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DEFENSE HEALTH CARE

Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weaknesses

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Highlights

Highlights of GAO-03-592T, a report to a testimony before the Subcommittee on Total Force, Committee on Armed Services, House of Representatives

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Why GAO Did This Study

During 2002, in testimony to the House Armed Services Committee, Subcommittee on Personnel, beneficiary groups described problems with access to care from TRICARE's civilian providers, and providers testified about their dissatisfaction with the TRICARE program, specifying low reimbursement rates and administrative burdens.

The Bob Stump National Defense Authorization Act of 2003 required that GAO review DOD's oversight of TRICARE's network adequacy. In response, GAO is (1) describing how DOD oversees the adequacy of the civilian provider network, (2) assessing DOD's oversight of the adequacy of the civilian provider network, (3) describing the factors that may contribute to potential network inadequacy or instability, and (4) describing how the new contracts, expected to be awarded in June 2003, might affect network adequacy.

GAO's analysis focused on TRICARE Prime—the managed care component of the TRICARE health care delivery system. This testimony summarizes GAO's findings to date. A full report will be issued later this year.

www.gao.gov/cgi-bin/getrpt?GAO-03-592T.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Marjorie Kanof at (202) 512-7101.

What GAO Found

To oversee the adequacy of the civilian network, DOD has established standards that are designed to ensure that its network has a sufficient number and mix of providers, both primary care and specialists, necessary to satisfy TRICARE Prime beneficiaries' needs. In addition, DOD has standards for appointment wait, office wait, and travel times that are designed to ensure that TRICARE Prime beneficiaries have adequate access to care. DOD has delegated oversight of the civilian provider network to lead agents, who are responsible for ensuring that these standards have been met.

DOD's ability to effectively oversee—and thus guarantee the adequacy of—the TRICARE civilian provider network is hindered in several ways. First, the measurement used to determine if there is a sufficient number of providers for the beneficiaries in an area does not account for the actual number of beneficiaries who may seek care or the availability of providers. In some cases, this may result in an underestimation of the number of providers needed in an area. Second, incomplete contractor reporting on access to care makes it difficult for DOD to assess compliance with this standard. Finally, DOD does not systematically collect and analyze beneficiary complaints, which might assist in identifying inadequacies in the TRICARE civilian provider network.

DOD and its contractors have reported three factors that may contribute to potential network inadequacy: geographic location, low reimbursement rates, and administrative requirements. However, the information the contractors provide to DOD is not sufficient to measure the extent to which the TRICARE civilian provider network is inadequate. While reimbursement rates and administrative requirements may have created dissatisfaction among providers, it is not clear that these factors have resulted in insufficient numbers of providers in the network.

The new contracts, which are expected to be awarded in June 2003, may result in improved network participation by addressing some network providers' concerns about administrative requirements. For example, the new contracts may simplify requirements for provider credentialing and referrals, two administrative procedures providers have complained about. However, according to contractors, the new contracts may also create requirements that could discourage provider participation, such as the new requirement that 100 percent of network claims submitted by providers be filed electronically. Currently, only about 25 percent of such claims are submitted electronically.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss issues related to the Department of Defense's (DOD) healthcare system, TRICARE. TRICARE's primary mission is to provide care for its eligible beneficiaries; currently, more than 8.7 million active duty personnel, retirees, and dependents are eligible to receive care through TRICARE. These beneficiaries receive their care through Military Treatment Facilities (MTFs) or through TRICARE's civilian provider network, which is designed to complement the availability of care offered by MTFs. MTFs supply most of the health care services TRICARE beneficiaries receive.[1]

TRICARE faces new challenges in ensuring that its civilian network can provide adequate access to care that complements the capabilities of MTFs. In 2003, DOD will award new contracts for the delivery of care in the civilian network. As a result, the providers who choose to participate may change, while those who remain will operate under new policies and procedures. During this time, TRICARE is still responsible for ensuring that its civilian network provides adequate access to care, even if the provider for some beneficiaries' care is changed.

TRICARE also faces beneficiary and provider dissatisfaction with its existing civilian network. During April 2002, testimony before the House Armed Services Committee, Subcommittee on Personnel, beneficiary groups described problems with access to care from TRICARE's civilian providers. Also, providers testified about their dissatisfaction with the TRICARE program, specifying low reimbursement rates and administrative burdens.

In response to these concerns, the Bob Stump National Defense Authorization Act of 2003 (NDAA 2003) required that we review DOD's oversight of the adequacy of the TRICARE civilian network.[2] My remarks will summarize the findings of our analysis to date, and we will issue a full report later this year. Our analysis, including our testimony today, focuses on TRICARE's civilian provider network. Specifically, I will discuss (1) how DOD oversees the adequacy of the civilian provider network, (2) an

[1]The military health system was funded at about $26.4 billion for fiscal year 2003. Approximately 20 percent of this amount, $5.2 billion, was budgeted for the TRICARE civilian provider network.

[2]Pub. L. No. 107-314, .§712,116 Stat. 2458, 2588 (2002).

assessment of DOD's oversight of the adequacy of the civilian provider network, (3) the factors that may contribute to potential network inadequacy or instability, and (4) how the new contracts might affect network adequacy.

To examine how DOD oversees the civilian provider network and interacts with the contractors, we interviewed officials at TRICARE Management Activity (TMA) in Washington D.C., the office that ensures that DOD health policy is implemented, and officials at TMA-West, the office that carries out contracting functions, including administering the civilian contracts and writing the Requests for Proposals for the future contracts. To assess DOD's oversight of the TRICARE network, we reviewed and analyzed extensive information from network adequacy reports from each of the contractors. We also interviewed DOD regional officials, known as lead agents, and MTF officials from 5 of 11 TRICARE regions. In addition, we interviewed officials from each of the four managed care support contractors who develop and maintain the network of providers to augment the care provided by MTFs. We visited and discussed network management and provider complaints with representatives of each contractor. We focused our work on TRICARE Prime—the managed care component of the TRICARE health care delivery system. We conducted our work from June 2002 through March 2003 in accordance with generally accepted government auditing standards.

In summary, to oversee the adequacy of the civilian network, DOD has established standards that are designed to ensure that its network has a sufficient number and mix of providers, both primary care and specialists, necessary to satisfy TRICARE Prime beneficiaries' needs. In addition, DOD has standards for appointment wait, office wait, and travel times that are designed to ensure that TRICARE Prime beneficiaries have adequate access to care. DOD has delegated oversight of the civilian provider network to lead agents, who are responsible for ensuring that these standards have been met.

DOD's ability to effectively oversee—and thus guarantee the adequacy of—the TRICARE civilian provider network is hindered in several ways. First, the measurement used to determine if there is a sufficient number of providers for the beneficiaries in an area does not account for the actual number of beneficiaries who may seek care or the availability of providers. In some cases, this may result in an underestimation of the number of providers needed in an area. Second, incomplete contractor reporting on access to care makes it difficult for DOD to assess compliance with this standard. Finally, DOD does not systematically collect and analyze

beneficiary complaints, which might assist in identifying inadequacies in the TRICARE civilian provider network.

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Background

TRICARE has three options for its eligible beneficiaries:

- TRICARE Prime, a program in which beneficiaries enroll and receive care in a managed network similar to a health maintenance organization (HMO);
- TRICARE Extra, a program in which beneficiaries receive care from a network of preferred providers; and
- TRICARE Standard, a fee-for-service program that requires no network use.

The programs vary according to the amount beneficiaries must contribute towards the cost of their care and according to the choices beneficiaries have in selecting providers. In TRICARE Prime,[3] the program in which active duty personnel must enroll, the beneficiaries must select a primary

[3]Out of more than 8.7 million eligible beneficiaries, nearly half are enrolled in TRICARE Prime.

care manager (PCM)[4] who either provides care or authorizes referrals to specialists. Most beneficiaries who enroll in TRICARE Prime select their primary care providers from MTFs, while other enrollees select their PCMs from the civilian network. Regardless of their status—military or civilian—PCMs may refer Prime beneficiaries to providers in either MTFs or TRICARE's civilian provider network.[5]

Both TRICARE Extra and TRICARE Standard require co-payments, but beneficiaries do not enroll with or have their care managed by PCMs. Beneficiaries choosing TRICARE Extra use the same civilian provider network available to those in TRICARE Prime, and beneficiaries choosing TRICARE Standard are not required to use providers in any network. For these beneficiaries, care can be provided at an MTF when space is available.

DOD employs four civilian health care companies or managed care support contractors (contractors) that are responsible for developing and maintaining the civilian provider network that complements the care delivered by MTFs. The contractors recruit civilian providers into a network of PCMs and specialists who provide care to beneficiaries enrolled in TRICARE Prime. This network also serves as the network of preferred providers for beneficiaries who use TRICARE Extra. In 2002, contractors reported that the civilian network included about 37,000 PCMs and 134,000 specialists. The contractors are also responsible for ensuring adequate access to health care, referring and authorizing beneficiaries for health care, educating providers and beneficiaries about TRICARE benefits, ensuring providers are credentialed, and processing claims. In their network agreements with civilian providers, contractors establish reimbursement rates and certain requirements for submitting claims. Reimbursement rates cannot be greater than Medicare rates unless DOD authorizes a higher rate.

[4]A primary care manager is a provider or team of providers at an MTF or a provider in the civilian network to whom a beneficiary is assigned for primary care services when he or she enrolls in TRICARE Prime. Enrolled beneficiaries agree to initially seek all nonemergency, nonmental health care services from these providers.

[5]DOD's policy is to optimize the use of the MTF. Accordingly, when a referral for specialty care is made by a civilian PCM, the MTF retains the "right of first refusal" to accommodate the beneficiary within the MTF or refer the beneficiary to the civilian provider network for the needed medical care.

DOD's four contractors manage the delivery of care to beneficiaries in 11 TRICARE regions. DOD is currently analyzing proposals to award new civilian health care contracts, and when they are awarded in 2003, DOD will reorganize the 11 regions into 3—North, South, and West—with a single contract for each region. Contractors will be responsible for developing a new civilian provider network that will become operational in April 2004. Under these new contracts DOD will continue to emphasize maximizing the role of MTFs in providing care.

The Office of the Assistant Secretary of Defense for Health Affairs (Health Affairs) establishes TRICARE policy and has overall responsibility for the program. The TRICARE Management Activity (TMA), under Health Affairs, is responsible for awarding and administering the TRICARE contracts. DOD has delegated oversight of the provider network to the local level through the regional TRICARE lead agent. The lead agent for each region coordinates the services provided by MTFs and civilian network providers. The lead agents respond to direction from Health Affairs, but report directly to their respective Surgeons General. In overseeing the network, lead agents have staff assigned to MTFs to provide the local interaction with contractor representatives and respond to beneficiary complaints as needed and report back to the lead agent.

DOD Has Standards for Network Adequacy and Requires Contractors' Compliance

DOD's contracts for civilian health care are intended to enhance and support MTF capabilities in providing care to millions of TRICARE beneficiaries. Contractors are required to establish and maintain the network of civilian providers in the following locations: for all catchment areas,[6] base realignment and closure sites,[7] in other contract-specified areas, and in noncatchment areas where a contractor deems it cost-effective. In the remaining areas, a network is not required.

DOD requires that contractors have a sufficient number and mix of providers, both primary care and specialists, necessary to satisfy the needs of beneficiaries enrolled in the Prime option. Specifically, it is the

[6]Catchment areas are geographic areas determined by the Assistant Secretary of Defense for Health Affairs that are defined by five-digit zip codes, usually within an approximate 40-mile radius of inpatient MTFs.

[7]Base realignment and closure (BRAC) sites are military installations that have been closed or realigned as the result of decisions made by the Commissions on Base Realignment and Closure.

responsibility of the contractors to ensure that the network has at least one full-time equivalent PCM for every 2,000 TRICARE Prime enrollees and one full-time equivalent provider (both PCMs and specialists) for every 1,200 TRICARE Prime enrollees.[8]

In addition, DOD has access-to-care standards that are designed to ensure that Prime beneficiaries receive timely care. The access standards[9] require the following:

- appointment wait times shall not exceed 24 hours for urgent care, 1 week for routine care, or 4 weeks for well-patient and specialty care;
- office wait times shall not exceed 30 minutes for nonemergency care; and
- travel times shall not exceed 30 minutes for routine care and 1 hour for specialty care.

DOD does not specify access standards for eligible beneficiaries who do not enroll in TRICARE Prime. However, DOD requires that contractors provide information and/or assist all beneficiaries—regardless of which option they choose—in finding a participating provider in their area.

DOD has delegated oversight of the civilian provider network to the regional TRICARE lead agents. The lead agents told us they use the following tools and information to oversee the network.

- Network Adequacy Reporting—Contractors are required to provide reports quarterly to the lead agents. The reports contain information on the status of the network—such as the number and type of specialists, a list of primary care managers, and data on adherence to the access standards. The reports may also contain information on steps the contractors have taken to address any network inadequacies.
- Beneficiary Complaints—The complaints come directly from beneficiaries and through other sources, such as the contractor or MTFs.

In addition to these tools, lead agents periodically monitor contractor compliance by reviewing performance related to specific contract requirements, including requirements related to network adequacy. Lead agents also told us they periodically schedule reviews of special issues

[8]In addition, all four contractors chose to closely follow the Graduate Medical Education National Advisory Committee (GMENAC) recommendation for determining the specialty mix requirements for their network.

[9]32 C.F.R. §199.17(p)(5)(2002).

related to network adequacy, such as conducting telephone surveys of providers to determine whether they are accepting TRICARE patients. In addition, lead agents stated they meet regularly with MTF and contractor representatives to discuss network adequacy and access to care.

If the lead agents determine that a network is inadequate, they have formal enforcement actions they may use to correct deficiencies. However, lead agents told us that few of the actions have been issued. They said they prefer to address deficiencies informally rather than take formal actions, particularly in areas where they do not believe the contractor can correct the deficiency because of local market conditions. For example, rather than taking a formal enforcement action, one lead agent worked with the contractor to arrange for a specialist from one area to travel to another area periodically.

DOD's Civilian Provider Network Oversight Has Weaknesses

DOD's ability to effectively oversee—and thus guarantee the adequacy of—the TRICARE civilian provider network is hindered by (1) flaws in its required provider-to-beneficiary ratios, (2) incomplete reporting on beneficiaries' access to providers, and (3) the absence of a systematic assessment of complaints. Although DOD has required its network to meet established ratios of providers to beneficiaries, the ratios may underestimate the number of providers needed in an area. Similarly, although DOD has certain requirements governing beneficiary access to available providers, the information reported to DOD on this access is often incomplete—making it difficult to assess compliance with the requirements. Finally, when beneficiaries complain about availability or access in their network, these complaints can be directed to different DOD entities, with no guarantee that the complaints will be compiled and analyzed in the aggregate to identify possible trends or patterns and correct network problems.

Required Provider-to-Beneficiary Ratios May Not Account for Actual Number of Beneficiaries or Availability of Providers

In some cases, the provider-to-beneficiary ratios underestimate the number of providers, particularly specialists, needed in an area. This underestimation occurs because in calculating the ratios, the contractors do not always include the total number of Prime enrollees within the area. Instead, they base their ratio calculations on the total number of beneficiaries enrolled with civilian PCMs and do not count beneficiaries enrolled with PCMs in MTFs. The ratio is most likely to result in an underestimation of the need for providers in areas in which the MTF is a clinic or small hospital with a limited availability of specialists.

Moreover, in reporting whether their network meets the established ratios, different contractors make assumptions about the level of participation on the part of civilian network providers. These assumptions may or may not be accurate, and the assumptions have a significant effect on the number of providers required in the network. Contractors generally assume that between 10 to 20 percent of their providers' practices are dedicated to TRICARE Prime beneficiaries. Therefore, if a contractor assumes 20 percent of all providers' practices are dedicated to TRICARE Prime rather than 10 percent, the contractor will need half as many providers in the network in order to meet the prescribed ratio standard.

Information Reported on Access Standards Was Incomplete

In the network adequacy reports we reviewed, managed care support contractors did not always report all the information required by DOD to assess compliance with the access standards. Specifically, for the network adequacy reports we reviewed from 5 of the 11 TRICARE regions, we found that contractors reported less than half of the required information on access standards for appointment wait, office wait, and travel times. Some contractors reported more information than others, but none reported all the required access information. Contractors said they had difficulties in capturing and reporting information to demonstrate compliance with the access standards. Additionally, two contractors collected some access information, but the lead agents chose not to use it.

Beneficiary Complaints Are Not Systematically Collected and Evaluated

Most of the DOD lead agents we interviewed told us that because information on access standards is not fully reported, they monitor compliance with the access standards by reviewing beneficiary complaints. Beneficiaries can complain about access to care either orally or in writing to the relevant contractor, their local MTF, or the regional lead agent. Because beneficiary complaints are received through numerous venues, often handled informally on a case-by-case basis, and not centrally evaluated, it is difficult for DOD to assess the extent of any systemic access problems. TMA has a central database of complaints it has received, but complaints directed to MTFs, lead agents, or contractors may not be directed to this database.

While contractor and lead agent officials told us they have received few complaints about network problems, this small number of complaints could indicate either an overall satisfaction with care or a general lack of knowledge about how or to whom to complain. Additionally, a small number of complaints, particularly when spread among many sources,

limits DOD's ability to identify any specific trends of systemic problems related to network adequacy within TRICARE.

DOD and Contractors Report Three Factors That May Contribute to Network Inadequacies

DOD and contractors have reported three factors that may contribute to network inadequacy: geographic location, low reimbursement rates, and administrative requirements. While reimbursement rates and administrative requirements may have created dissatisfaction among providers, it is not clear how much these factors have affected network adequacy because the information the contractors provide to DOD is not sufficient to reliably measure network adequacy.

DOD and contractors have reported regional shortages for certain types of specialists in rural areas. For example, they reported shortages for endocrinology in the Upper Peninsula of Michigan and dermatology in New Mexico. Additionally, in some instances, TRICARE officials and contractors have reported difficulties in recruiting providers into the TRICARE Prime network because in some areas providers will not join managed care programs. For example, contractor network data indicate that there have been long-standing provider shortages in TRICARE in areas such as eastern New Mexico, where the lead agent stated that the providers in that area have repeatedly refused to join any network.

According to contractor officials, TRICARE Prime providers have expressed concerns about decreasing reimbursement rates. In addition, there have been reported instances in which groups of providers have banded together and refused to accept TRICARE patients due to their concerns with low reimbursement rates. One contractor identified low reimbursement rates as the most frequent cause of provider dissatisfaction. In addition to provider complaints, beneficiary advocacy groups, such as the Military Officers Association of America (MOAA), have cited numerous instances of providers refusing care to beneficiaries because of low reimbursement rates.

By statute, DOD cannot generally pay TRICARE providers more than they would be paid under the Medicare fee schedule. In certain situations, DOD has the authority to pay up to 115 percent of the Medicare fee to network providers.[10] DOD's authority is limited to instances in which it has determined that access to health care is severely impaired within a

[10]See 32 C.F.R. §199.14(h)(1)(iv)(D),(E)(2002).

locality. In 2000, DOD increased reimbursement rates in rural Alaska in an attempt to entice more providers to join the network, but the new rates did not increase provider participation.[11] In 2002, DOD increased reimbursement rates to 115 percent of the Medicare rate for the rest of Alaska. In 2003, DOD increased the rates for selected specialists in Idaho to address documented network shortcomings. In 1997, DOD also increased reimbursement rates for obstetrical care. These cases represent the only instances in which DOD has used its authority to pay above the Medicare rate.[12] Because Medicare fees declined in 2002, and there is a potential for future reductions, some contractors are concerned that reimbursement rates may undermine the TRICARE network.

Contractors also report that providers have expressed dissatisfaction with some TRICARE administrative requirements, such as credentialing and preauthorizations and referrals. For example, many providers have complained about TRICARE's credentialing requirements. In TRICARE, a provider must get recredentialed every 2 years, compared to every 3 years for the private sector. Providers have said that this places cumbersome administrative requirements on them.

Another widely reported concern about TRICARE administrative requirements relates to preauthorization and referral requirements. Civilian PCM providers are required to get preauthorizations from MTFs before referring patients for specialized care. While preauthorization is a standard managed care practice, providers complain that obtaining preauthorization adversely affects the quality of care provided to beneficiaries because it takes too much time. In addition, civilian PCMs have expressed concern that they cannot refer beneficiaries to the specialist of their choice because of MTFs' "right of first refusal" that gives an MTF discretion to care for the beneficiary or refer the care to a civilian provider.

Nevertheless, there are not direct data confirming that low reimbursement rates or administrative burdens translate into widespread network

[11]U.S. General Accounting Office, *Defense Health Care: Across-the-Board Physician Rate Increase Would Be Costly and Unnecessary*, GAO-01-620 (Washington, D.C.: May 24, 2002).

[12]Similarly in April 2002, DOD adopted a policy that will authorize a 10 percent bonus payment to select TRICARE providers working in medically underserved areas as defined by Health Resources and Services Administration, consistent with Medicare payment policy. DOD plans to implement the bonus payment in July 2003.

inadequacies. We found that out of the 2,156 providers who left one contractor's network during a 1-year period, 900 providers cited reasons for leaving. Only 10 percent of these providers identified low reimbursement rates as a factor and only 1 percent cited administrative burdens.

New Contracts May Address Some Network Concerns, but May Create Others

DOD's new contracts for providing civilian health care, called TNEX, may address some network concerns raised by providers and beneficiaries, but may create other areas of concern. Because the new contracts are not expected to be finalized until June 2003, the specific mechanisms DOD and the contractors will use to ensure network adequacy are not known. DOD plans to retain the access standards for appointment and office wait times, as well as travel-time standards. However, instead of using provider-to-beneficiary ratios to measure network adequacy, TNEX requires that the network complement the clinical services provided by MTFs and promote access, quality, beneficiary satisfaction, and best value health care for the government.[13] However, TNEX does not specify how this will be measured.

TNEX may reduce administrative burden related to provider credentialing and patient referrals. Currently, TRICARE providers must follow TRICARE-specific requirements for credentialing. In contrast, TNEX will allow for network providers to be credentialed through a nationally recognized accrediting organization. DOD officials stated this approach is more in line with industry practices. Patient referral procedures will also change under TNEX. Referral requirements will be reduced, but the MTFs will still retain the "right of first refusal."

On the other hand, TNEX may be creating a new administrative concern for contractors and providers by requiring that 100 percent of network claims submitted by providers be filed electronically. In fiscal year 2002, only 25 percent of processed claims were submitted electronically.[14] Contractors stated that such a requirement could discourage providers from joining or staying in their network. However, DOD states that electronic filing will cut claims-processing costs and save money.

[13]DOD defines best value health care as high quality care delivered in the most economical manner for the military health system that optimizes the MTF system while delivering the highest level of customer service.

[14]This percentage does not include pharmacy claims or claims for care provided to Medicare-eligible beneficiaries under TRICARE For Life.

Another concern that has been raised by beneficiary groups extends beyond the network and potentially impacts beneficiaries who use TRICARE Standard. TNEX will no longer require contractors to provide information to all beneficiaries, including Standard beneficiaries, about providers participating in their area and to assist them in accessing care. Under the existing contracts, contractors are required to provide beneficiaries with the name of at least one participating provider, offer to contact the provider on behalf of the beneficiary, and offer to contact at least three local providers if a participating provider is not available locally. In contrast, TNEX does not include these requirements. MOAA and other beneficiary groups are concerned about this omission because they have received an increasing number of complaints from their constituents related to difficulties in finding providers who accept TRICARE Standard beneficiaries.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other Members of the Subcommittee may have.

Contacts and Acknowledgments

For more information regarding this testimony, please contact me at (202) 512-7101. Kristi Peterson, Allan Richardson, Louise Duhamel, Marc Feuerberg, Krister Friday, Gay Hee Lee, and John Oh also made key contributions to this statement.