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Report to the Chairman, Subcommittee on Defense, Committee on Appropriations, House of Representatives

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DEFENSE HEALTH CARE

Implementing Coordinated Care—A Status Report

GAO/HRD-92-10

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Human Resources Division

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October 3, 1991

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we examine a number of issues related to the status of the Department of Defense's (DOD) efforts in implementing its managed health care concept, called Coordinated Care, throughout the military health services system. We categorized the issues into two study objectives that this report addresses:

- Describe the status of managed care implementation in DOD.
- Identify any design, implementation, or evaluation concerns that need to be addressed.

The information in this report represents a follow-up to our March 14, 1991, testimony before the Subcommittee on Defense, Senate Committee on Appropriations,[1] and supplements an August 27, 1991, briefing that we provided to your staff. Our scope and methodology are described in appendix I.

Background

DOD's health care costs have been escalating rapidly, particularly in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),[2] where costs increased from $1.4 billion in fiscal year 1985 to an estimated $3.6 billion in fiscal year 1991. As a result, in June 1990, the Assistant Secretary of Defense (Health Affairs) unveiled a plan, to be implemented over 3 years, for containing DOD's health care costs and improving beneficiaries' access to high-quality care.

Coordinated Care, the centerpiece of the plan, will essentially transform military health care into a system of managed care similar to health maintenance organizations. It involves (1) providing a case manager, through whom all medical care is provided or referred, (2) seeking out cost-effective alternative health care settings, (3) establishing strong

[1]The Military Health Services System—Prospects for the Future (GAO/T-HRD-91-11, Mar. 14, 1991).

[2]CHAMPUS finances private sector health care for about 6 million eligible non-active-duty beneficiaries.

utilization review and quality assurance programs to assure that only appropriate, high-quality care is given, and (4) providing financial and other incentives to promote the delivery of cost-effective care.

On October 1, 1991, the Deputy Secretary of Defense approved the Coordinated Care proposal for implementation. However, before implementation, the Assistant Secretary (Health Affairs), in coordination with the DOD Comptroller, must project the program's cost and submit it to the Deputy Secretary for review. In a memorandum approving the program, the Deputy Secretary stated that the medical personnel, facilities, programs, and funding and other resources will be subject to the authority, direction, and control of the Assistant Secretary (Health Affairs). The Assistant Secretary is to carry out this responsibility by issuing instructions to the services' military medical departments through the service secretaries.

In lieu of selecting either of its principal ongoing managed care demonstration projects—the CHAMPUS Reform Initiative (CRI) and Catchment Area Management (CAM)—for sole use in its Coordinated Care program, DOD has chosen to combine key features of each. Coordinated Care adopts the CAM approach of giving military hospital commanders the responsibility and accountability for administering the program in their areas of responsibility, but it envisions extensive use of contractor services to supplement hospital resources as CRI does. One tri-service Coordinated Care site has thus far been designated, in the Tidewater, Virginia, area, and planning is underway to implement the program. Additionally, Health Affairs has approved the Army's plans to implement Coordinated Care at 11 sites in fiscal year 1992. Appendix II describes the Coordinated Care program as of October 1, 1991.

Results in Brief

Since June 1990, DOD has made significant advances in moving to a managed health care system, especially in light of the magnitude and complexity of this undertaking. The Deputy Secretary's October 1, 1991, approval of Health Affairs' Coordinated Care program represents an important milestone in getting this effort off the ground. However, DOD is behind schedule because many complex operational details and some policies still need to be developed and decided upon. For example, it is unclear exactly what will be expected of military hospital commanders in terms of management responsibilities and accountability, how CRI will be blended into the Coordinated Care program, what additional resources will be needed to implement the program and where they will come from, when sufficient budgeting and resource allocation systems

will be in place to implement a managed care system, when the military services will be ready to implement Coordinated Care, and how Coordinated Care will be evaluated.

Until recently, DOD had made little progress in implementing Coordinated Care at its one site in Virginia. This was largely because of disagreements and uncertainties among Health Affairs and the services over funding responsibilities and policies. Additionally, there was only one person assigned full time to the project. The Deputy Secretary's recent decision to assign the Assistant Secretary (Health Affairs) responsibility for developing a unified medical budget and to allocate resources as the Assistant Secretary instructs should help resolve this and other funding disputes that may arise among the services.

One important issue that we raised in our March 1991 testimony—the need to provide for uniform benefits and cost sharing—is not addressed in the current Coordinated Care program. Benefits and cost-sharing requirements within individual categories of beneficiaries (for example, retirees, survivors, and their dependents) will not be uniform in DOD's Coordinated Care program. Enrolled beneficiaries who are able to obtain their medical care at a military hospital will pay less than $10 a day for inpatient care, whereas those who must use civilian providers will pay a large part of the bill, usually 25 percent. Currently, uneven benefits and cost-sharing requirements that vary across the country add to beneficiaries' confusion and uncertainty about their medical benefits.

Accomplishments Have Been Achieved

Notwithstanding the fundamental issues that Health Affairs and the services still need to work out as they implement Coordinated Care throughout the military health services system, the recent decision by the Deputy Secretary represents an important step toward this objective. This and other actions indicate to us that DOD is making a concerted effort to improve its health care system.

For example, all the key components of DOD—the operational, personnel, financial, legal, and medical components—have at least tentatively endorsed the principles and concepts of Coordinated Care as the future DOD health care system. All the components agree with most aspects of the Coordinated Care program, and there are free and open exchanges of ideas regarding those features that they disagree about. The success of Coordinated Care depends on this collaboration continuing.

Questions remain on a number of subjects relating to how Coordinated Care will be operationalized. We discuss these issues in the following sections.

DOD Does Not Know How It Will Measure Military Hospital Commanders' Performance

The Coordinated Care program gives military hospital commanders responsibility for the cost and quality of and access to medical care for all beneficiaries in their areas, including those who use civilian providers under CHAMPUS. It also gives commanders responsibility for all funds now used to pay for care in both military and civilian settings in their areas. Currently, DOD's hospital commanders do not control beneficiaries' access to outpatient care delivered in civilian settings under CHAMPUS, nor do they have fiscal responsibility for any civilian care, inpatient or outpatient. In some cases, incentives exist for them to push costly care out of their facilities and into the civilian sector.

Placing effective control, fiscal responsibility, and accountability for beneficiary care at the local military hospital level will help provide needed incentives and authority to manage more effectively, such as by directing patients toward less costly providers and settings that provide high-quality care. DOD is developing the data systems necessary to support these activities, such as a capitation budgeting and resource allocation system, like that described in the next section of this report.

Also, Health Affairs has a project underway to design performance measures on the cost and quality of and access to care, which it will use as its basis for holding military commanders accountable for the provision of health care in their areas. The project is not expected to be completed for some time. During fiscal year 1992, Health Affairs intends to obtain an outside peer review of the proposed performance measurement plan, which will likely push its implementation into fiscal year 1993. Completing this effort will be pivotal to the successful completion of Coordinated Care since hospital commanders will be key factors in DOD's implementation efforts.

Adequate Budgeting and Resource Allocation Systems May Not Be Developed Quickly Enough

Closely related to the issue of holding military hospital commanders accountable for the cost and quality of and access to care is the need to develop adequate and accurate budgets that will ensure equitable allocations of available funds to each commander. As we reported in our March 1991 testimony, better budgeting tools are needed because DOD has no effective system for equitably allocating resources. DOD's plans indicate that no such system will be available until fiscal year 1997, when a capitation-based methodology will be introduced.

Military hospital budgets are currently based on the workloads of various medical departments. This workload-driven budgeting system creates incentives, for example, to admit patients inappropriately and retain them longer than medically necessary in order to justify additional resources.

The system that DOD is designing differs in several ways from its current system. The capitation system, several variations of which are used by health maintenance organizations around the country, allocates resources on the basis of expected health care utilization for a defined group of individuals adjusted for such factors as gender, age, and health status (for example, mixes of diseases/injuries and severity of illnesses).

Over the next 6 years, as the new budgeting system is being developed, DOD will be using a series of interim budgeting and allocation steps. For example, next year it will begin using inpatient information that is now being collected and analyzed from earlier efforts to move toward a budgeting system based on patients' diagnoses. As more and better patient-level data become available, the budgeting process will be modified. Whether these interim steps will be adequate to support and encourage the early implementation of Coordinated Care remains to be seen.

Limited Start-Up Resources Have Been Allocated

Experience with CRI and other managed care initiatives in DOD and elsewhere indicate that significant start-up resources are required to implement managed care. For example, enrollment systems, educational materials, provider networks, utilization management systems, and information systems all need to be in place before care is delivered. The services have not earmarked or committed any additional money for these efforts in fiscal years 1992 and 1993, and have designated very few people to assist in implementing Coordinated Care.

Health Affairs has estimated that start-up costs totaling $216 million could be needed by the services to implement Coordinated Care at the local level over the 3-year implementation period. Others in DOD have indicated that the costs could be as high as $360 million. None of the services' start-up costs were included in the fiscal year 1992 and 1993 budget requests; therefore, it is unlikely that any "new" money will be provided for start-up. Whatever resources are made available will have to come from another source. The services have not made firm commitments to provide this money.

In addition, costs will be incurred at the national level to institute claims-processing, enrollment, and other information system changes necessary to accommodate the Coordinated Care system. Health Affairs estimates these costs to be $946 million. Health Affairs officials said that these expenditures will be offset by significant reductions in the growth of military health care costs. Health Affairs, in its fiscal year 1992 and 1993 budget submissions, requested $166 million and $150.6 million, respectively, for Coordinated Care initiatives.

As of early September 1991, the services had not agreed on the resources that each would provide, nor had resources been committed to DOD's Coordinated Care site in the Tidewater, Virginia, area. Only one full-time person had been working on the project since it began in September 1990 though mid-August 1991. The project had an operating budget of $800 per quarter,[3] provided by the Portsmouth Naval Hospital, which has been used to purchase a facsimile machine and other office supplies. There was no administrative help beyond a part-time electrician's mate who is at the hospital for medical reasons. As a result, little progress had been made on the start-up tasks described earlier.

In mid-August 1991, the Navy decided to put together and send a team of people to Tidewater to speed implementation of the tri-service project. Navy officials informed us that these people, referred to as a "rapid implementation team," have expertise in various areas that are needed to start up the project, such as communications, procurement, managed health care, and information systems. Navy officials also informed us that the project has been budgeted $50,000 to cover start-up costs, an amount they consider adequate to get the project underway. Also, the Air Force and Army have each provided a representative to work full

[3]In fiscal year 1991, the Congress appropriated $4 million to plan and implement an automated telephone appointment system for the Tidewater site. This system will be used to better coordinate and schedule patient appointments among the services' hospitals and clinics in the Tidewater area.

time on the project. Plans call for the project to begin delivering health care on October 1, 1992.

Extent of Services' Cooperation in Implementing Coordinated Care Remains Unclear

The services need to cooperate fully in implementing Coordinated Care, particularly in committing resources to projects where they share responsibility. Experience at DOD's one Coordinated Care site suggests that this and future projects will be in jeopardy each year unless there is more central control over the budgeting and allocation of resources among shared service projects. In our March 1991 testimony, we suggested that consolidating the administrative and command structures of the services' medical departments may also offer the potential for improved efficiency. The Deputy Secretary's October 1, 1991, decision to give the Assistant Secretary (Health Affairs) the authority and responsibility for programming, budgeting, and allocating funds for all DOD medical activities[4] (except for military personnel) represents a positive step toward addressing this and other concerns.

The organizational structure of military medicine is a much-studied issue. Since the 1940s, many public and private sector studies have suggested changes to the way military health care is organized. Several have recommended consolidation of health care activities and authorities.

Most recently, a March 1991 report to the Deputy Secretary of Defense by DOD's Director of Administration and Management concluded that a single accountable official should have the responsibility for and the authority to manage resources and oversee programs for both the wartime and peacetime missions of military health care. The report presented three organizational alternatives as potential improvements to DOD's cost-containment strategy and to ensure cohesiveness between the two missions, by reducing duplication and fragmentation and making important resource trade-offs. The report concluded that consolidation would result in more efficient management of overlapping military health care areas and major savings in personnel.

The services have resisted major organizational changes in favor of maintaining their own health care systems, primarily on the grounds

[4]As a result of this decision, Health Affairs will be responsible for consolidating (1) all funding for DOD medical programs, including operations and maintenance, procurement, research and development, and CHAMPUS funds, but excluding the personnel funds for active and reserve medical military personnel, into a single defense medical appropriations account and (2) military medical facility construction funds into a separate appropriations account.

that each has unique medical activities and requirements. But as the March 1991 report points out, the Navy medical system handles sea, land, and air elements, indicating that one system can perform all functions and that there appear to be more similarities than differences. Furthermore, the report pointed out that in wartime the U.S. military fights (and provides medical care) under the authority of unified and specified commands, not as individual services.

Over the next several years, Coordinated Care sites, such as that in the Tidewater area, will be developed in several other large overlapping service areas, like the Washington, D.C., metropolitan area. The potential exists for regular disagreements and uncertainties such as that which has occurred in Tidewater. The Deputy Secretary's recent decision should help to resolve such disagreements. It remains to be seen, however, whether this action will be sufficient to overcome the often significant disagreements among the services' medical departments and whether further organizational changes will need to be made to help assure the successful implementation of DOD's Coordinated Care program.

It Is Unclear How CRI Will Be Blended With Coordinated Care

DOD officials told us that they are planning to continue CRI in California and Hawaii by competitively recontracting for a 5-year period following the current demonstration contract, which expires in January 1993. Coordinated Care as outlined in DOD's proposal will operate in other parts of the country.

There are significant differences between CRI and the Coordinated Care program that create potential conflicts in benefits and cost-sharing requirements for beneficiaries, accountability of hospital commanders, claims processing, and utilization management practices. For example, the CRI contractor has responsibility for performing all utilization management functions as well as claims-processing tasks for California and Hawaii. Under Coordinated Care, all these functions are to be handled by contractors separate from those administering the overall program.

Hospital commanders under CRI also have a different level of responsibility or accountability than envisioned under Coordinated Care. For example, the CRI contractor shares the financial risk for health care costs that exceed the contract price (adjusted for events that are beyond the contractor's control, such as inflation or beneficiary population growth) and in this sense is accountable for cost overruns. Military hospital commanders, under CRI, do not share the risks in these situations.

The CRI contractor, in cooperation with the hospital commanders, is also responsible for assuring health care access to the enrolled beneficiary population. Under Coordinated Care, military hospital commanders will be accountable for the cost and quality of and access to health care for all beneficiaries in the hospital's area of responsibility.

Unless resolved, these differences between CRI and the Coordinated Care program could lead to a confusing system of health care for both beneficiaries and administrators.

Benefits and Cost-Sharing Requirements Vary

DOD's Coordinated Care program, along with its plans to continue CRI, creates differences in benefits and cost sharing among beneficiaries. As pointed out in our March 1991 testimony, we believe uniform benefits and cost sharing within each category of beneficiary are necessary to achieve equity and consistency in program operations. Under Coordinated Care, beneficiaries will be directed (by a gatekeeper) to health care providers rather than being able to choose providers themselves. Individuals who are directed to civilian providers will have to pay more than those who gain access to a military facility. Currently, DOD has no definitive plans to resolve the matter.

Several differences in benefits and cost sharing within categories of beneficiaries will exist under Coordinated Care as now contemplated by Health Affairs. For example, retirees, survivors, and their dependents who enroll but are directed to civilian sources of care will pay the annual CHAMPUS deductibles for outpatient care ($150 per person and $300 per family) and copayments of 25 percent for both inpatient and outpatient care. In contrast, those who are able to obtain their care in a military hospital or clinic will pay nothing for outpatient care and the current nominal fee for inpatient care. (In fiscal year 1991 the charge was $8.55 a day or $25 per hospital stay, whichever is greater. Each year it is adjusted slightly for inflation.) Copayments for civilian outpatient care for dependents of active-duty members will be set at 20 percent, and these beneficiaries will pay only the nominal fee for inpatient civilian care. They also pay deductibles for civilian outpatient care.

Coordinated Care's benefit and cost-sharing features also differ from CRI's. For example, any person who has the option to enroll under Coordinated Care, but does not, will have to pay higher deductibles than now exist under CHAMPUS. These nonenrollees will also be prohibited from obtaining care in military medical facilities except in emergencies.

Nonenrollees in CRI currently pay standard CHAMPUS deductibles and copayments and also have access to military medical facilities.

Under CRI, enrolled beneficiaries who obtain civilian primary care pay $5 for each outpatient visit. Retirees, their families, and survivors pay $75 per day for inpatient hospital care (up to $750), while dependents of active-duty members pay nothing. DOD's Coordinated Care program will impose standard CHAMPUS deductibles and copayments for some enrolled beneficiaries who obtain civilian care.

Senior Health Affairs officials said that they intend to keep working toward more uniform benefits and cost-sharing arrangements but are planning to implement Coordinated Care, at least initially, with these differences. The dilemma they describe is that they do not know whether because of the ease in administration and increased use of the direct care systems, the enhanced benefits that CRI has introduced, for example, are more cost-effective than requiring beneficiaries to pay some share of their health care costs and the associated costs of having to keep track of individuals' annual deductibles. Also, they are unsure what the impact of cost sharing is on utilization.

These differences may be difficult for beneficiaries to comprehend and more difficult for network health care providers as well as contractors who process health care claims for DOD to administer. Further, they create inequities among the beneficiary population.

The Services May Not Be Ready to Implement Coordinated Care

In our March testimony we pointed out that hospital commanders will need much more technical assistance before moving ahead with systemwide managed care efforts. Developing managed care programs—including establishing networks of private providers, negotiating discounts, designing enrollment systems, establishing population-based budgets, and educating military physicians and beneficiaries on the impending changes—requires expertise and data that many military hospital officials do not possess. DOD's Coordinated Care program recognizes that greater demands will be placed on military personnel in terms of their business acumen and that the services will need to develop plans to train personnel in the new business skills required to manage local health networks effectively.

The services are at various stages and taking different approaches toward implementing Coordinated Care, including their efforts to

develop the necessary managed care expertise. However, service officials have all indicated that thus far the pace and intensity of training in managed care techniques has produced only a limited number of people with sufficient knowledge and skills to develop and operate managed care systems as envisioned by the Coordinated Care program. They and we see this as a significant limitation in the ability to quickly implement managed care systemwide, giving rise to the question as to when the services will be prepared to adopt Coordinated Care on a full-scale basis.

DOD's Coordinated Care Evaluation Strategy Is Evolving

DOD—through its contractor, the Rand Corporation—has a substantial research effort underway to determine the feasibility and cost-effectiveness of the CRI and CAM demonstration projects. However, there is no comparable study underway or planned for Coordinated Care. Instead, as described earlier in this report, DOD is devising a system of performance indicators and measurement that it can use to assess the performance of hospital commanders in delivering cost-effective, accessible, high-quality health care. Whether the performance measurement system being developed will serve as a suitable substitute for a comprehensive evaluation like that being conducted for CRI and CAM remains to be seen. In his October 1, 1991, memorandum approving the Coordinated Care program, the Deputy Secretary of Defense instructed that, within 90 days, measures of performance by which to evaluate DOD's effectiveness in performing its medical mission be submitted for his review.

Rand's evaluation methodologies for CRI and CAM are almost identical. They should provide the basis for sound conclusions and meaningful comparisons of the two concepts, including their advantages and disadvantages. Rand officials point out, however, that the evaluation methodologies are not perfect, because neither CRI nor the CAM demonstrations were devised with evaluation requirements as a fundamental consideration. Therefore, the research lacks some "purity." For example, the control sites chosen are not always good matches with the test sites, some baseline information is lacking, the number of test sites is smaller than ideal, and the projects started at different times. DOD and Rand are working together, adding study questions, to improve both evaluations.

Rand, which has already published preliminary information on CRI, estimates that its final report will be published in early 1992. Rand officials expect to brief DOD and selected congressional committees this fall on qualitative information they have obtained on the CAM projects but do not expect to produce data-oriented reports on these projects until 1993.

Conclusions

As stated in our March 1991 testimony, we believe that despite a slow start, DOD is headed in the right direction with its managed care efforts. With the adoption of Coordinated Care as the centerpiece of its efforts to refine the military health care system, there is the real potential for gaining more control over costs, improving beneficiary access, and maintaining high-quality care.

Moreover, the Deputy Secretary's recent decision memorandum appears to be a positive response toward overcoming the funding and staffing problems evidenced in DOD's early attempts to implement Coordinated Care at its one tri-service site. It remains to be seen, however, whether other organizational changes need to be made to help assure the successful implementation of Coordinated Care.

We also believe DOD is correct in trying to incorporate the best features of CRI and CAM into the design of Coordinated Care rather than making a distinct choice of either demonstration project as the sole model for the program.

Because many fundamental and difficult operational decisions still need to be made, the expectations for the success of Coordinated Care should be tempered by realism about the prospects for quick results. Given where DOD is with its design and implementation of the effort, its 3-year timetable appears to be unrealistic and needs to be modified.

As DOD continues to work through the issues needing to be resolved, there is one overriding matter we believe requires change before Coordinated Care is implemented nationwide—adopting uniform benefits and cost sharing. We believe that uniform benefits and cost sharing within each category of beneficiary should be established. The choice for DOD appears to be to either introduce cost sharing in military facilities equal to that incurred by beneficiaries who must use civilian providers or eliminate cost sharing when civilian care is ordered. Cost sharing is almost universal in the private sector and should be considered in DOD.

Recommendations

We recommend that the Secretary of Defense develop and submit to the Congress a plan for adopting uniform DOD benefits and cost sharing within each category of enrolled beneficiary regardless of whether the care is provided in a military hospital or a civilian setting.

We also recommend that the Secretary direct the Assistant Secretary of Defense (Health Affairs) to review DOD's timetable for the systemwide

implementation of Coordinated Care and report the results of that review—including revised time frames, as appropriate—to the Congress.

We discussed the contents of this report with DOD health officials and incorporated their comments where appropriate. We are sending copies of this report to appropriate congressional committees; the Secretary of Defense; the Director, Office of Management and Budget; and other interested parties.

This report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues, who may be reached on (202) 275-6207 if you have any questions concerning the report. Other major contributors are listed in appendix III.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Contents

Abbreviations

CAM	Catchment Area Management
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CRI	CHAMPUS Reform Initiative
DOD	Department of Defense

Scope and Methodology

This report draws heavily on our evaluations over the past several years of CRI, CAM projects, and other DOD health care initiatives. The GAO reports and testimonies resulting from these evaluations are listed on page 24.

We visited all five CAM sites:

Army

Ft. Sill, Lawton, Oklahoma.
Ft. Carson, Colorado Springs, Colorado.

Air Force

Bergstrom Air Force Base, Austin, Texas.
Luke-Williams Air Force Base, Phoenix, Arizona.

Navy

Naval Hospital, Charleston, South Carolina.

We visited the CRI contractor's (Foundation Health Corporation) offices in Sacramento, California (CRI operates in California and Hawaii). We also visited DOD's designated Coordinated Care site, known as TRICARE, in Portsmouth, Virginia. At these locations, as well as at each service's medical headquarters and within Health Affairs, we have had discussions with senior and mid-level officials covering a wide range of issues, including:

- beneficiary enrollment, benefits, and cost-sharing plans,
- budgeting and resource needs,
- quality assurance and utilization management plans,
- evaluation and performance measurement strategies,
- mission preparedness and other organizational implications,
- implementation time frames,
- education and training requirements, and
- private sector managed care programs.

We also had discussions with officials of the Rand Corporation (DOD's evaluation contractor) and the Congressional Budget Office regarding the topics listed above as well as their published and planned evaluations of managed care in DOD.

To supplement our discussions, we obtained written materials and documentation, such as correspondence communicating the services' positions on Coordinated Care policies, evaluation methodologies, descriptions of various demonstration projects and proposals, budget figures, and studies by other organizations.

Our work, most of which was conducted between September 1990 and October 1991, was performed in accordance with generally accepted government auditing standards.

Summary of DOD's Coordinated Care Program as of October 1, 1991

The Coordinated Care program seeks to improve the military health care system by increasing access to care, enhancing the quality of care, and containing cost growth. To achieve this, several changes are envisioned in health care delivery techniques, accountability, and financing.

Health Care Delivery

Coordinated Care's health care delivery changes consist of several key features. These include (1) introducing an enrollment process for beneficiaries, (2) assigning enrolled beneficiaries a primary care provider who will manage their health care needs, (3) creating civilian provider networks to handle workloads that military providers cannot, (4) establishing specialized treatment centers to provide expensive and/or highly specialized health care to those who need it, (5) reducing differences in benefits within categories of beneficiaries, and (6) introducing a standard quality assurance and utilization management program throughout the system.

Enrollment System

The Coordinated Care program calls for an enrollment process to identify the local beneficiary population for which a military hospital commander is responsible. Dependents of active-duty members will have the first option to enroll. Where there are enough military and civilian health care providers, other beneficiaries (that is, retirees, survivors, and their dependents) will have an option to enroll.

CHAMPUS beneficiaries who have the option to enroll but do not will still be eligible for the existing CHAMPUS benefit package; however, they will face higher cost-sharing levels. Additionally, they will not be able to receive health care services in military facilities, except for emergencies and for outpatient prescription drugs.

Beneficiaries who are eligible for Medicare (those who are age 65 and over and those who qualify for other reasons, such as disability) will be permitted to enroll in Coordinated Care, but will continue to receive care from military hospitals on a space-available basis. All care obtained outside the military hospital will be billed to the Medicare program.

Primary Care Providers

Beneficiaries who enroll in Coordinated Care will be assigned a primary care provider who will serve as a gatekeeper for directing the patient to the appropriate source of medical care. Either a military physician or a civilian physician under contract with the military hospital may serve as the primary care provider. The primary care provider will serve as

the point of entry for all of an enrollee's health care needs, except for emergencies. All referrals to other sources of care, such as specialty care, must be made by the primary care provider. Using primary care providers to manage enrollees' health care delivery is designed to promote greater continuity of care, enhance case management of care delivered, and improve efficiency by reducing the delivery of a higher level of care than required by the patient.

Provider Networks

Military hospital commanders will be responsible for ensuring that all enrolled beneficiaries have access to care in their service area. In many areas, this will require the military hospital commander to establish a network of civilian health care providers (primarily hospitals and physicians) to complement the military hospital's capabilities. These networks of civilian providers will make it easier for the military hospital commanders to enroll all beneficiaries who wish to be enrolled and assign them to a primary care provider. In some areas of the country it may also be necessary for the military hospital commander to establish networks of specialists to supplement the military hospital staff.

Specialized Treatment Facilities

To reduce costs and assure quality for certain low-volume, high-cost medical procedures, DOD plans to establish specialized treatment facilities on a regional or national level. These facilities may be either military or civilian hospitals and will be selected on the basis that they are less expensive than other sources of care and deliver high-quality care. Beneficiaries who do not use a specialized treatment facility when one is designated and available will be responsible for the cost of their care.

Benefits and Cost Sharing

Over the long term, Coordinated Care envisions a simpler, more equitable health care system in which enrollees would have more uniform benefits and lower out-of-pocket costs than beneficiaries choosing not to enroll. However, Coordinated Care maintains the present cost-sharing requirements for all enrolled beneficiary categories and increases cost sharing for people who have the option to enroll but do not. The program also calls for Health Affairs and the services to define a uniform set of covered benefits and services, to the extent possible. However, because of unique circumstances in some local areas, it anticipates local differences.

Utilization Management and Quality Assurance

A comprehensive utilization management and quality assurance program, to ensure appropriate utilization of high-quality health care, is envisioned under Coordinated Care for both military hospitals and civilian network providers. Health Affairs and the services are establishing policies, procedures, guidelines, and instructions for such a program. This program is being designed to allow comparisons of the quality and cost-effectiveness among different health care service areas. DOD will contract for these services on a regional basis and use one set of guidelines and criteria for judging the appropriateness of medical care.

Accountability

Under Coordinated Care, military hospital commanders will be responsible for the cost and quality of and access to health care for all beneficiaries in their service areas, including those who obtain health care from civilian health care providers. At present, military hospital commanders are not held accountable for managing the health care obtained from civilian providers under CHAMPUS. These hospital commanders will be given control of funds now used to pay for care under CHAMPUS, in addition to their normal hospital budget. Health Affairs is developing a system of performance measurement to gauge how well hospital commanders do and compare them. The services will develop incentives to reward hospital commanders on the basis of their performance.

Financing

Under Coordinated Care, Health Affairs plans for the services to use a capitation-based resource allocation methodology that will derive budgets for military hospital service areas based on the demographics of the beneficiary population for which the hospital commander is responsible. In addition, DOD financial and accounting systems will be modified so that each military commander can see the full cost of the assets he or she employs in relation to the output of his or her health care delivery network. For example, each commander will receive data on such things as the replacement cost of DOD assets and the costs of recruiting, training, paying, and retiring military medical personnel. Output measures will include such things as utilization and quality trends.

Major Contributors to This Report

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Related GAO Products

DOD's Management of Beneficiaries' Mental Health Care (GAO/T-HRD-91-30, May 15, 1991).

The Military Health Services System—Prospects for the Future (GAO/T-HRD-91-11, Mar. 14, 1991).

Defense Health Care: Potential for Savings by Treating CHAMPUS Patients in Military Hospitals (GAO/HRD-90-131, Sept. 7, 1990).

Potential Expansion of the CHAMPUS Reform Initiative (GAO/T-HRD-90-17, Mar. 15, 1990).

Defense Health Care: Workload Reductions at Military Hospitals Have Increased CHAMPUS Costs (GAO/HRD-89-47, July 10, 1989).

Implementation of the CHAMPUS Reform Initiative (GAO/T-HRD-89-25, June 5, 1989).

VA/DOD Health Care: Further Opportunities to Increase the Sharing of Medical Resources (GAO/HRD-88-51, Mar. 1, 1988).

Defense Health Care: CHAMPUS Reform Initiative: Unresolved Issues (GAO/HRD-87-65BR, Mar. 4, 1987).

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