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BY THE COMPTROLLER GENERAL

# Report To The Congress

OF THE UNITED STATES

## Government Loses Revenue Because Of Low Medical Care Charges To Liable Third Parties

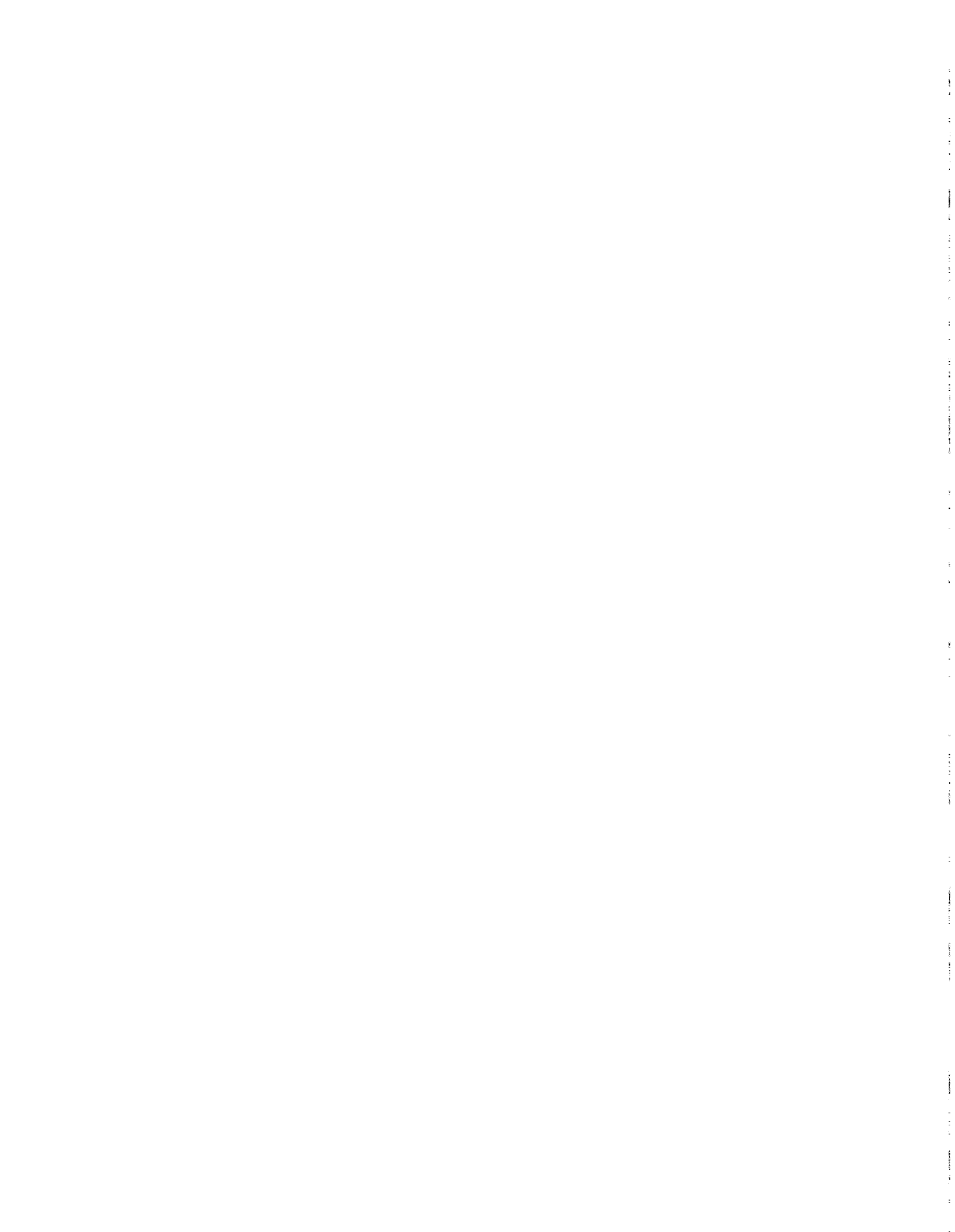
The Government provides free medical care to eligible beneficiaries, such as service members and veterans. When a beneficiary requires treatment because of injuries caused by the negligence of another, the Government is authorized by law to recover the cost of medical care from the negligent party.

From October 1, 1978, to September 30, 1980, the Government failed to recover an estimated \$4 million because the rates charged were set significantly below the rates estimated by the Department of Defense and Veterans Administration to reflect the actual cost of care in their hospitals. At GAO's urging, the Office of Management and Budget adopted the use of the Defense and VA budgeted rates which are much closer to actual cost and should result in significant increases in revenues. Even so, these rates are still too low and unless they are periodically adjusted to more accurately reflect the full cost of care provided in Defense and VA hospitals, the Government may continue to lose about \$2 million a year.



AFMD-82-2  
DECEMBER 16, 1981

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

B-205545

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

This report discusses the medical care reimbursement rates charged by the Government to liable third parties for treatment provided in Government hospitals. The report recommends actions to ensure that the rates more accurately reflect the cost of care provided. We made this review to determine if the Department of Defense and the Veterans Administration were complying with the rate setting provision of the Federal Medical Care Recovery Act.

We requested official comments from the Office of Management and Budget, Department of Defense, and Veterans Administration, but their responses were not received within the 30-day period required by Public Law 96-226.

Copies of this report are being sent to the Director of the Office of Management and Budget, the Secretary of Defense, and the Administrator of Veterans Affairs.

A handwritten signature in cursive script that reads "Charles A. Bowsher".

Comptroller General  
of the United States



D I G E S T

The Government, which provides free medical care to service men and women, veterans, and other eligible beneficiaries, is authorized by the Federal Medical Care Recovery Act to recover the cost of care provided or paid for when any of its beneficiaries require medical treatment because of the negligent actions of a third party. These actions most often involve automobile accidents. GAO made its review to determine compliance with the rate setting provision of the act. (See p. 1.)

Millions are being lost, however, because the rates charged liable third parties do not cover the cost of care provided in Department of Defense and Veterans Administration (VA) hospitals. (See p. 5.)

Both Defense and VA annually compute recovery rates for the coming fiscal year based on estimated hospital costs and patient workloads. These rates (called budgeted rates) are normally used to recover hospital costs incurred as a result of negligent actions by third parties. From October 1, 1978, to May 11, 1981, however, the rates charged third parties were set substantially below the budgeted rates. The lower rates, known as cost containment rates, were put into effect in an attempt to hold down the rise in hospital costs. GAO estimates that if during fiscal 1979 and 1980 the budgeted rates were used, the Government could have increased its claims against third parties by almost \$8 million and its recoveries by almost \$4 million.

GAO found no evidence that cost containment rates limited increases in medical care costs, and at GAO's urging the cost containment rates were discontinued on May 11, 1981, and budgeted rates are now being used to recover hospital costs from liable third parties.

Although the renewed use of budgeted rates will substantially increase cost recoveries, GAO found that the budgeted rates were appreciably less

than rates reflecting the actual cost of care provided in Defense and VA hospitals. The Government can substantially increase its claims and collections by insuring that rates charged third parties more closely approximate the actual cost of hospital care. (See p. 7.)

#### AUTHORITY TO SET RATES

The authority to set medical care recovery rates has been delegated to the Office of Management and Budget (OMB) by the President, who was authorized by the Federal Medical Care Recovery Act to establish rates reflecting the reasonable value of care furnished in Government hospitals. OMB generally accepted the budgeted in-patient and out-patient medical recovery rates recommended by Defense and VA, the two agencies primarily affected by the act.

The agencies develop budgeted rates several months before the start of the fiscal year in which they are to be effective by using data contained in their annual budget submissions to the President.

#### COST CONTAINMENT RATES LIMITED RECOVERIES

During fiscal 1979, OMB set rates independently of the agencies' recommended budgeted rates to conform to former President Carter's cost containment guidelines. The cost containment rates, which were well below agency budgeted rates, were issued under the assumption they would aid in containing the growth in Federal medical care costs.

GAO, however, found no evidence that cost containment rates were effective in limiting medical care costs. Instead, negligent third parties and their insurance companies paid less for medical care than the cost incurred by the Government. (See p. 5.)

Based on a review of over 60 percent of the 17,748 medical care recovery claims Defense made against liable third parties during fiscal 1979, GAO estimates 1/ that the use of cost containment

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1/See pp. 3-4 for an explanation of the methodology on which the estimates were based.

rates instead of budgeted rates decreased Government revenues from Defense and VA claims by about \$4 million during fiscal 1979 and 1980. (See p. 6.)

#### OMB DROPS COST CONTAINMENT RATES

GAO informed the Director, OMB, in an April 17, 1981, letter, that the Government could materially increase annual collections if Defense were allowed to make claims against liable third parties using its budgeted rates instead of cost containment rates. (See app. I.) OMB agreed and in a letter to GAO included a new authorized recovery rate schedule, effective May 11, 1981, which reflected the rates recommended by Defense and VA. The response stated that Defense was "authorized to charge third party reimbursement rates which reflect the full cost of care provided in DOD hospitals." (See app. II.) OMB officials subsequently informed GAO that this policy also applied to VA.

#### AGENCIES NEED TO IMPROVE BUDGET RATE ACCURACY

For the past several years, Defense and VA have continually established budgeted rates lower than rates reflecting the actual cost of care in their hospitals. This became the practice because the agencies budgeted lower costs than were actually incurred and higher patient workloads than were actually handled. Since rates are determined by dividing patient workloads into costs, these agency budget inaccuracies resulted in lower rates. For instance, budgeted in-patient rates for the 3-year period fiscal 1978 through 1980 were below actual Defense and VA rates by an average of 11.3 percent and 21.2 percent a year, respectively. In addition to the increase in revenue that should result from adoption of budgeted rates, another \$2 million could possibly be recovered each year if these rates were required to more closely reflect full cost. (See pp. 7-8.)

To provide for full cost recovery as authorized by the Federal Medical Care Recovery Act and as required by OMB, the agencies need to develop more accurate budgeted recovery rates. To aid in doing this, Defense and VA need to devote more attention to setting and monitoring rates. They need to monitor the accuracy of budgeted rates by

(1) developing actual rates when actual cost and patient workload data become available, (2) comparing actual rates with budgeted rates, and (3) determining and analyzing variances. These analyses would provide them the necessary information to understand why their budgeted rates are continually understated, which would aid them in developing more accurate forecasts and would allow them to recommend to OMB that rates be adjusted to reflect actual results during the year.

#### RECOMMENDATION

GAO recommends that the Secretary of Defense and the Administrator of Veterans Affairs develop for OMB medical care recovery rates to be charged liable third parties which more accurately reflect the actual cost of care provided in their hospitals. To this end, as cost and workload data become available during the year, (1) actual costs per in-patient day and per out-patient visit should be developed and compared with amounts being charged, (2) variances should be determined and analyzed, and (3) recovery rates should be adjusted during the year to conform to actual results. Further, since the authority to set medical care recovery rates has been delegated to OMB, GAO recommends that the Director, OMB, monitor the implementation of the above recommendation and revise recovery rates accordingly, if he believes the rates are reasonable.

#### AGENCY COMMENTS

GAO requested official comments from the Office of Management and Budget, Department of Defense, and Veterans Administration, but their responses were not received within the 30-day period required by Public Law 96-226.



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ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
GAO	General Accounting Office
OMB	Office of Management and Budget
VA	Veterans Administration



## CHAPTER 1

### INTRODUCTION

The Government has the right to recover the cost of medical care provided to Federal beneficiaries who are injured or suffer a disease because of circumstances creating a liability on the part of a third person. The Government has this right under Public Law 87-693, approved September 25, 1962 (42 U.S.C. 2651-2653), and commonly referred to as the Federal Medical Care Recovery Act. For instance, if a serviceman is injured in an automobile accident caused by an insured motorist's negligence, the Government can generally recover from the motorist's insurance company the cost of medical care provided the injured serviceman.

The act has two major purposes: To provide for the recovery from negligent third parties of the fair and reasonable value of care furnished or paid for, and to ensure that negligent parties and their insurance companies do not pay less than the full cost of care resulting from injuries caused to individuals entitled to medical care at Federal expense.

The act provides that the President prescribe pertinent regulations, including those that establish the reasonable value of care furnished in Federal hospitals. This rate setting authority has been delegated to the Office of Management and Budget (OMB).

In prescribing the medical care recovery rates for an in-patient day and an out-patient visit, OMB--through fiscal 1978--generally used the rates recommended by the Departments of Defense and Health and Human Services and by the Veterans Administration (VA), the three agencies affected by the act. Using data contained in their annual budget submissions to the President, the agencies develop recommended rates several months before the start of the fiscal year in which they are to be effective.

The recovery rates OMB established subsequent to fiscal 1978 were developed to conform with former President Carter's cost containment guidelines, whereby OMB limited the increase in recovery rates from one year to the next in an effort to help contain the rise in hospital costs in the United States. Consequently, these rates were lower than most of the budgeted rates recommended by the agencies.

### OVERVIEW OF THE MEDICAL CARE RECOVERY PROGRAM

Claims for medical care recoveries are generally handled by representatives of the agencies' legal staffs. At Defense, where the majority of our work was done, claims are handled by each service's Judge Advocate General. The majority of the claims result from automobile accidents which cause injuries to service members or their dependents who require and receive medical care at Government expense. When treatment is provided by a military medical facility, that facility is responsible for notifying the responsible claims office that a possible third-party liability exists. If

treatment is provided by a civilian medical facility under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the CHAMPUS contractor responsible for paying the medical expense is responsible for notifying the appropriate military claims office. Upon receiving such notification, claims personnel investigate the incident and document medical costs. If appropriate, the claim is made against the liable third party. Claim amounts, which should not include amounts associated with non-medically essential convalescent time, are determined by multiplying the number of in-patient days and/or out-patient visits by rates OMB established.

In the 9 calendar years 1972 through 1980, claims totaling over \$282 million were made against liable third parties, and almost \$134 million, or 47 percent, was collected. Defense accounted for about 69 percent of the claims and 76 percent of the collections; VA accounted for 28 percent of the claims and 21 percent of the collections; and Health and Human Services accounted for the remainder.

The following table shows Defense and VA medical care recovery data for the 3 most recent calendar years. Note the annual increases in claims and collections, indicating continuing program growth.

Medical Care Claims and Collections

(Calendar 1978-1980)

<u>Calendar year</u>	<u>Agency</u>	<u>Claims</u>	<u>Collections</u>	<u>Percentage of claims collected (note a)</u>
1978	Defense	\$20,295,425	\$11,388,254	56
	VA	<u>11,291,251</u>	<u>3,879,088</u>	34
	Total	<u>\$31,586,676</u>	<u>\$15,267,342</u>	48
1979	Defense	\$27,369,140	\$14,735,941	54
	VA	<u>11,739,565</u>	<u>3,931,191</u>	33
	Total	<u>\$39,108,705</u>	<u>\$18,667,132</u>	48
1980	Defense	\$28,077,295	\$16,003,569	57
	VA	<u>13,860,997</u>	<u>4,150,077</u>	30
	Total	<u>\$41,938,292</u>	<u>\$20,153,646</u>	48

a/We are presently reviewing the reasons for the low agency collection rates and how the agencies manage claims.

## OBJECTIVE, SCOPE, AND METHODOLOGY

Our review was designed to determine whether the rates charged liable third parties were sufficient to cover the cost of care provided the Federal beneficiary and, if not, to quantify the amount of revenue loss to the Government. To determine this, we had to consider whether the philosophy underlying the cost containment rates led to containing Government hospital costs and whether agency budgeted rates accurately reflected the full cost of care furnished.

To accomplish our objective, we:

- Reviewed the Federal Medical Care Recovery Act and supporting legislative history.
- Interviewed the OMB officials responsible for carrying out the cost containment guidelines and perused material they gave us explaining the rationale for the guidelines.
- Interviewed Defense health affairs officials and Defense and VA officials responsible for preparing budgeted rates and accumulating actual cost and workload data. We reviewed and analyzed Defense and VA data supporting budgeted in-patient and out-patient recovery rates. Also, using actual cost and workload data, we computed in-patient and out-patient rates and analyzed differences between budgeted and actual rates. We did not, however, attempt to verify the accuracy of the financial data reported as actual.

We did no work at the Department of Health and Human Services because of the small size of its program and because an official said its budgeted rates were accepted without change when OMB imposed cost containment rates.

The audit was made in accordance with generally accepted government auditing standards, except that we did not verify the accuracy or completeness of computerized Air Force claims data, nor did we visit local Air Force offices to check the accuracy of data supplied us. However, we believe the quality of the computerized data was enhanced by the review by local officials, who adjusted the computerized claims listings to agree with their records. These adjustments were minor and had a negligible effect (less than 5 percent) on the totals.

To quantify the amount of revenue loss to the Government, we had to first determine the number of in-patient days and out-patient visits involved in the claims made by Defense and VA against liable third parties during calendar 1979. This data was not maintained by either agency.

We determined this data for the Army and Navy during visits to the following offices, which were chosen to get a mix of offices handling a large claims volume and those handling a small volume.

Army

Ft. Bragg, N.C.  
Ft. Carson, Colo.  
Ft. Stewart, Ga.  
Ft. Belvoir, Va.  
Ft. Lee, Va.  
Ft. Eustis, Va.  
Walter Reed, Wash., D.C.  
Ft. McNair, Wash., D.C.  
Aberdeen Proving Ground, Md.  
Ft. Meade, Md.

Navy

San Diego Naval Station, Calif.  
Washington Navy Yard, Wash., D.C.

The Air Force, through an automated data collection system, maintains a centralized record of all claims. At our request, Air Force officials sent each office located in the United States a list of its claims made during 1979. They asked the local officials to indicate the number of in-patient days and out-patient visits for each claim.

The calendar 1979 claims data reviewed represented about 61 percent of the 17,748 claims made by the services during 1979. From this data, we determined the number and ratio of in-patient days and out-patient visits per claim dollar. Because we believe that the same proportion of in-patient days and out-patient visits found in the claims we reviewed exists in all claims, we extrapolated the results found in the 1979 claims we reviewed to total service claims for 1979 and 1980. Although these estimates are not based on a statistical sample, we believe they are fairly good estimates of 1979 and 1980 claims because they are based on actual data from a large percentage (61 percent) of total Defense claims in 1979.

VA maintains data on dollar amounts claimed against liable third parties but does not maintain patient workload statistics. Therefore, since we did not visit any VA offices, we used the patient workload ratios resulting from our review of Defense's calendar 1979 claims to estimate the number of in-patient days and out-patient visits involved in VA claims against liable third parties during calendar 1979 and 1980. We believe this estimating procedure is valid because the agencies' medical care recovery programs operate under similar laws, policies, procedures, and circumstances of hospitalization. The VA official responsible for budgeting medical care recovery rates considered this methodology reasonable and the results conservative.

To determine the dollar value of additional claims that would have been made if the higher budgeted rates were used, we multiplied the differences between budgeted and cost containment rates by the estimated number of in-patient days and out-patient visits. Since all claims are not collected (see footnote to table on p. 2), we then multiplied the value of the additional claims by Defense and VA collection rates to determine the Government's revenue loss.

## CHAPTER 2

### MEDICAL RECOVERY RATES WERE TOO

#### LOW TO RECOVER FULL COSTS

Between October 1, 1978, and September 30, 1980, the Government failed to recover an estimated \$4 million in medical care costs because the cost containment rates charged liable third parties were lower than the rates that agencies budgeted to recover the cost of care provided in Defense and VA hospitals. In April 1981, during our review, we advised OMB that the cost containment rates were too low. OMB agreed and promptly authorized the agencies to use their budgeted rates. Although these rates were higher, they were still too low to recover the cost of medical care provided. Unless agency budgeted rates are adjusted to more accurately reflect full cost, the Government may lose about \$2 million a year.

#### MILLIONS NOT RECOVERED DUE TO USE OF COST CONTAINMENT RATES

During fiscal 1979, OMB required Defense and VA to use cost containment rates instead of their budgeted rates when making claims against liable third parties for recovery of medical care costs. The cost containment rates were generally lower than agency budgeted rates. If the agencies had billed at their budgeted rates, claims against liable third parties would have increased by an estimated \$8 million during calendar 1979 and 1980, and actual recoveries (the increased claims multiplied by agency medical recovery collection rates) would have increased by almost \$4 million.

The cost containment rates were developed by OMB to conform with then President Carter's cost containment guidelines to help contain the rise in hospital costs in the United States. The guidelines limited recovery rate increases from one year to the next based on an inflation-indexed formula. The President has legislative authority to set medical care reimbursement rates; however, the Federal Medical Care Recovery Act (1) authorizes him to establish rates reflecting the reasonable value of care furnished in Government hospitals and (2) gives the Government the right to recover the cost of medical care provided. Thus, as a result of setting reduced rates, the actual costs of care provided are not recovered, as clearly authorized by law.

An OMB official told us that the cost containment rates did not succeed in containing the rise in hospital costs. Further, during our review, we found no evidence that the President's cost containment philosophy and resulting rates prevented the growth of Defense or VA hospital costs. The main beneficiary of the cost containment rates was the liable party's insurance company, which paid less to the Government for an injured party's in-patient day and out-patient visit than it was actually costing the Government.

The following schedule shows, with the exception of one VA rate, that rates budgeted by the agencies were as close or closer to the rates reflecting the actual cost of medical care provided by the Government than were the cost containment rates. Thus, in the absence of better pricing criteria, the budgeted rates should have been used.

<u>Service provided</u>	<u>Dates effective</u>	<u>Rates per day/visit</u>					
		<u>Defense</u>			<u>VA</u>		
		<u>OMB</u>	<u>Budget</u>	<u>Actual</u>	<u>OMB</u>	<u>Budget</u>	<u>Actual</u>
In-patient	Oct. 1, 1977 - Sept. 30, 1978	\$206	\$206	\$245	\$132	\$132	\$144
	Oct. 1, 1978 - May 31, 1979	206	242	272	132	160	201
	June 1, 1979 - Sept. 30, 1979	226	242	272	151	160	201
	Oct. 1, 1979 - Apr. 6, 1980	226	298	309	151	175	222
	Apr. 7, 1980 - Sept. 30, 1980	254	298	309	170	175	222
	Oct. 1, 1980 - May 10, 1981	254	336	(a)	170	243	(a)
Out-patient	Oct. 1, 1977 - Sept. 30, 1978	20	20	25	39	39	37
	Oct. 1, 1978 - May 31, 1979	20	23	27	39	45	47
	June 1, 1979 - Sept. 30, 1979	23	23	27	45	45	47
	Oct. 1, 1979 - Apr. 6, 1980	23	29	31	45	45	51
	Apr. 7, 1980 - Sept. 30, 1980	26	29	31	51	45	51
	Oct. 1, 1980 - May 10, 1981	26	33	(a)	51	57	(a)

a/Actual fiscal 1981 data not available.

Based on a review of over 60 percent of the 17,748 medical care recovery claims made against liable third parties by Defense during fiscal 1979, had Defense and VA billed liable third parties using their budgeted rates rather than cost containment rates, we estimate they would have increased the amount of their claims for recovery of medical care costs by almost \$8 million during calendar 1979 and 1980 and would have increased their collections by almost \$4 million, as shown below.

<u>Year</u>	<u>Claims (note a)</u>			<u>Collections (note a)</u>		
	<u>Defense</u>	<u>VA</u>	<u>Total</u>	<u>Defense</u>	<u>VA</u>	<u>Total</u>
1979	\$3,082,000	\$722,000	\$3,804,000	\$1,671,000	\$242,000	\$1,913,000
1980	<u>3,193,000</u>	<u>853,000</u>	<u>4,046,000</u>	<u>1,807,000</u>	<u>256,000</u>	<u>2,063,000</u>
	<u>\$6,275,000</u>	<u>\$1,575,000</u>	<u>\$7,850,000</u>	<u>\$3,478,000</u>	<u>\$498,000</u>	<u>\$3,976,000</u>

a/The methodology used to calculate additional claims and collections is described on pp. 3-4.

Considering the large loss of revenue to the Government, we concluded that OMB should drop the cost containment rates as soon as possible.



## OMB DROPS COST CONTAINMENT RATES

On May 11, 1981, OMB changed its authorized medical care recovery rates, dropping the cost containment rates in favor of fiscal 1981 agency budgeted rates. (See app. II.) This action was in response to our April 17, 1981, letter to the Director, OMB, in which we informed him of the results of our review of Defense's calendar 1979 medical care recovery activities. (See app. I.)

In our letter to the Director, we informed him that (1) rates budgeted by Defense more closely approximated the reasonable value of medical care furnished by Defense hospitals than did the cost containment rates and (2) the Government could increase medical recoveries by close to \$2 million each year if Defense were allowed to use its budgeted rates. We asked whether the present administration intended to authorize Defense to charge its budgeted rates. We also advised him that we intended to review the effect of cost containment rates on VA medical recovery activities.

OMB's May 14, 1981, response stated that effective May 11, 1981, Defense was "authorized to charge third party reimbursement rates which reflect the full cost of care provided in DOD hospitals." OMB officials subsequently informed us that this policy also applied to VA.

## AGENCIES NEED TO IMPROVE ACCURACY OF ESTIMATED RATES

Even though the budgeted medical care recovery rates of Defense and VA are closer to actual cost and their use will result in increased collections, they are still too low to permit the Government to recover the full cost of medical care provided in its hospitals. For the past several years, the agencies have continually budgeted lower costs than were actually incurred and higher patient workloads than were actually handled. Since rates are determined by dividing patient workload into costs, these agency budget inaccuracies result in lower rates. If this condition is not corrected, the Government may still lose about \$2 million each year in medical costs resulting from actions by negligent third parties.

The agencies need to improve the accuracy of their budgeted medical care recovery rates to bring them more into line with actual results. To do this, they need to devote more attention to setting and monitoring rates. Rate setting accuracy would be enhanced by the results of historic comparisons of budgeted and actual costs and patient workloads, including the determination and analyses of variances. The monitoring, and if necessary the altering, of rates should be done periodically during the year by comparing budgeted costs and workloads with actual data as it becomes available.

As shown in the rate schedule on page 6, rates reflecting the actual cost of care in Defense and VA hospitals have, with the exception of VA's fiscal 1978 out-patient rate, continually exceeded the budgeted rates established by the agencies for recovery from liable third parties. This is contrary to the clear authority contained in the Federal Medical Care Recovery Act--to recover the fair and reasonable value of care furnished.

The budgeted rates were too low because the agencies, which establish these rates several months before the start of the fiscal year in which they are to be effective, have continually budgeted lower costs than were actually incurred and higher patient workloads than were actually handled. For the 3-year period fiscal 1978 through 1980, Defense and VA underbudgeted daily in-patient care by an average of 11.3 percent (\$28) and 21.2 percent (\$33) per year, respectively. Out-patient care per visit was similarly underbudgeted by 16.7 percent (\$4) and 4.7 percent (\$2).

Analyses of the differences between actual and budgeted in-patient rates indicate that 75 percent of Defense's variance and 27 percent of VA's variance were caused by budgeting for more patient workload than actually occurred. Conversely, 25 percent and 73 percent of the variances were caused by budgeting lower costs than were actually incurred. Similar analyses of out-patient rate differences indicate that each agency's variances were caused equally by overbudgeting patient workload and underbudgeting costs.

If the agencies continue to underestimate medical care recovery rates, the Government may not be able to recover from liable third parties an estimated \$2 million a year. At Defense, between fiscal 1978 and 1980, the difference between collections based on actual rates versus budgeted rates would have been about \$5.3 million, or about \$1.8 million a year. At VA, the difference would have been about \$1.5 million for the 3 years, or about \$500,000 a year.

At present, the agencies make the clerical computations necessary to establish budgeted rates, but do not perform the managerial functions necessary to monitor and follow up to assure that the budgeted rates are on track with actual rates. For instance, actual rates are developed at VA but not until well after the close of the pertinent fiscal year. Actual rates are not developed at all at Defense. The agencies do not compare current budgeted costs, patient workloads, or rates with current actual data or with prior year data. Thus, they do not determine and analyze differences, chart trends, or make other meaningful comparisons necessary to develop more accurate forecasts. Further, at Defense there are no formal program procedures, no written instructions to the services regarding the data to be included in the service budgets, and no indepth review of service-supplied cost and workload estimates.

By monitoring the accuracy of budgeted rates during the year, the agencies could recommend to OMB that recovery rates be adjusted

as necessary. This could be done by interim (perhaps quarterly or semi-annual) comparisons of budgeted and actual cost and patient workload data as it becomes available.

#### CONCLUSIONS

Medical care recovery rates budgeted by Defense and VA have been set too low. Agency budgeted rates should approximate the full cost of care provided, as authorized by the Federal Medical Care Recovery Act.

OMB has now authorized the agencies to charge recovery rates which reflect the full value of care provided. To do this, the agencies need to improve the accuracy of their forecasts and monitor the accuracy of budgeted rates during the year. They should compute actual rates, compare them with budgets, and analyze variances, which would allow them to adjust rates as necessary during the year. Also, knowing the reasons for the differences between budgeted and actual costs and patient workloads will aid the agencies in developing more accurate forecasts.

#### RECOMMENDATION

We recommend that the Secretary of Defense and the Administrator of Veterans Affairs develop for OMB medical care recovery rates to be charged liable third parties which more accurately reflect the actual cost of care provided in their hospitals. To this end, as cost and workload data become available during the year, (1) actual costs per in-patient day and per out-patient visit should be developed and compared with amounts being charged, (2) variances should be determined and analyzed, and (3) recovery rates should be adjusted during the year to conform to actual results. Further, since the authority to set medical care recovery rates has been delegated to OMB, we recommend that the Director, OMB, monitor the implementation of the above recommendation and revise recovery rates accordingly, if he believes the rates are reasonable.



UNITED STATES GENERAL ACCOUNTING OFFICE  
WASHINGTON, D.C. 20548

APR 17 1981

ACCOUNTING AND FINANCIAL  
MANAGEMENT DIVISION

The Honorable David A. Stockman  
Director, Office of Management  
and Budget

Dear Mr. Stockman:

The General Accounting Office is presently reviewing the Department of Defense's standard hospital cost accounting system and its implementation of the Federal Medical Care Recovery Act (42 U.S.C. 2651-3). Briefly, the act authorizes recovery by Defense of the reasonable value of medical care furnished by military hospitals primarily to active and retired military personnel and their dependents on account of injury incurred under circumstances where a third party was liable.

Our findings, to date, indicate that the Government can increase collections by close to \$2 million each year if Defense was allowed to use its hospital rates when seeking reimbursement from liable third parties in lieu of those developed under former President Carter's cost containment guidelines.

The purpose of this letter is to (1) confirm the findings we orally presented to members of your staff on January 22, 1981, and (2) find out whether the present administration intends to authorize Defense to charge rates which more closely approximate the costs incurred by Defense hospitals.

In an effort to help contain hospital costs in the United States, former President Carter instructed the Office of Management and Budget (OMB) to develop hospital in-patient and out-patient rates to be used by the military rather than Defense developed rates when seeking reimbursement from liable third parties.<sup>1/</sup> These cost containment rates became effective for fiscal year 1979. Previously, OMB authorized Defense to use its own rates. The OMB rates are lower than the budgeted rates developed by Defense to reflect the average expected cost of hospital in-patient days and out-patient visits.

<sup>1/</sup>We understand that rates developed by the Veterans Administration and the National Institute of Health were also affected by this change in policy. We intend to visit these two organizations in the near future.

We found that the Defense rates more accurately approximate the reasonable value of medical care furnished by Defense hospitals than do the rates promulgated by OMB. The main beneficiary of the cost containment guideline rates is the liable party's insurance company, which pays less to the Government for an injured party's in-patient day and out-patient visit than is actually costing the taxpayer.

We estimated that during calendar year 1979, using the OMB rates, the military services made claims to recover costs involving 79,052 in-patient days and 68,990 out-patient visits in military hospitals. As indicated in the following table, Defense could have made claims for an additional \$3.1 million against liable third parties if the Defense rates were used.

SCHEDULE SHOWING EFFECT OF  
DIFFERENCES IN OMB AND DEFENSE RATES  
CALENDAR YEAR 1979

Service Provided	Date Effective	Rates			Days/ Visits	Effect of Rate Difference
		OMB	Defense	Difference		
In-Patient	1/1/79 - 5/31/79	\$206	\$242	\$36	30,309	\$1,091,124
	6/1/79 - 9/30/79	226	242	16	29,930	478,880
	10/1/79 - 12/31/79	226	298	72	18,813	1,354,536
					<u>79,052</u>	
Out-Patient	1/1/79 - 5/31/79	\$ 20	\$ 23	\$ 3	29,994	89,982
	6/1/79 - 9/30/79	23	23	--	22,402	-0-
	10/1/79 - 12/31/79	23	29	6	16,594	99,564
					<u>68,990</u>	<u>\$3,114,086</u>

Based on the military services' collection rates, we estimate that if the additional \$3.1 million in claims had been asserted the Government would have increased its recovery of medical costs by \$1.7 million.<sup>1/</sup>

<sup>1/</sup>The military services' collection rate is only 54 percent. The reason for this low rate of collection and how the services manage the claims asserted are among the subjects of our continuing audit.

We plan to present these findings in a report to the Congress. If you wish, we would be pleased to meet with you or members of your staff to discuss our findings in more detail. We would appreciate being advised within 10 days as to whether OMB intends to authorize Defense to charge rates which more closely approximate the costs incurred by Defense hospitals.

Sincerely yours,

(signed) D. L. Scantlebury

D. L. Scantlebury  
Division Director and  
Chief Accountant of GAO

cc: Mr. Campbell (AFMD)  
Mr. Simonette (AFMD)  
Mr. Lowe (AFMD)



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET  
WASHINGTON, D.C. 20503

MAY 14 1981

Mr. D. L. Scantlebury  
Division Director and  
Chief Accountant of GAO  
U. S. General Accounting Office  
Washington, D.C. 20548

Dear Mr. Scantlebury:

This is a reply to your letter of April 17, 1981, concerning third party reimbursement rates for Department of Defense hospitals.

Effective May 11, 1981, the Department of Defense is authorized to charge third party reimbursement rates which reflect the full cost of the care provided in DOD hospitals. We have enclosed for your information a copy of the Federal Register notice which specifies the new rates.

Sincerely,

David Sitrin  
Deputy Associate Director  
for National Security

Enclosure

OFFICE OF MANAGEMENT AND BUDGET  
COST OF HOSPITAL AND MEDICAL CARE AND TREATMENT FURNISHED  
BY THE UNITED STATES

Certain Rates Regarding Recovery From  
Tortiously Liable Third Persons

By virtue of the authority vested in the President by Section 2(a) of the Act of September 25, 1962, (76 Stat. 593: 42 U.S.C. 2652), and delegated to the Director of the Office of Management and Budget by Executive Order No. 11541 of July 1, 1970, (35 F.R. 10737), the following three sets of rates are established for use in connection with the recovery, as authorized by such Act, from tortiously liable third persons of the cost of hospital and medical care and treatment furnished by the United States (Part 43 of Chapter I of Title 28 of the Code of Federal Regulations) through three separate Federal agencies. These rates have been determined to represent the reasonable cost of hospital, nursing home, medical, surgical or dental care and treatment (including prostheses and medical appliances) furnished or to be furnished:

(a) For such care and treatment furnished by the United States in Federal hospitals, nursing homes, and outpatient clinics, administered by any of the three Federal agencies-- Department of Defense, Veterans Administration, or Department of Health and Human Services--with the exception of Department of Defense operated medical treatment facilities in Panama.

(b) For such care and treatment furnished at Government expense in a facility not operated by the United States, the rates shall be the amounts expended by the United States for such care and treatment.

(c) For such care and treatment of the United States Government medical treatment facilities in Panama, Panama-specific rates shall be those established and in effect at the time the care and treatment is furnished, by the Department of Defense for such care and treatment furnished in Panama to beneficiaries of other United States Government agencies.



	Effective May 11, 1981 and thereafter		
	<u>DOD</u>	<u>VA</u>	<u>HHS</u>
<u>Hospital care per inpatient day:</u>			
General medical, surgical, and tuberculosis care .....	336	245	224
-- in Panama .....	397	--	--
Psychiatric care .....	--	154	--
-- in Panama .....	141	--	--
Nursing home care .....	--	98	--
Burn Center, U.S. Army Institute of Surgical Research, Brooke Army Medical Center, Houston, Texas	1,010	--	--
<u>Outpatient medical and dental treatment:</u>			
Per outpatient visit .....	33	54	44
-- in Panama .....	44	--	--

For the period beginning May 11, 1981, the rates prescribed herein supersede those established by the Director of the Office of Management and Budget on April 7, 1980, (45 F.R. 24293).

MAY 4 1981

DAVID A. STOCKMAN

Date

Director, Office of Management and  
Budget

(903009)



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