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REPORT TO THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES

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Costs Of Physician And Psychiatric Care--Civilian Health And Medical Program Of The Uniformed Services

B-133142

Department of Defense

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

089734

JULY 9, 1971

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133142

Dear Mr. Chairman:

The General Accounting Office has made a review of costs incurred for services furnished by physicians, including psychiatrists, under the Civilian Health and Medical Program of the Uniformed Services and for related administrative activities and costs. The review was made in response to your request of October 20, 1969. This is the fourth report pursuant to this request. We expect to issue a summary report on the review shortly.

We have not obtained written comments from the Department of Defense on the matters included in the report. We have discussed the substance of our findings with officials of the Office for the Civilian Health and Medical Program of the Uniformed Services and with officials of those fiscal agents included in our review.

In accordance with arrangements made with your office, we plan to send copies of this report to the responsible officials in the Department of Defense. We plan to make no further distribution of this report unless copies are specifically requested, and then we shall make distribution only after your agreement has been obtained or public announcement has been made by you concerning the contents of the report.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

The Honorable George H. Mahon
Chairman, Committee on Appropriations
House of Representatives

COMPTROLLER GENERAL'S REPORT TO THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

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WHY THE REVIEW WAS MADE

The Chairman, Committee on Appropriations, House of Representatives, asked the General Accounting Office (GAO) to make a comprehensive review of the Civilian Health and Medical Program of the Uniformed Services. (See app. I.)

This report, GAO's fourth of a series on this subject deals with payments to physicians, including psychiatrists; surveillance over the cost and quality of services; administrative costs; and related audits. It is based on reviews conducted in California, Colorado, Georgia, Virginia, and Nebraska.

Written comments have not been obtained from the Department of Defense on matters discussed in this report.

FINDINGS AND CONCLUSIONS

As of September 30, 1970, physician claims under the program were being paid under 48 contracts with Blue Shield and Blue Cross agencies, State medical societies, and private insurance companies. These organizations--known as fiscal agents--processed and paid $84.4 million in physician fees under the program for fiscal year 1970. (See pp. 7 and 8.)

Use of the reasonable-charge concept

Maximum-fee schedules for paying physician claims were discontinued and the reasonable-charge concept was adopted in 1967 and 1968. Under the reasonable-charge concept, which was adopted by the Social Security Administration Medicare program in 1966, a physician received his customary charge for each service rendered as long as the charge was within the prevailing level of charges made for that service by other physicians in the same locality.

Physician profiles are histories of each physician's past charges for a specific medical service and are used in determining a physician's customary charge for that service. This method for determining reasonable charges was adopted by the program. The prevailing charge is derived from individual physician profiles and is the charge most frequently and widely used by physicians in a locality for a particular medical procedure.

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GAO noted that the control provided by the use of profiles was somewhat limited since the use of profiles allowed physicians, over a period, to influence the amounts they would receive for specific procedures by charging higher fees which would eventually provide the justification for increased fees. (See p. 9.)

Tests by GAO and studies by the Department of the Army show that average amounts paid for selected medical procedures have increased as much as 70 percent in some States since the reasonable-charge concept was adopted.

Reasons given by fiscal agent officials for these increases included (1) the use of usual and customary fees encouraged physicians to develop a higher profile through increased charges in billings, (2) the trend toward specialization had increased fees, and (3) some physicians charged only what they knew to be allowable under fee schedules, although their normal charges were higher. (See p. 17.)

GAO found that there was little standardization among the fiscal agents in the bases for paying claims against the program. Many fiscal agents were not considering customary charges of physicians and paid fees based on schedules of allowances or relative value scales--a method of determining the amount of a physician's fee for a particular service by using agreed levels of units of effort and values per unit. (See pp. 10 to 13.)

The establishment of physician profiles for paying reasonable charges does not appear feasible or economical for many of the program's fiscal agents. (See pp. 14 and 15.)

GAO believes that a different procedure for determining fees to be paid to physicians may be warranted because of problems, or potential problems, in implementing the reasonable-charge concept. (See p. 18.)

Comparison of payments made to physicians

Average payments made for selected medical procedures under the program were generally in line with average payments under other health care programs. Comparisons of amounts charged by individual physicians against the program with amounts they charged against other health care programs for the same medical procedures showed that some physicians charged one program more than another program for the same service--possibly due to complications in individual cases. GAO did not, however, find indications of physicians charging consistently higher amounts to the program. (See pp. 19 to 25.)

Substantial amounts paid individual physicians, clinics, and group practice organizations

The number of physicians or clinics or group practices receiving more than $20,000 from the program increased about 72 percent in 1969 over the

number receiving more than $20,000 in the previous year. Of these, 13 physicians--eight of whom were psychiatrists--received over $50,000. (See pp. 25 and 26.)

Psychiatric care

Psychiatric care benefits under the program usually are more liberal than those under other health programs. Approval is required for care in excess of 90 days, but there is no limitation on dollar value or the number of days of care authorized. (See pp. 27 and 28.)

GAO found that extensive care had been provided to program beneficiaries and that several psychiatrists had been paid large amounts under the program. (See pp. 29 to 32.)

The fiscal agents included in GAO's review had made no attempts to determine whether patients receiving psychiatric care in high-cost facilities could obtain the prescribed care in lower cost facilities. (See p. 33.)

GAO found that psychiatric care had been approved and provided in facilities which did not conform to criteria prescribed by the program office. (See pp. 33 to 37.)

Utilization reviews of medical care furnished

Utilization reviews--evaluations of the quality, quantity, or timeliness of medical services--had not been performed on a systematic basis by any of the four fiscal agents included in GAO's review. One of them recently implemented procedures which should help in performing adequate reviews. The program office has provided limited guidance to fiscal agents for establishing utilization review procedures. GAO believes that effective utilization reviews are necessary. (See pp. 38 to 41.)

Administrative costs and weaknesses in controls

Administrative costs of fiscal agents processing physician claims against the program increased from $754,000 in fiscal year 1966 to $5.8 million in fiscal year 1970. Reasons for the increase included (1) computerization of fiscal agent operations to handle increased claims resulting from the expansion of benefits and increased use of the program, (2) full allocations of costs to the program as it became a larger part of the fiscal agents' business, and (3) the hiring and training of additional employees by the fiscal agents to cope with the expanded program. (See pp. 42 and 43.)

Standards for evaluating the performance of fiscal agents are lacking. As a result, widely varying costs for processing the program claims and

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different levels of contract performance have been accepted. (See pp. 45 to 47.)

GAO identified problems in the payment by the California fiscal agent of physicians' claims for obstetrical and psychiatric care stemming from errors in computer programs and the lack of management controls. (See pp. 29 and 48.)

Handling outpatient deductible and other insurance provisions

For outpatient care, a deductible is applied against claims submitted. Payments made to physicians on behalf of certain beneficiaries under other insurance must be applied against related claims under the program. GAO noted that the program was incurring additional costs by not limiting the amounts physicians might receive in these instances to the amounts payable through application of reasonable-charge criteria. (See pp. 51 to 57.)

GAO believes that the certification of other insurance on the claim form should be revised to elicit a more informative response as to whether the beneficiary has other health insurance which may pay all or a portion of the claimed amount. (See pp. 57 and 58.)

Legislation for the program requires that all beneficiaries, other than dependents of active duty members, declare other insurance provided by law or through employment. GAO believes that an opportunity for reduced costs exists if the same legal and administrative provisions pertaining to other insurance apply to all beneficiaries. (See pp. 56 and 57.)

Need for expanded audit coverage and related evaluation controls

Audit work performed by the Department of Health, Education, and Welfare's Audit Agency in reviewing the activities of the program's fiscal agents was limited. Insufficient time was spent by the Audit Agency on the assignments to adequately cover fiscal agent activities; however, GAO believes that execution of the expanded program coverage planned by the Audit Agency staff should result in valuable benefits to the Government. (See pp. 59 to 63.)

RECOMMENDATIONS OR SUGGESTIONS

GAO believes that the Executive Director, Office for the Civilian Health and Medical Program of the Uniformed Services, should consider

--developing a more effective, less costly method for determining the amounts to be paid to physicians (see p. 18.)

--issuing guidelines for use in establishing effective control over psychiatric care (see p. 37.)

--seeking ways to use available Government facilities for both inpatient and outpatient psychiatric care of dependents and to transfer patients to lower cost civilian or Government facilities whenever medically feasible (see p. 37);

--establishing and enforcing more definitive criteria for approving psychiatric facilities under the program (see p. 37);

--providing guidelines outlining the requirements for effective utilization reviews, approval of the utilization review systems of the fiscal agents, and conduct of effective surveillance to ensure that these systems are implemented properly (see p. 41);

--establishing performance standards for effectively evaluating and comparing the operations of fiscal agents and for taking prompt action to improve the operations of fiscal agents whenever their costs or levels of performance are considered unacceptable (see pp. 49 and 50);

--applying the reasonable-charge limitation on bills to beneficiaries for payment under the deductible provisions and limiting payments to physicians, where combined with other insurance payments, to the reasonable charge for service rendered (see pp. 54 and 56);

--proposing legislation which would require dependents of active duty members to report other insurance provided by law or through employment (see p. 57); and

--revising the claim form to obtain a more informative certification as to the beneficiaries' other health insurance coverage (see p. 58).

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Contents

ABBREVIATIONS

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

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GAO believes that the certification of other insurance on the claim form should be revised to elicit a more informative response as to whether the beneficiary has other health insurance which may pay all or a portion of the claimed amount. (See pp. 57 and 58.)

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--revising the claim form to obtain a more informative certification as to the beneficiaries' other health insurance coverage (see p. 58).

CHAPTER 1

INTRODUCTION

The Civilian Health and Medical Program of the Uniformed Services[1] (CHAMPUS) was established pursuant to the Dependents' Medical Care Act of 1956 (Pub. L. 569, 84th Congress) and the Military Medical Benefits Amendments of 1966 (Pub. L. 89-614, 10 U.S.C. 1071). Under CHAMPUS, medical care is provided by civilian sources to dependents of active duty members, dependents of deceased members, and to retired members and their dependents. Authorized services under CHAMPUS include physician care on an inpatient or outpatient basis, hospital care, drugs, and special care to handicapped persons. This report contains the results of the review of the physician component of CHAMPUS.

In our review we examined into (1) the amounts paid to participating physicians under CHAMPUS, (2) the basis for payment of physician charges, (3) the administrative costs incurred by fiscal agents in processing claims for care furnished by physicians, (4) the extent of fiscal agent surveillance over the cost and quality of services provided to beneficiaries, and (5) the adequacy of audits made by responsible Government agencies of administrative costs incurred and benefit payments made for physician services under CHAMPUS.

Because of the lack of criteria and data for evaluating the reasonableness of physician charges and profits--included in the Committee's request--agreement was reached with the office of the Chairman that we should concentrate our efforts on comparing payments to physicians made under CHAMPUS with those made under other medical programs. It was also agreed that we would identify large amounts paid to physicians under CHAMPUS during selected periods. The results of our comparisons and the data on high-income physicians are shown in chapter 3.

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[1]The term "uniformed services" includes the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

CHAMPUS operates on a cost-sharing plan whereby a portion of the cost of medical services is paid by the beneficiary receiving the care. Active duty members whose dependents receive inpatient care are required to pay the first $25 or $1.75 a day, whichever amount is greater, of the hospital charges while the Government pays the remainder of the hospital charges and the reasonable fees of medical professionals. Retired members and their dependents and the dependents of deceased members pay 25 percent of total charges for inpatient care.

For outpatient care, including drugs, all beneficiaries pay a $50 deductible ($100 maximum deductible for each family) each fiscal year. After they have paid the deductible, dependents of active duty members pay 20 percent of the remaining charges for outpatient care while retired members and their dependents and the dependents of deceased members pay 25 percent of these charges. In addition, retired members and dependents of other than active duty members having insurance provided by law or through employment are required to use the benefits of such insurance before payment can be made under CHAMPUS.

Responsibility for administering CHAMPUS has been delegated from the Secretary of Defense and the Secretary of Health, Education, and Welfare, through channels, to the Executive Director, Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), who functions under the jurisdiction of the Surgeon General, Department of the Army.

OCHAMPUS, located at Fitzsimons General Hospital near Denver, Colorado, administers the program in the United States, Puerto Rico, Canada, and Mexico. Health benefits in other overseas areas, including the processing and payment of physician claims, are administered by the Military commanders for such areas. OCHAMPUS also has contracted with various types of organizations--referred to as fiscal agents--to process and pay physician and outpatient drug claims. As of September 30, 1970, OCHAMPUS had 48 contracts with fiscal agents for paying claims in the 50 States, the District of Columbia, and Puerto Rico. OCHAMPUS processes and pays claims from Canada and Mexico. The fiscal agents, grouped by types of organizations, are as follows:

	Number of contracts	Number of entities (States, District of Columbia, and Puerto Rico)
Blue Shield agencies	36	36
State medical societies	5	5
Insurance companies	3	7
Medical society and Blue Shield	1	1
Medical society and insurance company	2	2
Blue Cross agency	1	1
	48	52

Twenty-two of the fiscal agents also function as fiscal agents (carriers) for the Social Security Administration's Medicare program.

Payment of physician fees accounted for $84.4 million, or more than 35 percent of the total benefit payments made under CHAMPUS by the Government in fiscal year 1970. By comparison, payments for outpatient drugs under CHAMPUS in fiscal year 1970 totaled only about $2.8 million, or slightly more than 1 percent of total benefit payments.

CHAPTER 2

BASES USED FOR PAYING CHAMPUS CLAIMS

OCHAMPUS began converting from fee schedules for paying physician claims to the reasonable-charge concept in May 1967, as each contract with a fiscal agent expired. Thus, CHAMPUS followed the example of the Social Security Medicare program which adopted the concept in 1966.

The reasonable-charge concept requires consideration of 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 bases for payments prior to 1967--the maximum levels of fees were established for various medical services through negotiations between OCHAMPUS and the medical society of each State.

OCHAMPUS recently notified its fiscal agents to adopt the physician profile method of determining reasonable charges. Profiles represent histories of each physician's past charges for a specific medical service and they are used to determine the physician's customary charge for that service. The prevailing charge for a particular medical procedure is derived from the individual physician profiles and is the charge most frequently and widely used by physicians in a locality. The use of this method, however, enables physicians to influence the amounts they will receive for specific procedures. By charging higher fees, the physicians will eventually create justification for increased fees.

Physician fees had shown significant increases after the reasonable-charge concept was introduced, whereas they had remained relatively constant during the period when fee schedules were used. An OCHAMPUS study and our tests showed that average amounts paid for selected procedures had increased by as much as 70 percent in some States after the reasonable-charge concept was adopted. Some increase appeared to have been warranted at the time of conversion, since the fee schedules then in use were due to be updated. Also, part of the increase was due to the general rise in physician fees throughout the United States during the period.

OCHAMPUS contracts with fiscal agents that also process Medicare claims require that payments to physicians be no higher than those under Medicare for similar services. During February 1969 Medicare imposed a freeze on physician fees at the December 1968 level. This freeze on fees has had little influence on CHAMPUS payments because (1) more than half of the CHAMPUS fiscal agents do not process Medicare claims, (2) some fiscal agents have developed, or are now developing, physician profiles based on charges after the freeze became effective, and, (3) the most prevalent medical services furnished under CHAMPUS, such as tonsillectomy and adenoidectomy (under age 18) and obstetrics, are not common to Medicare and, consequently, are not subject to the fee limitations set by Medicare.

There has been little uniformity among CHAMPUS fiscal agents in the methods of determining amounts payable to providers of care. Methods used by fiscal agents in these determinations include physician profiles, schedules of allowances, the California Relative Value Scale (see pp. 12 and 13), and combinations of these methods.

EVALUATION OF METHODS OF PAYING CHAMPUS CLAIMS

CHAMPUS contracts provide that, if the fiscal agent processes both CHAMPUS and Medicare claims, the fiscal agent ensures that payments for services to the sources of care be no higher than payments for comparable services furnished in comparable circumstances under Medicare. For CHAMPUS fiscal agents that do not process Medicare claims, the contracts provide that steps be taken to ensure that payments under CHAMPUS are no greater than those made on behalf of private policyholders and subscribers of the fiscal agent.

In converting to the reasonable-charge concept, CHAMPUS followed the lead of the much larger Medicare program. Since both programs operate within the same medical care system, it appears that the smaller program would inevitably be influenced strongly by policy initiatives taken by the larger program.

According to the Social Security Administration, payments for claims under the reasonable-charge method requires that charges under Medicare should be no higher than charges for comparable services provided to policyholders and subscribers of the Medicare fiscal agent (carrier) under comparable circumstances. The Social Security Administration interpreted it to be the intent of the Congress--in passing Public Law 89-97 which governs Medicare--that reasonable charges would be determined on the basis of customary charges of a physician and of the prevailing charges of other physicians in the same locality. Prior to the inception of Medicare, the concept of paying physicians on the basis of customary and prevailing charges was not widely used by Blue Shield Plans; payments by Blue Shield organizations were usually made on the basis of fee schedules.

Methods of paying CHAMPUS claims

CHAMPUS contracts with fiscal agents require that reasonable charges be determined by taking into consideration the customary charge for services usually made by the physician, as well as the prevailing charges of other physicians in the same locality for similar services.

Different methods used by CHAMPUS fiscal agents for determining the reasonableness of physicians' charges, as of June 1970, according to data obtained by OCHAMPUS, follow.

	Number of fiscal agents
Physician profile	27
Schedule of allowances	15
California Relative Value Scale	1
Other (combinations):	
Relative value scale and schedule of allowances (some physician profile)	1
Schedule of allowances and physician profile	1

The bases for payments used by each of the four fiscal agents we visited are described in exhibit A.

At the time of our review, some fiscal agents were in the process of developing physician profiles based on current charges of physicians. OCHAMPUS officials recently informed us that they were requiring all fiscal agents to adopt the use of physician profiles to conform with contract requirements. The Social Security Administration, in developing the reasonable-charge basis, required the use of profiles except when carriers used a relative value scale, as an interim measure, when data was insufficient for determining the customary charge of the physician for a particular medical procedure or service.

Some observations on the use of physician profiles, relative value scales, and fee schedules for determining amounts to be paid to physicians are discussed below.

Physician profiles

The profile system, when combined with a local peer review for reasonableness, appears to be a flexible and responsive system. It represents an administrative mechanism for paying physicians on the basis of their usual and customary charges as recorded by fiscal agents. But physician

profiles are largely controlled by physicians themselves. They can, if they so desire, influence their profiles by charging higher fees which will, over a period of time, provide the justification for higher fees in the future.

Relative value scales

Relative value scales, such as the California Relative Value Scale, establish general guidance for formulating medical fees. Elements included in this guidance are uniform descriptions and a standardized identification code for medical services, standard values for recognized units of effort or service for individual medical procedures, and segmentation of medical and surgical procedures.

Essentially, the relative value scale consists of five separate sections or studies showing, within each section, the value of one service or procedure in relation to another. For example, in the surgery section, if a value of 40 units were assigned to an appendectomy and 80 units to a cataract operation and if a $6-a-unit conversion factor were established, the charge for these surgical procedures would be computed as follows: appendectomy, 40 units times $6 equals $240; cataract operation, 80 units times $6 equals $480. In essence, use of a relative value scale is similar to use of a fee schedule and is useful for evaluating the reasonableness of physician charges, especially for rarely performed and unusual procedures.

Fee schedules

Use of fee schedules provides a simple and inexpensive method of determining maximum payments for common physician procedures. Fee schedules are, however, relatively inflexible and changes are cumbersome to accomplish. There is some indication that the inflexibility in fee schedules may have contributed to the nonparticipation of some physicians in CHAMPUS.

Problems in applying and using the reasonable-charge basis of payment under CHAMPUS

Introduction of the reasonable-charge concept has caused OCHAMPUS to lose its previous controls over amounts paid to physicians through the negotiated fee schedules. Under the method used for establishing the reasonable charge, physicians can, if they wish, influence the levels of future payments for their services.

Fees paid to physicians over the period of a CHAMPUS contract remained relatively stable under fee schedules; but fees paid under the reasonable-charge basis are subject to change without OCHAMPUS approval unless special limitations, such as a freeze on fees, are imposed. Fees also vary among localities, whereas under fee schedules they were uniform within fairly broad geographic areas.

CHAMPUS fiscal agents that do not process Medicare or private insurance claims on a reasonable-charge basis could have difficulty in establishing physician profiles because of the broad data base needed for setting a reasonable charge for individual medical procedures. Physician profiles become more effective as the number of charges included in the profile increases. About 70 percent of the charges in physician profiles used by the Georgia fiscal agent--to pay claims when fees charged exceeded relative value scale maximums--consisted of a single charge for a medical or surgical procedure performed by an individual physician. Further, 11 CHAMPUS fiscal agents that did not process Medicare claims paid even fewer claims based on physician profiles than the Georgia fiscal agent. The lack of an adequate data base for establishing profiles probably applies also to them.

Administrative costs associated with establishing and maintaining physician profiles are significant. The estimated cost to the fiscal agent in South Dakota for developing customary and prevailing charge profiles for CHAMPUS was $4,300 to $6,000; and the estimated cost of using profiles, excluding the cost of other claim processing procedures, was $1.13 per claim. An OCHAMPUS official said that

one fiscal agent estimated that, if the use of profiles were adopted, the cost per claim would be almost double.

The average administrative cost per claim, based on actual or proposed rates for the most recent contract periods, for fiscal agents using physician profiles was $6.20; while the average cost per claim for fiscal agents using schedules of allowances or relative value scales was $3.60. It must be recognized, however, that the higher administrative costs per claim of some fiscal agents might be indicative of more effective and comprehensive claims and utilization reviews.

In California, the one State in our review which had been operating under the physician profile system, it was not feasible for us to audit the profiles. The computer programming and processing necessary to identify the specific claims that support a physician's customary charge would be very expensive.

EFFECT OF CONVERSION TO
REASONABLE-CHARGE BASIS

The average cost per claim and the total physician costs of CHAMPUS remained relatively stable between fiscal year 1960 and fiscal year 1966, a period when fee schedules were in effect and the types of beneficiaries and authorized benefits remained constant. Fee quotations from attending physicians during this period, which were used in compiling the physician fees index of the Consumer Price Index, showed an increase of about 19 percent.

The CHAMPUS average cost per claim and the physician fees index followed comparable trends after the reasonable-charge method of payment was adopted. The rate of increase for CHAMPUS, however, exceeded the rate of increase for the physician fees index, probably because physician charges against CHAMPUS had been at a lower level under the prior use of fee schedules which served to limit amounts paid.

Our limited review of data for selected surgical procedures from four States also showed a general upward trend in payments to physicians. Average amounts paid[1] (see exhibit B) generally increased noticeably after conversion to the reasonable-charge method, with the exception of payments in the State of Ohio, where a new fee schedule had been established shortly before the conversion. It appears reasonable that some increase in fees might have occurred had new fee schedules been negotiated instead of the conversion to the reasonable-charge method. But the average amount paid in Colorado increased by as much as 77 percent for one procedure--dilation and curettage--6 months after converting from the fee schedules. Also, fees for most procedures have continued to increase beyond the increases which occurred immediately after the conversion to the reasonable-charge method.

Periodic studies made by OCHAMPUS of payments to physicians for selected surgical procedures show the increases

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[1]Payments include the amounts paid by both the fiscal agent and the beneficiary through deductible and coinsurance provisions.

which have occurred since fiscal year 1966. Our interim report, B-133142 dated May 19, 1970, showed examples of increases in average amounts paid for selected procedures of 16 to 76 percent from the first 6 months of 1966 to the first 6 months of 1968.

A Columbia University study of the physician component of CHAMPUS stated that payments for surgical procedures had increased substantially--an average increase of 24 percent during the period July 1966 to July 1967--after the change from maximum-fee schedules to the reasonable-charge method. The study stated also that (1) the Social Security Medicare program had set a precedent for generous reimbursement of physicians through the use of the reasonable-charge concept, which the smaller CHAMPUS found itself unable to withstand, and (2) the Department of Defense had agreed to adopt the reasonable-charge concept after apparently concluding that it would cost CHAMPUS no more than the alternative of raising the maximum allowances under fee schedules.

Fiscal agent officials provided various reasons for increased physician fees. Responses included opinions that: (1) the concept of reimbursing a physician on the basis of his usual and customary fees had enticed doctors to develop, through increased charges in billings, a higher profile for these charges, (2) a trend toward specialization had increased the fees, and (3) some physicians had charged only what they knew to be allowable under fee schedules even though their normal charges were higher.

Officials of the State medical societies offered the following reasons for increased physician costs: (1) the general inflationary trend had applied to physicians, e.g., the higher costs for labor, supplies, and taxes, (2) modern medical school teaching methods and the fear of malpractice suits had caused physicians to perform more services than they had previously performed, (3) the cost of malpractice insurance had increased substantially, and (4) the advent of Medicare had caused physicians to become more fee conscious.

CONCLUSIONS AND RECOMMENDATIONS

We have found no system or basis of payment for physician services that will prove entirely satisfactory for all parties concerned. The availability of physicians measured against the demand for care and availability of money operates to determine fee levels in a manner similar to commodities or other services. Physician profiles can be influenced and controlled by physicians themselves. Maximum-fee schedules would operate to conserve Government funds but they might reduce the number of physicians willing to serve the program's beneficiaries, thus the objectives of the program might suffer.

We recommend that the Executive Director, OCHAMPUS, consider developing a more economical and effective method of determining physician fees than the profile method, which fiscal agents have been requested to adopt in implementing the reasonable-charge concept.

CHAPTER 3

COMPARISONS OF CHARGES AND PAYMENTS FOR PHYSICIAN CARE UNDER CHAMPUS AND OTHER HEALTH CARE PROGRAMS

Our comparisons of the average payments[1] made for selected medical procedures under CHAMPUS with average payments made under other health programs showed that payments under CHAMPUS were generally in line with payments under other programs which paid on the basis of reasonable charges. A comparison of the amounts charged by individual physicians for services provided under CHAMPUS with amounts those physicians charged for the same services under other programs showed that some physicians charged one program more than another for the same service, possibly because of complications in the individual cases. But no signs of consistently higher charges to CHAMPUS were observed.

We identified large amounts paid under CHAMPUS to individual physicians, clinics, or group practices during 1968 and 1969.

COMPARISONS OF AVERAGE AMOUNTS PAID UNDER CHAMPUS AND OTHER HEALTH PROGRAMS

Comparisons between average payments made by CHAMPUS, Medicare, the Federal Employees Health Benefits Program (hereinafter referred to as the Federal Employees Program) and private plans for obstetrical care, office visits, and five surgical procedures showed that amounts paid were generally about the same under each program when the reasonable-charge method was used. Amounts paid under programs using fee schedules were generally less than payments for similar services under CHAMPUS. Under fee schedules, however, special rates may have been agreed to by physicians due to special circumstances, such as the low-income bracket of the

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[1]Payments include the amounts paid by both the fiscal agent and the beneficiary through deductible and coinsurance provisions.

policyholder, or the policyholder may have been billed for an amount in addition to the amount paid by his program.

The results of our comparisons of amounts paid for claims in Colorado, Georgia, Ohio, and California are discussed below. Amounts paid by the various fiscal agents were paid on a reasonable-charge basis, except where otherwise noted.

Colorado

The CHAMPUS fiscal agent, a Blue Shield agency, also paid claims of Blue Shield private plans, Medicare, and the Federal Employees Program. CHAMPUS claims were paid on the basis of a private plan fee schedule or a relative value scale developed for the State, whichever was greater. The fiscal agent had not developed physician profiles for CHAMPUS or for other programs and plans.

Our comparisons showed that average payments to physicians under CHAMPUS were similar to average payments under Medicare, the Federal Employees Program, and one private plan but that they were greater for some procedures than two private Blue Shield plans which were paying on the basis of fee schedules. Fiscal agent officials stated that payments for one of the two Blue Shield plans, the most prevalent of that agent, represented only partial coverage for many subscribers whose income exceeded the income limit criteria of the plan. Data on the results of our comparisons of average amounts paid for selected physician procedures during the 6-month period ended June 1969 follow.

Programs	Tonsillectomy and adenoidectomy (under age 18)	Appendectomy	Cholecystectomy	Dilation and curettage	Total hysterectomy	Obstetrical care (delivery only)	Normal office visits
CHAMPUS	$71.17	$166.82	$305.56	$70.33	$345.55	$117.93	$5.19
Federal Employees Program	73.50	161.50	325.84	69.25	330.63	118.00	5.51
Blue Shield private plans:							
A-based on fee schedule	50.00	125.00	250.00	50.00	250.00	100.00	(a)
B-based " " "	73.30	150.00	309.20	62.80	324.20	114.00	(a)
C (note b)	76.92	162.50	343.75	72.00	343.75	123.50	(a)
Supplemental benefits plan (note c)	-	-	-	-	-	-	5.42
Medicare	(a)	161.21	340.00	67.17	336.67	(a)	5.69

[a]Not applicable.

[b]Only a small number of claims were paid under this plan from January to June 1969.

[c]This plan is available only to Blue Cross-Blue Shield members on a group basis.

Georgia

The fiscal agent in Georgia, which processes only CHAMPUS claims, utilizes both a relative value scale and physician profiles developed solely from CHAMPUS claims. The CHAMPUS fiscal agent was able to obtain from the fiscal agent processing Medicare claims only the dollar values for use with conversion factors in applying the relative value scale.

Our comparisons showed that the CHAMPUS fiscal agent had not allowed payments to physicians in any substantially greater amounts than payments allowed by fiscal agents for other programs on the reasonable-charge method. The majority of reviewed claims paid by a private insurance program were paid on the basis of fee schedules that were not intended to cover full payment. Details of our comparisons of average amounts paid during the 6-month period ended June 1969 follow.

Programs	Tonsillectomy and adenoidectomy (under age 18)	Appendectomy	Cholecystectomy	Dilation and curettage	Total hysterectomy	Obstetrical care: Total	Obstetrical care: Delivery only
CHAMPUS	$97.83	$181.43	$322.83	$97.17	$309.17	$207.63	$110.50
Federal Employees Program	99.31	195.67	317.66	86.25	328.38	202.28	115.58[a]
Private plan (note b)	46.02	130.87	175.50	43.50	176.50	(c)	(c)
Medicare (note d)	(e)	197.33	319.05	81.67	312.17	(e)	(e)

[a]The fiscal agent for the Federal Employees Program pays amounts on the basis of complete obstetrical care. The $115.58 is an estimate of the portion of total obstetrical care applicable to delivery only.

[b]Most payments under this plan were based on fee schedules. The average payments made were approximately one half of the average charges made for these procedures.

[c]Not compared.

[d]Medicare data is for the period April through June 1969 only.

[e]Not applicable.

Ohio

Comparisons of the CHAMPUS, the Federal Employees Program, and Medicare for six selected medical procedures for the period January to June 1969 showed that all the average amounts allowed under CHAMPUS were greater than those allowed under the Federal Employees Program and that the amounts allowed by CHAMPUS were greater for two of the four procedures that could be compared with Medicare experience. Payments under the Federal Employees Program during the period were based on fee schedules, and the average amounts allowed were more than $30 below the average amounts charged by the physicians. However, our review of claims under the Federal Employees Program for the January to May 1970 period, after the switch to the reasonable-charge basis, showed a substantial increase in the amounts paid.

We were unable to make comparisons with private plans because the CHAMPUS and Medicare fiscal agents did not have any comparable claims under their private plans and because the fiscal agent for the Federal Employees Program refused to allow us access to information on claims of its private business. Details of the comparisons of average amounts paid for physician services follow.

Programs	Tonsillectomy and adenoidectomy (under age 18)	Appendectomy	Cholecystectomy	Dilation and curettage	Total hysterectomy	Obstetrical care (total)
CHAMPUS (note a)	$84.00	$178.19	$300.35	$ 88.39	$294.61	$184.23
Federal Employees Program (note b)	61.67	156.97	237.00	54.75	262.83	154.33
Federal Employees Program (note c)	98.67	202.61	312.50	106.67	362.17	213.63
Medicare (note a)	(d)	195.93	280.33	83.85	311.17	(d)

[a]Paid January to June 1969 based on reasonable charges.

[b]Paid January to June 1969 based on fee schedule.

[c]Paid January to May 1970 based on reasonable charges.

[d]Not applicable.

California

The California fiscal agent processes CHAMPUS claims in addition to those for Medicare and the Federal Employees Program, but it was not feasible to compare average amounts paid by the programs because of the manner in which the records are maintained. We did, however, compare amounts allowed to individual physicians under CHAMPUS with amounts allowed under Medicare and under the fiscal agent's private plans, including the Federal Employees Program which is considered part of the fiscal agent's private business. Payments for all programs handled by this fiscal agent are based on physician profiles based on data from Medicare, CHAMPUS, Medicaid, and its private business.

We found that amounts allowed for payment to individual physicians for similar types of services were generally the same, or less, under CHAMPUS than the amounts the fiscal agent allowed for payment under Medicare or its private business programs. Medicare and CHAMPUS payments were based on profiles existing in December 1968, which were frozen as of that time. Private program claims were based on current profile data.

An official of the California Physicians' Service informed us, and our review indicated, that the current profiles were generally higher than the frozen profiles used for Medicare and CHAMPUS.

COMPARISONS OF CHARGES MADE BY INDIVIDUAL PHYSICIANS

Amounts charged to CHAMPUS by individual physicians for services provided to beneficiaries were generally the same as amounts charged for comparable services to other medical programs. Claims of 160 physicians who submitted one or more claims against CHAMPUS and one or more against at least one other program during a comparable time period included 24 claims charging CHAMPUS amounts greater than the physicians were charging other programs.

The differences were generally small, and we did not examine the claims in depth to determine if complications might have caused the increased charge. The remaining

136 physicians charged CHAMPUS the same or less than they charged other programs. In many cases our comparisons were necessarily based on one CHAMPUS claim--the only claim submitted by the physician during our selected period. Our comparisons were limited to claims submitted from California, Colorado, Georgia, and Ohio.

PHYSICIANS OR CLINICS RECEIVING LARGE AMOUNTS UNDER CHAMPUS

A total of 170 physicians, clinics, or group practices received amounts exceeding $20,000 from the Government under CHAMPUS in 1969. The total of 170 represents an increase of 72 percent from the previous year. The amounts ranged from $20,208 to $106,128. OCHAMPUS data showed that 124 of the 170 were individual physicians, including two dentists, and 34 were group practices or clinics. The remaining 12 could not readily be classified. Psychiatrists, obstetricians, and gynecologists comprised 69 percent of the 124 physicians.

Of 13 physicians who received over $50,000 under CHAMPUS in 1969, eight were psychiatrists and three were obstetricians. A psychiatrist in Virginia received the largest amount, $106,128. Nine physicians, including four psychiatrists and four obstetricians, received over $50,000 under CHAMPUS in 1968.

Data for physicians or clinics that received large payments in calendar years 1968 and 1969 follows.

Physicians, Clinics, and Group Practices
Receiving $20,000 or More Under CHAMPUS

	1968		1969		Increase	
	Number	Amount	Number	Amount	Number	Amount
Individual physicians	86	$2,835,635	124	$4,072,949	38	$1,237,314
Clinics or group practices	13	475,143	34	1,397,366	21	922,223
Unclassified	-	-	12	323,272	12	323,272
Total	99	$3,310,778	170	$5,793,587	71	$2,482,809

Physicians, Clinics, and Group Practices
Receiving Over $50,000 from CHAMPUS

	1968		1969		Increase	
	Number	Amount	Number	Amount	Number	Amount
Individual physicians	9	$656,576	13	$ 868,894	4	$212,318
Clinics or group practices	2	129,891	7	589,465	5	459,574
Total	11	$786,467	20	$1,458,359	9	$671,892

Utilization reviews conducted by fiscal agents of physicians who have been paid large amounts are discussed in chapter 5. We did not analyze the claims of these physicians and clinics in detail.

CHAPTER 4

NEED FOR GUIDELINES, CONTROLS, AND BETTER ADMINISTRATION OF BENEFITS FOR PSYCHIATRIC CARE

Psychiatric care benefits under CHAMPUS are generally more liberal than those authorized under other medical programs. Total costs of psychiatric care for 1969 under CHAMPUS were about $34.5 million, or about 16 percent of the total program costs. When all claims have been processed, the costs for 1970 are expected to be higher.

Psychiatric care furnished on an inpatient basis has been available in certain circumstances to eligible beneficiaries since inception of the program. The Military Medical Benefits Amendments of 1966 expanded benefits to include psychiatric care furnished on an outpatient basis. The amendments also authorized a special program for mentally retarded or physically handicapped dependents of active duty members. (See report B-133142 dated March 16, 1971.)

Authorized medical benefits under CHAMPUS include the treatment of nervous, mental, and emotional disorders. Hospitalization in excess of 90[1] days for patients with these disorders requires approval by OCHAMPUS. The responsible physician furnishes a medical statement containing the diagnosis and proposed plan of management. If the case is approved, OCHAMPUS notifies the sponsor, hospital or facility, physician, and fiscal agent of the approval. All cases require review when the approved period expires, or at least annually. Reapproval requires submission of a new medical statement and its review by OCHAMPUS. Many cases are approved retroactively. As of December 31, 1969, records of OCHAMPUS showed that there were about 3,400 active cases involving psychiatric care and that about 2,400 cases involving mental disorders had been closed.

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[1]Prior to November 21, 1969, the limitation was 45 days.

OCHAMPUS personnel consider the professional diagnoses and prescribed treatments by the attending physicians as acceptable criteria for approval. Therefore, little attempt has been made by OCHAMPUS to ascertain whether a patient will benefit significantly from the proposed treatment. OCHAMPUS has interpreted its responsibility for considering economy to relate exclusively to the sponsors' interests since the authorizing act is considered beneficial legislation which should be construed liberally.

OCHAMPUS had not established criteria for the performance of utilization reviews--evaluation of quality, quantity, or timeliness of medical services provided--by fiscal agents (see ch. 5) nor attempted to determine whether more economical sources of psychiatric care were available. Facilities for treatment of nervous, mental, or emotional disorders were being approved for care of beneficiaries, although they did not meet minimum criteria established by OCHAMPUS.

No standards have been established by OCHAMPUS to aid its fiscal agents in evaluating whether physician and hospital costs for a specific psychiatric diagnosis are reasonable, and there is no general agreement among psychiatrists with regard to standards for evaluating treatment for psychiatric cases. One authority on psychiatry told us that psychotherapy should be limited to one session a week after the third week of treatment, but another told us that the normal frequency should be approximately three sessions a week. The fiscal agents included in our review--those which pay psychiatric claims in California, Colorado, and Virginia--had not established such standards, although two of them were working toward that goal with the aid of psychiatrists.

Considering the cost to CHAMPUS, we believe that management improvements and better controls over the amounts paid for psychiatric care are needed. Following is a discussion of (1) the liberal benefits available under CHAMPUS as compared to other programs, (2) the extensive psychiatric care provided to CHAMPUS beneficiaries, (3) the charge practices of some psychiatrists, (4) the need to consider obtaining psychiatric care at lower cost facilities, and (5) the approval of care in facilities which do not conform to prescribed criteria.

COMPARISON OF BENEFITS UNDER CHAMPUS AND OTHER PROGRAMS

The benefits authorized for psychiatric care under CHAMPUS were generally more liberal than those authorized under other programs with which we made comparisons. (See exhibits C and D.) OCHAMPUS approval is required for inpatient care in excess of 90 days, but there is no limitation on dollar value or number of days of care authorized. Other programs impose such limitations on either a single-confinement or a lifetime basis. Psychiatric care benefits under the Medicare and Medicaid programs are specifically limited as to the number of days of hospital care, the number of visits, or the dollar amounts authorized for outpatient care.

In our review of claims for psychiatric care at the office of the fiscal agent for California, we noted that, for a 1-hour psychotherapy session about $3 more was being paid under CHAMPUS than under Medicare and about $5 more than under Medicaid. The contract between OCHAMPUS and its fiscal agents requires that amounts paid by fiscal agents for CHAMPUS beneficiaries be limited to the amount paid under Medicare for the same service.

We advised the fiscal agent of these overpayments and the fiscal agent informed us that they resulted from manual processing which was necessary because of the inability to price psychotherapy claims by computer. We plan to examine into the related circumstances and the adequacy of action taken during additional review work.

EXTENSIVE PSYCHIATRIC CARE PROVIDED TO CHAMPUS BENEFICIARIES

Once OCHAMPUS approval is given for extended psychiatric care, the amount that may be expended by a fiscal agent for such care is unlimited. We found that about $37,000 had been expended for hospitalization and psychiatric treatment for one patient; about $32,000 for another. Costs of over $4,000 were paid for treatment of one beneficiary for alcohol addiction; over $5,000 for treatment of adjustment reaction of adolescence, with depression, for another patient; and about $7,000 for treatment of a patient suffering from recurring hallucinations due to use of LSD.

Although the care and costs cited above may be entirely proper, they are significant for individual cases and indicate the need for close monitoring of such cases.

CHARGE PRACTICES OF SOME PSYCHIATRISTS

At offices of the three fiscal agents where we reviewed psychiatric care, we found that some psychiatrists charged for a hospital visit every day a patient was in the hospital and charged for other services on these same days. In Colorado one psychiatrist was paid about $105,000 for the care of patients for each of 1,288 consecutive days through June 30, 1970. This doctor was paid for some type of service for each day any of his patients was hospitalized. About December 1967 he began charging for services such as psychotherapy and electrostimulation therapy, in addition to the daily charge for a hospital visit.

Four other psychiatrists maintained offices in the same private psychiatric hospital as this doctor. Their billing practices were similar--payments ranged from 138 consecutive days for one doctor to 1,106 consecutive days for another, including 743 consecutive days charged for one patient.

One of these doctors in February 1967 began charging for other services in addition to visits, while another doctor did not start this practice until January 1970. One of the doctors was paid for providing psychotherapy and group therapy on the same day. We were informed that the fiscal agent recently changed his policy to allow payment for only one procedure a day.

Charges normally allowed to these doctors for services during January through June 1970 were $30 or $35 an hour for psychotherapy, $15 for group therapy, $15 for electrostimulation therapy, and $10 or $12 for daily hospital visits.

The doctors informed us that it was a practice at the hospital for (1) these doctors to visit en masse all the patients 3 days a week, (2) the attending physician to visit his patients alone 2 days a week, and (3) the "officer of the day" to visit all the patients on the remaining days. The doctors take turns being officer of the day, which includes making daily rounds and night calls when needed. A hospital visit consists of visiting the patients, conferring with the nurse concerning the patients, writing or changing of orders, and possibly conferring in person or by telephone with patients' relatives or with hospital personnel.

At the time of our review, the Colorado fiscal agent was initiating action to review the propriety of the claims submitted in these cases.

In California five psychiatrists, who each received over $20,000 from CHAMPUS during 1968, were considered by the fiscal agent as having been overpaid about $21,700 because they had billed for anesthesia in conjunction with, and as an addition to, charges for electroshock treatments or for a hospital admission examination on the same day as or the day following a psychiatric examination. One of these doctors received about $153,000 in 1968. His charges were considered to be within regulations; but, because he billed for more than one procedure a day, the fiscal agent reduced his charges by about $11,000. According to the fiscal agent's medical adviser, the doctor was in solo practice and worked up to 20 hours a day. CHAMPUS payments to this doctor were about $63,500 in 1969.

One psychiatrist in Virginia was paid about $106,000 by CHAMPUS during 1969. Included in his billings were 772 consecutive daily visits to one patient at $10 a visit. The fiscal agent did not pay the psychiatrist for more than one procedure in a single day but allowed only the most expensive psychiatric procedure billed each day. The doctor informed us that he did not personally make each visit. He explained that he and three other psychiatrists had an arrangement whereby all of their patients were visited daily by one of them. Each doctor billed for his own patients and the billings included charges for visits made by the other psychiatrists to his patients.

NEED TO CONSIDER OBTAINING PSYCHIATRIC CARE AT LOWER COST FACILITIES

Our comparison of costs for selected facilities in Virginia showed that the average daily rate for accommodation and food for psychiatric patients in general hospitals was $43 compared with $32 in private psychiatric hospitals and about $5 in State mental hospitals.

The OCHAMPUS fiscal agents for California, Colorado, and Virginia, where we made our review of psychiatric care, made no efforts to ascertain whether patients in high-cost facilities could obtain the prescribed care in lower cost facilities. OCHAMPUS once considered limiting inpatient care for nervous or mental disorders furnished at high-cost facilities to 45 days, but no action was taken.

At the six military hospitals we visited, very limited inpatient facilities for psychiatric care were available, but most of them had extensive outpatient psychiatric facilities which were used by CHAMPUS beneficiaries.

We obtained data from six Veterans Administration hospitals and found that three of them had facilities which could provide some inpatient psychiatric care to CHAMPUS beneficiaries--one of them had leased 159 psychiatric beds to a county organization; another had 30 vacant psychiatric beds at the time of our review; and the other had facilities and could provide treatment for CHAMPUS beneficiaries on a modest scale.

Veterans Administration policy allows retirees under certain circumstances to receive care in Veterans Administration facilities. We recognize that difficulties might be involved if other CHAMPUS beneficiaries, such as minors, were allowed psychiatric treatment in these facilities.

CARE APPROVED IN FACILITIES WHICH DO NOT CONFORM TO PRESCRIBED CRITERIA

A psychiatric hospital under CHAMPUS is defined in the interim joint directive of the Departments of Defense and Health, Education, and Welfare, dated December 8, 1966, as

"*** an institution for the treatment of nervous, mental or emotional disorders *** operated in accordance with the laws of the jurisdiction in which it is located and has a professional staff including one or more licensed physicians who are qualified psychiatrists (i.e., who have completed three years or more approved residency training or are board qualified or certified) in addition to such ancillary psychiatric personnel as psychologists, psychiatric or other social workers, psychiatric aides, occupational or vocational therapy personnel, teachers and nursing personnel as appropriate ***."

The Acting Secretary of Health, Education, and Welfare, in a letter dated December 8, 1966, expressed concern about the quality standards for hospitals and related facilities being paid under CHAMPUS and suggested that the issue could readily be resolved if pertinent regulations that govern facilities approved under the Medicare program were incorporated in the joint directive.

The definition of a psychiatric hospital has been broadly interpreted under CHAMPUS in order to provide treatment to children, who otherwise would be denied services because of the lack of psychiatric institutions which treat children and also meet the more limited criteria for a psychiatric hospital as defined by the American Medical Association, American Psychiatric Association, or the Social Security Administration.

Thus facilities are considered to be psychiatric hospitals by OCHAMPUS if the facility (1) is operated in accordance with the laws of the jurisdiction in which it is located and (2) has a professional staff including one or more licensed physicians who are qualified psychiatrists.

The requirement of the joint directive of the Department of Defense and the Department of Health, Education, and Welfare that a psychiatric facility be licensed by the jurisdiction where it is located has no meaning or effect where local statutes do not require licensure. OCHAMPUS officials stated that about half of the States do not require any type of licensing of psychiatric facilities and that, in some States, a facility can be licensed by as many as four different agencies.

In view of the statements of OCHAMPUS officials, we reviewed the records pertaining to three facilities furnishing psychiatric care to CHAMPUS beneficiaries. The results of this review follow.

1. One facility was providing care to some CHAMPUS beneficiaries under the special handicap provision of CHAMPUS and other CHAMPUS beneficiaries were receiving psychiatric care under the basic provision. The records show that OCHAMPUS had received complaints from sponsors and local welfare agencies concerning the quality of care given by the facility. Staff turnover at this facility was high and there were periods when no psychiatrist was on the staff. Onsite inspections by OCHAMPUS did not reveal circumstances adverse enough to warrant disapproving the facility. The director of the facility had tried to remove children under the special handicap provision of CHAMPUS and place them under the basic provision of CHAMPUS. This was disapproved after OCHAMPUS concluded that it was an apparent effort by the director to obtain more money.

   The facility notified OCHAMPUS by letter in April 1970, 4 months after the fact, that they had ceased to be a psychiatric hospital as of January 1, 1970. The letter stated that CHAMPUS was being billed $500 a month--the amount being charged for CHAMPUS beneficiaries under the handicapped portion--for residential care provided for each of the five children involved. The charge under the basic program (as a psychiatric hospital) had been $600 a month for each child. OCHAMPUS allowed payment of the $500 charges on the basis that custodial care was provided to the children. A further consideration was that the facility would not then try to collect payment from the sponsors.

2. Another psychiatric facility used by CHAMPUS was not licensed by the State Department of Public Welfare as required under State law. The facility had no psychiatrist on the staff, and there was no indication that the operator intended to obtain one. The admission policy of the facility precluded acceptance of children whose primary problem was nervous,

mental, or emotional. Thus the facility did not comply with either of the criteria set by OCHAMPUS.

After a review of the facility, OCHAMPUS requested the Surgeon General, Department of the Army, to approve (1) removing the facility from the CHAMPUS list of approved treatment facilities for nervous, mental, and emotional disorders, (2) denying new applications for admission, and (3) reviewing cases being treated, with a view to removing the beneficiaries from the facility.

In June 1969 the Deputy Assistant Secretary of Defense (Health and Medical), to whom the request had been referred, gave the facility until January 1, 1970, to meet the requirements of a psychiatric hospital. Although OCHAMPUS could not provide us with evidence that the facility had complied with the requirements, we noted that the Deputy Assistant Secretary in December 1969 directed that the facility be approved on the basis of his conclusion that it met the applicable requirements as a hospital and was a facility for the management and care of the emotional disorders of children.

3. A psychiatric residential treatment center for adolescents was approved for CHAMPUS beneficiaries on the basis that the consulting psychiatrist participated in the treatment of patients and consulted with the facility's staff once or twice monthly on weekends and that the facility met the established criteria for a residential treatment center for emotional disturbances.

   The State in which the facility is located does not require nonpublic schools to be licensed. Contrary to the State's Compulsory School Attendance Law, children have not been required to attend class and the facility has no certified teachers. A committee of the State legislature has been investigating this facility because of complaints from the community, a former instructor, a former resident, and sponsors of children in the facility.

Pending outcome of the investigation, OCHAMPUS has advised the facility that no new CHAMPUS beneficiaries should be accepted without its prior approval. But CHAMPUS continues to pay fees ranging up to $850 a month per pupil for patients enrolled in the facility.

RECOMMENDATIONS

We recommend that the Executive Director, OCHAMPUS, consider

--issuing guidelines for use in establishing effective control over psychiatric care, such as more frequent reviews of cases involving extensive outpatient visits, therapy sessions, and hospital stays;

--seeking ways to use available Government facilities for both inpatient and outpatient psychiatric care of dependents and to transfer patients to lower cost civilian or Government facilities whenever it appears to be medically feasible, and;

--establishing and enforcing more definitive criteria for approving psychiatric facilities under CHAMPUS.

CHAPTER 5

UTILIZATION REVIEWS

A utilization review has been defined by the Social and Rehabilitation Service of the Department of Health, Education, and Welfare as any organized activity which evaluates quality, quantity, or timeliness of the medical services provided.

Contracts between OCHAMPUS and the fiscal agents provide that fiscal agents apply safeguards against the furnishing of unnecessary medical services. Guidance provided by OCHAMPUS for this activity has been very limited. Consequently, utilization reviews of the fiscal agents vary considerably. They range from sophisticated automated systems, which automatically compare many facets of claims to detect those which have unique characteristics and thus merit individual review, to simple manual systems, in which the claims examiner uses his judgment to set aside for special review any claims which do not look "right."

Only one of the fiscal agents we visited had developed a utilization review encompassing multiple procedures and most of these had been in effect for only a short time. The other fiscal agents used no consistent or systematic procedures in performing utilization reviews although two of the agents were in the process of developing such procedures.

GUIDANCE FROM OCHAMPUS

Contracts between OCHAMPUS and the fiscal agents typically provide that the fiscal agent shall

> "*** Apply safeguards against unnecessary utilization of services furnished eligible beneficiaries. In carrying out his responsibility the Contractor must take the necessary steps to reconcile any inconsistencies encountered in its claims review. Issues involving apparent inconsistencies between diagnosis and treatment and any other questions relating to the reasonableness of items or services rendered by physicians

and other sources of care should be reviewed by the Contractor's medical staff. Claims review techniques developed as a result of the Contractor's experience may be used or adapted for operations applicable to this program. ***"

According to the Department of Health, Education, and Welfare, institutional services should be reviewed for such considerations as necessity of admission and duration of stay and noninstitutional services should be subject to surveillance for assurance that the services furnished are based on actual need and that frequency of the care and services furnished are appropriate and not excess to the need. A utilization review includes procedures for reviewing the need for medical services, evaluating the propriety of individual claims and analyzing accumulated claims for individual patients, and evaluating claims data to identify patterns and trends of normal and abnormal utilization of services.

Except for furnishing the requirement that fiscal agents review--using their own procedures--records of all physicians who receive $25,000 (formerly $20,000) or more during 1 year under the program, OCHAMPUS has not furnished specific utilization guidelines for application by all its fiscal agents. On occasion, OCHAMPUS has requested specific reviews of drug benefits and issued special instructions to a particular fiscal agent. One fiscal agent expressed some doubt as to the medical practices of physicians who had earned over $20,000 under CHAMPUS in one year. However, no actions were taken by the fiscal agent, apparently because no guidelines existed.

OCHAMPUS does not have complete records indicating the types of utilization procedures being used by the fiscal agents nor information on whether they are performing utilization reviews. An OCHAMPUS official estimated that fewer than 10 fiscal agents were mechanized sufficiently to perform complete utilization reviews.

IMPLEMENTATION OF UTILIZATION REVIEWS

Some differences in utilization reviews made by fiscal agents in four States included in our review are indicated below.

Fiscal agent has	California	Colorado	Georgia	Ohio
Medical advisors or consultants	Yes	Yes	No	Yes
Qualified utilization review staff	Yes	Yes	Yes	Yes
Qualified claims examiners and supervisors of claims examiners	Yes	Yes	Yes	Yes
Developed its own utilization guidelines	Yes	No	Limited	No
New utilization programs under development	Yes[a]	Yes	No	Yes
Computerized utilization review procedures	Yes	No	Limited	No

[a]Utilization review procedures have been in effect only a short time.

All the fiscal agents we reviewed had local medical review boards or committees to which questionable claims or cases could be referred, but an official of one of them said that he could not recall any referrals having been made in the past 2 years.

BENEFITS FROM UTILIZATION REVIEWS

OCHAMPUS does not maintain statistics on the amounts recovered or reductions in billings that have resulted from utilization reviews. Statistics of the California fiscal agent, however, showed that its medical advisers for CHAMPUS reviewed 2,093 claims and saved the program an estimated $273,000 during the period July 1968 through March 1969. This agent's audit review staff or the local review committees--composed of experienced medical personnel--completed reviews on 53 CHAMPUS claims pertaining to the period July 1968 through March 1969 and January through May 1970 and concluded that 39 of the claims were unacceptable. Related actions resulted in savings of about $3,300.

The California fiscal agent has also reviewed, or is presently reviewing, cases involving providers of care who were paid over $20,000 during 1968 or 1969 under CHAMPUS.

Twenty of the 45 providers reviewed for 1968 submitted questionable claims amounting to about $55,000. At the time of our review, eight of 65 providers paid over $20,000 during 1969 were found to have submitted questionable claims.

The Ohio fiscal agent referred 20 claims to its medical consultant during 1969. On six of the claims the amount charged by the physician was reduced by the fiscal agent in accordance with the recommendation of the medical consultant.

CONCLUSION AND RECOMMENDATIONS

We conclude that, to ensure that the medical services furnished to beneficiaries are necessary and of high quality and to prevent the expenditure of Government funds for unnecessary or substandard services, a system of effective utilization reviews is needed.

We recommend that the Executive Director, OCHAMPUS, consider (1) providing guidelines which outline the requirements for an acceptable utilization review system, (2) reviewing and approving the utilization review systems of the fiscal agents, and (3) conducting effective surveillance to ensure that the systems are properly implemented. OCHAMPUS efforts to develop such guidelines should be coordinated with those of the Social Security Administration, which has issued utilization review guidelines to the Medicare carriers. We recognize that the extent of use of a utilization review system would depend upon the apparent validity and the number of claims processed, the capabilities of fiscal agent claims examiners, and the prospective benefits versus the costs of performing the reviews.

CHAPTER 6

ADMINISTRATIVE COSTS OF FISCAL AGENTS PROCESSING CLAIMS FOR CARE FURNISHED BY PHYSICIANS

CHAMPUS incurs administrative costs primarily through cost-reimbursable contracts with fiscal agents which process and pay claims submitted by providers of care and by beneficiaries.

Fiscal agents are generally reimbursed for administrative costs through provisional rates per claim, which are estimated to cover processing costs and other approved expenses and which are applied to the number of claims processed during certain periods of time. Payments for administrative costs are based on invoices submitted periodically to OCHAMPUS by the fiscal agents.

After completion of a contract period, fiscal agents submit proposals for actual administrative costs incurred under each contract.

Costs are finalized on the basis of audits of costs conducted by the Department of Health, Education, and Welfare's Audit Agency (HEWAA) and subsequent contract settlement negotiations between fiscal agents and OCHAMPUS.

TREND OF ADMINISTRATIVE COSTS

Administrative costs of physician fiscal agents averaged about $917,000 a year for fiscal years 1958 through 1966. The Military Medical Benefits Amendments of 1966, which expanded the benefits available under CHAMPUS and extended authorized medical care coverage from civilian sources to retired members and their dependents and to dependents of deceased members, increased the volume of claims and placed additional responsibilities on the fiscal agents. These responsibilities included handling deductibles and cost-sharing arrangements and resolving situations in which other insurance--insurance provided by law or through employment--paid a portion of the physician's claim. Also, beginning in May 1967, the reasonable-charge concept of paying physician

claims was introduced as each of the contracts then in force expired.

Administrative costs of physician fiscal agents increased significantly after fiscal year 1966, as shown below.

Fiscal year	Number of claims processed	Administrative costs (note a)	Average cost per claim
1966	343,000	$ 754,000	$2.20
1967	387,000	1,544,000	3.99
1968	718,000	3,910,000	5.45
1969	995,000	5,338,000	5.36
1970	1,103,000[b]	5,777,000[b]	5.24

[a]Costs allocated by GAO to appropriate fiscal year.

[b]Fiscal year 1970 figures are unaudited.

Significant reasons for the increase in costs since fiscal year 1967 include (1) computerization of fiscal agent operations to handle the increased claims which followed the expansion of benefits in 1966 and the increased use of the program by beneficiaries, (2) allocation of full costs to CHAMPUS as it became a larger part of the fiscal agents' business--before 1967 CHAMPUS was a small portion of the business of fiscal agents, and apparently some expenses were not allocated because of the limited participation and impact--and (3) the hiring and training of additional employees to cope with the expanded program.

During fiscal year 1970 the administrative costs per claim ranged from $2.37 for Montana to $9.93 for the District of Columbia. A summary of administrative costs per claim for processing physician claims under CHAMPUS follows.

Costs per claim	Number of contracts: Fiscal year 1969	Fiscal year 1970
$3.00 or less	7	6
$3.01 to $4.50	26	23
$4.51 " $6.00	7	12
$6.01 " $7.50	5	3
$7.51 " $9.00	2	2
Over $9.00	1	2
	48	48

NEED FOR STANDARDS TO EVALUATE THE PERFORMANCE OF FISCAL AGENTS

OCHAMPUS has not effectively managed its fiscal agents because of a lack of standards and procedures for evaluating their performance. The OCHAMPUS contracts do not include any incentives for promoting efficiency and economy of operations. Further, OCHAMPUS has not maintained the type of data which would permit an effective evaluation of the operations of fiscal agents. OCHAMPUS has no way of correlating the cost per claim of a fiscal agent with features of that agent's operation, such as developing and using physician profiles and utilization reviews. Because of these deficiencies, OCHAMPUS must accept widely varying costs for processing claims and different levels of contract performance by fiscal agents.

Significant differences in the activities and duties performed by fiscal agents and in the productivity of their operations undoubtedly account for some of the variations in claim rates. The cost of living in different geographical areas and the condition of the related labor market should be considered in evaluating claim rate differentials.

Significant differences exist in the number of claims processed per day, backlog of claims, and claims returned. For example:

1. In June 1970, the number of claims processed daily per employee ranged from 30.3 in New Mexico to 4.1 in Utah.

2. At the end of June 1970, the backlog of claims on hand was 61.3 days for Utah but only .1 days for North Carolina.

3. For June 1970, claims returned to claimants for correction or completion, expressed as percent of claims processed, was 44 percent for Puerto Rico but only 4.7 percent for South Dakota.

Differences also exist in the manner in which the reasonable-charge concept for paying physicians has been applied (see ch. 2), and in the extent to which utilization

reviews have been performed (see ch. 5). Other differences noted were in the maintenance of family files and in the efforts made to inform providers of care on the various features of CHAMPUS. Family files--which are helpful in reducing the number of claims returned to the providers of services, in determining proper amounts of payments, and in detecting duplicate payments--are maintained by some fiscal agents but not by others. Efforts to implement a contractual requirement to keep providers informed about CHAMPUS have ranged from publication of a monthly newsletter to no action at all.

OCHAMPUS has not terminated any of its contracts with fiscal agents because of unsatisfactory performance or high administrative costs. OCHAMPUS officials informed us that this was due to experience in two attempts to change fiscal agents. In these cases, the Executive Director was directed by higher authority to retain the fiscal agents.

The following data relating to four fiscal agents we visited are indicative of differences among them in the activities and duties they perform and the productivity of their operations.

	California	Colorado	Georgia	Ohio
1970 claim volume (note a)	256,000	12,000	27,000	27,000
1970 cost per claim (note a)	$8.09[b]	$5.04	$2.66	$3.67
Claims paid per employee day, June 1970	8.6	15.1	15.7	6.5
Claims backlog, in days, at end of June 1970	24.6	3.4	26.4	33.7
Claims returned by fiscal agent in June 1970	17.8%	9.7%	18.5%	37.1%
Claims rejected by fiscal agent in June 1970	17.9%	14.7%	11.2%	1.0%

[a]Volume and cost figures shown are for contracts which ended in the period closest to the end of fiscal year 1970. For California, the data for the recent 2-year contract has been used--on an allocated basis where appropriate.

[b]Data supplied by the California fiscal agent states that the cost per claim has decreased to approximately $6.90 as of Jan. 11, 1971.

Contract requirements for physician fiscal agents have been standardized, but OCHAMPUS has not developed performance standards to measure the extent to which the fiscal agents are meeting contractual requirements. When OCHAMPUS receives an abnormal number of complaints or inquiries on questionable matters or observes that fiscal agents are making many mistakes in a specific area, a numbered OCHAMPUS letter or memo is issued to all fiscal agents. OCHAMPUS maintained no listing or index of the letters or memos it had issued; however, we have been informed that a listing has now been made and that a copy will be sent to each fiscal agent.

We were informed that advice was given to fiscal agents by telephone and that many problems were resolved in this manner, but we saw few records of the telephone conversations. Further, OCHAMPUS does not maintain records showing whether fiscal agents have performed the required or desired procedures, such as conducting utilization reviews and establishing and maintaining physician profiles and family history files. OCHAMPUS Contract Performance Review Branch does make onsite reviews of fiscal agent operations to evaluate their performances. This function is discussed in chapter 8.

We did not review the administrative costs of the largest physician fiscal agent--the California Physicians' Service, which accounts for about 34 percent of the total administrative costs of physician fiscal agents. At the time of our review, both HEWAA and California State auditors were auditing the fiscal agent's records of the public programs that the fiscal agent handled, e.g., Medicare, CHAMPUS, and Medicaid. Since many of the administrative costs incurred by the fiscal agent pertained to two or more of the public programs and possibly its commercial business and auditors would need to use the same records to verify costs and evaluate the allocations among the programs, we decided that it would be inappropriate for us to audit the records at that time.

PROBLEMS IN THE PAYMENT OF PHYSICIAN CLAIMS

During our review we observed and identified specific problems and lack of proper control in the payment of physician claims. These problems concern the prevention of duplicate payments and errors in processing of claims for certain types of care by the fiscal agent for California.

Duplicate payments made to physicians

Each of the fiscal agents included in our review had designed some procedure for detecting duplicate payments made to physicians. The procedures of the fiscal agents for California and Georgia were mechanical and those of the fiscal agents for Colorado and Ohio were manual.

Although we did not identify any duplicate payments during our review of the fiscal agent for California, we noted that voluntary refunds of about $6,600 were received by the fiscal agent from physicians during January through March 1970 for payments that had been made because the physicians had submitted claims for the same service more than once.

During our review we found that the fiscal agent for California had established on its computer two or more history files for the same sponsor. A limited test revealed that about 30 percent of the sponsors we checked had more than one history file and that the potential for making duplicate payments was increased by the existence of the multiple history files. Further, duplicate history files result in additional costs for computer access time, additional correspondence, and erroneous handling of deductibles payable by the sponsors.

Recently the fiscal agent put into operation a new computer program designed to detect and merge multiple history files for individual sponsors. This should reduce the problem of processing duplicate payments to physicians.

Errors in claims for obstetrical care

During our review of the activities of the fiscal agent for California, we found that, in processing physician

claims for medical procedure code 4822 (obstetrical care--delivery only), the reasonable charge was being computed incorrectly. Of 30 claims reviewed, we found that some overpayment occurred in 20 and that the average overpayment was $11.50 for these claims.

Discussions with the fiscal agent's computer officials revealed that the overpayments were caused by an error in the computer program. Subsequently we found other types of errors in processing claims. Because of the apparent lack of management controls over computer programming and processing and because of the possibility that a large amount in overpayments may have been processed, we are performing an additional review to determine the extent of this problem and the management controls needed to improve the computer services.

We found that neither the fiscal agent nor OCHAMPUS had developed procedures for periodically making test checks of the processing of claims by the computer to ensure that the computer programs had been correctly designed and compiled to cover all the features of an effective claims review and to ensure that the processing was being properly performed.

CONCLUSIONS AND RECOMMENDATIONS

Our limited review of the administrative costs incurred by the fiscal agents for Colorado, Georgia, and Ohio showed that they were allowable and allocable under the contracts. In general, however, OCHAMPUS has exercised limited managerial control over the activities of fiscal agents.

We believe that opportunities would be found for effecting significant economies for the program--both in administrative costs and in the payment of medical fees--if meaningful standards were developed for the duties and activities of fiscal agents. The Executive Director, OCHAMPUS, should consider developing standards to be used in evaluating the performance of the fiscal agents. Effective controls should also be established to prevent overpayments and duplicate payments to physicians. Further, a comprehensive operations manual is needed to achieve more uniform claim processing procedures and provide a complete and organized reference to the various program directives and guidance.

Whenever a fiscal agent's levels of performance or costs are considered unacceptable, OCHAMPUS should take prompt action to seek improvement in the operations of the fiscal agent.

CHAPTER 7

APPLICATION OF OUTPATIENT DEDUCTIBLE AND OTHER INSURANCE PROVISIONS OF CHAMPUS

In making settlements for medical care provided to beneficiaries, CHAMPUS requires that (1) a deductible be applied against claims submitted for outpatient care and (2) payments made on behalf of certain types of beneficiaries, under insurance provided by law or employment, be applied against related medical bills before CHAMPUS determines the amount it will pay against the balance of these bills. We found that the methods used for applying the deductible and the other-insurance provisions will in certain circumstances result in physicians' receiving more, in the aggregate, than the reasonable charge for the services they have rendered.

OCHAMPUS officials stated that they had not applied reasonable-charge criteria in processing these cases because they wished to avoid the possibility of a physician's requesting an additional payment from the sponsor as a result of reducing the aggregate amount paid a physician to the reasonable charge.

However, when filing a claim with a CHAMPUS fiscal agent, the physician agrees to accept payment of the reasonable charge as payment in full for services rendered. The reasonable-charge criteria are required to be applied in handling the deductible provisions of the much larger Government medical program--Medicare. Application of reasonable-charge criteria under CHAMPUS to outpatient deductible cases, as well as to cases where other insurance pays a portion of the claim, will result in savings to the Government.

The certification on CHAMPUS claim forms regarding other insurance creates a problem because the data requested and the space provided is inadequate for ensuring that the fiscal agent will receive sufficient data for prompt action to ascertain the amounts that the other insurance have paid and for applying such payments, where appropriate, against physician billings before CHAMPUS benefits are determined.

OUTPATIENT DEDUCTIBLE

Under the Military Medical Benefits Amendments of 1966, a deductible was established for outpatient care which must be met by sponsors each fiscal year before the Government shares in outpatient costs. Once the deductible of $50 for one dependent ($100 maximum deductible for each family) has been met, CHAMPUS pays 80 percent of the reasonable charges for outpatient care of dependents of active duty personnel and 75 percent of the reasonable charges of retirees and the dependents of retirees and deceased members.

After payment of the deductible, charges for outpatient services are subject to reasonable-charge determinations which limit them to the customary charges of the provider or the prevailing charges of other providers of care in the locality. No such limitation is applied, however, to the charges included in the deductible paid by the beneficiary. CHAMPUS incurs additional costs because of this policy. When charges included in the deductible exceed the reasonable-charge limitation, the deductible is used up more quickly than if the limitation were applied.

The increased costs to CHAMPUS stemming from failure to apply reasonable-charge criteria before computing the deductible are illustrated below by a comparison of the amount the fiscal agent for California would pay under the present method with the amount it would pay if the reasonable-charge method were applied to the deductible.

			Present method		Reasonable-charge method	
	Amount billed	Reasonable charge	Amount of deductible applied to bill	Amount payable by CHAMPUS after the deductible (note a)	Amount of deductible applied to reasonable charge	Amount payable by CHAMPUS after the deductible (note a)
First bill	$50	$33	$50	$ -	$33	$-
Second bill	30	22	-	17.60[b]	17	4[c]
	$80	$55	$50	$17.60	$50	$4

[a] CHAMPUS share is 80 percent of the reasonable charge for dependents of active duty personnel.

[b] 80 percent of $22.

[c] 80 percent of $5 ($22 "reasonable charge" less $17 deductible).

In this hypothetical case CHAMPUS would pay $13.60 less ($17.60 - $4), if the deductible were based upon the reasonable charge.

Our review of a sample of 50 claims paid during the week of March 25, 1970, by the fiscal agent for California showed that for 22, or 44 percent, the deductible was applied against billings which exceeded the reasonable charge and that this increased the amount paid on these claims by an average of more than $7. On the basis of this sample, the increased costs to CHAMPUS in California for the week of March 25, 1970, were approximately $2,700. Prior to February 1970 the fiscal agent for California applied reasonable-charge criteria to the deductible.

Our review of another fiscal agent, the Mutual of Omaha Insurance Company, showed that claims involving outpatient deductibles were handled the same as they were handled by the fiscal agent for California if the claims were submitted by a beneficiary; but, if a provider of care submitted the claim, the deductible was applied against the amount of the reasonable charge.

OCHAMPUS officials have informed us that they believe reasonable-charge determinations should not be used in applying a sponsor's deductible. They believe that benefits of the program should apply to the beneficiary, whenever possible. They believe that it is more equitable to credit the sponsor with the full amount billed rather than the reasonable charge, where this is lower, because using the reasonable-charge method may cause the sponsor to incur additional expense. In their opinion many physicians would attempt to collect from the beneficiaries the difference between the amount billed and the reasonable charge allowed by the fiscal agent, even though physicians had signed the CHAMPUS claim form agreeing to accept the CHAMPUS payment as full payment. OCHAMPUS also expressed the opinion that payment of the deductible was a private matter between the beneficiary and the provider of the service.

Participation in CHAMPUS by providers of care is voluntary. However, providers of care who participate in the program, agree to accept the CHAMPUS payment, based on reasonable charges, as payment in full for services and/or supplies provided. In signing the claim forms, providers agree to this, and they should not require the sponsors to pay any charges beyond the deductibles.

The OCHAMPUS contracts with fiscal agents, who are also Medicare carriers, provide that CHAMPUS payments not exceed those for the Medicare program. Under Medicare, only reasonable charges are required to be applied to the deductible.

Conclusions and Recommendation

In our opinion the reasonable-charge limitation should apply to charges billed to beneficiaries for payment under the deductible provision as well as those billed to CHAMPUS. We agree that the beneficiary should not be required to pay the difference between charges billed by a physician and his reasonable charge for the services as determined by the fiscal agent.

In our opinion, the principle that the provider of care accept the reasonable charge as full payment should extend to payments of billings for the deductible made by beneficiaries. This would be consistent with procedures of the Medicare program and would lower the costs to CHAMPUS, and beneficiaries would pay only reasonable charges for services.

We recommend that the Executive Director, OCHAMPUS, consider issuing policy guidance to all fiscal agents that pay physician claims to include only reasonable charges when computing the deductible amount to be paid by the beneficiaries.

OTHER INSURANCE

The Military Medical Benefits Amendments of 1966 provide that retirees and their dependents and the dependents of deceased members, having other insurance provided by law or through employment covering medical benefits, apply the benefits received 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. No requirement exists for dependents of active duty members to declare other insurance provided by law or through employment. When other insurance is reported by dependents of active duty members, it is on a voluntary basis.

Where beneficiaries have private insurance--insurance not provided by law or through employment--and payments are made directly to the beneficiaries, the insurance is not considered in making the CHAMPUS payment. If, however, payment for private insurance is made directly to the source of care, CHAMPUS will pay the remaining charges up to the amount that it would have paid had there been no other insurance. Even though CHAMPUS has adopted the reasonable charges as the basis for paying physician claims, the CHAMPUS regulations permit physicians to be paid, in the aggregate, amounts greater than the reasonable charges when other insurance pays a portion of the amount claimed.

We reviewed 57 claims where other insurance had paid portions of billed charges. We found that, for 10 of these claims, the physicians received more than the reasonable charges when the CHAMPUS payment was combined with the other insurance payment. Seven claims paid by the California fiscal agent exceeded the reasonable charges by a total of $431.50. The three remaining claims paid by other fiscal agents exceeded the reasonable charges by a total of $155. Amounts paid on the remaining 47 claims did not exceed reasonable charges because the physician billings did not exceed the reasonable charges established for the services rendered.

We were informed by OCHAMPUS officials that the purpose of the regulations, which allowed payment in excess of reasonable charges, was to protect the sponsor so that physicians would not attempt to collect the difference between the amount billed and the reasonable charge from the sponsor. We believe that the full payment concept used by CHAMPUS--under which the physician, in signing his claim, agrees to accept the CHAMPUS payment as full payment for his services--should be sufficient to protect the sponsor and that payment of a portion of a claim by other insurance should not entitle a physician to more than the reasonable charge.

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In making our review, we noticed that the law pertaining to CHAMPUS is silent with respect to other insurance that might be held by dependents of active duty personnel. Thus it is not necessary for fiscal agents to ascertain whether payments against physician billings have been made by other insurance or, if they have, to take such payments into account in processing physician claims against dependents of active duty personnel.

Because of the absence of legal requirements concerning the handling of payments of physician billings by other insurance on behalf of dependents of active duty personnel, CHAMPUS pays more than it would pay if the statutory provisions for retirees and their dependents and dependents of deceased personnel were applied to dependents of active duty personnel. Further, it is possible at this time for dependents of active duty personnel or their sponsors to receive payments from CHAMPUS for amounts billed by physicians for services that have already been paid in full or in part by other insurance and for physicians to be paid, in the aggregate, more than the reasonable fee for such services.

Recommendation

We recommend that the Executive Director, OCHAMPUS, consider limiting CHAMPUS payments to physicians, when payments are to be combined with other insurance payments, to the reasonable charges for the services rendered.

We recommend also that the Executive Director propose legislation that payments involving dependents of active duty members not be authorized when other insurance, medical service, or health plan is provided by law or through employment unless the person receiving the benefit under CHAMPUS certifies that the particular benefit he is claiming is not payable under the other plan. This would result in (1) applying, uniformly to all beneficiaries, the congressional concept against double coverage and double payment and (2) processing physician billings for all CHAMPUS beneficiaries on a uniform basis.

CERTIFICATION OF OTHER INSURANCE

We noted a significant problem involving the certification on the CHAMPUS claim forms of other insurance provided by law or through employment. There is no space on the form for the sponsor or beneficiary to provide sufficient identifying data on other insurance that he has, which may pay a portion of the claim. The certification states only that (1) there is no other insurance or (2) other insurance possessed does not cover the medical procedure on the claim.

The form contains the following statements and requests that the applicable statement be checked:

> "*** (I am not) (the patient is not) enrolled (neither is sponsor) in any insurance, medical service, or health plan provided by law or through employment.
>
> "*** (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service, or health plan provided by law or through employment; however the particular benefits claimed on this form are not payable under the other plan."

Thus, if a retiree, retiree's dependents, or dependents of deceased members had other insurance provided by law or through employment which provided benefits, insufficient information would be furnished to the fiscal agent for taking action to apply payments made by such insurance against the physician bill before CHAMPUS benefits are determined.

An examination of 104 claims of retirees, their dependents, and dependents of deceased personnel at the office of one fiscal agent showed that 18 claims did not indicate whether the personnel had other insurance. We were informed by officials of the fiscal agent that, if the beneficiary showed that he had other insurance but did not state the name of the carrier, the data was ignored by the fiscal agent in processing the claim. We found that about $18,100 was refunded during the first quarter of 1970 because claims were paid by both other insurance and this CHAMPUS fiscal agent. We believe that this problem is due, in part, to the inadequate wording on the claim form.

We discussed this matter with OCHAMPUS officials, and they stated that recommendations for revising the claim form were being prepared for submission to the Surgeon General of the Army.

Recommendation

We recommend that the Executive Director, OCHAMPUS, consider revising the claim form so that it will obtain a positive certification as to whether the patient has other health insurance and, if so, the name of the insurance company, the policy number, and the nature of benefits under the policy.

CHAPTER 8

REVIEWS AND AUDITS OF PHYSICIAN FISCAL AGENT ACTIVITIES

The organizations currently responsible for making reviews and audits of fiscal agents on a regular basis are (1) the OCHAMPUS Contract Performance Review Branch, which makes continuing analyses of fiscal agent operations and makes onsite visits to evaluate fiscal agent performance, (2) HEWAA, which has audited the fiscal agents since October 1967, and (3) the Inspector General, Office of the Surgeon General, Department of the Army, which performs periodic contract-compliance inspections of fiscal agents and also inspects OCHAMPUS.

Initially, the Army Audit Agency had responsibility for auditing OCHAMPUS and its fiscal agents. The responsibility for auditing fiscal agents was transferred in July 1965 to the Defense Contract Audit Agency. In October 1967, HEWAA made an agreement with the Defense Contract Audit Agency to perform the CHAMPUS contract audits for the Defense agency. Since the Army Audit Agency and the Defense Contract Audit Agency are not directly involved in evaluation of fiscal agents, our comments on their work and roles will be included in the final report in this series.

Comments on our review of the compliance inspections made by the Inspector General were included in our interim report entitled "The Civilian Health and Medical Program of the Uniformed Services," B-133142 dated May 19, 1970. We stated that it appeared that the inspections had been of limited value to management for improving CHAMPUS due to the limited time spent on the inspections, the failure to identify the program's significant problem areas, and the absence of significant recommendations.

The reviews of the Contract Performance Review Branch and the audits of HEWAA were also limited by insufficient time, which restricts the depth of review and scope of work performed. The work of the review branch appears to be useful for coping with problems on a limited basis; i.e.,

peculiar to one specific fiscal agent, but not for detecting new or previously existing problems not known to the fiscal agent. It appears to us that HEWAA has devoted a large amount of time to auditing administrative costs--which amount to about 3.5 percent of benefit payments--of the fiscal agents in relation to other significant problem areas in the physician component of CHAMPUS. On the basis of our discussions with HEWAA audit staffs at locations we visited, however, it appears that expanded audit coverage of CHAMPUS is being planned.

REVIEWS BY CONTRACT PERFORMANCE REVIEW BRANCH

The functions of the Contract Performance Review Branch, Directorate of Contract Management, OCHAMPUS, are described in the CHAMPUS Annual Report as follows.

> "Conducts a periodic program of onsite comprehensive reviews of contractor operations and prepares reports.
>
> "Reviews, on contractor site, selected materials to ascertain degree of adherence to established policy and adequacy of service to program beneficiaries.
>
> "Evaluates all areas of the contractors operation which cannot be evaluated without an onsite review.
>
> "Documents actions taken by the contractor to raise the level of performance when such action is required.
>
> "Conducts special non-scheduled reviews as needed due to developing operational problems as determined by the Contracting Officer."

The branch was established effective December 1, 1967, to develop the capability of evaluating contractor performance on a regularly scheduled basis and to ensure contract compliance by civilian contractors.

Plans provide that reviews be completed in about 7 days, including issuance of the report. The reviews ordinarily involve about 3 days of fieldwork at the site by two officials. Before making field visits, members of review teams obtain data concerning known problem areas and operational statistics from OCHAMPUS files.

The reviews ordinarily cover administrative costs, the claims flow process, the program for providing information about CHAMPUS to providers of medical care, and some of the claims for verification of the correctness of coding and deductible procedures. The reviews also determined whether physician profiles had been developed, checked for duplicate payments, and determined methods being used to detect overutilization of medical care. Team members hold a 1- to 8-hour workshop with the fiscal agent's claims examiners, during which procedures are reviewed and problem areas are discussed.

Conclusion

Although the contract performance review teams have an intimate knowledge of CHAMPUS and of problem areas that are common to all fiscal agents and those that are unique to specific fiscal agents, we believe that their effectiveness is limited by their inability to make adequate evaluations of fiscal agent activities in the brief time spent on each review.

We believe that, to more effectively evaluate fiscal agent activities, CHAMPUS should expand the scope of the work performed in the areas of benefit payment reviews, claim processing procedures and controls, application of deductibles and other insurance benefits, and other significant aspects of the physician component of the program.

HEWAA AUDITS

Under the agreement with the Defense Contract Audit Agency, HEWAA has undertaken audits of prime contracts and subcontracts for medical care provided in the continental United States, Alaska, Hawaii, and Puerto Rico. HEWAA has agreed to perform the audits in accordance with the Defense

Contract Audit Agency Audit Manual. This manual provides that specific consideration be given in the audits to:

--selectively testing and evaluating the contractor's internal procedures for determining the validity, accuracy, and reasonableness of individual claims;

--the allowability, reasonableness, and allocability of administrative costs;

--reviewing the proposed administrative claims rate for reasonableness;

--reviewing the contractor's program for identification and correction of the causes for delays in submitting claims;

--examining timeliness of processing and paying the authorized benefits claimed; and

--reviewing receipts and disbursements of the special bank account maintained for advance payments for those contracts which contain an advance payment provision.

Our analysis of the most recent audits performed by HEWAA at offices of four fiscal agents included in our review shows the following statistics.

Fiscal agent	Review of administrative costs	Review of benefit payments and controls
	(man-days expended)	
California (note a)	50	186
Colorado	14	19
Georgia	34	34
Ohio (note b)	58	58

[a]The audit of administrative costs was in process at the time of our review.

[b]Audit coverage shown for Ohio applies to Mutual of Omaha Insurance Company which also processes claims from 5 other States and Puerto Rico.

Our analysis of the audit programs used by the HEWAA staffs in performing the above audits shows also that the audits generally provide sufficient coverage of fiscal agent procedures. We did note, however, that in several instances the audit programs failed to indicate coverage of utilization review procedures or of procedures to prevent duplicate payments. We noted also that the related audit reports failed to mention some of the problem areas identified in our reviews of fiscal agents, such as the payment of more than reasonable charges to physicians where other insurance and deductibles were involved and the need for guidelines for dealing with charges made for psychiatric care.

Conclusion

In the past a major portion of the time allotted in most States for audit by HEWAA has been expended on reviewing administrative expenses. We noted that the HEWAA staff in San Francisco had recently allocated more time to examining into the manner in which the fiscal agent is reviewing and processing claims and had identified several significant problem areas. Some of the HEWAA staffs responsible for auditing the other fiscal agents we reviewed expect to give considerably more coverage to reviewing benefit payments in their future audits. We believe that the expanded coverage should be beneficial to the program.

CHAPTER 9

SCOPE OF REVIEW

Our review was performed during 1970 at OCHAMPUS, located at Fitzsimons General Hospital near Denver, Colorado, and at offices of four of the 45 CHAMPUS fiscal agents who process and pay physician and drug claims, see below:

California Physicians' Service
San Francisco, California

Colorado Medical Service, Inc.
Denver, Colorado

Medical Association of Georgia
Atlanta, Georgia

Mutual of Omaha Insurance Company
Omaha, Nebraska

The California Physicians' Service is a voluntary medical service plan sponsored by the California Medical Association. It was established as a nonprofit corporation in 1939 and is a charter member of the National Association of Blue Shield Plans. Colorado Medical Service, Inc., is the corporate name of the Colorado Blue Shield plan.

The Medical Association of Georgia is an association of county medical societies. The stated purposes of the Association are to promote the science and art of medicine and the betterment of public health. The Mutual of Omaha Insurance Company is a mutual (not-for-profit) life insurance company organized under the statutes of the State of Nebraska to administer prepaid medical and life insurance programs. Our review of claims at Mutual of Omaha Insurance Company was generally limited to those submitted from the State of Ohio.

During our review we also contacted medical insurance companies to obtain information on amounts paid physicians for selected medical procedures by the Social Security Administration's Medicare Program, by the Federal Employees Program, and by private insurance plans.

Our review of psychiatric care included work at the office of the fiscal agent for Virginia--Blue Cross/Blue Shield of Virginia--as well as offices of the fiscal agents for California and Colorado. Also, we visited selected military, Veterans Administration, and civilian hospitals that provide psychiatric care and held discussions with individual psychiatrists and officials of a professional psychiatric organization.

EXHIBITS

EXHIBIT A

METHODS BY WHICH FISCAL AGENTS FOR THE STATES OF CALIFORNIA, COLORADO, GEORGIA, AND OHIO PAY CHAMPUS PHYSICIAN CLAIMS

CALIFORNIA

The California fiscal agent has been developing physician profiles from Medicare, CHAMPUS, Medicaid, and its private business records since November 1967. These profiles usually reflect the amount a physician bills under all programs administered by the fiscal agent for a particular procedure (customary charge), as well as the charge most frequently and most widely used in a locality for a particular medical procedure (prevailing charge).

A physician's customary charge (level-1 profile) equals the lowest fee accounting for more than 50 percent of the physician's charges over the 6 previous months. The prevailing charge (level-2 profile) is determined at the 90th percentile of all level-1 profiles for a particular service in that locality. No level-1 profile is established unless a physician has submitted at least five claims for a procedure. A level-2 profile is developed when at least five level-1 profiles exist in a locality for a particular procedure. There were 53 different localities in California at the time of our review.

The reasonableness of the amount billed by a physician for a procedure is determined by the fiscal agent by comparing the billed amount with the level-1 and level-2 profiles for a particular procedure and the lowest amount is paid. If no level-1 or level-2 profiles exist, the amount is compared with a level-3 profile. A level-3 profile is derived by taking the relative value of a procedure, as stated in the 1964 California Relative Value Scale, times a locality coefficient for one unit of service.

COLORADO

The Colorado fiscal agent has used as a screen for paying CHAMPUS claims the greater of a private plan fee schedule or the result of relative values times specified dollar

values assigned by category of service (surgery, anesthesia, medical services). The method of payment used in Colorado is classified by OCHAMPUS as a schedule of allowance.

A $5-per-unit value has been assigned to surgery to be used in conjunction with the relative values. The fiscal agent considers these schedules to be the prevailing medical charges in Colorado, but fiscal agent officials could not provide documentation as to how the dollar values being applied to the relative values were determined or precisely when use of these values was implemented.

The fiscal agent is currently working toward establishment of physician profiles. Data is being gathered on the 25 most common procedures of each physician in the State, by specialty. The contractor is developing customary charges for these physicians and prevailing charges for each of 5 localities. Only Medicare data are being used in the initial development of profiles.

GEORGIA

The fiscal agent adopted the California Relative Value Scale in implementing the reasonable-charge concept. For converting the relative values to fees, the fiscal agent received authorization from the Social Security Administration to obtain conversion factors purportedly used by the Georgia Medicare carrier. The factors for surgery consisted of three separate ranges, varying in amount according to the size of various cities within the State. For cities with the largest population, the range was from $5 to $7; for cities with lower populations, the range was from $4 to $6; and, for rural areas, the range was from $3 to $5.

As a corollary means of evaluating the reasonableness of physicians' charges, the fiscal agent developed computer printouts of CHAMPUS claims paid during a prior period, including all claims paid to individual physicians by the various medical or surgical procedures and all claims paid to physicians practicing within a certain area and considered them to be the CHAMPUS profiles.

According to the fiscal agent, if an attending physician's charge did not exceed the maximum computed by reference to the California Relative Value Scale, the charge was

generally allowed as reasonable. If the charge exceeded the maximum charge, the claims examiners would refer to the printouts developed from CHAMPUS claim data. They would first screen the claim against the physician's customary charge. If the charge exceeded his customary charge, the examiners would compare the charge to charges made by other specialists in the same locality or, if there were no other specialists in the locality, to charges submitted from an area of comparative population and/or economic level. The fiscal agent would pay the physician's actual charge up to the prevailing charge in the locality or in a comparable locality.

OHIO

Since implementation of the reasonable-charge concept in August 1967, the fiscal agent has used the 1964 California Relative Value Scale for determining reasonable charges. The fiscal agent multiplied the appropriate California Relative Value Scale units by a $5 conversion factor until August 1968. In August 1968 the contractor increased the units for certain procedure codes and increased the conversion factor for the Cincinnati and Cleveland areas to $7 and for all other areas to $6. The conversion factors were increased to $8 and $7, respectively, for services performed by specialists.

The fiscal agent did not develop or use customary charge profiles but had developed prevailing charges for determining conversion factors to be applied to the California Relative Value Scale units. OCHAMPUS had designated 10 areas to be used by the contractor in developing prevailing charges. Designated localities consisted of the physical limits of 9 listed cities and the rest of the State.

In March of 1970 the fiscal agent began accumulating charge data as a basis for establishing customary and prevailing charges, using Social Security Administration guidelines for Medicare. The contractor began using these charges in September 1970 in determining the reasonableness of CHAMPUS charges. Customary charges were developed from as few as two charges provided that only two charges had been received from the physician and both charges were for the same amount and for the same procedure. In all other

instances at least three charges for the same procedure are needed to develop a valid customary charge. Conversion factors are developed for each practitioner to be used when insufficient data is available to establish a valid customary charge.

Prevailing charges are developed from at least one charge from five different physicians for the same procedure. The prevailing charge is computed from the mean charge plus one standard deviation.[1] Prevailing charges are developed for each county in the State. Conversion factors are developed on a county and State basis and are used when insufficient data is available to establish a valid prevailing charge. Specialists receive no more than the prevailing charge for the area.

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[1]Standard deviation--a basic statistical measure of the average difference of the amounts in a series measured from their mean.

TREND IN AVERAGE PAYMENTS MADE TO PHYSICIANS

	Code 2992-tonsillectomy and adenoidectomy (under age 18)		Code 3261-appendectomy	
	Average amount paid	Increase or decrease over fee schedule and prior period rates (percent)	Average amount paid	Increase over fee schedule and prior period rates (percent)
COLORADO:				
Fee schedule (note a)	$ 58.00		$125.00	
After initiating reasonable-charge concept (note b)	69.75	20.3	150.50	20.4
January to June 1969	71.17	2.0	166.82	10.8
GEORGIA:				
Fee schedule (note c)	74.00		161.50	
After initiating reasonable-charge concept (note b)	77.00	4.1	171.50	6.2
January to June 1969	97.83	27.1	181.43	5.8
OHIO:				
Fee schedule (notes d and e)	91.00		177.50	
After initiating reasonable-charge concept (notes b and f)	92.00	1.1	177.50	-
January to June 1969	84.00	-8.7	178.19	.4
CALIFORNIA:				
Fee schedule (note g)	83.00		220.00	
January to March 1970 (note h)	107.91	30.0	291.36	32.4

a Period immediately prior to November 1, 1967. The fee schedule used was effective November 1, 1965.

b Period about 6 months after going off fee schedules.

c Period immediately prior to January 1, 1968. The fee schedule used was effective July 1, 1966.

d Period immediately prior to August 10, 1967. The fee schedule used was effective July 1, 1967.

e Paid amounts represent the amounts that would be allowable under the fee schedules.

Code 3515-cholecystectomy		Code 4612 or 4650-dilation and curettage		Code 4614 or 4617-total hysterectomy	
Average amount paid	Increase over fee schedule and prior period rates (percent)	Average amount paid	Increase or decrease over fee schedule and prior period rates (percent)	Average amount paid	Increase or decrease over fee schedule and prior period rates (percent)
$250.00		$ 40.00		$250.00	
297.50	19.0	71.00	77.5	330.00	32.0
305.56	2.7	70.33	-1.0	345.55	4.7
262.00		64.00		260.50	
298.50	13.9	81.50	27.3	300.50	15.4
322.83	8.2	97.17	19.2	309.17	2.9
290.00		75.00		290.00	
295.00	1.7	85.00	13.3	344.00	18.6
300.35	1.8	88.39	4.0	294.61	-14.4
330.00		83.00		330.00	
408.88	23.9	116.05	39.8	460.90	39.7

f
There are some differences between the averages, obtained from OCHAMPUS, shown in the interim report, and these averages due to differences in sampling methods.

g
Period immediately prior to July 1, 1967. The payments were based on Medicare Manual and Schedule of Allowances.

h
January to March 1970 allowable payments used for California were based on December 1968 "frozen" profiles.

COMPARISON OF PSYCHIATRIC BENEFITS AND RESTRICTIONS

FOR INPATIENT CARE UNDER CHAMPUS

AND OTHER SELECTED PROGRAMS

Criteria	CHAMPUS	Medicare
Covers all inpatient expenses except convenience items	Yes	Yes
Unlimited total dollar payment	Yes	Yes
Unlimited number of days of care	Yes, with authorization required after 90 days	No, limited to 190 days in lifetime (note a)
Beneficiary considered inpatient for periods before and after hospitalization	Yes, 30 days before, 120 days after (note b)	No
Program pays for services without requiring cost sharing from patient	No, dependents of active duty members pay $1.75 per day or $25 per stay, whichever is greater. Other beneficiary types pay 25% of reasonable charges	No, patient pays $52 first 60 days; $13 per day for next 30 days; $26 per day for last 60 days in a benefit period (note c)
Availability of supplemental benefits plan	Not applicable	No

[a]Days of care in a nonpsychiatric hospital for mental illness are not counted against the 190 lifetime days.

[b]Considering these periods as inpatient care, charges for psychiatric and other types of care rendered to dependents of active duty personnel are paid by CHAMPUS in their entirety; whereas, if the periods are construed as outpatient care, the sponsor must pay 20% of the costs; and, if the deductible has not been met, pay the portion needed to pay the annual deductible of $50 for an individual or $100 for a family. For other types of beneficiaries the savings to the sponsor would be less because CHAMPUS would pay only 75% of the charges.

[c]Amounts to be paid by the patient are subject to adjustment annually by the Secretary of Health, Education, and Welfare.

EXHIBIT C

Medicaid		Federal Employees Program		Other programs
California	Colorado	High option	Low option	Colorado private Blue Shield program
Yes	Yes	Yes	Yes	Yes
Yes	Yes	No	No	No
Yes, after 8 days authorization required or removal to a county or State hospital required if hospitalized in a private hospital	No, 18 days each benefit period. The State must approve additional care	No, 365 days per hospital confinement	No, 30 days per hospital confinement	No, after 6 months of treatment, physician must certify that patient has improved, or will improve, or benefits cease
No	No	No	No	No
Yes	Yes	No	No	No
Not applicable	No	Yes, $100 deductible, 20% cost sharing, lifetime maximum of $50,000	Yes, $150 deductible, 25% cost sharing, lifetime maximum of $20,000	Yes, $100 deductible, 20% cost sharing, $10,000 maximum per year, or $25,000 lifetime per beneficiary

COMPARISON OF PSYCHIATRIC BENEFITS AND RESTRICTIONS FOR OUTPATIENT CARE UNDER CHAMPUS AND OTHER SELECTED PROGRAMS

Criteria	CHAMPUS	Medicare
Program covers all services of psychiatrists, psychologists, testing, and related specialists	Yes	Yes
Unlimited total dollar amount paid by the program	Yes	No, limited to $250 per year
Unlimited visits by physicians without prior authorization	Yes	Yes
Program pays for services without requiring payment of a deductible from patient	No, deductible of $50 per individual, or $100 per family, per year	No, deductible of $50 per individual per year
Program pays for services without requiring cost sharing from patient	No, Dependents of active-duty members pay 20%. All other beneficiary types pay 25%	No, 20% of cost paid by patient

EXHIBIT D

Medicaid		Federal Employees Program		Other programs
California	Colorado	High option	Low option	Colorado private Blue Shield program
No, covers psychiatric services only	Yes	Yes	Yes	Yes
Yes	Yes	No, $50,000 lifetime limitation	No, $20,000 lifetime limitation	No, $10,000 benefit year and $25,000 lifetime limitations
No, limited to 6 visits in a 6-month period	No, limited to 12 visits per year	Yes	Yes	Yes
Yes	Yes	No, $100 deductible per person	No, $150 deductible per person	No, $100 deductible per person
Yes	Yes	No, 20% of cost paid by patient	No, 25% of cost paid by patient	No, 50% of cost paid by patient

APPENDIX

Congress of the United States
House of Representatives
Committee on Appropriations
Washington, D.C. 20515

October 20, 1969

Honorable Elmer B. Staats
Comptroller General of the
United States
U. S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Staats:

In the last several years the cost to operate the military Medicare program has increased substantially. The program was first instituted in fiscal year 1957 at a cost of about $24,500,000. For fiscal years 1966, 1967 and 1968 expenses were about $75,616,000, $108,676,000 and $162,374,000, respectively. The preliminary report of obligations for fiscal year 1969 shows $177,366,000, and the budget estimate for 1970 is in excess of $200 million.

While testimony before the Committee indicates that there has been an annual increase in the number of beneficiaries and an increase in the cost of benefits received, it appears that cost increases are greater than might be expected and not in proportion to benefits derived.

The Committee is interested in knowing whether the fees being paid participating physicians, hospitals, or others for services rendered are in line with those which would be customarily charged to non-subscribers of medical-hospitalization programs. We would also like to know whether any substantial profits have been realized by anyone servicing the program.

We would appreciate the General Accounting Office making a comprehensive review of the military Medicare program and reporting to the Committee on its findings as soon as possible. If you so

desire, various aspects may be reported individually, with a summary report upon completion of all work. The review should include, but not necessarily be limited to the following areas:

1. An evaluation of the reasonableness of total cost incurred by fiscal years.

2. The reasonableness of fees charged and profits realized by participating individuals, medical facilities or other organizations.

3. The reasonableness of expenses incurred in the administration of the program.

4. A determination of the eligibility of participants.

5. The adequacy of audits made by responsible Government agencies of the administration and operation of the program and benefit payments made under the program.

Sincerely,

Chairman