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

Subject: Military Treatment Facilities: Emergency Department Utilization

Military Treatment Facilities (MTF) operate emergency departments as part of the system that offers health care to 8.2 million active duty service personnel, retirees, and their dependents under TRICARE, the Department of Defense's (DOD) managed health care program. Because increased TRICARE enrollment has reduced the availability of care at MTF clinics for beneficiaries not enrolled in TRICARE, concerns have been raised that nonenrolled beneficiaries are obtaining nonemergency care through MTF emergency departments. In this context, you asked us to provide information on (1) the services' efforts to determine requirements for MTF emergency departments, (2) the type of care emergency departments are providing, and (3) the extent to which emergency department patients were TRICARE enrollees.

To assess requirements for MTF emergency departments, we obtained policies, procedures, and regulations from the Office of the Surgeon General's emergency medicine consultant for each service.[1] To identify the type of care provided in emergency departments and to determine who were the primary users of them, we obtained copies of the most recent service audits relating to emergency departments and discussed them with service representatives. We also visited and obtained data from six MTF emergency departments that we

[1] Each Surgeon General has a military emergency medicine physician who provides advice on issues related to this specialty.

judgmentally selected.[2] Further, we obtained comparable information and criteria from civilian professional organizations–namely, the American Medical Association, the American Hospital Association, the American College of Emergency Physicians, and the Joint Commission on Accreditation of Healthcare Organizations. We obtained national data on emergency department usage from the Centers for Disease Control and Prevention. In addition, we visited Kaiser Permanente and interviewed personnel there to obtain a perspective on a civilian health maintenance organization's emergency department usage.

In summary, recent Army, Navy, and Air Force evaluations have identified 17 MTF emergency departments that possibly could be closed because their services could be provided more efficiently through civilian emergency departments. As a result, some emergency departments have been closed and others are scheduled for closure in the near future. However, DOD officials stated that some MTF emergency departments will always be needed for training or readiness needs or because civilian facilities are unavailable. Most of the health care services provided in MTF emergency departments are for nonemergency or nonurgent conditions–a situation consistent with that at civilian-sector emergency departments. Nonetheless, according to civilian and military emergency department personnel, this patient workload keeps staff busy and trained while waiting for emergencies. In four of the six MTFs we reviewed, more than 40 percent of the emergency department users were beneficiaries not enrolled in TRICARE Prime. Although these nonenrolled personnel may be using emergency departments to gain access to free military health care, information is not available to determine how much nonemergency care was provided to nonenrolled beneficiaries.

BACKGROUND

The military health system, which offers care to 8.2 million military and civilian beneficiaries, has a dual role of supporting wartime and contingency deployments and caring for active-duty members, retirees, and family members during peacetime. Care is provided in about 580 MTFs worldwide supplemented by civilian providers under TRICARE. Active-duty personnel get their care, at no charge, primarily from MTFs, which may be medical centers, hospitals, or clinics. However, other beneficiaries must choose from TRICARE's triple-option benefit, which includes a health maintenance organization, a preferred provider option, and a fee-for-service benefit. Beneficiaries who enroll in Prime, the health maintenance organization, are eligible for no-cost outpatient visits in military hospitals and clinics. However, they must pay a small co-payment for visits when they receive care from a civilian provider. All retirees under 65 and their dependents and survivors are

[2] Winn Army Community Hospital, Fort Stewart, Ga.; Weed Army Community Hospital, Fort Irwin, Calif.; Naval Hospital Jacksonville, Jacksonville, Fla.; San Diego Naval Medical Center, San Diego, Calif.; 6th Air Refueling Wing Hospital, MacDill Air Force Base, Fla.; and Mike O'Callaghan Federal Hospital, Nellis Air Force Base, Nev.

subject to enrollment fees if they enroll in Prime.[3] Retirees over age 65 are eligible for Medicare, but not for TRICARE, and can obtain care in MTFs only on a space-available basis.

Although MTFs historically provided care for all beneficiaries on a space-available basis at no cost to them, this care has become difficult to obtain in some areas. Between 1987 and 1997, 35 percent of MTFs in the United States were closed and many others have been downsized to outpatient clinics. Further, DOD and the services continue to review the need for MTFs and to search for alternative ways to deliver cost-effective health care. TRICARE gives enrolled beneficiaries preference for treatment at MTFs so no-cost, space-available care has become increasingly difficult for older retirees to obtain.

The military health care system must still provide for emergency medical care. Emergency services are defined as those needed to evaluate and treat medical conditions of such recent onset and severity that a prudent layperson would believe urgent or unscheduled medical care is required. Emergency care facilities exist primarily to save a person's life, limb, or sight, and to prevent undue suffering or loss of body tissues. This care can range from comprehensive life-saving care to first aid. Because emergencies are unpredictable, facilities providing emergency services must be available 24 hours a day, 7 days a week. As of October 1999, the services operated 79 emergency medical departments worldwide (as shown by table 1).

Table 1: Worldwide MTF Emergency Departments by Service and Location, as of October 1999

	United States	Overseas	Total
Army	20	4	24
Navy	15	9	24
Air Force	23	8	31
Total	58	21	79

Source: Each service's Office of the Surgeon General.

[3] TRICARE's three benefit options–Prime, Standard, and Extra–have different cost shares. Beneficiaries make an annual decision about which of the options to use. Retirees under age 65 and their dependents and survivors who chose the Prime option pay an annual enrollment fee of $230 for an individual and $460 for a family. Copayments are lower under Prime than other options. TRICARE Standard, the fee-for-service option, provides beneficiaries with greater freedom in selecting civilian physicians but requires the highest beneficiary cost share. Under TRICARE Extra, the preferred-provider option, beneficiaries do not pay annual premiums and, by using physicians in the TRICARE network, can lower their copayments to 5 percent less than under TRICARE Standard.

DOD Efforts to Assess the Need for MTF Emergency Departments

The Air Force and Army audit agencies have recently completed evaluations of MTF emergency department operations, and the Navy Surgeon General's emergency medicine consultant studied the need for Navy emergency departments. As a result of these evaluations and other factors, such as base closures and the downsizing of military hospitals to outpatient clinics, several military emergency departments have closed. The services justify most of the remaining emergency departments based on readiness or training requirements, or the fact that civilian emergency care is not available in an area.

The Air Force Audit Agency published a report on its study of 18 Air Force emergency departments in the continental United States.[4] According to the report, most of the care provided in these emergency departments was not emergency or urgent care. The report said that 11 of the 18 MTF emergency departments could be closed because an equal or higher level of emergency care could be obtained at nearby civilian hospitals. Further, the Air Force compared the cost of operating on-base emergency departments at these 11 MTFs with the cost of obtaining emergency medical care from local civilian sources and found that, over a 6-year period, about $31 million could be saved by using civilian hospital emergency departments. The Air Force has since closed, or has scheduled to close by the end of fiscal year 2000, 8 of the 11 emergency departments. Most emergency department closures occurred when the MTF they were part of was downsized from a hospital to an outpatient clinic. However, the commanders at 3 of the 11 MTFs disagreed with report's recommendation, and there are no plans to close these emergency departments.

The Army Audit Agency reviewed operations at three Army MTFs and reported that these emergency departments were providing mostly nonurgent, low-acuity care for the convenience of military health service beneficiaries.[5] It also found that, for patients with true emergencies, these MTFs relied on nearby civilian hospitals to provide care because, in general, the civilian hospitals had better diagnostic and treatment equipment, more specialty skills available on staff, and sophisticated intensive-care units.

As a result of this report, the Army medical command conducted a review of its 22 emergency departments in the continental United States to determine where civilian facilities might offer a better option for providing emergency care. This evaluation concluded that 5 emergency departments could

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[4] Report of Audit: Air Force Emergency Room Operations (Air Force Audit Agency, Project 96051010, Mar. 11, 1997).

[5] U.S. Army Medical Command Emergency Room Operations (Army Audit Agency, AA 99-72, Dec. 7, 1998).

potentially be closed but that 17 emergency departments were necessary to prepare physicians for wartime duties or to provide emergency services at installations that conduct high-risk military training with the potential for life-threatening injuries or that are located in isolated areas with inadequate or no civilian emergency services. However, three of the five emergency departments identified as potential closure candidates participate in graduate medical education (GME). Because of their training mission, it does not seem likely these three emergency departments will be closed unless their GME programs could be transferred to another MTF that DOD has determined must remain open for reasons of medical necessity. According to an Army Medical Command representative, the Army does not plan to close any of these five emergency departments.

The Navy Surgeon General's emergency medical consultant considered whether any of the Navy's 15 emergency departments in the United States could be closed. According to him, because of the need to prepare physicians for wartime duties and to meet GME requirements, only two Navy MTF emergency departments could be considered for elimination. However, while adequate civilian care is available for one of these two, the other is in an isolated location that conducts high-risk training with the potential for life-threatening injuries, making closure unlikely.

MTF Emergency Departments Provide Mostly Nonemergency Care

Consistent with Air Force and Army Audit Agency findings, our analysis of emergency room data from the six MTF emergency departments we visited showed that between 54 and 95 percent of the services provided were for nonemergency or nonurgent conditions. These findings are also consistent with the literature and MTF personnel statements.[6] In addition, in 1993 GAO reported that a large number of civilian emergency department patients had nonurgent conditions.[7]

According to MTF emergency department personnel, some nonemergency or nonurgent cases, such as lacerations, are appropriately handled in emergency departments. However, they reported that in other cases, patients came to emergency departments because they did not understand the definition of an emergency or because it was more convenient than seeking care elsewhere.

Although emergency departments exist primarily to address life-threatening conditions, these facilities also treat urgent care conditions requiring treatment within a few hours, such as minor burns or broken bones. Also, in

[6] Robert M. Williams, M.D., Dr.P.H., "The Costs of Visits to Emergency Departments," The New England Journal of Medicine, Vol. 334, No.10 (Mar. 7, 1996), pp. 642-646.

[7] Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (GAO/HRD-93-4, Jan. 4, 1993).

some instances, patients come to emergency departments because they cannot distinguish between life-threatening conditions and minor illnesses or injuries that can wait for treatment until the next day. For example, symptoms such as chest pains, may suggest a heart attack, even though the visit may ultimately result in a diagnosis of indigestion. In such instances a visit to the emergency department is appropriate to rule out life-threatening conditions.

One reason for the high use of emergency departments for nonurgent care is that these departments do not refuse to see patients. Although MTFs are not directly subject to the requirements of the Emergency Medical Treatment and Active Labor Act, they all elect to follow this law, which requires emergency departments to evaluate all patients who come for care and treat emergencies. Further, for professional reasons, physicians do not want to turn anyone away who has not been seen. Then, once a physician has examined and evaluated patients, frequently little additional time is required to treat them. For example, military physicians told us they want to take humane action and help people who are ill or in pain, and frequently this can be accomplished by writing a prescription.

Further, providing nonemergency and nonurgent care in emergency departments keeps nurses and physicians busy while they wait for true emergencies. For this reason, many hospitals do not discourage nonurgent visits. One of the MTFs we visited–Naval Hospital Jacksonville–encourages, rather than discourages, the use of its emergency department for nonemergency episodic illnesses, such as earaches and sore throats. Its emergency department director believes that, because patients want episodic illnesses treated immediately and these illnesses generally require only one-time visits, the emergency department is a logical place to handle them rapidly. He noted that patients seem to be very satisfied because their problems can be rapidly addressed. Finally, the director believes this process is improving access to care at Naval Hospital Jacksonville. He stated that because primary care clinics are seeing fewer episodic cases, primary care managers can enroll more Prime patients in their clinics.

Many Emergency Department Patients Are Not Enrolled in TRICARE Prime

At the MTFs we visited, a significant amount of emergency department care was provided to beneficiaries not enrolled in TRICARE Prime. Based on our review of emergency department data from six MTFs, we estimated that between 23 and 66 percent of the care provided went to nonenrolled beneficiaries and that up to 10 percent went to retirees 65 years of age or older who were not eligible to enroll in TRICARE Prime. These older retirees may use emergency departments for care because they are no longer eligible for TRICARE benefits. However, because the data do not disaggregate

nonurgent visits by type of beneficiary, we could not tell what kinds of care nonenrolled beneficiaries received.

DOD officials reviewed a draft of this report and concurred with the information it provides. We are sending copies of this correspondence to the Honorable William S. Cohen, Secretary of Defense, and will make copies available to others on request. If you or your staff have any questions or would like additional information, please contact me at (202) 512-7101, or Michael T. Blair, Jr., Assistant Director, at (404) 679-1944.

Cynthia Bascetta for

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

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