

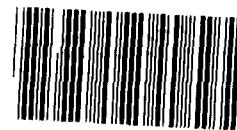
GAO

Briefing Report to Congressional
Requesters

March 1987

DEFENSE HEALTH CARE

CHAMPUS Reform Initiative: Unresolved Issues



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Human Resources Division

B-226377

March 4, 1987

The Honorable Beverly Byron
Chairman, Subcommittee on
Military Personnel and Compensation
Committee on Armed Services
House of Representatives

The Honorable John C. Stennis
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate

In a March 13, 1986, letter, the former Chairman, Subcommittee on Military Personnel and Compensation, House Committee on Armed Services, asked that we monitor the Department of Defense's (DOD's) development of changes to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In its report on DOD's Appropriations Bill for 1987, the Senate Committee on Appropriations directed us to also monitor the changes proposed for CHAMPUS and to keep the Committee informed of our concerns. We have periodically briefed your offices on our work and were requested to prepare this briefing report on the key issues we have identified to date that should be addressed before full implementation of the CHAMPUS changes. Our work is not yet complete and will continue.

In doing our work, we reviewed (1) DOD documents describing the proposed changes, (2) contractor studies performed to assist DOD in developing the changes, (3) industry comments provided in response to a request by DOD, and (4) current CHAMPUS statistical information and reports. We interviewed officials in the Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C. (the office responsible for developing the program to restructure CHAMPUS); officials in the Office of CHAMPUS, Aurora, Colorado; various DOD procurement officials; and officials from three beneficiary advocacy organizations--the Fleet Reserve Association, the Retired Officers Association, and the Non-Commissioned Officers Association.

BACKGROUND

CHAMPUS pays for much of the medical care provided by civilian hospitals, physicians, and other providers to dependents of

active-duty members, retirees and their dependents, and dependents of deceased members of the uniformed services. The uniformed services include the military services as well as certain personnel in three other agencies.

CHAMPUS costs have been increasing over the years and were nearly \$1.8 billion in fiscal year 1986. DOD is proposing to change CHAMPUS because of the significant cost increase and because of other problems it has identified in the program.

The contemplated changes to CHAMPUS, called the CHAMPUS Reform Initiative, are major. The objectives of the Initiative are to (1) contain costs, (2) increase beneficiary access to medical care, (3) improve coordination between CHAMPUS and the military treatment facilities, (4) assure quality of care, and (5) simplify administrative procedures. In addition to contracting for the processing and payment of claims for medical care, the new program will also use fixed-price contracts with private industry to provide care. As part of the Initiative, a new enrollment program is proposed that offers expanded benefits and lower costs to beneficiaries willing to obtain care from the contractor's network of providers. The contractor will also offer the existing CHAMPUS to beneficiaries who do not wish to enroll in the new program.

DOD originally planned nationwide implementation of the Initiative by the fall of 1987 using three large contracts. After receiving congressional direction and reviewing industry comments, DOD revised its original plan and will instead award smaller regional contracts and phase in implementation over at least a 2-year period. The request for proposal for the demonstration phase was initially scheduled to be published by January 16, 1987, and after some delay, was finalized on February 27, 1987.

The initial demonstration phase is supposed to begin not later than September 30, 1987. If this phase is successful, DOD intends to implement the Initiative nationwide in two follow-on phases.

ISSUES NEEDING RESOLUTION

Summarized below are the key issues that we believe DOD should resolve before it proceeds with nationwide implementation of the Initiative.

- Although a key objective of the Initiative is to contain CHAMPUS costs, industry has expressed reservations whether this can be accomplished with the program structure and improvements planned. The health care

industry is concerned that the benefit package prescribed is too restrictive for cost-efficient operation and that the lower beneficiary cost-sharing planned goes against industry trends of passing on more costs to health care users. Program improvements, according to industry, may also cause more beneficiaries to use the program. Also, because the Initiative is regarded as experimental, fixed-price contracts may not guarantee cost containment due to contract provisions that will allow for adjustments based on utilization and change orders resulting from clarification of contract specifications. (See p. 12.)

- DOD claims that beneficiaries are dissatisfied with the current military health care program and has designed features under the Initiative to address these problems. However, industry perceives problems with some of the key features designed to increase beneficiary satisfaction, such as mechanisms to refer beneficiaries to providers, quality assurance systems, and contractor staff working in military treatment facilities. Beneficiary organizations are concerned about the disruptions caused by a major restructuring and also that contractors will have a financial incentive to provide minimum medical care at the lowest costs. (See p. 15.)

- Instead of simplifying CHAMPUS procedures, as intended, the Initiative's procedural complexities may create problems in program administration. For example, mechanisms to identify health care providers for beneficiaries will create a new administrative function requiring the continuous exchange of information between the contractor-operated activity used to refer patients and military treatment facilities, beneficiaries, and contractor providers. Program administration may be complex because DOD has neither clearly defined how this activity will refer patient workload nor detailed the management information system necessary to support this function and because of the number of participants in this information exchange. (See p. 17.)

The effect of these issues should be assessed before proceeding with nationwide implementation of the Initiative. In reviewing two similar demonstrations involving the Medicare and Medicaid programs, we identified the need for both adequate demonstration phases and thorough evaluations.

The Initiative's demonstration phase provides an excellent opportunity to assess the above issues. However, DOD has not

developed a methodology for making the congressionally mandated evaluation of the demonstration. This methodology should be developed quickly so that the demonstration phase can be thoroughly evaluated. Also, sufficient time should be allowed for adequate evaluation of the demonstration, even if subsequent implementation phases have to be delayed.

RECOMMENDATIONS TO THE
SECRETARY OF DEFENSE

We are recommending that the Secretary, through the Assistant Secretary (Health Affairs), provide for a thorough evaluation of the Initiative's demonstration phase before DOD proceeds with implementation of subsequent phases. Specific provisions of the recommendations are on page 21.

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As requested by your offices, we did not obtain official DOD comments on this briefing report. We did, however, discuss its contents with officials of the Office of the Assistant Secretary of Defense (Health Affairs). In general, they agreed with our recommendations that a full evaluation of the Initiative is needed before proceeding with full-scale implementation. They also emphasized that full-scale implementation would not occur if the Initiative is found to be too expensive.

As arranged with your offices, we plan to distribute copies of this briefing report to the Chairmen of the House Committee on Appropriations and the Senate Committee on Armed Services; the Director, Office of Management and Budget; the Secretary of Defense; the Secretaries of the Army, Navy, and Air Force; and other interested parties. We will also make copies available to others upon request.

Should you need additional information on the contents of this briefing report, please call David Baine on 275-6207.



Richard L. Fogel
Assistant Comptroller General

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ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense

CHAMPUS REFORM INITIATIVE: UNRESOLVED ISSUES

INTRODUCTION

In December 1985, the Department of Defense (DOD) proposed a major restructuring of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS costs have risen from about \$1.2 billion in fiscal year 1984 to about \$1.8 billion in fiscal year 1986. In addition to contracting for the processing and payment of claims for medical care, the new program, called the CHAMPUS Reform Initiative, would use fixed-price contracts with private sector health providers for the provision of medical care to beneficiaries.

CHAMPUS pays for much of the medical care provided by civilian hospitals, physicians, and other civilian providers to dependents of active-duty members, retirees and their dependents, and dependents of deceased members of the uniformed services.¹ The approximately 6.2 million beneficiaries may also receive medical care on a space-available basis in the 168 military hospitals and hundreds of military clinics worldwide, and in the other uniformed services treatment facilities. Under CHAMPUS, however, beneficiaries must pay deductibles and cost-shares,² whereas care in uniformed services facilities is essentially free.

According to DOD, the current CHAMPUS needs restructuring because of many problems. The problems cited by DOD include (1) excessive costs resulting from CHAMPUS's outdated payment methods, (2) inadequate beneficiary access to care due to substantial CHAMPUS cost-sharing that does not offer an affordable alternative to the long delays in obtaining appointments in military facilities, (3) poor coordination between CHAMPUS and military treatment facilities, (4) little monitoring of quality of care provided by civilian providers because of the fragmented CHAMPUS structure, and (5) complex

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

²For outpatient care, beneficiaries pay an annual deductible of \$50 per person or \$100 per family, after which dependents of active-duty members pay a cost-share of 20 percent and all other beneficiaries pay 25 percent. For inpatient care, dependents of active-duty members pay \$25 or \$7.55 per day, whichever is greater, while other beneficiaries pay 25 percent of allowable charges.

administrative procedures and long delays in the payment of claims.

Development of the Initiative

To assist in studying the feasibility and design of the Initiative, DOD contracted with a consulting firm, ICF, Incorporated. The consultant's reports detailed various design features for DOD to consider and presented the potential effects these options might have on the military health care system. DOD selected the features it believed most likely to address the problems attributed to CHAMPUS.

DOD initially planned to award three fixed-price contracts under which a competitively selected contractor(s) would assume the entire financial risk for the financing and delivery of all CHAMPUS health care services in the United States. Contractors were expected to establish preferred provider networks consisting of adequate numbers and mixes of facilities and medical professionals to assure access to appropriate levels and types of care. DOD also planned that

- there would be no reduction in CHAMPUS benefits,
- there would be enhanced primary care (outpatient) benefits and reduced "out-of-pocket" expenditures by beneficiaries enrolling in preferred provider networks,
- beneficiary freedom would be preserved to select providers of their own choosing,
- the contractor would assume responsibility for processing claims,
- new quality assurance standards and procedures would be adopted, and
- staff sharing arrangements (contractor staff working in military facilities) would be developed to supplement staff at military treatment facilities.

DOD planned to implement the Initiative by the fall of 1987.

To obtain public comments on the feasibility and potential efficacy of the Initiative's features, DOD, in June 1986, issued a draft request for proposal, containing the basic structural requirements for the CHAMPUS Reform Initiative. DOD received more than 50 responses from various organizations, such as health care and insurance companies, national trade associations, and consortiums of companies interested in the Initiative. Some responses only expressed an interest in the Initiative and

notified DOD that the companies looked forward to the issuance of the actual request for proposal. Other responses included many detailed comments on specific features of the Initiative. These responses are discussed in subsequent sections of this briefing report.

Congressional Direction

The National Defense Authorization Act for Fiscal Year 1987 (Public Law 99-661, approved Nov. 14, 1986), directed DOD to demonstrate the Initiative's feasibility. The act requires that the demonstration begin before September 30, 1988, be conducted for at least 1 year, include a health care enrollment system, include the competitive selection of contractors, and not include more than one-third of the current CHAMPUS. The act stated that based on the demonstration results, DOD may proceed to implement the CHAMPUS Reform Initiative in two phases during a period of no less than 2 years.

The Conference Report for Continuing Appropriations for Fiscal Year 1987 (H. Rept. 99-1005, Oct. 15, 1986) also endorsed a demonstration of the CHAMPUS Reform Initiative and a phased implementation of the Initiative if the demonstration is determined successful. This report, however, required the demonstration to begin not later than September 30, 1987. The conference reports for both the Authorization Act and the Continuing Appropriations stated that DOD was to periodically report to the Congress as the Initiative is developed and implemented.

DOD's Revision of the Initiative

After having received direction from the Congress and reviewing industry comments, DOD revised its plan for the Initiative and reported the revisions to the Congress in November 1986. The major revisions were:

- The Initiative would be phased in, and experience gained from the first phase would be reflected in later phases.
- The geographic coverage in the first phase was to include CHAMPUS beneficiaries in six states.
- Additional provisions were made to reduce the financial risk of the contractor(s) if higher than expected utilization occurs.
- Provisions were included to ensure stability of medical care for beneficiaries should the demonstration fail.

In its November 1986 report, DOD described its plan to demonstrate the Initiative through three competitive contracts.

Each contract would cover two states--California and Hawaii, North Carolina and South Carolina, and Florida and Georgia.³

Key Elements of the Initiative

The Initiative's objectives are to contain CHAMPUS costs for both the government and beneficiaries, improve beneficiary access to health care, improve coordination between CHAMPUS and the military treatment facilities, assure quality of care, and simplify CHAMPUS procedures.

The primary features DOD plans to use in the Initiative to achieve these objectives are

- fixed-price contracts to help contain costs;
- a voluntary enrollment system, called CHAMPUS Prime, to prove beneficiary access to care and to simplify CHAMPUS administrative procedures;
- a "health care finder" mechanism to improve coordination between CHAMPUS, military treatment facilities, and beneficiaries; and
- quality assurance standards that contractors must adhere to.

Fixed-Price Contracts

According to DOD, the keystone of the Initiative is the competitive award of fixed-price contracts for health care under CHAMPUS, which will shift the financial risk of providing care from the government to private contractors. DOD believes that a prospective, fixed-price method will allow it to take advantage of its buying power in a competitive health care marketplace. It further believes that assigning financial risk to contractors will provide the incentive for them to establish (1) improved delivery systems, including preferred provider networks; (2) enhanced benefits; and (3) better coordination with military treatment facilities.

³In response to a specific requirement in the Conference Report for Continuing Appropriations, a fourth contract is also planned for the New Orleans, Louisiana, area for a 2-year test of the Initiative.

CHAMPUS Prime

A second major feature of the Initiative is a voluntary enrollment program--called CHAMPUS Prime--which, according to DOD, will improve beneficiaries' access to care. DOD states that access to care has been a major problem because military treatment facilities are overcrowded and appointments are difficult to obtain.

Under CHAMPUS Prime, enrollees must agree, for a fixed period of time (probably at least 1 year), to use the contractor's network of providers for their health care. In return, enrollees will have, in addition to their current CHAMPUS benefits, additional coverage for preventive care and lower cost sharing.

Beneficiaries who choose not to enroll in CHAMPUS Prime will continue to be eligible for benefits under basic CHAMPUS and be required to meet current cost-sharing requirements. The contractor will reimburse providers under basic CHAMPUS.

According to DOD, program administration will be simplified for CHAMPUS Prime enrollees because they will no longer be required to file claims.

Health Care Finder

To improve coordination between the military and civilian health care components of the military health care system, DOD, as part of the Initiative, will require the contractor to institute a health care finder mechanism. Such a mechanism is needed, according to DOD, because the current program results in utilization patterns that are largely a function of patient self-selection of health care providers, individual physician referral habits, and inability to obtain appointments in military facilities when needed.

The contractor is to establish the health care finder program, whereby beneficiaries seeking care will be routed to either military or civilian providers. According to the draft request for proposal, the health care provider will be located in, or near, a military treatment facility. It is envisioned that the health care finder will first seek to refer patients to military facilities and will direct them to civilian providers only if the needed services are not available, or not available on a timely basis, from the military facility.

Quality Assurance Standards

According to DOD, contractors will be required to meet specific standards for qualifications for physicians, hospitals, and other health care professionals selected for participation in

its preferred provider networks. In addition, DOD states that contractors will be required to establish a system-wide quality assurance program to evaluate the quality of patient care.

ISSUES NEEDING RESOLUTION

The Initiative's goals are directed toward improving CHAMPUS while containing its costs. Although the premises upon which the Initiative are based may be sound, we believe that the issues we have identified, if left unresolved, raise doubts about whether the Initiative will be ultimately successful. These issues include

- the possibility of cost increases,
- the potential effects on beneficiary satisfaction, and
- a potential increase in program complexity.

The demonstration phase is an ideal opportunity to measure the effect these issues may have on the Initiative's success in meeting its objectives. We noted, however, that DOD had not, as of February 24, 1987, developed a methodology for making a congressionally mandated evaluation of the demonstration. Also, given the timetable proposed for full-scale implementation of the Initiative, sufficient time may not be available for adequate evaluation of the demonstration phase before proceeding with subsequent phases. We believe that, in view of the many uncertainties of the Initiative, a thorough evaluation of the demonstration is important enough to justify delaying subsequent phases, if necessary, until an evaluation is complete.

Issue 1: Program Costs May Increase
Under Initiative

- o DOD proposes that CHAMPUS costs can be contained through fixed-price contracts, which allow contractors to use innovative delivery methods.
- o DOD proposes that savings from this approach will be adequate to fund program improvements.
- o Uncertainties exist as to whether savings from innovative delivery techniques, such as CHAMPUS Prime, will be adequate to fund program improvements.
- o Increased utilization under the Initiative may increase program costs.
- o Implementing the Initiative under fixed-price contracts may be costly.

According to DOD, CHAMPUS has not adopted any of the cost-saving methods that have been successful in other government programs as well as in the civilian sector. Rather, CHAMPUS has, in general, reimbursed providers, primarily hospitals, on the basis of billed charges. However, under recent legislation CHAMPUS has the authority to reimburse hospitals under diagnosis-related groups,⁴ the same methodology that Medicare uses. CHAMPUS is planning to implement this reimbursement methodology by January 1, 1988, and estimates that program savings of about \$258 million annually can be achieved from the use of the methodology.

To contain CHAMPUS costs, DOD has proposed to use fixed-price contracts to provide a means for DOD to take advantage of its nationwide buying power in a competitive health care marketplace. DOD plans that the contractor will establish preferred provider networks, which offer services at lower costs. DOD contends that restructuring CHAMPUS along the lines it proposes will not only contain costs, but also provide cost savings sufficient to fund program improvements to its health care delivery system. These program improvements include (1)

⁴"Diagnosis-related groups" refers to a prospective payment methodology whereby hospitals are reimbursed based on the patients' diagnosis, regardless of their length of stay.

enhanced benefits, (2) elimination of deductibles and cost sharing and possible substitution of a minimal fee per visit, (3) contractor liaison offices at most military hospitals, (4) an appointments system, (5) a preferred provider network, (6) an enrollment/disenrollment system, (7) a management information system to record and report on program activity, and (8) a quality of care monitoring system.

Although DOD believes that the Initiative will contain costs, it has not analyzed (1) the potential savings expected from the Initiative's cost-saving features, (2) the potential costs of making program improvements, or (3) the costs of implementing its various administrative requirements. Rather, DOD officials told us that they will rely on industry bids to determine whether the Initiative can achieve the objective of containing costs.

CHAMPUS Prime May Not
Adequately Reduce Costs
to Fund Program Improvements

DOD believes that the enrollment program, utilizing preferred provider networks and cost containment practices, will produce sufficient savings to finance proposed program improvements. Although DOD expects CHAMPUS Prime, a principal cost-saving feature of the Initiative, to produce savings to fund program improvements, industry responses indicated that DOD has placed requirements on this feature that reduce the potential savings available.

Several industry respondents indicated that the program improvements planned under the Initiative may not be feasible within CHAMPUS budget constraints. Some respondents stated that the proposal is overly restrictive on potential contractors' ability to design a cost-efficient benefits package and to establish methods for controlling utilization. Several organizations stated that the proposal also contradicts the trend in the health industry to shift benefit costs to the beneficiary, especially when benefits are being enhanced. According to industry comments, these factors are likely to reduce CHAMPUS Prime's cost-saving potential.

Increased Utilization Under
the Initiative May Increase
Program Costs

According to many industry comments on the Initiative, beneficiary utilization of the program may increase, which could increase program costs. Currently, only about one-sixth of CHAMPUS beneficiaries file claims under the program. CHAMPUS attributes this to such factors as: (1) coverage through other health insurance obtained through a second job or spouse's

employment, (2) access to low-cost care at a military facility, (3) lack of beneficiary awareness of CHAMPUS coverage, and (4) previous problems with CHAMPUS. Many industry respondents stated that increasing benefits and lowering cost sharing by beneficiaries may encourage increased utilization of CHAMPUS.

A program offering free primary care similar to that proposed under CHAMPUS Prime, the Army PRIMUS Clinic Program, appears to support industry views that utilization would increase. PRIMUS clinics will be operated by civilian contractors, and according to an Army official, the one clinic in operation has estimated a 50-percent workload increase over previous projections after being in operation for a short time. The Army plans to open additional clinics as funds become available. The Navy and Air Force have similar programs. The Navy established four clinics late in 1986. The Air Force has announced plans to establish clinics at three locations in fiscal year 1987 and hopes to expand to five clinics by fiscal year 1989. DOD has stated that these clinics will offer another alternative source of care for beneficiaries in the same manner as military treatment facilities.

DOD intends to include risk-sharing provisions in the Initiative to protect the contractor from costs associated with unanticipated increases in utilization which, to a great extent, place the government at risk for these costs. By adopting risk-sharing features, DOD hopes to encourage potential contractors to submit more reasonable bids on Initiative contracts instead of inflating their bids to cover the risk of increased utilization. These risk-sharing features would increase payments to the contractor should program utilization increase. However, according to DOD officials developing the Initiative, industry has overestimated the risk that program utilization will increase. The DOD officials do not believe the Initiative's program improvements will significantly increase program utilization.

Implementing the Initiative
Under Fixed-Price Contracts
May Be Costly

It may prove costly to implement the Initiative's innovative and complex features under fixed-price contracts. Under such contracts, if ambiguities in contract specifications (the product description) must be clarified, or if specifications must be changed, the contractor is entitled to higher compensation if additional work is required by the clarifications. These contract clarifications, called change orders, can result in substantial increases in the original contract price. Contracting officials we interviewed said that change orders are required more frequently in procurements, such as that contemplated under the Initiative, in which contract

specifications are complex and innovative. They noted that the government is in a weak position when negotiating change order prices because it is obligated under the initial contract and responsible for the ambiguity in the original specifications.

Increases in contract costs from change orders can be illustrated from Office of CHAMPUS fixed price contracts for claims processing services. The Office of CHAMPUS, when it first converted to fixed-price contracts for claims processing in 1976, experienced significant increases over original contract prices because of change orders. In fiscal year 1986, after more than 10 years' experience with fixed price contracts, the Office continued to experience about a 6-percent increase in costs because of change orders.

Issue 2: Initiative May Not Increase
Beneficiary Satisfaction

- o DOD cites problems in CHAMPUS and in military health care that create beneficiary dissatisfaction.
- o DOD seeks to address beneficiary dissatisfaction through improvements under the Initiative.
- o Industry perceives problems with some of the key factors designed to increase beneficiary satisfaction. Respondents advocated greater flexibility in designing benefit packages and in referral of patients.
- o Beneficiary groups are concerned about the disruptions that would be caused by the change and that contractors will have financial incentives to provide minimum medical care at the lowest cost.

DOD states that CHAMPUS beneficiaries are dissatisfied with the current program because of several problems. DOD claims that because of substantial beneficiary cost-sharing requirements, CHAMPUS does not offer an affordable alternative to the long delays in obtaining appointments in military treatment facilities, particularly for outpatient primary care. DOD also claims that beneficiaries and providers are frustrated by complex CHAMPUS procedures and by long delays in receiving payment of claims.

DOD expects the Initiative to improve beneficiary satisfaction. Key among these expectations are enhanced access

to care at both military and civilian facilities, assured quality of care by creation of specific quality assurance programs, presumably in addition to those now available to CHAMPUS beneficiaries at civilian facilities, and improved benefits offered by the successful contractor in addition to those now available under CHAMPUS. DOD also plans that, under the Initiative, beneficiary cost-sharing (both deductible and copayments) would be lowered or eliminated and that the necessity for CHAMPUS claims processing would be reduced and simplified.

Industry commented extensively on the Initiative's CHAMPUS Prime and health care finder features designed to enhance beneficiary satisfaction. Concerns expressed over these features included (1) inadequate contractor flexibility in designing the CHAMPUS Prime benefit package, (2) contractor inability to pass along expanded benefit costs to beneficiaries, and (3) the complexities of the health care finder mechanism. Industry respondents sought greater flexibility in designing a more cost-efficient benefit package and more opportunities to employ techniques aimed at encouraging use of preferred providers.

To reduce complexity, potential contractors suggested ways to reduce health care finder requirements. Several respondents stated that the referral protocols, especially those that allowed the beneficiary to choose the military treatment facility, the preferred provider, or a nonpreferred provider, would not enable the contractor to provide the desired continuity of care. The health care finder mechanism for steering care was also considered by respondents to be inconsistent with the goal of maintaining the beneficiary's free choice of provider.

Beneficiary organizations are concerned that satisfaction under the Initiative may decrease due to disruptions in the program and contractor-imposed limitations on access to care. The majority of beneficiary complaints, according to beneficiary organizations and CHAMPUS officials, relate to claims processing problems and have decreased in recent years, rising occasionally when the incumbent claims processing contractor is replaced by a new contractor. One of the beneficiary organization's primary concerns regarding the Initiative is that transitions, from the existing program to the new program and from one contractor to another once the program is in place, will create significant disruptions to beneficiary services. Because the beneficiary will rely on the contractor for many services in addition to claims processing under the Initiative, the beneficiary groups told us that there is a greater potential for beneficiary dissatisfaction due to disruptions in the contractor's services.

Beneficiary organizations are also concerned that implementation of the contractor's preferred provider network may lead to decreased satisfaction for beneficiaries. They note that to maximize profits, the contractor may seek to channel enrollees

to the lower cost network providers. This management of care will be new to many CHAMPUS beneficiaries, and they may perceive it as too restrictive.

Regarding the issue of beneficiary satisfaction, the beneficiary organizations noted that the Army, Navy, and Air Force have initiated programs to open primary care clinics in areas where military treatment facilities are overcrowded. (See p. 14.) They said that the one Army clinic open is very popular among beneficiaries and provides free services. They also told us that the concept of these clinics appears to address most of the problems DOD is attempting to correct through its Initiative.

Issue 3: Program Complexity May Increase Under the Initiative

- o DOD intends to simplify program administration.
- o Contractors will be required to implement many new administrative features while retaining the current CHAMPUS features intact. This may increase program complexity.
- o Industry has expressed concerns that the implementation schedule is too ambitious and will not allow time for adequate contractor development of necessary support systems to meet the Initiative's requirements.
- o Industry is concerned that management information system requirements have not been adequately specified.

One of the Initiative's objectives is to simplify administration of CHAMPUS. As an indication of the complexities under the current CHAMPUS, DOD has cited the numerous written complaints from beneficiaries (nearly 15,000 in 1985) and the many inquiries from CHAMPUS beneficiaries. DOD states that program administration will be simplified under the Initiative because beneficiaries who enroll in CHAMPUS Prime will no longer be required to file claims.

While the Initiative may reduce beneficiary problems associated with filing claims, it requires contractors to implement a number of new program features while retaining essentially intact the current CHAMPUS features. These new features, layered on top of the existing program, create the potential for increased program complexity for both the contractor and beneficiaries. In addition to CHAMPUS Prime and

the health care finder, new features include utilization review and quality control systems, a program to permit contractor staff to work in military treatment facilities, and a management information system. For beneficiaries not enrolling in the contractor's network of providers, all of the current requirements that DOD believes need correction, such as submission of claims and beneficiary cost sharing, would continue to apply.

In commenting on the draft request for proposal, industry expressed concerns that administrative requirements were excessive, overly restrictive, duplicative, and unclear. For example, some respondents expressed concern over what they believe are excessive reporting and recordkeeping requirements. Others said that requirements associated with the health care finder--such as 24-hour telephone service, referral and appointment setting, and 24-hour on-call physicians--were excessive. Others were concerned over the malpractice and liability insurance implications of contractor staff working in military treatment facilities.

Industry as well as the military services have also expressed reservations about coordination of activities between the contractor and the military treatment facilities. Industry respondents stated that the coordination envisioned under the Initiative would be difficult to achieve due to the issue of patient control and the complexity of the requirements. The services also want better clarification of the contractor's and military facility commanders' responsibilities and authorities in the areas requiring coordination. Each of the services has expressed concern about contractor management of the military direct care system.

Beneficiary organizations, as noted in the previous section, are concerned as well that the Initiative contains new and more complex administrative requirements. In addition, these organizations are concerned that beneficiaries will become reliant on contractors for more than just claims processing.

The potential for additional program complexity can also be illustrated through industry comments about various aspects of the Initiative. For example, the draft request for proposal established procedures and time guidelines to be followed by the contractor during phase-in of the Initiative. For the phase-in period, the contractor was given 6 months to start service after the award of the contract. Most of the organizations responding to the draft request for proposal felt that the 6-month transition period was inadequate to complete the tasks to start the service. The DOD contractor reviewing industry comments stated that the transition period should be extended.

Also, industry had a number of concerns with the requirements for a management information system to be developed by the contractor. The Initiative requires the system to include procedures for enrollment verification, claims processing activities, quality assurance monitoring, and other data management activities necessary to support contractor reporting to DOD. In commenting on the management information system requirements, respondents requested clarification on specific requirements, expressed concern over the level of control the government would have over modifications, and listed misgivings about the feasibility of management information system development within the time allowed.

DEMONSTRATION PHASE NEEDS TO
BE THOROUGHLY EVALUATED

The need for adequate demonstration phases for new activities such as the CHAMPUS Reform Initiative and comprehensive evaluations of those activities has been identified in connection with two demonstrations involving the Medicare and Medicaid programs. Each of these initiatives involved the award of risk-sharing contracts to private sector health provider organizations (health maintenance organization and/or preferred provider networks) in attempts to contain program costs. In reviews of these demonstrations, we identified numerous difficulties, ranging from problems with the financial viability of some of the participating organizations to difficulties involving beneficiary access to quality medical care.^{5,6} Several of the lessons learned from the two demonstrations may be applicable to the Initiative's demonstration phase, and both emphasize the need to proceed judiciously with initial phases of such complex undertakings before full implementation of completely revamped programs.

The Congress, in authorizing and appropriating funds to DOD for fiscal year 1987, directed DOD to demonstrate the feasibility of the Initiative before proceeding with full-scale implementation. The Conference Report on the National Defense Authorization Act of 1987 (H. Rept. 99-1001, Oct. 14, 1986) directed the Secretary of Defense to:

"Conduct a demonstration project on the proposed . . . Initiative to begin during fiscal year 1988, operate

5Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

6A report to be issued in March 1987 on Arizona's Medicaid program (GAO/HRD-87-14).

the project for at least one year, and apply the project to not more than one-third of the CHAMPUS program . . . Based on the results of the demonstration project, the Secretary may proceed to phase in fully the . . . Initiative over the next two years in remaining areas."

The Conference Report on the Continuing Appropriations Act for Fiscal Year 1987 directed DOD to reform CHAMPUS on a phased basis. The report stated that DOD

"Should initiate the first phase of CHAMPUS reform in one geographic region of the continental United States to include approximately one-third of the CHAMPUS beneficiary population as soon as practical but not later than September 30, 1987. Following this, at no less than 9 month intervals, the remaining geographic regions should be phased in with a nation-wide reform of CHAMPUS completed by mid-1989."

DOD officials told us on February 24, 1987, that a methodology to evaluate the demonstration project has not been developed. Because the Initiative may have significant effects on the military health care system and its beneficiaries, we believe that DOD should develop thorough evaluation criteria for the demonstration project as soon as possible. In evaluating the demonstration, DOD should, at a minimum, determine the effects the Initiative has had on meeting DOD's objectives. The evaluation should cover a period of time sufficient to develop the information necessary to adequately assess the Initiative's effects.

In addition, as noted in the discussion of issue number 1 (p. 12), CHAMPUS has authority to reimburse providers of inpatient care on the basis of diagnosis related groups and has estimated savings of about \$258 million annually if this mechanism were adopted. In evaluating whether the Initiative has achieved its cost containment objectives, we believe the costs under the Initiative should be compared with the existing program costs reduced by the potential savings achievable by use of diagnosis related groups. The comparison should also consider the effects on any new openings of PRIMUS-type clinics.

The timetable established for the Initiative's implementation, particularly that imposed by the Conference Report on Continuing Appropriations for Fiscal Year 1987, probably does not allow sufficient time for a thorough evaluation of the Initiative's demonstration phase, particularly in view of the many uncertainties discussed in this report. According to DOD officials, the target date for contract award of the demonstration project is September 30, 1987. The draft request for proposal initially established a 6-month transition period--

the time necessary from contract award to starting service. Industry commented that a 6-month transition period was not adequate to complete the tasks needed to start services.

It is difficult to predict with certainty how long the transition period should be. Office of CHAMPUS procurement officials told us, however, that contracts for claims processing services take about 14 months from issuance of requests for proposal to the successful contractor's start of work. This includes about 7 months for transition. The transition for one or more Initiative contracts, which will be substantially more complex than those for claims processing, may take considerably longer.

In view of the uncertainty of how much time will be needed for transition and the importance of a thorough evaluation of the demonstration phase before proceeding with additional phases, the target date established by the Conference Report on Continuing Appropriations for nationwide implementation of the Initiative may need to be reconsidered.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

In view of the many complexities and uncertainties involved in developing and implementing the Initiative, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to

- expeditiously develop a methodology for conducting a thorough evaluation of the Initiative's demonstration phase;
- assure that the Initiative's demonstration phase is of sufficient duration that issues such as those raised in this briefing report and those that may arise during the demonstration can be thoroughly evaluated before DOD proceeds to subsequent phases of the Initiative; and
- inform the Congress promptly if DOD determines that the congressionally directed timetable (mid-1989) for nationwide implementation of the Initiative cannot be met because of the need for a more thorough demonstration phase and subsequent evaluation of that phase.

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