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Report to Rep. George H. Mahon, Chairman, House Committee on Appropriations; Sen. John L. McClellan, Chairman, Senate Committee on Appropriations; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs (1200); Health Programs: Reimbursement Policies and Utilization Controls (1208).
Contact: Human Resources Div.
Budget Function: National Defense: Department of Defense - Military (except procurement & contracts) (051); Health: Health Care Services (551).
Organization Concerned: Department of Defense.
Congressional Relevance: House Committee on Appropriations; Senate Committee on Appropriations.
Authority: H. Rept. 94-1475.

Savings could be realized if the Department of Defense (DOD) used the Medicare reimbursement method in paying hospital bills under its Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Findings/Conclusions: An analysis of the effect of using the Medicare hospital reimbursement method for CHAMPUS for a random sample of 25 of 100 hospitals with relative large volumes of CHAMPUS business showed that: (1) CHAMPUS costs in fiscal year 1975 would have been about $1.4 million (11.2%) less than the billed charges of $12.8 million; and (2) the projected difference in CHAMPUS costs for the 100 hospitals would have been between about $2.2 million and $3.9 million less than the billed charges of $31 million. A major objection by hospitals and some related associations to using the Medicare method for CHAMPUS payments was that the increased administrative burden would not be justified by the small number of CHAMPUS patients at most hospitals. However, this concern might be alleviated by applying the method only to hospitals with large volumes of program business. Several alternate reimbursement systems are currently being studied by the Department of Health, Education, and Welfare. (DJM)

REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

Information On Use Of Medicare Reimbursement Method To Determine Hospital Payments Under The Civilian Health And Medical Program Of The Uniformed Services

Department of Defense

Savings could be realized if Defense used the Medicare reimbursement method for paying hospital bills under its Civilian Health and Medical Program of the Uniformed Services.

Hospitals and such organizations as the American Hospital Association object to using the Medicare reimbursement method for this program. Some of their concerns could probably be eliminated by applying the method only to hospitals with large volumes of program business.

This report also describes efforts by the Department of Health, Education, and Welfare to develop alternative reimbursement systems for Medicare and Medicaid.

HRD-77-128

JULY 27, 1977

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

B-133142

The Honorable John L. McClellan
Chairman, Committee on Appropriations
United States Senate

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

This report is in response to a request in House Report 94-1475, on the appropriations bill for the Department of Defense for fiscal year 1977. We were asked to examine the feasibility and advisability of and the cost savings that would result from using Medicare physician and hospital reimbursement criteria for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). As later agreed with your offices, we limited our review to hospital reimbursements and looked into the feasibility of using several alternative payment methods for CHAMPUS.

In May 1977 we briefed your offices on the initial results of our review. We were asked to curtail any additional audit work and prepare a report on the information already obtained. As requested, we did not obtain written comments on the report from the Department of Defense or the American Hospital Association, but we did discuss the contents with them.

We analyzed the effect of using the Medicare hospital reimbursement method for CHAMPUS for a random sample of 25 of 100 hospitals with relatively large volumes of CHAMPUS business. We found that:

--CHAMPUS costs in fiscal year 1975 would have been about $1.4 million (11.2 percent) less than the billed charges of $12.8 million.

--The projected difference in CHAMPUS costs for the 100 hospitals would have been between about $2.2 million and about $3.9 million (7.1 percent to 12.6 percent) less than the billed charges of $31 million.

These estimates of cost savings do not include any increases in costs to the Department of Defense for administering the program, to fiscal agents that process claims, or to hospitals. Based on the work we had done through May 1977, however, it did not appear that these costs would be significant in relation to the potential savings.

Officials of hospitals that we visited and of organizations, such as the American Hospital Association, that represent hospitals object to the use of the Medicare reimbursement method for CHAMPUS payments. They said that the Medicare reimbursement method does not reimburse hospitals for all costs attributable to Medicare patients. Some hospital officials also said that (1) they might refuse to participate in CHAMPUS if the Medicare reimbursement method is used and (2) unless hospitals were required to accept the CHAMPUS payment under the Medicare method as payment in full, they might bill the beneficiaries for the difference between the CHAMPUS payment and actual charges. In addition, officials of several hospitals we visited said they would increase their rates to recover from the public the "discount" CHAMPUS would receive under the Medicare reimbursement method.

A major objection to using the Medicare method for CHAMPUS payments was that the increased administrative burden would not be warranted in view of the small number of CHAMPUS patients at most hospitals. Perhaps this concern could be alleviated by requiring only hospitals with relatively large volumes of CHAMPUS business to use the Medicare method. For example, providers of inpatient care with over $50,000 worth of CHAMPUS business in fiscal year 1975 represented about 21 percent of all the CHAMPUS inpatient care providers and accounted for about 81 percent of total CHAMPUS inpatient payments. Therefore, if the Medicare method were applied only to hospitals with a relatively high volume of CHAMPUS business, most CHAMPUS inpatient payments could be determined by the Medicare method without causing an undue administrative burden on hospitals with a small number of CHAMPUS patients.

Several alternatives to the Medicare reimbursement method are being studied by the Department of Health, Education, and Welfare for possible use for the Medicare and Medicaid programs. None of these systems, however, has been developed to the extent that it could be used nationally for these programs or CHAMPUS.

Detailed information on these matters is included in appendix I, and further data on the estimated cost savings is in appendix II.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time we will send copies to interested parties and make copies available to others upon request.

Comptroller General
of the United States

Contents

ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
HEW	Department of Health, Education, and Welfare
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services

INFORMATION ON USE OF MEDICARE REIMBURSEMENT METHOD TO DETERMINE HOSPITAL PAYMENTS UNDER THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

INTRODUCTION

The Conference Report on Department of Defense Appropriations for 1977 (House Report 94-1475) directed us (1) to study the feasibility and advisability of requiring Social Security Act criteria of reasonable cost or reasonable charge for Medicare to be applied to payments under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and (2) to estimate the cost savings from using such criteria. The offices of the House and Senate Appropriations Committees later asked us to limit our review to the application of Medicare criteria to CHAMPUS hospital costs because the Department of Defense was already using Medicare criteria for making physician payments under CHAMPUS.

CHAMPUS

CHAMPUS provides financial assistance for medical care provided by civilian sources to dependents of active duty members, retirees, their dependents, and dependents of deceased members of the uniformed services. 1/ The program is administered by the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), at Fitzsimons Army Medical Center near Denver, under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs).

CHAMPUS benefits are divided into two categories--basic and handicap. Basic benefits cover inpatient and outpatient medical services, including medical treatment and surgery, psychiatric care, drugs, X-rays, and clinical laboratory tests. Handicap benefits cover remedial and custodial services for moderately or severely mentally retarded or seriously physically handicapped spouses and children of active duty members only.

1/The uniformed services are the Army, Navy, Air Force, Marine Corps, and Coast Guard and the commissioned corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

In fiscal year 1975, CHAMPUS payments for inpatient care at about 8,100 institutions in the United States, Canada, Mexico, and Puerto Rico were about $286 million. For inpatient hospital care, dependents of active duty personnel pay a total of $25 an admission or $4.10 a day, whichever is greater; other beneficiaries pay 25 percent of charges.

Medicare

Medicare is a Federal health insurance program for the aged, disabled, and certain others. It is authorized by title XVIII of the Social Security Act and administered by the Health Care Financing Administration of the Department of Health, Education, and Welfare (HEW).

The Medicare program has two parts: hospital insurance (Part A) and supplementary medical insurance (Part B). Part A covers inpatient hospital care, and after a hospital stay, inpatient care in a skilled nursing facility and home health care. Part B covers physician services, outpatient hospital services, and certain other services. Medicare does not cover nonmedical or custodial care.

In 1976 about 24.3 million persons were eligible for Medicare hospital insurance benefits. In fiscal year 1976 Medicare hospital insurance benefits totaled about $12.2 billion. About 6,800 hospitals participate in Medicare.

Medicare beneficiaries share the costs of their inpatient hospital care with the Government by paying deductibles and coinsurance. For example, for the first 60 days of inpatient hospital care, Medicare pays for all covered services over $124; from the 61st through the 90th day of inpatient hospital care, Medicare pays for all covered services except for a coinsurance payment of $31 a day paid by the beneficiary.

Scope of review

We reviewed legislation, regulations, policies, and practices relating to CHAMPUS, Medicare, and other reimbursement methods. We obtained cost and statistical data from Medicare cost reports and OCHAMPUS to estimate the cost of hospital care for CHAMPUS patients under the Medicare reimbursement method for a random sample of hospitals for which Mutual of Omaha processed CHAMPUS claims.

In addition, we obtained information from and spoke with representatives of

--OCHAMPUS,

--the Office of the Assistant Secretary of Defense (Health Affairs),

--HEW,

--27 hospitals in 7 States,

--four CHAMPUS fiscal agents,

--selected Medicare intermediaries,

--the Blue Cross Association,

--the American Hospital Association,

--the Federation of American Hospitals, and

--the Hospital Financial Management Association.

In May 1977 we briefed the offices of the Senate and House Appropriations Committees on the results of our fieldwork to that point. We were asked to curtail any additional fieldwork and prepare our report on the basis of information already obtained. Therefore, the scope of our review was limited in that we did not

--obtain much data on the additional administrative costs that would be incurred by OCHAMPUS, hospitals, and fiscal agents if Medicare criteria were used for CHAMPUS or

--make any attempt to estimate cost savings from changing to the Medicare criteria for hospitals for which the Blue Cross Association processed CHAMPUS claims.

COMPARISON OF CHAMPUS AND MEDICARE HOSPITAL REIMBURSEMENT METHODS

CHAMPUS

OCHAMPUS contracts with fiscal agents to process and pay claims. Until 1976 OCHAMPUS contracted with two fiscal agents--Mutual of Omaha and the Blue Cross Association--to handle inpatient claims. Mutual of Omaha served 17 States, Canada, and Mexico. The Blue Cross Association subcontracted with 52 Blue Cross plans to handle inpatient claims in the other 33 States, the District of Columbia,

APPENDIX I

and Puerto Rico. For fiscal year 1975 Mutual of Omaha paid about $107 million on the basis of billed charges for inpatient care and Blue Cross plans paid about $179 million under various reimbursement methods.

Of the 52 Blue Cross plans serving as CHAMPUS fiscal agents, 31 paid some or all CHAMPUS hospital claims on the basis of costs or costs plus a percentage of costs, or applied a discount to the hospitals' billed charges. The Blue Cross Association estimates that in fiscal year 1975 CHAMPUS paid $5.2 million less than billed charges as a result of these favorable reimbursement arrangements.

In February 1976 the Defense Department began competitive fixed-price contracting for processing and paying CHAMPUS claims. As of June 1, 1977, contracts covering 37 States and the District of Columbia had been awarded. Before such contracting, CHAMPUS hospital claims in 34 States were paid on the basis of billed charges. Claims in the other 16 States and the District of Columbia were paid on various other bases. According to the Director of OCHAMPUS, some fiscal agents awarded competitive fixed-price contracts will pay CHAMPUS hospital claims by applying a discount to the hospitals' billed charges. However, he could not tell us how many of the new fiscal agents would do so.

Medicare

HEW contracts with private organizations (intermediaries) to help it administer Part A of Medicare. The principal intermediary is the Blue Cross Association, which subcontracts most of its work to 72 Blue Cross plans throughout the United States. On July 1, 1975, Blue Cross was the intermediary for about 90 percent of the approximately 6,800 hospitals participating in Medicare. The other participating hospitals deal directly with HEW or with nine other intermediaries.

Intermediaries pay hospitals and other providers for services rendered to Medicare beneficiaries and transmit information and instructions between HEW and the hospitals.

Medicare reimburses hospitals on the basis of the lesser of (1) the reasonable costs of services provided to program beneficiaries or (2) the customary charges for such services. Hospitals can include most of their costs in determining their allowable Medicare costs, but they are

required to exclude certain costs and must calculate others as specifically prescribed by HEW. For example, HEW requires hospitals to exclude costs for research not related to patient care, bad debts of non-Medicare patients, and charity cases. Also, in computing depreciation, HEW requires that hospitals generally use historical costs of assets and straight-line depreciation instead of accelerated depreciation methods.

In recognition of the purported above-average costs of nursing care provided to aged, pediatric, and maternity patients, Medicare allows an additional 8-1/2 percent for inpatient nursing salary costs for such care as a reimbursable cost of the provider. In addition, HEW pays proprietary hospitals a return on their equity capital.

After hospitals determine their allowable costs by department or cost center, they must allocate the costs of their non-revenue-producing departments or cost centers (such as maintenance, housekeeping, and accounting departments) to those that produce revenue, including those for which the hospitals assess charges (such as the operating room, laboratory, and radiology department). Then, hospitals must apportion the costs of their revenue-producing departments or cost centers among Medicare and non-Medicare patients either using a departmental or a combination apportionment method.

Departmental method

Hospitals with more than 100 beds must use the departmental apportionment method. Under this method, Medicare payments for routine services (room, board, and nursing) and special care units (such as coronary or intensive care units) are determined by dividing the allowable costs for these services by the total number of inpatient days of care provided in each category or unit and multiplying the result (average cost per day) by the Medicare patient days of care provided. Medicare ancillary department (such as laboratory or radiology departments) payments are determined by calculating a ratio of total costs to total charges for each ancillary department and applying the ratio to the total charges for that department which apply to the Medicare program.

Combination method

Hospitals with fewer than 100 beds must use the combination apportionment method. Under this method, ancillary

department and special care unit costs are aggregated; a separate cost per day for special care units or cost for each ancillary department is not calculated. Medicare ancillary costs are determined by applying the ratio of total ancillary costs to total ancillary charges to Medicare beneficiary charges, excluding labor and delivery rooms. The Medicare share of special care unit costs is calculated using an average cost per day. Routine service costs applicable to Medicare are calculated as they are under the departmental method.

After the allowable Medicare costs for routine services, special care units, and ancillary departments are determined, the hospital's allowable return on equity (for proprietary facilities) is calculated and added to allowable costs. Deductibles and coinsurance paid by Medicare patients, net of bad debts, and any amounts paid to the hospital for Medicare patients by other payors are deducted. The result is the amount due the hospital for its Medicare patients for the year. If hospitals' allowable costs for the year exceed charges, reimbursement is limited to the charges.

The Medicare payment process consists of two basic steps--interim payments and a yearend settlement. The interim payments process involves estimating the amount due to providers for covered services furnished to Medicare beneficiaries on the basis of prior years' actual payments and periodically paying these amounts to providers. Such interim payments are made throughout the accounting period.

Within 90 days after the end of its fiscal year, the provider submits a cost report to the intermediary showing reimbursable costs. Upon final review and, if necessary, audit of the cost report, the intermediary determines the exact amount owed by the Medicare program to the provider, or vice versa. The intermediary then makes a settlement based on this determination. Providers can appeal the decisions of the fiscal intermediary on their cost settlements.

Implementation of Medicare hospital reimbursement method for CHAMPUS

Last year, the Senate Appropriations Committee recommended implementation of a reimbursement system for CHAMPUS hospital payments that was consistent with other Government programs. OCHAMPUS has been developing plans for implementing the Medicare reimbursement method for CHAMPUS.

OCHAMPUS was considering excluding hospitals with 10 CHAMPUS admissions or less and $10,000 or less in CHAMPUS payments annually from the requirement to use the Medicare method. These hospitals and the relatively few hospitals participating in CHAMPUS that do not participate in Medicare would be reimbursed under the method currently used by their fiscal agents. (See p. 4.) Facilities other than hospitals that do not participate in Medicare will be reimbursed at rates negotiated between CHAMPUS and the individual facilities. OCHAMPUS also plans to allow hospitals the 8-1/2-percent differential in costs of nursing care allowed by Medicare, but for a different reason. The Director of OCHAMPUS believes that this allowance is justified for CHAMPUS patients because many of them are maternity cases for which hospitals commonly do not recover their costs. (See p. 8.) We did not assess the reasonableness of using the 8-1/2-percent differential for CHAMPUS. However, following whatever provisions apply for Medicare will simplify the administration of the Medicare method for CHAMPUS.

COST SAVINGS TO CHAMPUS FROM USING MEDICARE REIMBURSEMENT METHOD

To obtain an indication of the potential cost savings to CHAMPUS from using the Medicare hospital reimbursement method, we applied that method to fiscal year 1975 CHAMPUS patients' services provided by a random sample of 25 of the 100 hospitals which had the greatest volumes of CHAMPUS business and for which Mutual of Omaha was the CHAMPUS fiscal agent. Under the Medicare method, the cost savings on payments made to the 25 hospitals would have been about $1.4 million (11.2 percent) less than billed charges of about $12.8 million. (See app. II.) At a 95-percent confidence level, the projected savings for the 100 hospitals would have been between about $2.2 million and $3.9 million (about 7.1 percent to 12.6 percent) of charges of about $31 million.

The 100 hospitals represented about 29 percent of the total inpatient care payments made by Mutual of Omaha in fiscal year 1975; the total Mutual of Omaha payments ($107 million) represented about 37 percent of the total CHAMPUS inpatient care payments of about $286.9 million. 1/

1/Hospitals for which Mutual of Omaha was the fiscal agent were selected for our initial estimate of potential cost savings because much of the necessary data was not readily available for hospitals for which Blue Cross plans were the fiscal agents.

The computation of cost savings for the 25 hospitals was by the Medicare departmental method, which would reflect the differences in departmental usage between CHAMPUS and Medicare patients. (See notes, p. 17.) The savings estimate does not include increases in administrative costs related to adoption of the Medicare reimbursement method.

At OCHAMPUS's request, a fiscal agent estimated the savings for a few hospitals using the gross ratio method (that is, computing the ratio of total allowable facility costs to total facility charges and applying it to total CHAMPUS charges). Using this method for 165 hospitals, we estimated that program savings would be about 14.8 percent. For the 25 hospitals in our sample mentioned above, the difference between CHAMPUS costs and charges under this method would have been about 13.4 percent. Because departmental ratios differ and CHAMPUS patients' usage by department differs considerably from that of Medicare patients, we believe the departmental method provides a more accurate estimate of the cost savings.

Representatives of the American Hospital Association and the Federation of American Hospitals believed that the savings to CHAMPUS from using Medicare reimbursement principles would be limited because CHAMPUS has a high volume of maternity patients and hospital costs often exceed charges for labor and delivery rooms. The cost data for the 25 hospitals in our sample did not support this argument. Of the 25 hospitals sampled, 22 served CHAMPUS maternity patients.

In 21 of the 22 hospitals, costs exceeded charges for labor and delivery rooms, often by a substantial amount. However, the amounts by which charges exceeded costs in other hospital departments almost always more than compensated for the losses incurred for labor and delivery rooms. Further, OCHAMPUS records show that maternity care accounts for only about 17 percent of CHAMPUS inpatient costs.

INCREASED ADMINISTRATIVE COSTS

Use of the Medicare hospital reimbursement method for CHAMPUS would result in increased administrative costs for OCHAMPUS, fiscal agents, and hospitals. Information was not readily available to estimate the increased costs nationwide. However, most persons we contacted who expressed an opinion on this subject believed that such costs would not be substantial.

OCHAMPUS

The OCHAMPUS Director believes that OCHAMPUS would incur additional administrative costs of about $500,000 annually if the Medicare reimbursement method were used to pay CHAMPUS hospital providers. About half of these costs will be primarily for additional personnel to

--develop policy and instructions for providers,

--monitor fiscal agent performance in applying the reimbursement methods,

--coordinate with Medicare, and

--investigate cases of possible deficiencies or abuses in applying the Medicare method.

The rest of the increased cost would be for data processing. In addition, some HEW costs for administering the program, such as Medicare intermediary costs of auditing providers, might be shared by OCHAMPUS.

Fiscal agents

CHAMPUS fiscal agents and/or Medicare intermediaries will incur additional administrative burdens if the Medicare reimbursement method is applied to CHAMPUS hospital payments. Some of these burdens would involve

--calculating and maintaining records of interim payments to hospitals,

--making desk reviews of CHAMPUS cost reports, and

--handling disputes and appeals by hospitals.

Mutual of Omaha estimates indicate that, if it were the fiscal agent for about half of the CHAMPUS hospital providers, its additional administrative costs for reimbursing hospitals using the Medicare method would be about $979,000 annually, excluding the costs of field audits. Assuming that the additional field audit work for CHAMPUS would be done by the Medicare intermediary, the additional audit costs for CHAMPUS would be about $646,000 annually. These estimates are based on the assumption that only hospitals with more than $10,000 in CHAMPUS payments and more than 10 CHAMPUS admissions would be required to use the Medicare method. The increased costs would be less if the Medicare methods were applied only to hospitals with

greater amounts of CHAMPUS payments, say $25,000 or $50,000 annually. Three of the four CHAMPUS fiscal agents we visited believed that their increased costs for applying the Medicare method to CHAMPUS would not be substantial. The other agent did not give us an estimate of such costs.

The Blue Cross Association could not provide an estimate of the increased costs to Blue Cross plans nationally if the Medicare reimbursement method were applied to CHAMPUS. As indicated on page 4, Blue Cross plans are the principal intermediaries for Medicare. Representatives of one Blue Cross plan we visited, which is a Medicare intermediary, said that their costs would not increase much if the scope of their field audits were expanded to include CHAMPUS hospital providers. Also, data provided by one plan indicated that about $66,000 (about 4.5 percent) of its audit and claim payment department expenses for fiscal year 1976 would be allocated to CHAMPUS from the Medicare and Medicaid programs. Another Blue Cross plan with agreements with 121 hospitals estimated that its administrative costs would increase by about $24,000 annually.

Hospitals

The additional administrative efforts that would probably be required of a hospital if the Medicare reimbursement method were used for CHAMPUS include

--maintaining a CHAMPUS log showing CHAMPUS hospital charges by department;

--keeping a record of coinsurance due from and paid by CHAMPUS patients; and

--preparing a separate cost report for CHAMPUS, based primarily on the Medicare cost report.

Of the 27 hospitals we visited, 17 did not provide us with opinions or estimates of what their increased administrative costs would be for using the Medicare method for CHAMPUS payments. Available information, however, indicated that such costs would not be substantial. Officials of four hospitals said that the additional administrative burden would not be significant, and officials of another said that the costs would be minimal. The other five hospitals gave the following estimates of administrative costs:

--About $4 for each CHAMPUS admission.

--About $5 to $10 per CHAMPUS claim plus $1,000 to $2,000 to complete the annual cost report

--About $300 to complete the cost report.

--Over $1,000 per year.

--About $5,400 to maintain a computerized CHAMPUS patient log and prepare the CHAMPUS cost report.

An official of one hospital told us that OCHAMPUS could help offset the hospital's additional cost of applying the Medicare reimbursement method to CHAMPUS payments by simplifying its claim form or making the form similar or identical to the Medicare claim form. He said the CHAMPUS hospital claim form is the most difficult and time-consuming claim form to complete. American Hospital Association representatives made a similar observation.

OBJECTIONS TO MEDICARE REIMBURSEMENT METHOD

Hospitals we visited and representatives of the American Hospital Association, the Federation of American Hospitals, and the Hospital Financial Management Association we contacted opposed using the Medicare cost reimbursement method. Some of their objections were:

--Hospitals are not reimbursed for all costs that they believe are valid.

--Retrospective cost reimbursement provides limited incentives for economy or efficiency.

--Medicare reimbursement does not provide enough funds for working capital or expansion and improvements.

--The Medicare method of apportioning costs does not consider the extra administrative efforts required of hospitals for Medicare patients.

--It would not be appropriate to require CHAMPUS to use a cost-based reimbursement method that is generally recognized as inflationary.

A principal objection raised by the hospitals and hospital associations was that the increased administrative burden would not be warranted in view of the small number of CHAMPUS patients at most hospitals. This problem could be alleviated by requiring only hospitals with

relatively large volumes--for example, more than $50,000 annually--of CHAMPUS business to use the Medicare reimbursement method. Fiscal year 1975 data developed during our review and presented in the following table shows that most providers of inpatient care to CHAMPUS patients have little CHAMPUS business.

CHAMPUS admissions/ payments criteria	CHAMPUS providers Number	Percent	CHAMPUS inpatient payments Amount	Percent
			(millions)	
1. a. Ten admissions or fewer and $10,000 or less	2,994	36.9	$ 6.5	2.3
b. More than 10 admissions and more than $10,000	5,126	63.1	280.4	97.7
	8,120	100.0	$286.9	100.0
2. a. Less than $25,000	5,426	66.8	$ 29.3	10.2
b. $25,000 or more	2,694	33.2	257.6	89.8
	8,120	100.0	$286.9	100.0
3. a. Less than $50,000	6,449	79.4	$ 55.8	19.5
b. $50,000 or more	1,671	20.6	231.1	80.5
	8,120	100.0	$286.9	100.0
4. a. Less than $100,000	7,196	88.6	$ 94.2	32.8
b. $100,000 or more	924	11.4	a/192.7	67.2
	8,120	100.0	$286.9	100.0

a/California, Florida, and Texas account for about 37.4 percent of these costs.

This table shows that OCHAMPUS could greatly reduce the number of hospitals required to use the Medicare reimbursement method for paying CHAMPUS claims and still have a high percentage of its hospital payments computed under the Medicare method. For example, criteria of more than 10 CHAMPUS admissions and $10,000 in CHAMPUS payments annually would subject about 63 percent of the inpatient care providers, accounting for about 98 percent of inpatient payments, to the Medicare reimbursement method. A criterion of $50,000 or more of CHAMPUS business annually would require about 21 percent of the inpatient care providers, accounting for about 81 percent

of total inpatient payments, to use the Medicare method. A criterion of $100,000 or more of CHAMPUS business annually would cover about 11 percent of the inpatient care providers and account for about two-thirds of the total inpatient payments.

IMPACT ON PATIENTS

Officials of some hospitals said that, if the Medicare reimbursement method is used for CHAMPUS patients, they may either require CHAMPUS patients to pay the difference between the amount paid by CHAMPUS and their billed charges or refuse to accept payment from CHAMPUS and bill the patient directly for total charges.

The Director of OCHAMPUS said that he would not want to adopt the Medicare hospital reimbursement method unless hospitals participating in Medicare would be required to accept CHAMPUS payments as payment in full. 1/ He believes that such a requirement is necessary to protect CHAMPUS beneficiaries. Several hospitals we visited said that, if such a requirement were implemented, they would increase their charges to the public to recover the difference between billed charges and the CHAMPUS payment. The hospitals argue that payments under the cost-based reimbursement system of Medicare do not cover all their costs.

ALTERNATIVES TO COST-BASED REIMBURSEMENT

The Congress and others have expressed concern about the inflationary effects of the Medicare system because it is a retrospective cost reimbursement system for hospitals. Most authorities reportedly agree that retrospective cost reimbursement has led to increased hospital costs because there is little incentive to control or reduce costs in such a system. In recognition of this problem, HEW, Blue Cross plans, and States are conducting experiments, demonstrations, and programs to control hospital costs. These efforts generally involve using alternative payment methods or imposing controls on hospital rates.

1/Under the Medicare program, payments to hospitals by Medicare, together with the coinsurance payment by the beneficiary, are generally considered payment in full and the hospitals cannot bill the patients for any additional amounts for covered services.

Prospective reimbursement

Many experiments with alternative reimbursement methods involve prospective reimbursement--that is, the establishment of payment rates before the period over which the rates are to be applied. Methods that can be used to establish prospective reimbursement rates include competitive bidding, negotiation, budget review, budget review by exception, economic formula, or a combination thereof. According to HEW, prospective reimbursement systems have not been adequately developed for nationwide use by Medicare or Medicaid. In general, the intensive effort required to implement prospective reimbursement systems makes them impractical for CHAMPUS because of the small volume of CHAMPUS business in most hospitals. However, if Medicare and Medicaid adopt such systems, it may become feasible for CHAMPUS to use them.

Medicaid competitive bid

In January 1977 HEW solicited proposals for grants to evaluate the feasibility of a competitive bid approach to reimbursing hospitals for Medicaid inpatient care. HEW's objectives are to stop paying the highest rates for hospital care except when absolutely necessary and to create greater incentives for hospitals to control costs by using prospective rates and competition among hospitals in selected major urban areas. This approach involves (1) determining the prices Medicaid will pay for specified inpatient hospital services through competition among hospitals at the beginning of each fiscal year and (2) eliminating hospitals with the highest prices from participation in Medicaid.

HEW recognizes that some problems have to be resolved before its competitive bid experiment can be implemented. For example, some Medicaid patients may have physicians who do not have practicing privileges at the hospitals with contracts. Therefore, the patients might be required to use a physician other than the one of their choice. Also, many teaching hospitals would probably be excluded from the program because their costs generally are higher than those of other hospitals. HEW's solicitation asks States submitting proposals to describe how they will deal with these problems.

Because there are several areas in the country with high concentrations of CHAMPUS patients, we discussed the feasibility of using the proposed Medicaid competitive bid experiment for CHAMPUS patients with the Director of OCHAMPUS and representatives of the American Hospital Association. They believed that the concept had potential for use in CHAMPUS in some areas if the physician privilege problem could be resolved.

Rate review programs

In 1976 the American Hospital Association identified 25 States that had hospital rate review programs in operation and 13 States that were considering implementing such programs. The Association defined a hospital rate review program as one in which a committee or board monitors, reviews, or establishes the rates, charges, or revenues of a group of health care facilities. The 25 operating rate review programs identified included 2,070 (35 percent) of the Nation's community hospitals.

These programs varied depending on the nature of hospital participation (voluntary or mandatory), the degree of control exercised by the rate-reviewing authority, the types of payors covered, and the hospital payment methods used. According to the Association, most operating rate review programs do not cover all hospitals in the States. Medicare and Medicaid participate in some of these programs by accepting the rates set as allowable charges under these programs.

APPENDIX II

SUMMARY OF ESTIMATED COST SAVINGS TO CHAMPUS USING MEDICARE DEPARTMENTAL METHOD AT 25 HOSPITALS

Hospital	Allowed CHAMPUS charges (note a)	Medicare departmental method: Estimated CHAMPUS cost (note a)	Medicare departmental method: Estimated cost savings	Medicare departmental method: Percent savings
A	$ 714,480	$ 677,194	$ 37,286	5.2
B	1,161,517	973,903	187,614	16.2
C	622,433	523,201	99,232	15.9
D	369,805	324,025	45,780	12.4
E	572,903	569,433	3,470	.6
F	478,101	439,238	38,863	8.1
G	479,103	399,485	79,618	16.6
H	418,701	407,562	11,139	2.7
I	390,709	313,071	77,638	19.9
J	497,301	448,089	49,212	9.9
K	909,778	740,982	168,796	18.6
L	265,677	265,677	0	0
M	152,269	145,831	6,438	4.2
N	301,537	274,099	27,438	9.1
O	477,083	441,156	35,927	7.5
P	280,289	273,506	6,783	2.4
Q	435,529	403,948	31,581	7.3
R	358,315	322,640	35,675	10.0
S	835,557	835,557	0	0
T	321,572	318,784	2,788	.9
U	266,339	219,043	47,296	17.8
V	781,079	663,602	117,477	15.0
W	593,299	491,138	102,161	17.2
X	248,178	247,041	1,137	.5
Y	909,079	678,869	230,210	25.3
	$12,840,633	$11,397,074	$1,443,559	11.2

a/Includes coinsurance and amounts payable by other payors.
(See note 1 on the following page.)

NOTES

1. Coinsurance payments by CHAMPUS beneficiaries and payments to hospitals by other payors, such as workmen's compensation, for CHAMPUS beneficiaries have not been deducted from the estimated CHAMPUS costs under the Medicare reimbursement method. Under the Medicare method these amounts would be subtracted from costs to determine the Government's liability for CHAMPUS beneficiaries. Since these amounts are included in both the allowed CHAMPUS charges and estimated CHAMPUS costs, they do not affect the estimated savings shown.

2. CHAMPUS routine service costs were estimated by multiplying the average routine service cost per day for Medicare patients by the number of CHAMPUS routine service days. Accordingly, to the extent that the Medicare average routine service cost per day included the 8-1/2-percent allowance for nursing care costs, that amount was also included in the estimated CHAMPUS routine service costs. The estimated cost savings for CHAMPUS patients would, therefore, be somewhat understated because the Medicare cost per day is heavily weighted for aged patients for whom hospitals are allowed an 8-1/2-percent adjustment for nursing care costs. Because a smaller percentage of CHAMPUS patients would generally be subject to the nursing care adjustment, routine service costs would be lower for CHAMPUS patients than for Medicare patients. If CHAMPUS adopts the Medicare criteria, it intends to follow Medicare's policy regarding the 8-1/2-percent allowance and, therefore, will apply it only to aged, pediatric, and maternity care patients.

3. Special care unit costs for CHAMPUS patients were estimated by multiplying the average cost per day for all special care units by the total number of CHAMPUS patient days in special care units. This method was used because the number of CHAMPUS patient days for each special care unit was not readily available. Under the Medicare method CHAMPUS special care unit costs would be determined by multiplying the number of CHAMPUS days by the cost per day for each special care unit. It is uncertain whether the cost estimates would have increased or decreased if the latter method had been used.

4. CHAMPUS cost estimates do not include bad debts attributable to CHAMPUS patients because the amounts involved were not readily available. Under the Medicare reimbursement method, the Government would reimburse hospitals for bad debts arising from the nonpayment of coinsurance by CHAMPUS beneficiaries. Hospital officials we contacted generally believed CHAMPUS bad debts were negligible. Therefore, we believe this factor would have little impact on the estimated cost savings.