a service of the Navy--and the Secretary of Health, Education, and Welfare--who administers the program for the Public Health Service, the National Oceanic and Atmospheric Administration, and the Coast Guard when not operating as a service of the Navy--are responsible for overall CHAMPUS policy guidance.

Until July 1972, the Secretaries had delegated responsibility for administering CHAMPUS to the Executive Director, Office for the Civilian Health and Medical Program

of the Uniformed Services (OCHAMPUS), who was under the jurisdiction of the Surgeon General, Department of the Army. In an effort to bring management control closer to the Secretary of Defense, responsibility for CHAMPUS was consolidated, effective July 1, 1972, under the Assistant Secretary of Defense (Health and Environment). A Uniformed Services Health Benefits Committee, whose membership includes the OCHAMPUS Director and a representative from each service, was established, effective December 4, 1974, to advise the Assistant Secretary. OCHAMPUS, located at Fitzsimons Army Medical Center near Denver, was designated a field activity under the policy guidance and operational direction of the Assistant Secretary of Defense (Health and Environment).

OCHAMPUS has contracted with "fiscal agents"--the Blue Cross Association and individual Blue Shield plans, private insurance companies, and State medical societies--to process and pay claims for medical care. The Blue Cross Association, through subcontracts with 52 Blue Cross plans, pays hospital claims in 33 States, the District of Columbia, and Puerto Rico. Mutual of Omaha pays hospital claims in the remaining 17 States, Canada, and Mexico. There are 46 fiscal agents who process physician, drug, dental, and handicap claims for the 50 States, the District of Columbia, Puerto Rico, Canada, and Mexico.

OCHAMPUS reimburses the fiscal agents for the administrative costs of processing and paying claims. Audits of these administrative costs are made by the Department of Health, Education, and Welfare Audit Agency (HEWAA).

CHAMPUS COSTS

CHAMPUS costs have risen substantially since the program began. In fiscal year 1958, the first full year of operation, the program cost \$91.2 million. During fiscal years 1959-66, costs remained relatively stable, ranging between \$52.7 million and \$75.6 million. However, the expanded benefits resulting from the 1966 amendments, which became effective during fiscal year 1967, have increased costs.

Costs are allocated to the year in which the medical services were provided rather than the year in which paid. Costs, as of December 31, 1974, for services provided in fiscal years 1966-74 follow.

<u>FY</u>	<u>Costs</u>	increase from FY <u>1966</u>
	(millions)	
1966	\$ 73.8	-
1967	106.0	44
1968	159.6	116
1969	197.3	167
1970	271.1	267
1971	326.0	342
1972	387.6	425
1973	433.2	487
1974	448.0	507

Fiscal year 1975 costs are estimated at \$551 million.

Administrative costs in fiscal year 1974 totaled \$19.4 million, 4.3 percent of program costs. Administrative costs are primarily payments to fiscal agents for processing claims and those costs incurred by OCHAMPUS.

CHAPTER 2

FOLLOWUP ON RECOMMENDATIONS ON HANDICAP COMPONENT

On March 16, 1971, we reported on "Improved Management Needed in the Program Providing Benefits to Handicapped Dependents of Servicemen" (B-133142). The Department of Defense (DOD) responded to this report, which contained 11 recommendations, on July 6 and September 20, 1971. Corrective action had been taken on five recommendations; partial action, on three recommendations; and no action, on three recommendations.

The actions taken have improved management and reduced costs of the handicap portion of CHAMPUS. Costs rose from \$3.7 million in fiscal year 1968 to \$30.5 million in fiscal year 1973 but then declined to \$17.1 million in fiscal year 1974. Costs are estimated at \$13 million for fiscal year 1975. DOD could further improve management of the handicap portion of the CHAMPUS program by

- adopting more comprehensive and specific standards for determining whether handicaps are serious enough to qualify for benefits,
- making its policy decisions faster,
- involving medical personnel more in this evaluation process,
- increasing audits and reviews of the handicap portion of CHAMPUS,
- developing a standard format for a complete medical statement by physicians, and
- developing methods for fiscal agents to use in determining the reasonableness of handicap charges.

ACTIONS TAKEN

During our prior review of the handicap portion of the CHAMPUS program, we found that:

- The liberal interpretation OCHAMPUS applied to the law in approving benefits had increased program costs. OCHAMPUS was deciding any questions concerning benefits in favor of the beneficiary and considered any treatment ordered by a physician as an allowable benefit, except for a few things specifically prohibited by law.

- Certain dental conditions were considered eligible for benefits on the basis of a questionable method of determining the degree of the handicap.
- Fiscal agents, because they had received little guidance from OCHAMPUS, frequently made improper payments for handicap claims.
- Key managerial positions had a rapid turnover, adversely affecting program administration.
- The policy requiring OCHAMPUS to approve handicap benefits before providing care was not enforced. Care was approved retroactively to avoid hardship to the sponsors rather than on the basis of qualification for benefits.

Our followup showed that, although DOD sometimes acted slowly on the above recommendations, corrective action had been taken. For example, OCHAMPUS discontinued retroactive approval in March 1975. DOD has reduced annual costs in the handicap program by over \$24 million and has improved program management.

FURTHER ACTION NEEDED

Comprehensive standards needed for approving benefits

We previously recommended that the general criteria and standards for approving care under the handicap portion of CHAMPUS be reevaluated and revised to specify, wherever possible, standards established by authoritative medical organizations for use as guidelines in approving or disapproving program benefits.

Sponsors (active duty members) must obtain OCHAMPUS approval before handicap benefits can be paid. This approval is given on the basis of a physician's statement diagnosing the handicap and recommending care. OCHAMPUS notifies fiscal agents of approved cases, and providers of care submit claims to the fiscal agents for payment for services.

We reported that OCHAMPUS had not established standards for evaluating requests for approval of care under the handicap portion of CHAMPUS. Instead, OCHAMPUS relied on the physicians' statements and recommendations, assuming that physicians would recommend care only when needed. Some of these statements were very brief, containing insufficient information for OCHAMPUS to assess whether the handicapping condition was serious enough to qualify under the program.

However, even when the statements provided comprehensive descriptions of the handicapping conditions, the lack of specific standards often made it difficult to determine whether the severity of the handicap qualified for benefits.

In response to our report, DOD stated that (1) specific standards had not been used because the professions involved had not precisely defined such standards and (2) OCHAMPUS was attempting to develop more precise standards and DOD was exploring with several professional organizations the possibility of formulating specific guidelines for OCHAMPUS use.

Our followup showed that specific, comprehensive standards have not been adopted. OCHAMPUS submitted proposed standards, similar to those used by the Social Security Administration in determining eligibility for disability benefits, to the Assistant Secretary of Defense (Health and Environment) on October 2, 1973. However, as of September 1975, DOD had not adopted them.

Without standards for classifying the severity of a handicap, OCHAMPUS continued to approve questionable cases. In one case, for example, OCHAMPUS approved care for a child diagnosed as having possible moderate mental retardation. No tests were administered to determine the degree of retardation.

OCHAMPUS informed us that in July 1974 it began using some standards, such as I.Q. scores, in evaluating some mental retardation cases. In addition, physicians are now requested to provide additional information when their original data submissions are incomplete.

Although some specific standards are being used in line with our recommendation for replacing the general guidelines, DOD should adopt more comprehensive standards.

Prompter DOD policy decisions needed

We previously recommended that certain policy decisions of DOD, which appeared to increase the program cost unnecessarily, be reconsidered. Two examples involved enuretic (bed-wetting) conditioning programs and the Doman-Delacato method of treating brain damage.

Private firms were selling enuretic programs to CHAMPUS beneficiaries who then claimed reimbursement under either the basic or the handicap portion. These programs consisted of instructions to the parent or other responsible family member, loan of an enuretic conditioning device which must be

returned to the vendor at the end of the program, and analysis of a report card sent to the firm by the parent every 10 days. The cost of these programs ranged from about \$220 to \$445.

Enuretic conditioning devices, with instructions for use, could be purchased from several national department stores, mail order houses, and drugstores at prices ranging from \$20 to \$33.

In the opinion of medical officers at OCHAMPUS and a majority of physicians replying to an OCHAMPUS inquiry, the quality of care and results obtained by using either the \$20 department store device or the more expensive enuretic programs sold by the private firms was about the same. In addition, medical advisory committees of two CHAMPUS fiscal agents had investigated the private firms and found such questionable practices as payments to physicians for recommending the firms' enuretic conditioning programs. The above information was submitted to DOD in June 1970. However, DOD directed OCHAMPUS to continue paying claims for the more costly enuretic programs because it believed that broader medical opinion was necessary to justify a policy change.

The Doman-Delacato method of treating brain damaged children involves having the children crawl on hands and knees and manipulating their extremities to develop vital brain layers. OCHAMPUS, supported by the opinions of 10 medical and professional associations, recommended in August 1968 that this treatment be disapproved for payment under CHAMPUS. In October 1968 the Surgeon General of the Army replied that the recommendation was not approved because the joint statement of the professional associations stopped short of an unequivocal condemnation of this treatment.

DOD, in its reply to our report, did not specifically address our recommendation that the policy decisions concerning the above treatments be reconsidered.

Our followup showed that DOD policy decisions have eliminated certain benefits previously authorized which have been determined to be not in accordance with the intent of the Congress in authorizing the handicap portion of CHAMPUS. However, many of these decisions have not been prompt. For example, effective September 19, 1974, the Doman-Delacato treatment method became payable under CHAMPUS only as part of a complete inpatient program in a residential care facility. In June and July of 1974, OCHAMPUS also submitted several suggestions to DOD for changes in cost-sharing for enuretic programs, and effective February 28, 1975, this treatment became payable

only under the basic program and only if prescribed and supervised by a physician. OCHAMPUS restrictions on sources of supply now generally limit the allowable cost of enuretic conditioning devices to about \$50.

But the program changes regarding the above treatments were not made until over 3-1/2 years after we recommended the changes. OCHAMPUS has also experienced considerable delays in obtaining DOD policy decisions on proposals for program changes. As of April 1975, proposals awaiting policy decisions included:

- Adopting standards for evaluating requests for handicap care, submitted October 2, 1973. (See p. 7.)
- Purchasing medical equipment from Government sources, submitted October 26, 1973. (See p. 38.)
- Removing inequities in present CHAMPUS rules on other insurance, submitted July 12, 1973. (See p. 34.)
- Approving handicap care on a decentralized basis, proposed in January 1974.

DOD officials said that an insufficient CHAMPUS policy staff has been one reason for the delay in carrying out new policies. DOD officials also said that a new CHAMPUS regulation was being written incorporating many of the new policies.

Although DOD has reconsidered certain policy decisions as recommended, further efforts are needed in considering proposals for policy changes and insuring that policy decisions are made faster.

Greater involvement by medical personnel needed in evaluating handicap cases

We previously recommended establishing a committee of medical personnel from OCHAMPUS and Fitzsimons Army Medical Center to meet regularly to decide approval of cases under the handicap portion of CHAMPUS. Only limited evaluations of physicians' recommendations for handicap care were being made. OCHAMPUS officials said they had to rely on physician recommendations and were precluded from practicing medicine.

In response to our recommendation, DOD stated that a case review committee had been established at OCHAMPUS for evaluating unusual cases, and that they were using Fitzsimons General Hospital medical experts extensively.

Our followup indicated that, contrary to DOD's response, a review committee has not been established. We were informed, however, that Fitzsimons Army Medical Center experts resolve questionable cases. This relationship has been formalized through a signed order designating certain medical officers at Fitzsimons as consultants to OCHAMPUS on matters pertaining to their specialty.

Requests for handicap benefits are currently reviewed by OCHAMPUS clerks. Further approval processing is performed as needed by a nurse, a CHAMPUS medical advisor, and Fitzsimons consultants.

In the opinion of our medical advisors, requests for benefits have been approved despite incomplete or unclear diagnoses. For example, one military physician gave the diagnosis "mental retardation * * *, normal intelligence." Another case was diagnosed as "mental retardation, moderately severe, * * * despite adequate mental ability." No evidence was submitted that tests had been administered to determine the degree of the handicaps. OCHAMPUS officials said followup letters are now being sent when diagnoses are incomplete.

In January 1974 OCHAMPUS proposed to DOD that the approval function for handicap cases be turned over to CHAMPUS fiscal agents. The proposal includes the adoption of standards, as discussed on pages 6 to 7, to determine qualification for program benefits. Each CHAMPUS fiscal agent would be responsible for reviewing applications to determine if the handicap condition is severe enough to qualify. As of May 1975, however, this proposal had not been adopted.

Although OCHAMPUS has not established a committee to review handicap cases as recommended, the mechanisms which were established, including use of Fitzsimons Army Medical Center experts, are adequate to perform the review and approval function. However, there is a need for greater involvement of available medical personnel in making such determinations as severity of handicaps, thoroughness of physician diagnoses, and need for the proposed care.

NO ACTION TAKEN AND PROBLEMS STILL EXIST

Increased audit coverage of the handicap portion of CHAMPUS needed

We previously recommended intensified auditing of the handicap portion of CHAMPUS. DOD responses to our report did not directly address this recommendation. Our followup showed that no such efforts have been made.

The U.S. Army Audit Agency did not review the handicap portion of the program during its 1968 audit of OCHAMPUS, even though it had never reviewed the handicap program. Audits of fiscal agents by HEWAA were limited to reviewing sample claims representing the entire CHAMPUS. Evaluations of fiscal agents' operations by the OCHAMPUS contract performance review branch did not include the handicap portion of CHAMPUS. Handicap claims are regularly audited at OCHAMPUS using sampling techniques based on volume of total claims (basic and handicap program). An OCHAMPUS official said the number of errors detected on handicap claims was believed proportionately lower than the number detected on basic program claims.

OCHAMPUS officials stated that handicap claims are normally not reviewed either by HEWAA in their audits when closing out contracts of fiscal agents or by the OCHAMPUS contract performance review teams when reviewing contractor operations.

Problems still exist in paying handicap claims. In addition to errors on the claim form, these problems include determining reasonableness of charges, applying sponsors' deductibles, and adequately justifying benefits. In reviewing claims for accuracy of payments, we found that one fiscal agent had made erroneous payments involving 4 of 10 patients. Another fiscal agent had made overpayments because the computer program did not reduce the amount billed to CHAMPUS by the sponsor's mandatory cost-sharing amount. One fiscal agent was paying the maximum \$350 per month to facilities, even though the facilities billed for a lesser amount because patients were not in their facilities for a full month.

The above problems indicate the continued need for additional audit effort of the handicap portion of the program.

Standard format for
medical statements needed

We previously recommended establishing a standard format for physician diagnosis to facilitate preparation of a complete medical statement for OCHAMPUS approval. In some cases, physicians' statements contained insufficient information to properly assess whether the beneficiary's condition qualified for CHAMPUS benefits and, if so, whether care should have been provided under the handicap or the basic portion of CHAMPUS. Also, cases were approved which appeared to be outside of intended CHAMPUS coverage. The proper classification under either the basic or handicap portion of CHAMPUS is important, as cost-sharing between the sponsor and CHAMPUS is different under each portion. Normally, costs to CHAMPUS are higher under the basic portion.

In response to our report, DOD recognized the need for a standard format and said OCHAMPUS was attempting to design one. However, our followup showed that a standard format has not been developed. OCHAMPUS has continued to accept incomplete and unclear statements. An OCHAMPUS official said that incomplete physician statements are being corrected by requesting additional information in followup letters.

We believe that, although followup letters are a way to obtain more complete physicians' statements, submission of statements on a standard format would be more effective and economical.

Need to determine reasonableness of charges

We previously recommended that (1) fiscal agents make every effort to determine that charges for handicap care are reasonable and (2) consideration be given to including on claims a certification by providers of care that the charges do not exceed those for other patients receiving comparable services. Neither the fiscal agents nor OCHAMPUS were reviewing charges for reasonableness under the handicap portion of CHAMPUS, and each considered it the responsibility of the other to do so. In response to our report, DOD stated that fiscal agents would hereafter be required to determine the reasonableness of charges for all types of care.

Our followup showed that, although OCHAMPUS requires fiscal agents to determine that charges for handicap care are reasonable, agents have not been instructed how to satisfy this requirement. Our investigation of four fiscal agents showed that none had established a method to evaluate the reasonableness of handicap charges, and all were paying whatever charges were billed to CHAMPUS. An OCHAMPUS official said he assumed fiscal agents were determining the reasonableness of charges on handicap claims, since they were contractually required to do so; however, the OCHAMPUS contract performance review team had not reviewed fiscal agent operations in this area.

Until recently, OCHAMPUS notified fiscal agents of estimated monthly charges of facilities treating handicapped beneficiaries. This notification procedure could have been a means of controlling increases in charges; however, fiscal agents often paid amounts greatly exceeding these estimated charges. For example, authorization for care of a handicapped patient in a certain State institution showed the estimated monthly cost to be \$150, but CHAMPUS was charged \$350, which the fiscal agent paid without question. Fiscal agents are now authorized to pay billed charges of facilities as long as they do not exceed the \$350 limit under the

handicap portion of CHAMPUS. This new policy has removed the potential for control.

OCHAMPUS has proposed to DOD that participation agreements be negotiated between OCHAMPUS and facilities approved for program participation. These agreements would, among other things, grant OCHAMPUS authority to examine facility financial records to insure that charges are reasonable and equivalent to charges to others.

Our followup showed that no determinations of reasonableness of charges were being made. Adoption of participation agreements and a certification on the claim form would help insure that charges are reasonable.

RECOMMENDATIONS

To further improve management of the handicap component of CHAMPUS, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health and Environment) to:

- Issue more comprehensive and specific standards for determining whether handicapping conditions qualify for program benefits.
- Make prompter evaluations and decisions regarding proposals for program changes and responses to requests for policy guidance.
- Require greater involvement of medical personnel in determining eligibility of cases. Medical personnel should evaluate severity of handicaps, thoroughness of physician diagnosis, and need for proposed care. If the function of approving handicap care is assigned to fiscal agents, OCHAMPUS will need to closely monitor their performance.
- Arrange with HEWAA to increase audit coverage and reviews of the handicap portion of CHAMPUS to include analysis of fiscal agents' performance in such areas as determining that charges are reasonable, applying sponsors' deductibles, and making correct claim payments.
- Develop a standard format for use by physicians in reporting diagnoses, to facilitate preparing a complete medical statement for OCHAMPUS approval.

--Develop methods for fiscal agents to use in determining reasonableness of handicap charges and include on claim forms a certification that charges to CHAMPUS are not greater than charges to others.

AGENCY COMMENTS

In commenting on our report in a letter dated September 17, 1975, (see app. I) DOD stated that:

- The standards proposed by OCHAMPUS for determining whether handicaps qualify were inadequate, but DOD is continuing efforts to develop acceptable standards.
- Every effort will be made to speed up evaluations and decisions regarding proposals for program changes and responses to requests for policy guidance.
- A physician's determination will be required in all cases where severity of handicap, completeness of diagnosis, or need for care is questionable.

DOD did not respond directly to our recommendation to increase audit coverage of the handicap program, but indicated that steps will be taken to improve audits in general. We believe increased audit coverage of the handicap portion of the program is still needed as recommended.

DOD stated that standard formats elicit only that information asked for, and increased attention is now being given to medical statements; therefore, a standard format for use by physicians in reporting diagnoses is unnecessary. We believe the use of a standard format would provide a more effective means of obtaining all required information.

According to DOD, long-range plans include participation agreements with facilities, with a negotiated rate which would make unnecessary a certification on claim forms that charges to CHAMPUS are not greater than charges to others. Until the use of negotiated rates is implemented, however, we believe the certification would be desirable.

CHAPTER 3

FOLLOWUP ON RECOMMENDATIONS ON HOSPITAL COMPONENT

On April 16, 1971, we reported on the "Potential for Reducing Hospital and Administrative Costs Under the Civilian Health and Medical Program of the Uniformed Services" (B-133142). DOD responded to the report, which contained seven recommendations, on September 24, 1971.

Costs for hospital claims rose from \$136 million in 1969, the last year for which cost data was included in our previous report, to \$256 million in fiscal year 1974, an 88-percent increase. Administrative expenses for hospital claims processed for CHAMPUS by the Blue Cross Association rose from \$4.92 in fiscal year 1969 to \$7.62 per claim in fiscal year 1974. The cost-per-claim for Mutual of Omaha, the other CHAMPUS contractor for hospital payments, rose from \$3.31 in fiscal year 1969 to \$5.65 in fiscal year 1974.

We reported that a comparison of hospital claims paid under CHAMPUS with claims paid under several medical insurance programs showed that CHAMPUS beneficiaries were generally charged the same for care and services as other hospital patients. We did find opportunities for improved administration and for substantial reductions in health care and administrative costs.

Our followup showed that corrective action had been taken on one recommendation, partial corrective action had been taken on four recommendations, and no action had been taken on two recommendations. DOD needs to:

- Improve the performance of contractors or obtain the services of more efficient ones.
- Attempt to obtain more favorable reimbursement formulas from certain contractors, or change to less costly contractors.
- Determine whether a duplicate claims review is justified, and if not, discontinue it.
- Increase audit coverage of contractors.

ACTIONS TAKEN

We previously recommended considering a pilot program to determine the feasibility of paying CHAMPUS claims on a

prepaid-group-practice basis. Several studies had indicated that prepaid group practice may be a more economical method of delivering medical services than the more common fee-for-service method.

In 1972 DOD proposed a bill advocating prepaid group practice for CHAMPUS, but it was not acted upon in the House of Representatives. The House passed a similar bill in 1973, but the Senate took no action. DOD expects to propose the bill again in the current Congress.

FURTHER ACTION NEEDED

Need to change contractors if advantageous to do so

We previously recommended that DOD consider examining the differences between the administrative cost-per-claim charged by the Blue Cross plans and that charged by Mutual of Omaha, and replacing inefficient contractors. We also recommended requesting other commercial insurance firms to submit proposals to act as program contractors.

OCHAMPUS was paying a wide range of rates for processing hospital claims. The rate was \$4.92 per claim in fiscal year 1969 for the Blue Cross Association and \$3.31 per claim for Mutual of Omaha. The rates of the 52 individual Blue Cross plans, which are consolidated into 1 overall rate for the Blue Cross Association, ranged from \$1.25 to \$8.64 in fiscal year 1968. We estimated that \$60,000 annually could have been saved if the claims-processing work of eight Blue Cross plans had been performed by Mutual of Omaha, whose cost-per-claim was lower. Savings would also have resulted if, in States where Mutual of Omaha was the contractor, Blue Cross plans took over processing and offered CHAMPUS the same favorable hospital reimbursement formulas that were available to these Blue Cross plans. These favorable formulas negotiated with hospitals allow the Blue Cross plans to pay less than the billed charges. The present division of States between the Blue Cross Association and Mutual of Omaha for processing claims has existed since 1956, when CHAMPUS was established.

OCHAMPUS' contracts with the Blue Cross Association and Mutual of Omaha for administrative expenses were cost-reimbursable. They contained no incentives for the contractors to reduce administrative costs by making their operations more efficient.

In response to our recommendations, DOD agreed that OCHAMPUS should examine the differences in the administrative

costs-per-claim charged by Blue Cross plans and by Mutual of Omaha and said appropriate instructions to that effect were being issued. DOD also stated that discussions were being initiated with other commercial insurance firms to develop concepts under which the program could operate more efficiently.

During our followup, OCHAMPUS officials denied receiving any instructions to study differences in claims-processing rates, although they have informally considered switching contractors in the past.

The administrative rate of the Blue Cross Association as of June 30, 1974, was estimated at \$7.62, an increase of \$2.70 since 1969. The Mutual of Omaha rate as of June 30, 1974, was \$5.65, an increase of \$2.34 since 1969. The rates for the 52 individual Blue Cross plans ranged from \$3.35 to \$15.94. Thirty-nine Blue Cross plans have a higher rate than that of Mutual of Omaha.

OCHAMPUS officials said they began an analysis of administrative costs in September 1974. OCHAMPUS has asked the Blue Cross Association to justify high administrative costs. If satisfactory answers are not provided, OCHAMPUS will talk with other contractors about taking over CHAMPUS activities.

OCHAMPUS officials said they had not considered requesting proposals from insurance companies. They said a change from the present cost-reimbursement type contract to an incentive contract would require more explicit identification of the contract's service and processing goals. They added that in any change of contractors, the additional costs of startup would have to be considered.

No significant action was taken until September 1974 on our recommendation to examine differences in administrative costs between the Blue Cross plans and Mutual of Omaha or assessing whether a change in contractors would be desirable. At that time OCHAMPUS began questioning and analyzing its contractors' administrative costs.

OCHAMPUS should follow through with these efforts, considering such factors as contractor's administrative costs, performance, controls, and services, to the point where decisions can be reached as to which contractors and subcontractors should be retained or replaced. Preferential rates obtainable under Blue Cross plans in States where Mutual of Omaha is currently the contractor should also be considered in this process.

We found no indication of any actions on our recommendation to request proposals from other insurance firms.

OCHAMPUS should identify additional contractors, including commercial insurance firms, interested in processing CHAMPUS claims. Incentive-type contracts should be explored with them.

Need to improve operating efficiency
of contractors

We previously recommended investigating the reasons for the different operating efficiency of contractors and taking action to improve the less efficient contractors. We found significant differences between the individual Blue Cross plans in claims-processing costs and employee production. Differences between the plans did not appear to be related to the quality of claims review. None of the Blue Cross Association officials questioned could account for the wide variance in rates. The OCHAMPUS contract performance review team, created in December 1967 to evaluate contractor performance and insure contract compliance, did not visit any contractors until September 1970. We also reported that one factor affecting the continuing rise in administrative costs was the high number of claims being returned by the plans to the hospitals for review.

In reply to our recommendation, DOD said it had increased the scope and frequency of OCHAMPUS contract performance reviews and placed greater emphasis on the management aspects of claims processing. This emphasis included (1) reviewing the contractors' and subcontractors' level of program knowledge and speed and accuracy in claim payment and (2) requiring contractors to perform appropriate utilization reviews. DOD also stated that its reviews would determine whether the contractors and subcontractors were following administrative practices that interfered with providing quality care to CHAMPUS beneficiaries. Family history files would be used to prevent duplicate payments and to detect erroneous payments. Annual seminars for CHAMPUS claims-processing personnel were to be scheduled for fiscal year 1972.

As a result of our recommendation, OCHAMPUS:

- Required quarterly cost reporting by fiscal agents and hospital contractors to assist in identifying fiscal and operating problems.
- Established claims-processing goals.
- Increased inspections of hospital contractors and subcontractors.

--Initiated efforts to reduce the number of claims returned and rejected, such as writing monthly letters to fiscal agents informing them of their return rate versus other fiscal agents and encouraging the use of (1) family files to research missing information and (2) telephone inquiries rather than return of claims.

Although OCHAMPUS required quarterly cost reporting, we learned that individual Blue Cross plans were not monitored very closely before August 1974, because the OCHAMPUS contract was with Blue Cross Association and not with the individual plans. OCHAMPUS did little followup to identify reasons for high claims-processing costs of individual plans, as its primary interest was with the overall Blue Cross Association cost. Claims-processing costs of the 52 individual Blue Cross plans from July 1, 1973, to June 30, 1974, showed that 10 plans had costs in excess of \$10 per claim. As of September 30, 1973, one plan reported a cost of \$21.51 per claim, and OCHAMPUS officials did not know the reason for the high cost. An OCHAMPUS official doubted that the Blue Cross Association investigated the range in administrative costs of its individual plans. During our followup in 1974, OCHAMPUS began to emphasize monitoring these costs.

Many individual Blue Cross plans were performing below OCHAMPUS claims-processing standards. For example, 11 of the 52 plans exceeded the specified time limit for processing a routine claim, and 16 of the plans exceeded the numerical limit for unpaid claims on hand.

The OCHAMPUS contract performance review team now schedules visits to hospital contractors and subcontractors about every 12 months. While the number of visits has been increased, in January 1971 OCHAMPUS discontinued reviewing administrative costs allocated to CHAMPUS for claims processing because of the shortage of OCHAMPUS personnel and the audit of administrative costs HEWAA performed in settling CHAMPUS contracts.

OCHAMPUS efforts to reduce the rate of returned and rejected claims have not been as productive as expected, and OCHAMPUS expects to revise its goal of 10 percent. The current rate of slightly over 30 percent is about the same as we reported in 1971.

The Blue Cross Association has proposed that it increase surveillance of plan performance through onsite evaluations. A decision on this proposal has been deferred, because OCHAMPUS is considering performing additional onsite inspections itself.

Although mechanisms to identify the less efficient contractors and subcontractors were established, efforts to monitor their performances were minimal. Only after we began our followup was a concerted effort made to identify reasons for high administrative costs, and as of April 1975 little had been done to improve efficiency.

OCHAMPUS should obtain the more favorable
Blue Cross plan reimbursement formulas
for paying hospitals

We previously recommended that OCHAMPUS attempt to obtain the more favorable Blue Cross reimbursement formulas for paying hospitals in areas where CHAMPUS is not obtaining them. We reported that 39 of the 52 Blue Cross plans processing CHAMPUS hospital claims offered CHAMPUS the same reimbursement formulas offered to their regular Blue Cross subscribers but that the remaining 13 plans with more favorable reimbursement formulas did not extend them to CHAMPUS. At least \$850,000 could be saved annually if these other plans extended the more favorable formulas to CHAMPUS.

The Blue Cross plans reimbursed hospitals on the basis of either some negotiated percentage of total billed charges or 100 percent of billed charges. The negotiated formulas at the time of our last review provided for reimbursing hospitals with from 85 to 99 percent of billed charges. Of the 13 plans not offering CHAMPUS the same favorable formulas as offered to Blue Cross subscribers, 4 did obtain for CHAMPUS a rate less than billed charges but not as low as for their own subscribers. The remaining nine plans charged CHAMPUS 100 percent of billed charges.

The OCHAMPUS contract with the Blue Cross Association provides that the association and the Blue Cross plans make available to the Government the benefit of the Blue Cross formulas. We found no evidence during our previous work that OCHAMPUS or Blue Cross had attempted, after 1963, to obtain the favored rates. Blue Cross officials said they had attempted to do so but failed.

In response to our report, DOD stated that OCHAMPUS had again asked the Blue Cross Association to attempt to obtain preferential rates. In the States served by Blue Cross where CHAMPUS is billed less than full charges but more than Blue Cross preferential rates, the association would be asked to attempt to secure the better rate at the time of contract renewal. DOD further stated that, if it was unsuccessful with respect to the 13 States in question, it would consider changing contractors.

Our followup showed that OCHAMPUS had attempted to obtain more favorable reimbursement formulas for CHAMPUS. From June 1971 to June 1973, the Blue Cross Association sent letters to eight plans where CHAMPUS did not receive favorable rates. OCHAMPUS was notified by the Blue Cross Association that replies from the plans were negative. No attempts were made to obtain further reductions from the five plans which already had given CHAMPUS reductions less than those given regular Blue Cross subscribers.

We were informed that hospitals accustomed to receiving billed charges in full will not now accept something less, especially in these times of rising hospital costs. Some hospitals that previously gave CHAMPUS preferential rates now refuse to do so--a trend expected to continue.

OCHAMPUS officials have not seriously considered dropping any of the Blue Cross plans that fail to extend the favored rates.

NO ACTION TAKEN AND PROBLEMS STILL EXIST

Duplicate claims-review procedure needs to be evaluated

We previously recommended consideration of discontinuing the duplicate claims-review procedure of the Blue Cross Association. Reviews of claims by the association largely duplicated those made at the plan level. In fiscal year 1968 the Blue Cross Association questioned less than 2 percent of the claims received from plans. Also, our test of claims at three plans had indicated they were doing an adequate job. CHAMPUS was the only health program, including the Federal Employees Health Benefits Program, Medicare, and private Blue Cross health insurance programs, for which the Blue Cross Association performed this type of claims review. This review process cost about \$80,000 in fiscal year 1968.

DOD stated in response to our recommendation that, although our observations and conclusions appeared to be valid, the Army and OCHAMPUS strongly supported continuing the claims-review procedure. DOD said it would ask the Blue Cross Association for detailed comments regarding each of the points we raised and for a full explanation of the association's basic position on this point.

Our followup showed that the Blue Cross Association still reviews claims. OCHAMPUS corresponded with the Blue Cross Association about the duplicate review following our previous work, but no information was available on how the issue was resolved. OCHAMPUS officials said they do not require this

review procedure; it is performed by the association to comply with the OCHAMPUS contract requirement for making accurate payments. The association's review includes a computer edit and a sampling of claims filed. OCHAMPUS had no information on savings resulting from this review or its current cost. OCHAMPUS believes, however, that the cost has increased over the \$80,000 for fiscal year 1968.

In addition to the claims-review process at the Blue Cross Association, hospital claims paid by the plans are now subject to sample audits by OCHAMPUS. This makes three levels of review--the plan, the association, and OCHAMPUS. Physician claims, on the other hand, are subject to only two review levels--the fiscal agent and OCHAMPUS.

The Blue Cross Association review is still being performed, and we could find no evidence that OCHAMPUS evaluated the operation to determine whether the results warranted the costs. In view of our previous findings and the OCHAMPUS audit of sample claims, an investigation should be made of the results being achieved from the Blue Cross Association claims-review operation.

Need to expand
review of CHAMPUS

We previously recommended making arrangements with HEWAA officials to expand the effort and scope of reviews of CHAMPUS.

HEWAA audits of the Blue Cross Association and selected plans were adequate for determining the allowability and allocability of proposed administrative costs, but the scope of the audits and the time spent on them were too limited to evaluate the reasonableness of these costs. We stated that HEWAA should examine the need for administrative services and determine whether the Blue Cross Association and the Blue Cross plans were performing efficiently. Additional audit work was needed to determine the eligibility of CHAMPUS beneficiaries and the reasonableness of hospital charges to CHAMPUS beneficiaries as compared with charges to other patients. In response, DOD stated that it was attempting to arrange for expanding the effort and the scope of HEWAA review.

Our followup showed that HEWAA had not been requested to expand its reviews of CHAMPUS hospital contractors and subcontractors. Letters submitted by OCHAMPUS to HEWAA requesting audits provided very general instructions. The guidelines used by HEWAA in CHAMPUS audits are provided by the Defense Contract Audit Agency (DCAA).

OCHAMPUS is attempting to identify areas requiring increased audit coverage by HEWAA. OCHAMPUS is also examining HEWAA's auditing schedule for CHAMPUS contracts to determine if the audits can be made nearer to the expiration date of the contracts.

We did not find any arrangements made with HEWAA for expanding the effort and scope of reviews of CHAMPUS. During our followup, OCHAMPUS began identifying areas for increased HEWAA attention.

RECOMMENDATIONS

To further improve CHAMPUS management, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health and Environment) to:

- Continue analyzing contractor administrative costs, request proposals from other commercial insurance firms to act as program contractors, and change contractors to take advantage of lower costs.
- Increase contractor monitoring, enforce standards, and take action to replace less efficient contractors and subcontractors.
- Ask the Blue Cross Association to make further efforts to provide CHAMPUS with the favorable reimbursement formula wherever possible. If the more favorable formula cannot be obtained, consider changing contractors.
- Discontinue the Blue Cross Association claims review, unless it can be substantiated that the benefits exceed the costs.
- Arrange with HEWAA for increased audit coverage of CHAMPUS and, in particular, of the areas pointed out in our April 1971 report.

AGENCY COMMENTS

DOD agreed with the above recommendations (see app. I) and said:

- It will continue to analyze contractor administrative costs and will consider regionalizing contractor operations and using competitive, fixed-price contracts.
- Increased staff will enhance efforts to monitor and audit contractors.

--The Blue Cross Association is analyzing extensions of preferential rates to CHAMPUS.

--The Blue Cross Association's duplicate claims review is being surveyed. DOD's tentative position is that it will be discontinued.

--Coordination between CHAMPUS, HEWAA, and DCAA is being increased to improve audits of CHAMPUS. DCAA is preparing a revised program for HEWAA to use in claims reviews.

CHAPTER 4

FOLLOWUP ON RECOMMENDATIONS ON PHYSICIAN COMPONENT

We reported on July 9, 1971, on "Costs of Physician and Psychiatric Care--Civilian Health and Medical Program of the Uniformed Services" (B-133142). DOD responded to this report, which contained 10 recommendations, on September 20, 1971.

Physician fees during fiscal year 1971 accounted for \$84.4 million, or more than 35 percent of the total benefit payments made under CHAMPUS. In fiscal year 1974, physician fees paid by CHAMPUS increased to approximately \$162.3 million, or 36 percent of total benefit payments.

Followup showed that corrective actions were taken on three recommendations, partial corrective action was taken on two recommendations, and no action was taken on five recommendations.

We believe that DOD could improve its management of this portion of CHAMPUS by:

- Providing fiscal agents with guidelines on how to determine reasonable charges.
- Increasing the monitoring of fiscal agent performance and taking effective corrective action when performance is unacceptable.
- Arranging for CHAMPUS beneficiaries to use Government facilities for psychiatric care and encouraging the use of lower cost civilian facilities.
- Assuring that fiscal agents implement effective utilization-review systems.
- Limiting total payment, when CHAMPUS is combined with other insurance, to the reasonable charge for the service provided.
- Taking action to prohibit CHAMPUS payment for services paid by other insurance.
- Revising the claims form to provide a more useful certification as to other insurance.

ACTIONS TAKEN

During our prior review of the physician component of CHAMPUS, we found that:

- Improved management and better controls over amounts paid for psychiatric care were needed because of (1) liberal benefits available under CHAMPUS, (2) extensive psychiatric care provided to CHAMPUS beneficiaries for long periods in high-cost facilities, and (3) the charge practices of some psychiatrists.
- More definitive criteria for approving psychiatric facilities under CHAMPUS were needed because of the many problems associated with this type of facility.
- Limits were needed to amounts applied to the deductible provision for outpatient care.

In August 1973 DOD initiated action to upgrade its standards for psychiatric facilities and, effective July 1, 1974, added additional requirements. No action was taken to establish effective controls over psychiatric care until June 1974, and no action to limit amounts applied to the deductible provision was taken until March 1975.

Although DOD has been slow in taking corrective actions in the above areas, its actions have been responsive to our recommendations. We are reviewing the effectiveness of the new administrative procedures and controls for psychiatric care.

FURTHER ACTION NEEDED

Need to provide fiscal agents with guidance for determining payments to physicians

We previously recommended that DOD consider developing a more efficient method for determining payments to physicians. Physician fees had remained relatively constant when fee schedules were in use, but increased substantially following the introduction of the reasonable charge concept. Some increase was warranted, as the fee schedules were due to be updated.

The reasonable charge concept requires considering an individual physician's customary charges for services and the prevailing charges of other physicians in the same locality for similar services. Under fee schedules--the basis for payments before 1967--OCHAMPUS and the medical society of each State negotiated maximum fee levels for

various medical services. An OCHAMPUS study and our tests showed that average amounts paid for selected procedures increased by as much as 70 percent in some States after the reasonable charge concept was adopted.

In recommending development of a system other than reasonable charges for paying physicians, we reported that none was found which would be entirely satisfactory to all concerned. Reasonable charges are updated periodically to reflect changes in physicians' customary and prevailing charges and, therefore, can be influenced and controlled by the physicians themselves. Fee schedules, which could conserve CHAMPUS funds, might reduce the number of physicians willing to service program beneficiaries.

In responding to our report, DOD stated that readopting fee schedules is unfeasible because they are unacceptable to the providers of care. DOD said it was considering alternative methods of determining payment levels for physicians and other individual providers of care. However, it did not foresee any immediate solution to this longstanding and complex problem.

During our followup, OCHAMPUS officials said they had considered our recommendation for developing a more efficient method of determining payments to physicians but knew no other method which was as acceptable to physicians as the reasonable charge method. This method of reimbursing physicians and other health providers for their services has come into widespread use for Government and private health plans.

At the time of our previous review, 27 of the 45 CHAMPUS fiscal agents paying physician claims had adopted the reasonable charge method. Currently, 36 fiscal agents are using this method. The remaining fiscal agents continue to use relative value scales, fee schedules, or combinations of the two.

During our followup, we reviewed the systems implemented by four fiscal agents to determine reasonable charges. OCHAMPUS guidance to fiscal agents has not been adequate to insure that reasonable charges are established equitably and uniformly. Because of the lack of specific criteria from OCHAMPUS, fiscal agents have developed different methods for establishing and updating reasonable charges under CHAMPUS. Consequently, physicians are not treated equally regarding the allowability of their charges.

OCHAMPUS requires fiscal agents to determine reasonable charges by considering the customary charges of each

physician and prevailing charges of other physicians in the locality for similar services. However, fiscal agents followed a number of different procedures, for example:

- One fiscal agent had not established customary charges, but paid amounts charged as long as they did not exceed prevailing charges.
- Another fiscal agent established customary charges at 90 percent of a physician's average charge for a given service, while other fiscal agents used the average charge as the customary charge.
- One fiscal agent updated reasonable charges semi-annually; another, quarterly; and two, annually.
- One fiscal agent did not keep records to support the reasonable charges established.

The reasonable charge concept is also used to determine payments allowable to physicians for services provided under Medicare. However, requirements for determining reasonable charges for Medicare are more comprehensive than for CHAMPUS. Some Medicare requirements not required for CHAMPUS include the following:

- The customary charge is calculated as the median of the charges of a physician for a given medical service over a 1-year period.
- The prevailing charge limit is calculated as the 75th percentile of weighted customary charges from the previous closed calendar year.
- Reasonable charges are revised once a year at the beginning of each fiscal year, based on data collected during the preceding calendar year.
- The prevailing charge levels recognized for physicians' services in a locality may not be increased over the previous fiscal year, except as justified by economic indexes reflecting changes in earnings levels.

We believe continued use of the reasonable charge concept by OCHAMPUS is warranted, as it has become one of the most prevalent reimbursement methods and alternative methods have not gained widespread acceptance. However, more comprehensive requirements, such as those for Medicare, should be provided to fiscal agents for determining reasonable charges.

Need to monitor performance of fiscal agents

We recommended that DOD consider establishing performance standards for effectively evaluating and comparing the fiscal agents' operations and for taking prompt action to improve them whenever costs or levels of performance were considered unacceptable. We reported that OCHAMPUS had no way of correlating a fiscal agent's administrative cost-per-claim with features of an agent's operations, such as the use of physician profiles and utilization reviews. In addition, significant differences existed among fiscal agents in the number of claims processed per day, backlog of claims, and claims returned. OCHAMPUS had no standards or procedures for evaluating the performance of these fiscal agents. Furthermore, OCHAMPUS contracts had no incentives for promoting efficiency. Lack of control in paying physician claims and other problems were also identified. These problems involved duplicate payments and errors in processing claims for certain types of care.

In response to our recommendation, DOD said it had taken the following actions:

- Publishing goals for claims-processing.
- Requiring monthly claims-activity and quarterly cost-processing reports.
- Making sample audits of paid claims at OCHAMPUS and providing fiscal agents with claims-processing reports.
- Sending special letters to fiscal agents, indicating that corrective action is needed or recognizing excellent performance.
- Making audits when necessary.
- Scheduling visits by the OCHAMPUS contracting officer to top executives, to insure that program objectives are understood.

Our followup showed that OCHAMPUS is developing further performance standards. An official said OCHAMPUS plans to give fiscal agents 6 months to meet the standards, and if they are unsuccessful, the contracting officer will decide whether terminating their contracts is warranted.

In August 1974 OCHAMPUS started to closely examine the performance and administrative costs of its fiscal agents. For example, a 1-year probationary contract was issued

(instead of the normal 2-year contract) to the fiscal agent whose productivity was the lowest of all contractors and whose cost-per-claim processed was the highest. Before these actions, however, little was done to question contractors on their administrative costs and productivity.

OCHAMPUS has taken preliminary steps to improve the operations of fiscal agents by establishing standards for claims-processing and obtaining current cost information. However, OCHAMPUS needs to closely monitor its fiscal agents, to keep performance in line with standards and to reduce claims-processing costs. OCHAMPUS should also consider replacing inefficient contractors.

NO ACTION TAKEN AND PROBLEMS STILL EXIST

Need to use government facilities for psychiatric care

We previously recommended that DOD consider using available Government facilities for both inpatient and outpatient psychiatric care of dependents and transferring patients to lower cost civilian or Government facilities whenever medically feasible. This recommendation resulted from work showing that greater use of space and services available in Veterans Administration hospitals, military hospitals, State hospitals, and lower cost psychiatric facilities would save money. No efforts had been made by fiscal agents visited in four States to ascertain whether patients in high-cost facilities could receive the prescribed care in lower cost facilities.

In response to our report, DOD stated that under current DOD-HEW joint policies, CHAMPUS long term care for nervous, mental, or emotional disorders requires ascertaining that the care cannot be provided more effectively or economically in a place other than that proposed. DOD said it was reemphasizing to its fiscal agents the importance of this concept.

Actions to implement our recommendation have not been taken. However, the Deputy Assistant Secretary of Defense (Health and Environment) stated in a September 9, 1974, letter to the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Government Operations, that a maximum may be placed on CHAMPUS payments, since an adequate number of reasonably priced facilities appears to be available to CHAMPUS beneficiaries. He stated that such a maximum would not deny full CHAMPUS cost-sharing to any beneficiary using reasonably priced facilities. DOD is also conducting a test in three selected areas that requires

retirees and their dependents and dependents of deceased members to use military medical facilities, when available, for all types of care. Formerly these dependents had the choice of military facilities or CHAMPUS.

Determinations were still not made under CHAMPUS on whether care could be provided more effectively or economically in a place other than that proposed. Fiscal agent representatives said they did not consider it their responsibility to determine placement of patients, since OCHAMPUS approved all inpatient care exceeding 90 days under procedures in effect before June 1974. OCHAMPUS, on the other hand, has considered this a responsibility of the fiscal agents.

OCHAMPUS officials said they have no authority to transfer patients. As part of the approval process, however, CHAMPUS payments for high-cost facilities can be terminated and patients can be advised to use other facilities. Payments can also be terminated if it is determined that the level of care provided is not warranted by the medical diagnosis. OCHAMPUS officials stated that in moving patients from one facility to another, consideration must be given to the free choice principle allowing patients to select their own physicians and institutions, and the physician-patient relationships which may be built up over a considerable period.

A DOD proposal made in September 1974 to establish a maximum for payments was still under consideration as of March 1975, and a test being conducted by DOD requires that available military medical facilities be used to a greater extent by certain beneficiaries. Adoption of DOD's proposal and wider application of the test requirements should result in savings to CHAMPUS.

Need to improve utilization reviews

We had recommended that DOD consider providing fiscal agents with guidelines for effective utilization reviews, reviewing and approving fiscal agents' utilization-review systems, and conducting surveillance to insure that the systems are properly implemented. Utilization review is any activity which evaluates quality, quantity, promptness, or necessity of the medical services provided. We pointed out that OCHAMPUS efforts to develop utilization-review guidelines should be coordinated with those of the Social Security Administration, which had issued such guidelines to the Medicare carriers.

OCHAMPUS had given fiscal agents only limited guidance for establishing required safeguards against payment for unnecessary medical services. Thus, utilization-review systems of the fiscal agents varied considerably. Only one of four fiscal agents reviewed had developed a utilization-review system encompassing multiple procedures. OCHAMPUS guidelines were limited to requiring fiscal agents to review records of all physicians receiving \$25,000 or more per year from CHAMPUS and, on occasion, requesting specific reviews of drug benefits.

In response to our report, DOD said fiscal agents were being required to develop utilization-review systems based on the broad spectrum of health care, and systems were checked by the OCHAMPUS contract performance review team.

Visits to three fiscal agents during our followup showed the continued need for improved utilization-review systems. For example:

- Two fiscal agents did not have formal utilization-review systems. One of these conducted reviews based on the "feeling" claims processors had about a medical provider.
- At another fiscal agent, utilization review consisted primarily of examining claims of providers expected to receive in excess of \$25,000 in 1 year.

The fiscal agents were also the claims-paying agents under the Medicare program, and each had developed more extensive utilization controls for that program than for CHAMPUS. Officials of the fiscal agents expressed the need for more definitive criteria for utilization review under CHAMPUS and said they would welcome utilization-review standards issued by OCHAMPUS.

The OCHAMPUS position on utilization review has been that guidelines, to be effective, have to be developed by the fiscal agent and supported by local medical societies. As recently as October 1974, OCHAMPUS issued a memorandum to fiscal agents reminding them that locally developed guidelines are to be provided to claims examiners. However, an OCHAMPUS official said that a utilization-review function will be established at OCHAMPUS beginning in February 1975. One objective of this function will be to review features of utilization-review systems adopted by the various CHAMPUS paying agents, leading possibly to general guidelines for all fiscal agents.

Effective actions have not been taken to assure that fiscal agents have adopted satisfactory systems for utilization review. OCHAMPUS has relied upon the individual fiscal agents to develop these systems and has not established a procedure for evaluating systems implemented. Initiation of a utilization-review function at OCHAMPUS, as planned, should help correct the problem.

Need to limit total payments to reasonable charges when other insurance is combined with CHAMPUS

We had recommended that DOD consider limiting total payments to physicians, when CHAMPUS payments are combined with other insurance payments, to the reasonable charges for the services rendered. CHAMPUS regulations allowed physicians to be paid amounts greater than reasonable charges when the CHAMPUS payment was combined with other insurance which paid a portion of the claim. In its response to our report, DOD did not address this recommendation.

The Military Medical Benefits Amendments of 1966 provides that retirees and their dependents and the dependents of deceased members, who have other medical insurance provided by law or through employment, apply this insurance toward payment of medical bills before CHAMPUS determines the amount it will pay against the balance of the bills. Under this procedure, known as the last-pay concept, CHAMPUS will pay the remaining charges up to the amount it would have paid had there been no other insurance. This procedure allows payments, when CHAMPUS and other insurance payments are combined, to exceed reasonable charges, even though CHAMPUS has adopted a limited-payment concept.

We previously reviewed 57 claims where other insurance paid portions of billed charges and found 10 where the other insurance combined with CHAMPUS payments exceeded reasonable charges by a total of \$586.50. Charges on the remaining 47 claims did not exceed reasonable charges.

The policy of allowing the total payment, when CHAMPUS is combined with other insurance, to exceed reasonable charges has remained in effect since our previous review. However, OCHAMPUS officials said that, as a result of a study initiated in September 1974 by the OCHAMPUS Legal Counsel's Office, the policy is expected to be revised to restrict these payments to reasonable charges.

Need to prohibit CHAMPUS payment
for services paid by other insurance

We previously recommended legislation prohibiting benefit payments for dependents of active duty members when the beneficiary is covered by other insurance provided by law or through employment, unless the beneficiary certifies that the benefit is not payable by the other insurance. This legislation would result in (1) uniform application of the congressional concept against double coverage and double payment and (2) uniform processing of physician billings for all CHAMPUS beneficiaries. The 1966 law expanding CHAMPUS required retirees and their dependents and the dependents of deceased members to report other insurance provided by law or through employment. However, the law does not mention other insurance that might be held by dependents of active duty personnel. DOD did not agree with our recommendation and was considering seeking legislation which would repeal the requirement that retirees and their dependents and the dependents of deceased members report other insurance provided by law or through employment.

Our followup showed that dependents of active duty members still are not required to report other insurance, but the law still requires such reporting by other CHAMPUS beneficiaries. OCHAMPUS pointed out the inequities in the present CHAMPUS rules to DOD in a July 12, 1973, memorandum, and a legislative proposal to require such reporting was submitted to DOD by OCHAMPUS on November 5, 1973. DOD has not acted on these proposals.

The absence of a requirement for reporting other insurance makes it possible for active duty members to collect from CHAMPUS for services that may have already been paid by other insurance and for physicians to receive combined CHAMPUS and other insurance payments in excess of reasonable charges.

Certification as to other insurance
needed on claim form

We had recommended that DOD consider revising the claim form to contain a positive certification of whether the patient has other insurance and, if so, the name of the insurance company, policy number, and nature of benefits under the policy. The certification states only that there is no other insurance, or other insurance possessed does not cover the medical procedure on the claim.

In response to our recommendation, DOD stated that a proposed revised claim form, clarifying the items referred

to in our report, was under review by the Army Surgeon General's Office. But OCHAMPUS is still using the same claim form as at the time of our previous review. An OCHAMPUS official informed us that several proposals for revised claim forms have been considered, but none has been approved. OCHAMPUS is considering a universal claim form designed for all Government health programs, with an addendum attached to provide the additional information needed by CHAMPUS.

The portion of the claim form concerning other insurance continues to be a major problem. This part of the claim form is often either incorrectly prepared or incomplete. For example, of 524 claims returned in December 1973 by 1 fiscal agent for further information, 204, or 39 percent, were returned because of inaccuracies or omissions concerning other insurance.

RECOMMENDATIONS

To improve management related to physician and psychiatric care provided under CHAMPUS, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health and Environment) to:

- Adopt more comprehensive requirements, such as those used for Medicare; provide fiscal agents with detailed guidelines for determining reasonable charges; and assure compliance by requiring OCHAMPUS and HEWAA to review the reasonable charge systems implemented by fiscal agents.
- Require that monitoring efforts over fiscal agent performance be increased and that corrective actions be taken when performance or administrative costs are unacceptable.
- Continue to study ways to achieve greater use of available Government facilities for both inpatient and outpatient psychiatric care of dependents, and establish means to encourage use of lower cost civilian facilities whenever medically feasible.
- Provide utilization-review guidelines to fiscal agents, and review, approve, and monitor utilization-review systems.
- Limit total payments to physicians, when CHAMPUS payments are combined with other insurance payments, to the reasonable charges for the services rendered.

--Take action to prevent payment under CHAMPUS for services paid by other insurance, medical services, or health plans.

--Revise the claim form to provide a positive certification as to whether other insurance exists, and, if so, details on that insurance.

AGENCY COMMENTS

DOD generally agreed with the above recommendations (see app. I) and stated that:

--The Medicare system for determining reasonable charges is to be adopted, and a detailed implementing process is under study.

--Steps have been taken to limit CHAMPUS coverage for individuals who are also entitled to care through Medicare or the Veterans Administration, and a project has been initiated to identify situations where State-provided services may be used and CHAMPUS payments are not required.

--OCHAMPUS has created an organizational element responsible for coordinating all utilization-review functions and, with the assistance of medical advisors, developing and monitoring a utilization-review program.

--A review of legal implications will be made to determine if payment to physicians can be limited when combined with other insurance.

--A legislative proposal is being developed to prevent CHAMPUS payment to dependents of active duty members for services paid by other means.

--The next revision of the claim form will include a positive certification regarding other insurance.

CHAPTER 5

FOLLOWUP ON RECOMMENDATIONS

CONTAINED IN SUMMARY REPORT

On July 19, 1971, we reported on "Potential for Improvements in the Civilian Health and Medical Program of the Uniformed Services" (B-133142). This report summarized the information contained in the four earlier reports and presented our observations on several additional aspects of the program, along with three additional recommendations.

Followup work showed that corrective actions had been taken on only one of the three recommendations.

Action is still needed to insure that benefits are provided only to eligible individuals and to arrange for CHAMPUS beneficiaries to purchase medical equipment from Government sources.

ACTIONS TAKEN

In our previous review, we found that although fiscal agents are required to submit samples of claims to OCHAMPUS for review, OCHAMPUS had no effective procedures for following up with fiscal agents on questionable claims, and OCHAMPUS audits of claims were sporadic and ineffective.

Actions taken by OCHAMPUS, such as improving its training and supervision of claims examiners and requiring examiners to follow up with fiscal agents to insure corrective action, were responsive to our recommendation.

NO ACTION TAKEN AND PROBLEMS STILL EXIST

Issuance and recovery of identification cards

We had recommended strengthening military regulations and procedures to insure proper issuance and recovery of identification cards. DOD, in responding to our report, did not address this recommendation.

We had found that some identification cards containing erroneous information were being issued and some cards were not being recovered from dependents no longer eligible for benefits, and OCHAMPUS was not always notified of dependents receiving care at the time the sponsor was separated from military service. Procedures and controls over the issuance and recovery of identification cards were deficient at

all nine military installations we visited. As a result, CHAMPUS was incurring costs for individuals ineligible for care. For example, our examination of claims associated with 346 married personnel who left the service early or were listed as deserters showed that CHAMPUS paid about \$4,800 for care provided to dependents after they were no longer eligible for benefits.

During our followup we found no evidence of DOD action on our recommendation. However, DOD is considering a feasibility study of a central eligibility system for CHAMPUS to prevent payment of benefits to ineligible. Such a system would meet the intent of our recommendation.

Purchase of medical equipment from Government sources

We recommended a study of savings available to CHAMPUS if beneficiaries could purchase medical equipment from Government sources. DOD did not address this recommendation to its response to our report.

We had found that medical equipment purchased by CHAMPUS beneficiaries was frequently available from Government sources at considerably lower prices than from civilian vendors. For example, a hospital bed was purchased for \$397 from a civilian source while a comparable bed was available at \$221 from a Government source. A hearing aid purchased at \$350 from a civilian vendor cost \$110 from a Government source.

During our followup, an OCHAMPUS official informed us that the purchase of medical equipment for CHAMPUS beneficiaries from Government sources was suggested to the Office of the Army Surgeon General in April 1971, but apparently no action was taken. A proposal to make such purchases possible was also submitted to DOD by OCHAMPUS on October 26, 1973, but has not been acted upon.

We believe the potential for reducing CHAMPUS costs by purchasing medical equipment from Government sources still exists. Purchases of equipment under CHAMPUS in 1973 cost approximately \$1.3 million.

RECOMMENDATIONS

To further improve CHAMPUS management we recommend that the Secretary of Defense:

- Strengthen procedures to insure proper issuance and recovery of identification cards or establish other controls to guarantee that benefits are provided only to eligible individuals.

--Make arrangements to permit CHAMPUS beneficiaries to purchase medical equipment from Government sources.

AGENCY COMMENTS

DOD agreed with these recommendations (see app. I), saying it

--is studying an enrollment system to better control eligibility of beneficiaries and

--has established a subcommittee of the Uniformed Services Health Benefits Committee to research purchasing medical equipment from Government sources for CHAMPUS patients.

CHAPTER 6

SCOPE OF REVIEW

Our review was directed at following up on recommendations contained in our 1971 CHAMPUS reports. Work was performed at OCHAMPUS, located at Fitzsimons Army Medical Center, near Denver, and the Office of CHAMPUS Policy (OCHAMPUS) in Washington, D.C. On March 20, 1974, we sent a letter to the Assistant Secretary of Defense (Health and Environment) requesting written comments on each recommendation in our prior reports and the actions taken, or in process, to carry out the recommendations. We did not receive a reply to our letter. We also visited four CHAMPUS fiscal agents to evaluate their systems for paying reasonable charges of physicians and to assess their utilization-review systems. These four fiscal agents were:

Arizona Blue Shield Medical Service
Phoenix, Arizona

Blue Shield of Florida, Inc.
Jacksonville, Florida

New Mexico Blue Cross & Blue Shield, Inc.
Albuquerque, New Mexico

Blue Cross-Blue Shield of Tennessee
Chattanooga, Tennessee

In each State listed above where the Medicare carrier was not the same as the CHAMPUS fiscal agent, we also contacted the Medicare carrier.

Our work at OCHAMPUS primarily involved determining whether our recommendations had been acted upon. In those cases where changes had been made as a result of the recommendations, we made limited tests of effectiveness. Where no action had been taken, we obtained information from OCHAMPUS, fiscal agents, and selected facilities to determine if the situations still existed.



ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301

SEPT. 17, 1975

HEALTH AND
ENVIRONMENT

Mr. Gregory J. Ahart
Director
Manpower and Welfare Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

This is in response to your letter of June 27, 1975 to the Secretary of Defense requesting comments with respect to recommendations contained in Draft Report to the Congress entitled "Need to Improve the Management of the Civilian Health and Medical Program of the Uniformed Services" (OSD Case #4108).

The comments, criticisms, and recommendations contained in the report generally appear to be justified. We also have been concerned over the slowness in implementing those changes recommended in the series of reports on the program issued in 1970 and 1971 and others we considered necessary and appropriate. Change in any program is often met with inertia. Change in a program such as CHAMPUS must not only overcome resistance but it must deal with active opposition to change from a great number of sources. Each of the changes that have been effected was objected to by those beneficiaries who were no longer going to receive financial assistance for a service they had come to expect and by the providers of that service whose income was diminished. These objections took the form of letter-writing campaigns to members of Congress and personal visitations to the CHAMPUS Policy Office by representatives of professional organizations and special interest groups. The broad field of psychotherapy is represented by no less than eighteen organizations/associations with offices in Washington, D.C.

All changes were preceded by a careful consideration of their impact and their validity in relation to the public law on which the program is based. All challenges to the changes were answered with carefully reasoned responses. Even so, several of the changes have resulted in court actions against DoD. They have also precipitated Congressional bills intended to negate or override the changes. All of this has consumed a great deal of the time and energy of the CHAMPUS Policy staff and, unfortunately, resulted in the inordinate delay of some proposed and planned changes.

The decisions as to which changes should be made and in what priority order they should be made were based, for the most part, on savings which might be realized. It was also policy decision to deal with the benefits package first and then, having resolved those issues, move on to management and operational issues.

The recommendations contained in the report were organized in three components. Comments on the recommendations are made within the same structure and in the same sequence as in the report:

1. Program for the Handicapped (PFTH)

a. The need for comprehensive and specific standards for determining whether handicapping conditions are serious enough to qualify for benefits under the PFTH is recognized. The standards proposed by the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) in October 1973 were not considered adequate as they would have permitted coverage of certain conditions whose cause, severity, and nature were still a matter of controversy, i.e., learning disabilities. There are also certain reservations as to the use of the standards used by the Social[®] Security Administration to determine eligibility for disability insurance. These standards were developed with an adult population in mind and are based upon the employability of the individual seeking benefits. The majority of PFTH beneficiaries is children and adolescents and the measurement of the severity of a mental or physical handicap in this population is an entirely different matter. Efforts continue to develop an acceptable set of standards.

b. Every effort will be made to improve the timeliness of evaluations and decisions regarding proposals for program changes and responses to requests for policy guidance made by OCHAMPUS. There are, however, certain factors touched upon in the introductory remarks of this letter which create variances between OSD priorities and OCHAMPUS priorities.

c. The need for medical inputs into the evaluation of cases for approval or disapproval under the PFTH is recognized. There is no doubt that the best possible situation would be for each case to receive an in-depth review by a highly qualified physician. This, however, is somewhat impractical with the limited number of physicians available to provide actual patient care in the military departments. Procedures have been established to assure greater involvement by the Medical Advisor in the evaluation of PFTH cases for approval or disapproval. Specifically, case reviewers have had their limits of authority clearly outlined by Standing Operating Procedures. In addition,

the Chief, Health Benefits Division, OCHAMPUS, has been directed to obtain a physician's determination in all cases involving questionable severity of handicap, completeness of diagnosis, or need for care. There are no plans at this time to decentralize the approval functions of the PFTH.

d. Specific detailed audits of claims for services received under the PFTH are performed by the staff of OCHAMPUS, based on a sampling of claims requested from the fiscal agents by OCHAMPUS. At the present time, the main function of the contract performance visits by members of the OCHAMPUS staff is to review the general management and operations of the contractor's CHAMPUS department. The purpose of the audits performed by HEWAA is to review the contractor's operations prior to the closing of a contract, including a review of costs claimed, fees and other charges claimed, and administrative costs (claim processing costs).

e. "Standard formats" for reports prepared by physicians are not especially good solutions in this type of problem. Content is more important than form and a standard format elicits only that information asked for. The increased attention now being given medical statements furnished with applications for PFTH benefits and appropriate follow-up have reduced, if not obviated, the need for an additional form for completion by physicians.

f. Recent efforts to insure payment of charges no greater than those charged the general public for similar services have consisted of written instructions to CHAMPUS contractors on this subject on three occasions since March 15, 1974. Estimated cost data were removed from OCHAMPUS approvals for care under the PFTH because it was determined that the estimated costs furnished OCHAMPUS when such approvals were sought by the sponsor/facility were frequently inflated, and when the source of care was challenged on actual costs, the source of care stated they felt they were authorized to charge the amount on the authorization furnished by OCHAMPUS. Long-range plans include the development of standards for institutions serving beneficiaries under the PFTH. Such standards can then be used as the basis of participation agreement to include a negotiated rate. This would negate the need for a certification on the claims forms and produce better control over charges.

2. Recommendations on the Hospital Component of CHAMPUS

a. The analysis of contractor administration costs will be continued. A thorough evaluation of CHAMPUS contract administration

is currently in progress in H&E. The elements of reported contractor costs are being scrutinized and the OCHAMPUS staff has been instructed to intensify its evaluation of contractor costs and work performance. Further DCAA, HEWAA, and CSCA are currently performing a joint review of administrative costs at selected locations. At the same time, we are seriously considering the pros and cons of regionalizing contractor operations. Consideration is also being given to competitive firm fixed-price contracts. Increased staffing for the Contract Management Division will also enhance OCHAMPUS abilities to better monitor contractors and conduct on-site audits.

b. Comments on the preceding recommendation also apply to this recommendation.

c. Blue Cross Association is conducting an analysis, upon the direction of the Contracting Officer, of their individual subcontracting Blue Cross Plans to ascertain which are being offered preferential rates by hospitals in their locale. Based upon this study, OCHAMPUS, in concert with Blue Cross Association, will possibly eliminate some Plans in multi-plan states. Additionally, consideration will be given to changing contractors for entire states where it appears advantageous to do so.

d. The Contracting Officer is presently surveying the duplication of claims review procedures between the individual Blue Cross Plans and the Blue Cross Association. The tentative position of OCHAMPUS is to delete the edit currently being accomplished at Blue Cross Association. It is anticipated a determination will be made on this subject in the near future.

e. OCHAMPUS has increased its coordination with both HEWAA and DCAA, with the goal of improving the audits being performed by HEWAA. OCHAMPUS has reviewed the HEWAA manual and the DCAA manual and is waiting for response from HEW and DCAA regarding recommended changes to improve the audit effort. At times, the responsiveness of HEWAA to CHAMPUS requirements has varied, dependent upon workload/priorities of the particular regional office. Since DCAA has primary responsibility for HEWAA support of CHAMPUS, changes to the DCAA manual have been developed and are in final coordination for publication. In order to resolve concern regarding claim processing costs, in July 1975 DCAA, HEWAA, and the CSC initiated a special review of processing costs at selected contractor locations. It is expected that this review will determine the reason(s) for the disparity in claims processing rates among contractors and result in a program for use by cognizant agencies in reviews of administrative costs at all other contractor locations. Additionally, DCAA is preparing a revised program for claims reviews for use by the HEWAA.

3. Recommendations on the Physician Component of CHAMPUS

a. OCHAMPUS has been directed to implement the Medicare profile system in the near future. A detailed implementing process is under study with contractors and many are now gearing up to enable implementation when so directed. Estimated cost associated with the implementation is \$1,146 million. Many changes in the contractors' automated programs will be required to effect this profile system. Changes have also been effected in Section 401.3, Chapter III, Title 20, which will permit the release of information relating to payments to, and utilization data concerning, providers and other organizations and facilities furnishing services under Title XVIII by SSA intermediaries to CHAMPUS contractors.

b. Since August 1974, significant steps have been taken to evaluate the performance of contractors. Detailed reviews and analyses of a newly developed reporting system have enabled OCHAMPUS to identify problem areas and institute necessary corrective actions.

c. The present uniformed service policies with regard to the issuance of certificates of non-availability are being reviewed with the view toward standardizing them and making the guidelines for their issuance more definitive. Consideration is also being given to extension of the non-availability certificate to those categories of CHAMPUS beneficiaries whose election of facilities can, by law, be limited. Steps were also taken on March 7, 1975 to limit CHAMPUS coverage on those individuals who also had coverage under the Social Security Amendments of 1972 and those individuals who were entitled to care by the Veterans Administration for their service-connected disabilities. The OCHAMPUS legal staff has also been given a project to research the state statutes with the purpose of identifying those situations where entitlement to state-provided services may exist and CHAMPUS payments not required.

d. In February 1975, OCHAMPUS created an organizational entity which has primary responsibility for coordinating all utilization review functions developed for use in the CHAMPUS contractor system. This element, working with the OCHAMPUS Medical Advisor and Director of Health Services, is charged with developing and monitoring a Utilization Review Program considering both the local and national norms of health delivery standards. Additionally, OCHAMPUS has recently sent out a survey requiring contractors to assess and report their current utilization review capabilities "in-house" and the status of their relationships among local medical societies and other peer organizations.

e. This recommendation will be given careful review to ascertain what the legal implications may be. If the legal review determines that such a restriction may be imposed and not be considered an interference in the business of the other insurance carriers, appropriate instructions will be issued to CHAMPUS contractors.

f. A legislative proposal is being developed which will place the same requirements on the dependents of active duty members that are now placed by the law on the retired member, his dependents, and the survivors of deceased active duty and deceased retired members.

g. The next revision of the claim form will incorporate a positive certification as to whether other insurance exists and, if so, details on that insurance.

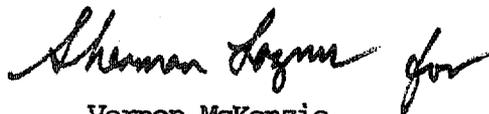
4. Recommendations in Summary Report

a. The study of an enrollment system is still underway. The G.E. Tempo Corporation did a study of the various alternative systems that could be used to produce detailed actuarial data and effect better control over eligibility. These alternatives are currently under review. The procedures and controls over the issuance and recovery of identification cards are the responsibility of the individual uniformed service.

b. At the June 3, 1975 meeting of the Uniformed Services Health Benefits Committee (USHBC), a subcommittee was established to study the entire question of support for CHAMPUS patients provided by uniformed service medical facilities. This subcommittee will also research the possibilities of purchasing medical equipment from Government sources for CHAMPUS patients.

The efficient management of the Civilian Health and Medical Program of the Uniformed Services is of major concern to the Department of Defense. These recommendations on the part of the General Accounting Office are, therefore, appreciated and our efforts will include their careful consideration.

Sincerely,



Vernon McKenzie
Principal Deputy Assistant Secretary

PRINCIPAL OFFICIALS
OF THE DEPARTMENTS OF DEFENSE AND THE ARMY
RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
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SECRETARY OF DEFENSE:		
James R. Schlesinger	June 1973	Present
William P. Clements, Jr. (acting)	Apr. 1973	June 1973
Elliot L. Richardson	Jan. 1973	Apr. 1973
Melvin R. Laird	Jan. 1969	Jan. 1973
ASSISTANT SECRETARY OF DEFENSE (HEALTH AND ENVIRONMENT):		
Dr. James R. Cowan	Feb. 1974	Present
Dr. Richard S. Wilbur	July 1971	Sept. 1973
DEPUTY ASSISTANT SECRETARY (HEALTH RESOURCES AND PROGRAMS):		
Sherman Lazrus	Apr. 1975	Present
Vernon McKenzie	July 1971	Apr. 1975
<u>DEPARTMENT OF THE ARMY</u>		
SECRETARY OF THE ARMY:		
Robert R. Froehle	July 1971	May 1973
Stanley R. Resor	July 1965	June 1971
THE SURGEON GENERAL:		
Lt. Gen. H. B. Jennings, Jr.	Oct. 1969	Sept. 1973

Note: Before July 1972, the Secretary of the Army administered CHAMPUS through the Army Surgeon General. Thereafter, the Deputy Assistant Secretary (Health Resources and Programs) assumed responsibility for the program under the direction of the Assistant Secretary of Defense (Health and Environment).

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