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REPORT BY THE

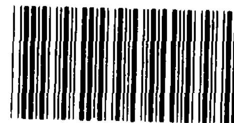
Comptroller General

OF THE UNITED STATES

Savings To CHAMPUS From Requirement To Use Uniformed Services Hospitals

The Civilian Health and Medical Program of the Uniformed Services saved over $30 million during the 12-month period following the requirement that beneficiaries residing within 40 miles of uniformed services hospitals obtain available nonemergency inpatient care there, rather than at civilian hospitals.

According to the Defense Department, a serious shortage of military physicians currently exists and is expected to continue for at least several years. If this assessment is accurate, the potential for significant additional benefits from the requirement is limited. However, some further savings could be realized through improvements in administration of the requirement.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HRD-79-24
DECEMBER 29, 1978

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

B-133142

The Honorable Warren G. Magnuson
Chairman, Committee on Appropriations
United States Senate

Dear Mr. Chairman:

In response to your Committee's request, we reviewed the Defense Department's administration of section 750 of Public Law 94-212. This section of the fiscal year 1976 Defense Appropriation Act, which has been included in subsequent Defense Appropriations Acts, prohibits paying Civilian Health and Medical Program of the Uniformed Services funds for nonemergency inpatient care available at a uniformed services hospital within 40 miles of the beneficiary's residence.

The report discloses that in the 12-month period following implementation of the "40-mile rule," from February 1976 through January 1977, inpatient admissions to civilian hospitals of retirees and their dependents and dependents of deceased personnel--the beneficiaries most affected by the requirement--decreased by 14 percent, resulting in savings to the program of over $30 million.

According to the Department of Defense, a serious shortage of military physicians currently exists and is expected to continue for at least several years. If this assessment is accurate, the potential for significant additional benefits from the requirement is limited. However, the report contains several recommendations to the Secretary of Defense for improving the administration of the requirement which could result in further savings.

As requested by the Committee, we did not obtain written comments from the Department of Defense on the report, but we did discuss its contents with Department officials.

As arranged with your office, we are providing copies of this report to the Secretary of Defense and other interested parties.

Sincerely yours,

ActingComptroller General
of the United States

REPORT BY THE COMPTROLLER GENERAL OF THE UNITED STATES

SAVINGS TO CHAMPUS FROM REQUIREMENT TO USE UNIFORMED SERVICES HOSPITALS

D I G E S T

The 40-mile rule, the requirement that beneficiaries of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) residing within 40 miles of uniformed services hospitals obtain non-emergency inpatient care there, if available, rather than at civilian hospitals, has resulted in substantial savings to CHAMPUS and increased use of uniformed services hospitals.

Unused beds in the uniformed services hospitals remained relatively high. However, the potential for greater use of available beds by program beneficiaries is limited, if the Defense Department's assessment of its physician staffing problems is accurate.

Beneficiaries residing within 40 miles of a uniformed services hospital may be authorized to use civilian hospitals for inpatient care if the uniformed services hospitals issue them nonavailability statements. In fiscal year 1977, about 72,800, or 58 percent, of the nonavailability statements issued were for uniformed services hospitals' inability to provide needed care either because of physicians not being available or lack of physical capabilities.

Shortages of physicians were most often cited as the reason care was not available. In fiscal year 1976, the military services were short 691 physicians or about 6 percent of the 11,750 physicians authorized. The Defense Department has testified that, as of January 1978, military services' on-board physician strength was about 10 percent below their authorized strengths and that the shortages will continue at least for several years. (See pp. 9 and 10.)

Although additional benefits from the 40-mile rule may be limited by physician shortages, some increased benefits may be attained through improved administration.

Defense Department instructions for implementing the 40-mile rule authorize uniformed services hospital commanders, because of unusual geographic or transportation problems, to alter the 40-mile radii around their hospitals and, thereby, exempt some beneficiaries from the requirement to obtain nonavailability statements. The implementing instructions also set forth a number of criteria under which CHAMPUS beneficiaries may obtain nonavailability statements even though care may be available at the uniformed services hospital which issues the statements. (See p. 12.)

Of the eight primary hospitals GAO visited, five had exempted beneficiaries in certain areas from the 40-mile rule for various reasons. For example, Fort Carson Army Hospital, near Colorado Springs, Colorado, exempted beneficiaries residing in Pueblo, Colorado, which is 39 miles away, because the hospital had more patients seeking care than it could accommodate.

Fort Carson hospital officials believed that beneficiaries residing in Pueblo would be unduly burdened by having to drive to Fort Carson to learn that care was not available. However, between January 1977 and July 1977, the program paid over $97,000 for Pueblo beneficiaries for types of care regularly available at Fort Carson Army Hospital. (See p. 13.)

Among the reasons nonavailability statements may be obtained although care is available are excessive waiting time and continuity of care. However, no definitive guidance is provided to the uniformed services as to what constitutes excessive waiting time. (See pp. 15 and 16.)

The continuity of care reason is intended to be used for patients who have been receiving care from civilian physicians and continued care from those physicians is medically indicated. Criteria pertaining to this exception are also vague and the determination that continued care from a civilian physician is medically indicated is very subjective.

For this reason, policies for issuing nonavailability statements varied considerably. Some military hospital officials believe the continuity of care exception is being used as a loophole to avoid adhering to the 40-mile rule. (See pp. 17 to 19.)

Uniformed services hospitals did not always attempt to determine whether medical care was available at other uniformed services hospitals within the 40-mile radius of the beneficiaries' residences. Coordination on a case-by-case basis was sporadic. As a result, nonavailability statements have been issued by one uniformed services hospital although the required care was available at another uniformed services hospital in the area. (See pp. 21 to 23.)

Fiscal agents were fulfilling most of their responsibilities for making sure that claims for nonemergency inpatient care were accompanied by nonavailability statements. (See p. 23.)

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

The Secretary should take the following actions to improve the administration of the 40-mile rule:

- --Establish procedures for approval of alterations to the 40-mile radii by higher Defense Department levels.
- --Clearly define what is meant by excessive waiting time and issue instructions for more strict and consistent application of

the continuity of care reason for issuing such statements.

--Require periodic exchanges of medical capability listings between hospitals within overlapping 40-mile radii.

--When availability of needed care cannot be determined from medical capability listings, require case-by-case coordination between hospitals.

As requested by the Senate Committee on Appropriations, GAO did not obtain written comments from the Department of Defense on the report, but GAO did discuss its contents with Department officials.

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ABBREVIATIONS

AMC	Army Medical Center
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
GAO	General Accounting Office
NRMC	Naval Regional Medical Center
OB/GYN	Obstetrics/Gynecology
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services

CHAPTER 1

INTRODUCTION

In response to a request from the Chairman, Senate Committee on Appropriations, we reviewed the Department of Defense's (DOD's) administration of section 750 of Public Law 94-212. This section of the fiscal year 1976 Defense Appropriation Act, enacted February 9, 1976, prohibits paying Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds for nonemergency inpatient care available at a uniformed services hospital within a 40-mile radius of the patient's residence. This restriction on the use of CHAMPUS funds has been repeated in subsequent DOD appropriations acts.

CHAMPUS PROGRAM ADMINISTRATION

CHAMPUS provides financial assistance for medical care provided by civilian sources to dependents of active duty members, retirees and their dependents, and dependents of deceased members of the uniformed services. 1/ The program originated in 1956 with the Dependents' Medical Care Act (Public Law 84-569) and was expanded by the Military Medical Benefit Amendments of 1966, 10 U.S.C. 1071 et seq. (Public Law 89-614).

CHAMPUS benefits are divided into two categories--basic and handicap. Basic benefits apply to all beneficiaries and cover both inpatient and outpatient medical care, including such services as surgery, hospitalization, outpatient prescription drugs, X-rays, clinical laboratory tests, and psychiatric care. Handicap benefits apply only to spouses and children of active duty members and cover rehabilitative services and care for the moderately or severely mentally retarded or seriously physically handicapped persons.

Costs of care are shared by the Government and beneficiaries. For basic benefits, dependents of active duty members pay a total of $25, or $4.40 a day, whichever is

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

greater, for inpatient care; other beneficiaries pay 25 percent of total charges. For outpatient care, there is a deductible of $50 for each beneficiary ($100 maximum deductible for each family) each fiscal year, after which dependents of active duty members pay 20 percent and other beneficiaries pay 25 percent of the remaining charges. No limit is set on the Government payment under the basic program. For handicap benefits, active duty members pay a specified monthly amount, ranging from $25 to $250, depending on the rank of the active duty member, and the Government pays the remaining charges up to $350 a month. The active duty member pays any charges exceeding these amounts.

The Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), located at Fitzsimons Army Medical Center near Denver, administers the program under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs). OCHAMPUS contracts with fiscal agents, such as Blue Cross and Blue Shield plans and Mutual of Omaha, to process and pay claims.

CHAMPUS costs were as follows:

Fiscal Year	Cost
	(millions)
1968	$160.9
1969	219.9
1970	271.1
1971	326.1
1972	387.9
1973	451.1
1974	481.1
1975	514.8
1976	516.3
1977	566.3

OCHAMPUS estimated that 77.6 percent of the fiscal year 1976 costs (excluding Canada, Mexico, and Puerto Rico) were incurred by persons living within 40 miles of uniformed services hospitals. Although data is not available from OCHAMPUS concerning the amount of CHAMPUS funds spent for inpatient care of persons residing within 40 miles of uniformed services hospitals, an estimated 80 percent of total CHAMPUS costs in fiscal year 1976 were for inpatient care.

REQUIREMENTS FOR USING UNIFORMED SERVICES HOSPITALS FOR INPATIENT CARE

Dependents of active duty members, retirees and their dependents, and dependents of deceased members of the uniformed services are entitled to receive care in uniformed services medical facilities if space, staff, and other resources are available. They may also receive care from civilian sources under CHAMPUS. The uniformed services facilities where care may be obtained are the Army, Navy, Air Force, and Public Health Service. The military health care system includes 180 hospitals, while the Public Health Service operates 8 hospitals which accept CHAMPUS beneficiaries.

The Surveys and Investigations Staff of the House Appropriations Committee reported in 1974 that uniformed services inpatient hospitals were experiencing low utilization. 1/ Also, staffing of uniformed services hospitals decreased only slightly or even increased during a period when substantial reductions occurred in hospital workloads. The House Appropriations Committee was concerned that CHAMPUS costs were increasing significantly, while uniformed services hospitals were extensively underutilized.

Also, a December 1975 Military Health Care Study performed jointly by DOD, the Department of Health, Education, and Welfare, and the Office of Management and Budget concluded that the cost of most health care delivery alternatives may be greater than the cost of providing care through the direct care portion of the Military Health Services System. The study report stated that some savings would be expected from moving small amounts of work from CHAMPUS to military medical facilities. The report recommended that efficient use of CHAMPUS should be sought by restoring the program to its intended role as a supplement to, rather than a substitute for, military direct care.

Prior to enactment in February 1976 of section 750, Public Law 94-212, only dependents of active duty members residing with the active duty member and living within 30 miles of a uniformed services hospital were required to obtain care, if available, at those hospitals. Retirees and their dependents, dependents of deceased members, and dependents of active duty

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1/"Medical and Dental Care in the Department of Defense," Surveys and Investigations Staff, House Appropriations Committee, April 1974.

members residing apart from the active duty member could choose between obtaining available care from uniformed services hospitals or using CHAMPUS.

Section 750, Public Law 94-212, changed the previous requirement by requiring all classes of CHAMPUS beneficiaries residing within 40 miles of a uniformed services hospital to obtain nonemergency inpatient care, if it was available, at the hospital. The intent was to increase the use of uniformed services hospitals and to reduce CHAMPUS costs. No additional funding or staffing for the hospitals was provided to implement the requirements of section 750. The restriction on the use of CHAMPUS funds was repeated in subsequent DOD appropriations acts. 1/

NONAVAILABILITY STATEMENTS

A beneficiary residing within 40 miles of a uniformed services hospital and seeking nonemergency inpatient care must--before using CHAMPUS--obtain a nonavailability statement certifying that the required care cannot be provided by that hospital. If the hospital initially contacted by the beneficiary cannot provide the care, the hospital is responsible for determining the availability of the care at other uniformed services hospitals within 40 miles of the beneficiary's residence. In order for the beneficiary to obtain CHAMPUS benefits, the statement must be submitted by the beneficiary or health care provider to a fiscal agent along with the CHAMPUS claim for payment. Nonavailability statements are not required for emergency care or outpatient care regardless of whether the beneficiaries reside within 40 miles of uniformed services hospitals.

SCOPE OF REVIEW

We made our review at the Offices of the Assistant Secretary of Defense (Health Affairs) and the Surgeons General of the Army, Navy, and Air Force and the headquarters of the Public Health Service in Washington, D.C. To assess the effect of the 40-mile rule, we also reviewed records and held discussions with officials at OCHAMPUS, Denver, Colorado, and at eight uniformed services hospitals selected on the basis of CHAMPUS use in their areas. Also, to assess coordination

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1/The restrictions of section 750, Public Law 94-212, and subsequent legislation will hereinafter be referred to as the "40-mile rule," as commonly termed throughout DOD.

of services between facilities, we visited selected hospitals and clinics within the 40-mile radii of the eight hospitals. The facilities we visited and the CHAMPUS costs incurred for persons residing within the 40-mile radii of the eight hospitals are listed in appendix I. We also visited three CHAMPUS fiscal agents--California Physicians Service, San Diego, California; Dikewood Industries, Inc., Albuquerque, New Mexico; and Mutual of Omaha, Omaha, Nebraska--to review procedures for paying claims involving nonavailability statements.

Our work included reviews of DOD's and the uniformed services' instructions for implementation of the 40-mile rule, local hospital procedures and practices regarding issuance of nonavailability statements, data on the number of nonavailability statements issued, and the reasons for their issuance.

CHAPTER 2

EFFECT AND ADMINISTRATION

OF 40-MILE RULE

In the 12-month period following implementation of the 40-mile rule, from February 1976 through January 1977, admissions to civilian health care facilities of the CHAMPUS beneficiaries most affected by the rule decreased by 14 percent, resulting in estimated savings to CHAMPUS of more than $30 million. Admissions to uniformed services hospitals increased somewhat, but overall use of available beds in these hospitals remained low. While the 40-mile rule has resulted in savings to CHAMPUS and increased admissions to uniformed services hospitals, the potential for significant additional benefits from the restriction is limited if DOD's assessment of its military physician staffing problems is accurate.

DOD's implementation of the 40-mile rule has provided for some exemptions from the 40-mile requirement and permitted certain criteria under which beneficiaries can obtain nonavailability statements even though care of the type sought could have been provided at uniformed services hospitals. 1/ As a result, large numbers of beneficiaries residing within the 40-mile radii of some hospitals have been exempted from the requirement to obtain nonavailability statements. Also, 42 percent of the nonavailability statements issued during fiscal year 1977 were issued for reasons other than the hospital's inability to provide the needed care. Because uniformed services hospitals have adopted different policies concerning the conditions under which nonavailability statements can be obtained, beneficiaries are treated inconsistently insofar as their use of CHAMPUS is concerned.

Formal procedures generally did not exist for coordination among hospitals in the same areas to determine availability of care, and, in some cases, care was authorized

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1/The legislation pertaining to the 40-mile rule gives DOD the discretion to determine whether care required by CHAMPUS beneficiaries is available in uniformed services hospitals. DOD's instructions permitting alterations to the 40-mile radii of some hospitals and the issuance of nonavailability statements for reasons other than hospitals' inabilities to provide needed care are, in theory, a reasonable application of the discretion vested in DOD to implement the 40-mile rule.

under CHAMPUS although it was available in a uniformed services hospital in the area.

Our review of fiscal agents' procedures for paying CHAMPUS claims involving nonavailability statements showed that these fiscal agents were generally adhering to the requirements regarding the processing of those claims.

EFFECT OF 40-MILE RULE ON CHAMPUS COSTS AND USE OF UNIFORMED SERVICES HOSPITALS

Several studies have been made related to the 40-mile rule. For example, an August 1976 study by the Rand Corporation for the Air Force showed that the 40-mile rule would result in about a 3-percent increase in the inpatient and outpatient workload of nine Air Force hospitals. Rand estimated a decrease in CHAMPUS costs of $26 million, or 4.5 percent, of the fiscal year 1975 CHAMPUS budget. An October 1977 Air Force study on the effect of the 40-mile rule on Air Force hospital workloads supported the Rand study, showing a 3.1-percent increase in admissions. A DOD and Department of the Army study of the effect on CHAMPUS costs from requiring all CHAMPUS beneficiaries residing within 30 miles of Fitzsimons Army Medical Center (AMC) near Denver, Colorado, to obtain both inpatient and outpatient care at the hospital showed savings of about $586,000, of which $534,000 was for inpatient care. The effect on the overall workload and supply costs of Fitzsimons was determined to be minimal.

The results of our review of this matter are discussed below.

CHAMPUS savings

A comparison of admission data to civilian hospitals for retirees and their dependents and dependents of deceased personnel for the 12-month period immediately preceding the implementation of the 40-mile rule with the first complete 12-month period following the change illustrates the effect the rule has had on CHAMPUS costs.

Time period	Admissions	Average length of stay (days)	Hospital days	Average hospital cost per day to Government	Total inpatient cost
Feb. 1975 to Jan. 1976	210,128	a/8.76	1,840,721	a/$118.64	$218,383,139
Mar. 1976 to Feb. 1977	180,603	a/8.76	1,582,082	a/118.64	187,698,208
Reduction	29,525				
Reduction in admissions	14%				
Savings to CHAMPUS					$ 30,684,931

a/Average length of stay for period March 1976 to February 1977. Data on average length of stay and Government cost per inpatient day for March 1976 to February 1977 has been applied to February 1975 to January 1976 admissions to reflect the effect of reduced admissions at 1976-77 costs.

The above data show that savings to CHAMPUS from decreased admissions for inpatient care for retirees and their dependents and dependents of deceased personnel amounted to over $30 million for the first 12-month period after implementation of the 40-mile rule. The reduced admissions under CHAMPUS of over 29,500 compares to previous increased admissions for these beneficiaries of about 16,000 per year--from 145,000 in 1971 to over 209,000 in 1975.

According to CHAMPUS officials, factors other than the 40-mile rule, such as increased use of ambulatory surgical centers by CHAMPUS beneficiaries, may have contributed to the reduced admissions, but they believe the 40-mile rule has been the most important factor in reducing CHAMPUS admissions and achieving savings for inpatient care.

Since the early years of the program, most dependents of active duty members residing near uniformed services hospitals have been required to attempt to obtain inpatient care at these hospitals before using CHAMPUS. The only effect of the 40-mile rule on active duty dependents was to increase the radius requirement from 30 to 40 miles and to require dependents residing apart from the service member to use uniformed services hospitals for inpatient care. According

to the Rand study mentioned previously, most active duty dependents reside within 30 miles of uniformed services hospitals. Therefore, the 40-mile rule would have little effect on the cost of CHAMPUS benefits for these beneficiaries.

Increased use of military hospitals

DOD information shows that during the 12-month period following implementation of the 40-mile rule, total inpatient admissions to military hospitals increased by about 3 percent. During the same period, admissions of retirees increased by 8 percent while admissions of dependents of retirees and deceased personnel increased by about 5 percent. These categories of beneficiaries were most affected by the 40-mile rule. The percentage increases of admissions of these beneficiaries to military hospitals are shown below:

	Military hospitals		
	Air Force	Navy	Army
	----------(percent)----------		
Retirees	12.5	9.7	5.4
Dependents of retired and deceased	10.6	2.4	.8

Physician staffing problems restrict additional benefits from 40-mile rule

While the 40-mile rule has apparently resulted in a small increase in admissions to uniformed services hospitals, available beds could accommodate a considerable number of additional beneficiaries if sufficient medical personnel, especially physicians, were available.

In fiscal year 1976, DOD operated 181 hospitals with a constructed 1/ bed capacity of 39,172 and an actual operating bed capacity of 22,798. The average daily patient load was 17,493--an occupancy rate of 45 percent based on constructed bed capacity and 77 percent based on operating beds. Inpatient utilization data at the eight primary hospitals we visited is shown in appendix II.

About 72,800, or 58 percent, of all nonavailability statements issued in fiscal year 1977 were for care not

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1/Constructed bed capacity is the number of beds that could be established as operating beds in the space available.

available at uniformed services hospitals. An additional 12,100 nonavailability statements, or about 10 percent, were issued because waiting time until the care would be available would be excessive. (See p. 16.) Shortages of physicians, rather than other types of staff or specialized equipment, were most often cited by hospital officials as the reasons that care was not available.

Information we obtained from DOD shows that, in fiscal year 1976, the military services were short 691 physicians or 6 percent of the 11,750 physicians authorized. In March 1978, the Principal Deputy Assistant Secretary of Defense (Health Affairs) testified that, as of January 1978, the on-board military physician strength of the services was 10,561--9.7 percent short of the 11,692 authorized physician positions. Using what its officials called "optimistic" assumptions, DOD projects that, based on current estimates of requirements and expected physician strengths, the physician shortage will continue at least through fiscal year 1983.

Most services which were not available to CHAMPUS beneficiaries at uniformed services hospitals in fiscal year 1977 were in four medical specialty areas as shown below:

Medical specialty	Number of nonavailability statements issued	Percent of all nonavailability statements issued
Obstetrics/Gynecology (OB/GYN)	63,160	51
Surgery	14,451	12
Otolaryngology	10,799	9
Neuropsychiatry	9,031	7
		79

Army data as of September 30, 1977, illustrates the physician shortages that existed in the Army in these four specialty areas:

Specialty	Authorized (note a)	Assigned (note a)	Percent short of authorized staff
OB/GYN	283	249	12
Surgery	361	346	4
Otolaryngology	103	84	18
Psychiatry	214	149	30

a/Figures include fellows, interns, residents, and practicing physicians.

As illustrated below, many nonavailability statements issued by the eight primary hospitals we visited were for care in specialty areas where the hospitals were short of their authorized staff.

--Of the 719 nonavailability statements issued by William Beaumont Army Medical Center (AMC) during fiscal year 1977, 233, or about 32 percent, were for otolaryngology services. Only two of three otolaryngologists positions were filled.

--Of the 384 nonavailability statements issued by Malcolm Grow Air Force Medical Center during fiscal year 1977, 225, or 59 percent, were for OB/GYN. Since July 1977, only four of the six authorized OB/GYN physician positions have been filled.

--Of the 2,433 nonavailability statements issued by MacDill Air Force Base Hospital in fiscal year 1977, 30 percent were for OB/GYN, 16 percent for surgery, 12 percent for internal medicine, and 12 percent for otolaryngology. In June 1977, the hospital lost two of its four gynecologists, and, as a result, the quota for deliveries declined from 75 to 45 per month. Physician shortages in the other specialties were also given as the reason for issuance of the nonavailability statements.

In addition, uniformed services hospitals generally do not have either the necessary staff or physical capability to meet CHAMPUS beneficiaries' total demand for inpatient psychiatric care. CHAMPUS costs for such care amounted to $62.4 million in fiscal year 1976, or 15 percent of its total costs for all inpatient care. None of the eight uniformed services hospitals we visited provided inpatient psychiatric care to CHAMPUS beneficiaries. The number of nonavailability statements issued for psychiatric care does not accurately reflect the extent of psychiatric care provided under CHAMPUS, since many psychiatric cases are regarded as emergencies which do not require issuance of a nonavailability statement. Most of the hospitals we visited provided psychiatric inpatient care, but only to active duty members. Hospital officials informed us that, in addition to the lack of psychiatrists and support staff, physical facilities for providing inpatient psychiatric care are fully used by active duty patients.

Because of the needs of CHAMPUS beneficiaries for care in certain specialties, some hospitals could not serve all CHAMPUS beneficiaries even if all their authorized positions were filled and the physical capability to provide the care was available. For example, in fiscal year 1977, Naval Regional Medical Center (NRMC), Portsmouth, Virginia, had eight OB/GYN physicians although it was authorized only seven. Still, the hospital issued 2,879 nonavailability statements for this specialty.

IMPROVEMENTS NEEDED IN ADMINISTRATION OF 40-MILE RULE

DOD instructions to the uniformed services authorize hospital commanders to alter the 40-mile radii around their hospitals and, thereby, exempt some beneficiaries from the requirement to obtain nonavailability statements because of unusual geographic or transportation problems. DOD's instructions also set forth six criteria--in addition to hospitals' inability to provide needed care--under which nonavailability statements may be issued to CHAMPUS beneficiaries.

According to DOD officials, the implementing instructions for the 40-mile rule essentially continued DOD's policies relating to its own prior administrative requirement that dependents of active duty personnel residing within 30 miles of a uniformed services hospital obtain care, if available, at those hospitals. (See pp. 3 and 4.)

During fiscal year 1977, 42 percent of all nonavailability statements were issued for the six DOD-approved reasons. Hospitals' use of these reasons to justify the issuance of nonavailability statements have, in some instances, resulted in beneficiaries using CHAMPUS when such use of the program appeared unwarranted.

Altering the 40-mile radius requirement

DOD's initial implementing instructions gave hospital commanders the authority to adjust their 40-mile radius areas for factors, such as unusual geographic or transportation problems, which unreasonably increase the travel time and expense to beneficiaries. In subsequent instructions, DOD authorized commanders to issue nonavailability statements to beneficiaries who reside within 40 miles of their hospitals but who must travel more than 40 miles. A 30-mile travel distance was established for maternity patients.

Of the eight hospitals we visited, five had altered the 40-mile rule by exempting beneficiaries in certain areas within their 40-mile radii from the requirement to obtain nonavailability statements. Two hospitals exempted certain areas because of a combination of limited capabilities and transportation barriers; another hospital because of transportation problems alone; and two hospitals because certain areas exceeded 40 travel miles.

Fort Carson Army Hospital, near Colorado Springs, exempted beneficiaries residing in Pueblo, Colorado, and also in mountainous areas to the west of the hospital. There are no unusual geographical or transportation barriers between Fort Carson and Pueblo which is 39 miles away. According to a hospital official, the hospital had more persons seeking care than could be accommodated, and rather than requiring patients to drive from Pueblo to learn that care was not available, the decision was made to exempt beneficiaries residing in Pueblo from the 40-mile rule. Between January 1977 and July 1977, CHAMPUS paid $97,033 to beneficiaries residing in Pueblo for types of care regularly available at the Fort Carson Army Hospital. Also, the mountainous areas to the west excluded by Fort Carson were not excluded by the Air Force Academy Hospital also near Colorado Springs, Colorado, which also serves most of the same area. Air Force Academy Hospital officials said that the Colorado Springs/ Fort Carson area was the most convenient source of medical care for beneficiaries residing in those areas.

The Air Force Regional Hospital at MacDill Air Force Base, Florida, reduced its 40-mile radius to an area approximately 20 miles in radius, mainly because of congested travel conditions. The adjusted area is within 1 hour's driving time of the hospital. MacDill has a policy of granting automatic issuance of nonavailability statements to retirees and their dependents. An official explained that the hospital's in-house capability is not sufficient to meet the demands of the retired population.

The Portsmouth NRMC has also altered its service area by exempting beneficiaries residing on the eastern shore of Virginia, a peninsula separated by the Chesapeake Bay. The only direct access to Norfolk from the eastern shore is the Chesapeake Bay Bridge-Tunnel, which is 20 miles long and costs $14 for a round trip. The decision to exempt this area appears to be in accordance with DOD instructions, in view of the excessive cost and limited access.

By using a criterion of 40 travel miles rather than a 40-mile radius, two hospitals visited excluded considerable numbers of beneficiaries from the requirement to seek care at uniformed services hospitals. William Beaumont AMC excluded beneficiaries residing in Las Cruces, New Mexico, which is within the 40-mile radius of the medical center, but is 46 travel miles away. There are no travel obstacles between the two cities. Between January 1977 and June 1977, CHAMPUS paid $74,766 for Las Cruces beneficiaries for care routinely available at the medical center.

The Public Health Service Hospital in Galveston, Texas, excluded Houston from its designated service area even though parts of Houston are within the hospital's 40-mile radius. We noted also that exclusions had been granted beneficiaries residing in Baytown and Deer Park which are within the 40-mile radius of the hospital. The 40-mile travel distance criterion was given as the reason for these exclusions.

A DOD official informed us that the guidance on 40 travel miles was not meant to be a substitute for the 40-mile radius. It was only to recognize that there may be instances where strict adherence to the 40-mile radius could cause hardships because of factors such as water barriers and toll gates. Exemptions to the 40-mile radius specified by the legislation were to be made on a case-by-case basis.

We believe decisions to alter the 40-mile radius because of unusual geographic or transportation barriers should be reviewed by higher commands to ensure uniformity between hospitals so that beneficiaries are not treated inequitably and to ensure compliance with the intent of the law. DOD should also make clear that the 40-travel-mile criterion is to be applied on a case-by-case basis.

Reasons for issuing
nonavailability statements

As previously stated, 58 percent of all nonavailability statements issued in fiscal year 1977 were issued because the types of care required by beneficiaries could not be provided by the uniformed services hospitals at which they sought such care. Determinations of whether care can be provided in the hospital or whether a nonavailability statement should be issued to authorize CHAMPUS use are normally made by the physician, except in instances where the hospital has no capability to provide particular medical services. In those cases, nonavailability statements are usually issued automatically by CHAMPUS advisors.

Requests for nonavailability statements for reasons other than the hospitals' inability to provide needed care are also evaluated by physicians on a case-by-case basis. Some hospitals include department chiefs in the review process. These nonavailability statements are signed by the hospital commanders or their designees. DOD's implementing instructions provide six other categories of reasons under which beneficiaries may be issued nonavailability statements in lieu of using uniformed services hospitals. These categories of nonavailability statements and the percent issued for each reason during fiscal year 1977 are as follows:

--Excessive waiting time--10 percent (the hospital's capabilities are fully utilized to the point that additional workload would degrade care for others).

--Continuity of care--11 percent (the patient has been receiving outpatient care from civilian sources; hospitalization is required; and continued care from the same physician is medically indicated).

--Retroactive issuances--11 percent (the hospital would have issued the nonavailability statement had it been requested prior to the patient's receiving needed care).

--Personal hardship--3 percent (the conditions are such that travel to the uniformed services hospital would be unreasonably difficult or costly).

--Professional disagreement--1 percent (a conflict of professional opinion exists between military and civilian physicians as to the proper course of treatment).

--Other reasons--6 percent.

Our observations regarding the uses of DOD's approved reasons for issuing nonavailability statements follow.

Type of care not available

Adequate procedures existed at all but two hospitals visited for determining whether the care requested by beneficiaries could be provided. Clinic physicians generally determined whether care could be provided and made appropriate recommendations to the hospital commanders, or their designees, who signed the nonavailability statements. 1/

1/We accepted physicians' professional judgment in making these determinations.

However, procedures at the El Toro branch clinic of the NRMC, Long Beach, and at the NRMC, Camp Pendleton, were inadequate.

Nonavailability statements at the El Toro branch clinic were presigned by the administrative officer, the designee of the Commander of the NRMC, Long Beach. The statements were issued by a health benefit counselor without review by the administrative officer to assure that the required care was unavailable at Long Beach or other hospitals in the area. One nearby hospital, NRMC, at Camp Pendleton, apparently could have taken care of patients issued nonavailability statements by El Toro. (See p. 23.)

In addition, nonavailability statements presigned by El Toro personnel were given to another clinic for issuance. El Toro had no knowledge of whether the statements were issued because the hospital did not have the ability to provide the needed care or for other authorized reasons.

At NRMC, Camp Pendleton, a large number of nonavailability statements were issued for care normally available within the hospital. The determination that care was not available was made, in most cases, by a health benefits counselor without the evaluation of a clinic physician or department chief. A clinic physician informed us that he would have disapproved some of the nonavailability statements since the care could have been provided by the hospital. This situation was later corrected by requiring that clinic physicians determine whether care was available.

Excessive waiting time

More definitive guidance is needed as to when hospitals can issue nonavailability statements for excessive waiting time. DOD instructions state that when the care is available at the uniformed services hospital, but the additional workload would degrade care for others, nonavailability statements are allowed to be issued for excessive waiting time. DOD instructions do not define what constitutes an excessive wait. The Air Force regulations establish it at 30 days; however, the other services have not set a time period. An official at the Public Health Service Hospital in Galveston, Texas, believed that excessive waiting time should be determined on a case-by-case basis. He said 2 or 3 months is not an excessive wait for some elective procedures while 1 day could be excessive for acute care. In the opinion of an official at the NRMC at Bremerton, Washington, excessive waiting time is not a valid reason for elective procedures, such as tonsillectomies or adenoidectomies. At other hospitals,

however, the normal practice was issuing nonavailability statements for tonsillectomies and adenoidectomies because of excessive waiting time.

Continuity of care

DOD instructions allow issuing a nonavailability statement when the patient has been receiving outpatient care from a civilian source, hospitalization is required, and continued care from the same physician is medically indicated. At most of the hospitals we visited, physicians in the clinical departments evaluated the requests for nonavailability statements for continuity of care reasons. Some hospitals required a letter from the civilian physicians stating why continued care from them was necessary. Hospital officials indicated that the criteria pertaining to continuity of care are extremely vague and that the requirement that continued care from a civilian physician be medically indicated is a very subjective determination.

Some hospitals take a strict approach in issuing nonavailability statements for continuity of care reasons while others are much more lenient. For example, the NRMC at Bremerton, Washington, requires patients to be examined by military physicians. If the examining physician determines that the medical service needed is available at NRMC Bremerton, the request for a nonavailability statement is denied. The hospital issued only four nonavailability statements for continuity of care in fiscal year 1977. In contrast, MacDill Air Force Base Regional Hospital issued 301 nonavailability statements (approximately 12 percent) for continuity of care. Nonavailability statements were issued to retirees and their dependents for reasons of continuity of care if the beneficiaries merely preferred to see a civilian physician.

In fiscal year 1977, over 11 percent of all nonavailability statements were issued for continuity of care. The numbers and the percentages of total statements issued for this reason at the eight primary hospitals we visited are shown below:

Hospital	Number issued	Statements issued for continuity of care as a percent of total statements
William Beaumont AMC	122	17.0
Fort Carson Army Hospital	98	6.4
NRMC Camp Pendleton, Calif.	111	18.0
NRMC Bremerton, Wash.	4	4.9
NRMC Portsmouth, Va.	493	9.8
Air Force Regional Hospital MacDill Air Force Base	301	12.4
Malcolm Grow Air Force Medical Center	55	14.3
Public Health Service Hospital Galveston, Tex.	157	20.0
Total	1,341	11.6

During our review of statements issued for continuity of care, we noted that many patients started their outpatient care with civilian physicians and desired to remain under their care. Beneficiaries are not required to obtain a nonavailability statement for outpatient care received from civilian sources. The commanding officer of the Air Force Regional Hospital at March Air Force Base said continuity of care is not necessarily a valid reason if the patient chose to go to a civilian physician for outpatient care, instead of being seen by a physician at the military hospital. An official at Malcolm Grow Air Force Medical Center stated that continuity of care is being used as a loophole to avoid adhering to the 40-mile rule. Officials of other hospitals made similar comments.

The medical necessity of continued care from the same civilian physicians was not evident in the supporting documentation for many nonavailability statements issued for continuity of care. For example:

--On April 8, 1977, NRMC Camp Pendleton issued a nonavailability statement for a dilation and curettage to a woman who had visited a civilian physician for the first time on April 6, 1977. The basis for issuing the nonavailability statement was a letter from the physician describing the diagnosis and treatment. He did not recommend that he provide the treatment, and there was no continuity of care involved.

--William Beaumont AMC issued a nonavailability statement for the repair of an abdominal incisional hernia, identified while a patient was being examined by a physician at William Beaumont AMC. The patient contacted her civilian physician who had operated on her previously, and he requested permission to repair the hernia.

--At the Public Health Service Hospital in Galveston, Texas, a woman, who was seen for the first time by a certain civilian physician in December 1976, received a nonavailability statement for continuity of care reasons for gynecological surgery by the physician in January 1977.

--At the NRMC, Camp Pendleton, a nonavailability statement for continuity of care was given to a woman who had started her prenatal care at the NRMC but had switched to a civilian physician.

Retroactive issuances

According to DOD instructions, a nonavailability statement may be issued retroactively if it would have been issued had the patient requested it prior to receiving the care. Some hospitals appeared to be misusing this reason for issuing nonavailability statements. For example, 104, or 13 percent, of all the nonavailability statements issued by the Public Health Service Hospital in Galveston, Texas, during fiscal year 1977 were issued retroactively. This occurred mainly because the beneficiaries were unaware that the Public Health Service Hospital is regarded as a uniformed services hospital or that nonavailability statements were necessary.

Personal hardship

DOD instructions allow nonavailability statements to be issued for personal hardship reasons when hospital commanders determine that travel to the military hospital would be unreasonably difficult or costly, or would adversely affect the patient's physical condition. Exceptions for personal hardship are evaluated on a case-by-case basis. The only hospital we visited that issued many nonavailability statements for personal hardship was NRMC at Camp Pendleton, which issued 143 such statements. Of these, 134 were to maternity patients residing within 30 miles of the hospital. Hospital officials believed it was undesirable to require maternity patients to travel 30 miles to the hospital.

Professional disagreement

If a military physician disagrees with the course of treatment recommended by a civilian physician, DOD instructions permit the patient to receive a nonavailability statement and receive care by the civilian physician. Less than 1 percent of the nonavailability statements issued during fiscal year 1977 were because of professional disagreement. Justifications for issuing nonavailability statements for this reason were generally well documented, showing the position of both the military and civilian physicians.

Other

In addition to the six primary reasons, DOD instructions provide for issuance of statements for "other" reasons if

--the patient requests delivery by natural childbirth, but the technique is not offered by the hospital or

--the patient requests maternity care but the active duty person's discharge date is prior to the expected date of delivery.

Our review showed that nonavailability statements in the "other" category were also issued for reasons other than those specified in the DOD instructions. For example:

--The NRMC, Camp Pendleton, issued a nonavailability statement to a woman for a gynecological operation because her husband was hostile to NRMC physicians.

--The NRMC, Camp Pendleton, issued a nonavailability statement to a maternity patient because the patient had previously had an unspecified "bad experience" at the hospital.

Nonavailability statements issued because of preference for civilian medical services

Contrary to DOD instructions, nonavailability statements were being issued because of patients' preferences for civilian care. For example:

--NRMC, Camp Pendleton, issued a nonavailability statement to a patient for maternity care because a civilian physician had attended her during two previous pregnancies, and she preferred to retain him as her attending physician.

--Fort Carson Army Hospital issued a nonavailability statement to a patient for maternity care even though the patient's prenatal care was begun at Fort Carson. The patient had two previous deliveries by the same civilian doctor and did not want to enter the Fort Carson hospital.

--Fort Carson Army Hospital issued a nonavailability statement to another maternity patient because the patient lacked confidence in the hospital's staff.

--McDonald Army Hospital issued a nonavailability statement to a patient who had started her prenatal care at the military hospital and then decided she preferred a civilian doctor.

Coordination of services among hospitals

DOD's guidelines require that when nonemergency inpatient care cannot be provided by the uniformed services hospital initially contacted by a CHAMPUS beneficiary, the commander of that hospital must determine whether the required care is available at any other uniformed services hospital within a 40-mile radius of the beneficiary's residence. To evaluate the coordination among hospitals on the availability of care to CHAMPUS beneficiaries, we selected five hospitals for review that were located in geographic areas having more than one uniformed services hospital. (See app. I.)

The commanders of most of the major hospitals we visited were members of triservice regional or subregional review committees, which meet regularly to determine ways to improve interservice health planning and delivery of health care. These committees recommend coordination procedures, including exchanges of medical capability listings, to assure that nonavailability statements are issued only when required medical care is not available at hospitals in overlapping areas.

We found that the exchanges of lists of services not available had generally been discontinued or not followed routinely and coordination of services on a case-by-case basis for care was often sporadic. For example, pursuant to a March 1976 triservice subregion meeting, the Fort Carson and the Air Force Academy hospitals agreed to exchange monthly letters of "services not available." These letters delineated medical services not anticipated to be available and services which could not be provided on a referral basis because of workload demands. The letters were intended to obviate the

need for the hospital at which a beneficiary requested care to contact the other hospital to determine whether the care was available before issuance of the nonavailability statement.

The exchange of letters was discontinued after January 1977, because, according to one official, the letters just repeated the same information month after month. At the time of our review, there was no coordination on a case-by-case or other routine basis. None of the nonavailability statements or related supporting documentation at the Fort Carson or Academy hospitals indicated that any coordination had taken place. Records were unavailable that would show whether lack of coordination had resulted in issuance of individual nonavailability statements at one hospital for care which was available when it was needed at the other hospital.

In the Portsmouth, Virginia, area the only formal coordination procedures routinely followed by the uniformed services hospitals are quarterly triservice meetings attended by representatives from the hospitals. Problems affecting the capabilities and services available at each hospital are discussed at the meetings. Medical availability and capability lists are subsequently to be distributed to the hospitals for determining availability of medical services prior to issuing nonavailability statements. According to an official at the Public Health Service Hospital in Norfolk, only one list of services available at the NRMC, Portsmouth, was received during the past year. He did not view this to be a problem, however, because he was aware of the NRMC's capabilities from telephone contacts he has with CHAMPUS advisors there. The majority of coordination for medical services between hospitals in the Portsmouth area consists of informal contacts.

In addition, some hospitals did not coordinate at all or contacted only one other hospital. An official at NRMC, Portsmouth, told us that other hospitals are not contacted prior to issuing nonavailability statements because, if the NRMC does not have the capability, he did not believe it likely that the other hospitals would have it. An official of the Public Health Service Hospital cited a similar rationale for not contacting the hospitals at Langley Air Force Base or at Fort Eustis prior to issuing nonavailability statements. According to the Director of the Public Health Service Hospital, however, this lack of formal coordination may have resulted in underutilization of general medical and surgical capabilities at the Public Health Service Hospital.

In southern California, coordination procedures were established in February 1976, requiring a routine exchange of listings of medical capabilities among various uniformed services hospitals in the area. There are three hospitals whose areas overlap with Camp Pendleton. At the time of our review, however, only Camp Pendleton and one of the three hospitals continued to exchange listings.

CHAMPUS advisors at the uniformed services hospitals at Camp Pendleton, March Air Force Base, Long Beach, and San Diego told us that they contact each other to determine availability of medical care prior to issuing nonavailability statements. However, no documentation was available to verify this statement. The CHAMPUS advisor at Long Beach's branch clinic at El Toro acknowledged that coordination is not done on a case-by-case basis.

Our review of nonavailability statements issued at the El Toro branch clinic for November 1977 disclosed that 25 nonavailability statements were issued to beneficiaries residing within the 40-mile overlap area with NRMC, Camp Pendleton hospital. Review of these cases by an official at the Camp Pendleton hospital disclosed that, of the 25 cases for which nonavailability statements were issued, 24 could have been accepted at Camp Pendleton.

Claims processing by CHAMPUS contractors

In processing claims, CHAMPUS fiscal agents are responsible for assuring that claims for nonemergency inpatient services provided beneficiaries residing within a 40-mile radius of uniformed services hospitals are accompanied by nonavailability statements.

To determine the adequacy of claims processing concerning nonavailability statement requirements, we reviewed 309 claims for care received by patients residing within 40 miles of the various uniformed services hospitals. These claims were processed by three fiscal agents. Of the 309 claims, only 7, or about 2 percent, were paid without required nonavailability statements. Therefore, fiscal agents are generally following requirements concerning nonavailability statements.

CONCLUSIONS

While the 40-mile rule has resulted in savings to CHAMPUS and increased utilization of uniformed services hospitals, the potential for significant additional benefits from the requirement is limited, if DOD's assessment of its physician staffing problems is accurate. However, DOD implementation of the 40-mile rule has provided for some exceptions that appear to be limiting additional benefits which could be realized from the requirement.

The only exception provided in the law for CHAMPUS beneficiaries not to use uniformed services hospitals for nonemergency inpatient care is, if the required care is not available. DOD's instructions for implementing the 40-mile rule have provided a number of additional exceptions, intended to alleviate hardships on beneficiaries from complying with the rule, which are not related to the uniformed services hospitals' ability to provide the needed care. Justifications for issuing nonavailability statements for some of the reasons approved by DOD seemed questionable. For example, uniformed services hospitals need more definitive guidance from DOD concerning what constitutes excessive waiting time for elective medical procedures so that this reason for issuing nonavailability statements can be administered more consistently.

Also the use of nonavailability statements for continuity of care reasons appeared to be especially subject to abuse because uniformed services officials generally were reluctant to require beneficiaries who began their outpatient care with civilian sources to use inpatient care available in the uniformed services hospital. Nonavailability statements are not required for outpatient care. We believe, and CHAMPUS officials concur, that the exception to the 40-mile rule for continuity of care reasons should be more strictly administered. Nonavailability statements should be issued for this reason only in cases in which available care in a uniformed services hospital, as compared to a civilian source, would constitute a lesser quality of care in relation to the medical requirements of a patient.

Coordination procedures among hospitals in overlapping areas which involved exchanging lists of services not available have generally been discontinued or are not followed routinely. Coordination of services on a case-by-case basis for types of care normally available was sporadic.

CHAMPUS fiscal agents were generally processing claims in accordance with nonavailability statement requirements.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary take the following actions to improve the administration of the 40-mile rule:

--Establish procedures for approval by higher DOD levels, such as the Assistant Secretary of Defense (Health Affairs), of alterations to the 40-mile radii now decided upon by hospital commanders, to exempt certain beneficiaries from the requirement to obtain non-availability statements.

--Clearly define what is meant by the excessive waiting time exception to the 40-mile rule and implement instructions for more strict and consistent application of the continuity of care reason for issuing such statements.

--Require periodic exchanges of medical capability listings between hospitals within overlapping 40-mile radii.

--Require case-by-case coordination between hospitals when availability of needed medical services for which a nonavailability statement is requested cannot be determined from medical capability listings.

UNIFORMED SERVICES FACILITIES

VISITED DURING OUR REVIEW

Primary hospital reviewed	CHAMPUS inpatient costs within 40-mile radius of primary hospital calendar year 1976	Facilities visited whose 40-mile radii overlap with primary hospital's
	(millions)	
William Beaumont Army Medical Center El Paso, Tex.	$1.0	None
Fort Carson Army Hospital Fort Carson, Colo.	$3.8	Air Force Academy Hospital, Air Force Academy, Colorado
Naval Regional Medical Center Bremerton, Wash.	$4.3	Public Health Service Hospital Seattle, Washington
		Madigan Army Medical Center Tacoma, Washington
		Naval Hospital, Whidbey Island Oak Harbor, Washington
Naval Regional Medical Center Camp Pendleton, Calif.	$11.3	Naval Regional Medical Center Long Beach, California
		Naval Regional Medical Center, Long Beach Branch Clinic, Marine Corps Air Station El Toro, California
		Naval Regional Medical Center San Diego, California
		Air Force Regional Hospital March Air Force Base, California

Primary hospital reviewed	CHAMPUS inpatient costs within 40-mile radius of primary hospital calendar year 1976	Facilities visited whose 40-mile radii overlap with primary hospital's
	(millions)	
Naval Regional Medical Center Portsmouth, Va.	$14.5	McDonald Army Hospital Fort Eustis, Virginia
		Langley Air Force Base Hospital Hampton, Virginia
		Public Health Service Hospital Norfolk, Virginia
Malcolm Grow Air Force Medical Center Andrews Air Force Base, Md.	$5.5	Walter Reed Army Medical Center Washington, D.C.
		DeWitt Army Hospital Fort Belvoir, Virginia
		Kimbrough Army Hospital Fort Meade, Maryland
		National Naval Medical Center Bethesda, Maryland
Air Force Regional Hospital MacDill Air Force Base, Fla.	$6.3	None
Public Health Service Hospital Galveston, Tex.	$5.4	None

(10197)

OCCUPANCY RATES OF MAJOR UNIFORMED SERVICES HOSPITALS VISITED

Hospital	Constructed bed capacity (note a)	Authorized operating beds (note b)	Average daily beds occupied	Occupancy rate as a percent of Constructed bed capacity	Occupancy rate as a percent of Authorized operating beds
Andrews Air Force Base Hospital	350	250	198	57	79
MacDill Air Force Base Hospital	150	70	47	31	67
Fort Carson Army Hospital	324	174	125	39	72
William Beaumont AMC	608	444	382	63	86
Bremerton NRMC	218	98	68	31	69
Camp Pendleton NRMC	600	301	184	31	61
Portsmouth NRMC	905	633	506	56	80
Galveston Public Health Service Hospital	150	150	106	71	71

a/Constructed bed capacity is the number of beds that could be established as operating beds if the demand existed. This statistic reflects space only; it does not consider equipment, utility, or staff requirements.

b/Operating beds is a derived statistic based on past use of the hospital.

APPENDIX II

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