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The Honorable Steve Buyer
Chairman
The Honorable Neil Abercrombie
Ranking Minority Member
Subcommittee on Military Personnel
Committee on Armed Services
House of Representatives

Subject: Military Health Care: TRICARE's Civilian Provider Networks

The Department of Defense's (DOD) managed care program, called TRICARE, was designed in part to improve its beneficiaries' access to health care. However, beneficiaries have continued to complain about their difficulties in trying to obtain care, including their concerns about the adequacy of civilian networks that DOD uses to supplement care provided in military treatment facilities. In response to these complaints, you asked us to (1) determine DOD's requirements for and oversight of network adequacy, (2) address the content and methodology of DOD's July 1999 report to the Congress on network adequacy, and (3) report the changes to network adequacy requirements that DOD anticipates under its next round of TRICARE contracts, referred to as managed care support 3.0.

We obtained DOD's current network adequacy requirements and discussed their origin with officials at DOD's TRICARE Management Activity (TMA), which solicits, awards, and oversees the TRICARE contracts. We discussed with TMA officials how the network is monitored, and we reviewed copies of the quarterly reports they used in their monitoring efforts. We also reviewed TMA's methodology as well as the regional data and statistics used in DOD's July 1999 report on network adequacy. Last, we spoke with TMA officials about changes that will be made to network adequacy requirements in the next round of TRICARE contracts. We performed our work between October 1999 and February 2000 in accordance with generally accepted government auditing standards.

In summary, DOD's network adequacy requirements are based on California's Knox-Keene Act, which provides guidelines for health maintenance organizations (HMO) on numerous aspects of access to care, including network adequacy ratios and the

amount of time it takes to drive to a provider's office.[1] In addition to following these standards, most of DOD's managed care support contractors that administer the program have elected to use more stringent guidelines for certain types of specialty care. To determine whether its standards are being met, DOD requires the contractors to oversee of the adequacy of their networks, including the submission of quarterly reports that DOD uses to monitor the contractors' performance. Some monitoring is also performed in response to beneficiaries' complaints, which are addressed individually.

In reviewing DOD's report, we determined that its methodology was sound and the information was sufficient to describe how well the contractors are meeting standards as well as any weaknesses and their underlying causes. While the overall network is generally adequate, DOD reported some "spotty" deficiencies in rural areas—particularly those that are considered medicallyunderserved and those with low managed care penetration. These conditions are not unique to TRICARE—they also exist in the Medicare program.[2] So far, the contractors have addressed network adequacy issues through various means, such as bringing innonlocal providers on a temporary basis to treat beneficiaries.

Although the civilian provider networks are generally adequate, DOD plans to modify its current network adequacy requirements in its next round of contracts in order to focus more on beneficiaries' satisfaction. DOD officials stated that, rather than achieving specified quantitative standards, the key to an adequate network lies with the beneficiaries' ability to obtain care from a qualified provider within DOD's established appointment time and distance standards. Its changes include instituting an on-line directory to help ensure that beneficiaries have access to an accurate up-to-date list of network providers, providing contractors with cash incentives to ensure beneficiaries' satisfaction with health care, and imposing financial penalties on contractors for not meeting standards.

BACKGROUND

DOD's primary medical mission is to maintain the health of its 1.6 million active duty service personnel and to provide them with health care during military operations. DOD additionally offers health care to 6.6 millionnonactive duty beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. Under TRICARE, care is provided in military-operated hospitals and clinics worldwide and is supplemented by civilian providers. TRICARE is a triple-option benefit program designed to give beneficiaries the choice of an HMO, a preferred provider organization, and a fee-for-service benefit. The HMO option, called TRICARE Prime, is the only option for which beneficiaries must enroll. TRICARE

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[1]The Knox-Keene Health Care Service Plan Act of 1975 regulates health care service plans through requirements for basic health care services, quality assurance, accessibility of services, consumer protection, medical decisionmaking, and financial viability.

[2]Physician Shortage Areas: Medicare Incentive Payments Not an Effective Approach to Improve Access (GAO/HEHS-99-36, Feb. 26, 1999).

Extra is the preferred provider organization option, and TRICARE Standard is the fee-for-service option.

DOD contracts regionally for the administration of the TRICARE program. Among the contractors' many responsibilities are establishing and maintaining a provider network that augments and supplements care provided at the military treatment facilities to support the TRICARE Prime and Extra options. These networks are to be established in all catchment areas, all base realignment and closure sites, and all noncatchment areas where the beneficiary population is large enough to justify a network.[3] DOD uses historical claims data to identify noncatchment areas where networks are needed. The contractors are required to have their provider networks in place 30 to 60 days before the start of health care delivery under their contracts. To establish a network, a contractor must recruit providers and verify their professional credentials before they are authorized to provide care.

The Strom Thurmond National Defense Authorization Act for Fiscal Year 1999 (P.L.105-261) required the Secretary of Defense to review and report on the adequacy of provider networks under TRICARE. DOD's report concluded that, overall, the TRICARE Prime provider network is sufficient to ensure that health care services are accessible and available in a timely manner. DOD stated that most contrators had experienced a higher-than-normal provider turnover during the early part of health care delivery because of providers' dissatisfaction with administrative requirements and reimbursement rates. However, as TRICARE regions mature, more providers enter the network than leave.

DOD'S NETWORK ADEQUACY AND OVERSIGHT REQUIREMENTS

DOD's health care access standards specify the following requirements for an adequate network: 1 provider (regardless of specialty) to every 1,200 Prime enrollees and 1 primary care manager to every 2,000 Prime enrollees.[4] DOD also has specific requirements for appointment timeliness and a 30-minute drive time standard. TMA officials stated that TRICARE's access standards are based on those defined in California's Knox-Keene Act, which also requires 1 provider for every 2,000 enrollees as well as a 30-minute maximum drive time to the provider's office. In addition to using DOD's requirements, some contractors have elected to use the nationally recognized Graduate Medical Education National Advisory Committee's standards to determine the number and mix of specialty providers for their network. This

[3]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 military inpatient treatment facilities. Base realignment and closure sites are military installations that have been closed or realigned as the result of decisions made by the Commissions on Base Realignment and Closure.

[4]A primary care manager is a provider or team of providers at a military treatment facility or a civilian network provider 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.

committee's standards for specialty providers are presented as ratios of the number of providers needed per 1,000 enrollees for each of 24medical specialties. The contractors that use these requirements are Anthem Alliance (regions 2 and 5), Humana Military Healthcare Services (regions 3 and 4), Foundation Health Federal Services (regions 6, 9, 10, and 12), and TriWest (central region).[5]

DOD requires contractors to monitor their provider networks. Monitoring includes verifying (1) the availability of providers in a network; (2) providers' adherence to contract requirements, such as appointment standards; (3) beneficiaries' ability to obtain appointments within access standards; and (4) the investigation and resolution of specific complaints or concerns expressed by beneficiaries or providers. In addition, the contractors are required to have full-time provider representatives visit a designated number of providers' offices each month to address providers' concerns and to determine whether they are meeting contract requirements, such as appointment standards.

Further, DOD assigned a lead agent in each region primary responsibility for monitoring certain aspects of the TRICARE contracts, such as network adequacy.[6] The contractors submit quarterly network adequacy reports to their respective lead agents with basic information on catchment and noncatchment area network adequacy, primary care manager enrollment, and provider turnover. During the contract start-up period and the first 6 months of health care delivery, they submit these reports monthly so that the lead agents can more closely track network development activities.

DOD officials stated that commanders of military treatment facilities typically address network adequacy issues within their catchment areas. They usually review a contractor's network adequacy report for their catchment areas and resolve any problems with the contractor. For example, if a commander indicates that the military pediatrician is leaving, the contractor will need to supplement that need in the network. This potential deficiency would then be discussed and reflected in the quarterly network adequacy report. Any network adequacy issue that cannot be resolved among the contractors, commanders, and lead agents would be elevated to TMA. As of February 2000, only one case has been elevated to TMA for resolution.[7]

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[5]Sierra, the contractor for region 1, developed its provider network with a configuration similar to the committee's standards that was adjusted for historical military beneficiary health care use. Foundation Health Federal Services uses DOD's standards for region 11.

[6]The lead agent office is the responsible organizational entity and designated uniformed services focal point for supporting contract administration in a specific TRICARE region.

[7]On January 21, 1999, the central region lead agent requested the issuance of an official deficiency notice to the contractor for noncompliant network development. Network shortfalls were noted in various specialties in the following areas: Cannon AFB, N. Mex.; Ellsworth AFB, S. Dak.; Fort Leonard Wood, Mo.; Fort Riley, Kans.; Holloman AFB, N. Mex.; Malmstrom AFB, Mont.; Mountain Home AFB, Idaho; Pikes Peak Area (Colorado Springs), Colo.; Whiteman AFB, Mo.; and William Beaumont/White Sands, Tex. According to TMA officials, many military installations in this region are in remote areas and various network specialty providers do not exist in or near them. Beneficiaries are given the

TMA officials added that some network monitoring results from complaints, which are addressed individually by TMA and contract officials. TMA officials stated that while some beneficiaries in rural areas have experienced legitimate problems obtaining specialty care, other beneficiaries complain about access problems when network providers are available. For example, some beneficiaries do not want to pay to see a civilian provider because they prefer to receive care at a military facility at no cost. In other instances, some beneficiaries may not be able to get an appointment with the provider of their choice.[8]

DOD'S METHODOLOGY FOR THE NETWORK ADEQUACY REPORT

DOD's report to the Congress on the adequacy of civilian provider networks was prepared by TMA officials, who coordinated this effort with the lead agents' offices for each region. TMA obtained information on network adequacy from each lead agent, summarized it by region, and compiled it into the report. Our review of the data the lead agents supplied showed that the information was sufficient to describe how well the contractors are meeting standards as well as any weaknesses and their underlying causes.[9]

TMA officials explained that the report to the Congress represents the TRICARE network at a "snapshot in time" because the TRICARE civilian network is constantly in flux as providers continually join and leave. While the overall network is generally adequate, DOD reported some "spotty" deficiencies in rural areas—particularly those that are considered medically underserved and those with low managed care penetration. However, these conditions are not unique to TRICARE. TMA officials added that while the isolated problem areas when the report was produced may have been resolved, other areas may have taken their place. However, the underlying causes usually remain the same as discussed in the report—for example, rural areas with low managed care penetration. So far, the contractors have addressed network adequacy issues through various means, such as bringing innonlocal providers on a temporary basis to treat beneficiaries. TMA officials remarked that network problems tend to be isolated and infrequent but receive a lot of press. Also, the majority of military health care is still delivered within the military facilities. A recent enrollment report showed that 87 percent of family members who are enrolled had selected their primary care manager at a military treatment facility.

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choice of traveling longer distances to obtain specialty care from a network provider or being referred to a nonnetwork specialty provider closer to home.

[8]For additional information on appointment access within military treatment facilities, see Defense Health Care: Appointment Timeliness Goals Not Met; Measurement Tools Need Improvement (GAO/HEHS-99-168, Sept. 30, 1999).

[9]We reviewed but did not verify the lead agents' data. The lead agents are responsible for verifying the accuracy of the data they receive from contractors.

NEW APPROACH TO NETWORK ADEQUACY

In the next generation of TRICARE contracts, referred to as managed care support 3.0, DOD has modified its requirements for network adequacy. While DOD has retained its access standards for appointment and drive times, it has eliminated the requirement that contractors have 1 provider per 1,200 enrollees and 1 primary care manager per 2,000 enrollees. DOD officials explained that even though contractors can demonstrate that they meet these ratios, beneficiaries may still have access problems. The determining factor for an adequate network is whether a beneficiary has a qualified provider available within both the appointment time and distance standards.

In addition, contractors will be required to maintain an accurate, up-to-date list of network providers that will indicate whether they are accepting new patients. To achieve this standard, the contractors will need to maintain network data on-line because the network is constantly changing. Currently, by the time the lists of providers are published, they are obsolete. Beneficiaries will be able to obtain this network information directly from the Internet. If they do not have access to the Internet, they can contact a health care finder, who will have access to this information.[10]

Under managed care support 3.0, DOD has also changed the incentives and disincentives for contractors to establish and maintain an adequate network. For example, they will receive cash awards based on beneficiaries' satisfaction with their health care, including access. DOD officials stated that to provide a strong incentive, the cash awards could be larger than the contractors' projected profit in the contracts. Beneficiaries' satisfaction will be monitored quarterly for each contract through a survey that will be based on the Health Plan Employer Data and Information Set measures, which are commonly used by the health care industry.[11] Beneficiaries who received care during a given quarter will be randomly sampled for the survey.

The contractors will also be financially penalized if they do not meet contractual standards, whether prescribed by DOD or proposed by a contractor. A contractor whose performance falls below the standard for a certain activity will not be paid for work not completed. For example, a contractor that achieves only 70 percent of a standard will be paid only 70 percent of the price it bid to meet that requirement. In response to a question about whether this would encourage contractors to "pad" their prices, DOD officials responded that TMA will examine historical cost data and look at the number of staff contractors propose for each task to evaluate the work unit prices for reasonableness.

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[10]A health care finder is an employee of a contractor who facilitates referrals of beneficiaries to military or civilian health care services.

[11]The Health Plan Employer Data and Information Set is a group of standardized performance measures designed to give purchasers and consumers information to compare the performance of managed health care plans.

Another incentive for contractors to build and maintain complete and robust networks will be the new requirement that they pay the beneficiaries' cost of care, which can be up to 115 percent of allowed charges less copayments, when a Prime beneficiary is referred to a nonnetwork provider because a network provider is not available. This requirement is currently included in the contracts for regions 1, 2, and 5.

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DOD officials reviewed a draft of this report and concurred with the information it provides. We will send copies this correspondence to the Honorable William S. Cohen, Secretary of the Department of Defense, and others upon request. Ifyou have any questions or would like additional information, please call me on (202) 512-7101, or Michael T. Blair, Jr., Assistant Director, on (404) 679-1944.

Cynthia Bascetta for

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