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DEFENSE HEALTH CARE

Disability Programs Need Improvement and Face Challenges



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Abbreviations

ADFM	active duty family member(s)
ADL	activities of daily living
CHAMPUS	Civilian Health and Medical Program for the Uniformed Services
DME	durable medical equipment
DOD	Department of Defense
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FEHBP	Federal Employees Health Benefits Program
HCBS	Home and Community Based Services
HHD	Home Health Demonstration
HMO	health maintenance organization
ICMP-PEC	Individual Case Management Program for Persons with Extraordinary Conditions
MCSC	Managed Care Support Contractor
OPM	Office of Personnel Management
PFPWD	Program for Persons with Disabilities
PTFH	Program for the Handicapped
REM	Rare and Expensive Case Management Program
SNF	skilled nursing facility
TFL	TRICARE For Life
TMA	TRICARE Management Activity



October 12, 2001

Congressional Committees

The Department of Defense (DOD) health program—TRICARE—provides medical care for about 8.3 million active duty service members and retired beneficiaries and their respective dependents and survivors. As supplements to TRICARE, DOD provides benefits for persons with extraordinary disabling physical or mental disorders through its Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) and for less severely disabled active duty dependents through its Program for Persons with Disabilities (PFPWD). Recently, military families and advocacy groups have raised concerns about problems accessing ICMP-PEC benefits. Also, the DOD Authorization Act for fiscal year 2001 entitled all 1.4 million military retirees age 65 and older and their dependents and survivors to TRICARE benefits for life (TFL)¹ effective October 1, 2001, which may have caseload and cost effects on ICMP-PEC.²

The 2001 Defense Authorization Act required that we review DOD's supplemental disability programs—ICMP-PEC and PFPWD.³ As agreed with your offices, our objectives were to determine each program's number of participants and benefit costs; whether the programs are generally meeting their purposes, accessible to their target groups, and adequately administered; the extent to which PFPWD's monthly maximum benefit limit may affect beneficiaries' ability to obtain services; how the programs' selected benefits generally compare to Medicare, Medicaid, and Federal Employees Health Benefit Program (FEHBP) plan benefits; and whether and, if so, what program improvements may be needed.

In doing the work we interviewed and obtained program records from TRICARE Management Activity (TMA) officials, TRICARE Managed Care Support Contractors (MCSC) representatives, DOD Regional Lead Agent Medical Directors and case managers, and military beneficiary advocacy groups. We reviewed the programs' legislative histories and policies,

¹The Floyd D. Spence National Defense Authorization Act for 2001, hereinafter cited as the 2001 Defense Authorization Act.

²P.L. 106-398, Section 712.

³P.L. 106-398, Section 701(d).

ICMP-PEC case files, an ICMP-PEC database installed during our review aimed at providing needed ICMP-PEC management data, TMA's proposed ICMP-PEC rule published in the *Federal Register* in August 2001,⁴ and PFPWD claims data. We reviewed Medicare, Medicaid, and FEHBP plan documents. Also, we discussed illustrative ICMP-PEC and PFPWD cases and the general comparability of program and plan benefits with officials and representatives from California, Maryland, and Alabama Medicaid programs and three FEHBP plans. Further methodological details are given in appendix I. We conducted our work from December 2000 through August 2001 in accordance with generally accepted government auditing standards.

Results in Brief

As of June 2001, there were 38 ICMP-PEC participants whose total services for fiscal year 2001 were projected to cost about \$6 million with annual per-case costs projected to range from about \$13,000 to \$382,000. Also, 10 participants from earlier demonstration programs were granted continued care coverage under ICMP-PEC with projected fiscal year 2001 costs of about \$2.5 million. Despite record system and database improvements made during our work, TMA managers still cannot track ICMP-PEC's actual case-by-case costs. Regarding PFPWD, for fiscal year 2000, the most recent year for which data were available, there were 3,843 participants whose services cost about \$12 million.

Currently ICMP-PEC lacks a clearly enunciated purpose, well-defined eligibility criteria and benefits, and an efficient application process. This complicates regional program managers' ability to identify potentially qualifying cases and makes TMA's case acceptance/denial and benefit-level decisions seem arbitrary. Also the program's ambiguities obstruct efforts to inform potential participants of its availability. Some regional program managers told us that as a result they believe ICMP-PEC's caseload is lower than the actual number of eligible patients. Further, some ICMP-PEC regional managers told us that the application process is complex and administratively burdensome, involving many clinical reviews of a patient's condition before final approval or denial. However, given the high average cost per beneficiary, clearly defined eligibility criteria and an effective eligibility determination process are critical. Recently enacted

⁴The ICMP-PEC proposed rule explains legislative changes made to the program and makes amendments to clarify specific policies that relate to the program. *Federal Register*, Vol. 66, No. 148, August 1, 2001, pp 39699-39705.

TRICARE changes, effective October 1, 2001, entitling senior retirees to lifetime DOD health benefits, potentially including ICMP-PEC benefits, further underscore the need to address ICMP-PEC's problems before expected caseload increases occur. In this respect, TMA's proposed rule for ICMP-PEC does not clearly enunciate its purpose nor does it substantially change eligibility criteria; therefore current problems may persist. And, while the rule attempts to clarify ICMP-PEC's services and would extend service priority to active duty family members (ADFM) before retirees and their dependents, the rule and its accompanying operating policies and procedures are not expected to be completed until the end of 2001.

PFPWD is an established program with well defined criteria and benefits that assist thousands of ADFMs with their special health care service and equipment needs. Potential participants have clear expectations of whether they qualify and, according to regional program managers, have ready access to the program. Further, PFPWD's application process is relatively straightforward and, for the most part, is managed and operated at regional levels. Case managers told us, however, that they need to do a better job and lack procedures for communicating across regions about PFPWD patients leaving and entering their jurisdictions. Because patients changing jurisdictions must reapply for the program in their new location, managers said they need to better facilitate and help expedite PFPWD patients' reapplications.

Prior to April 2001, PFPWD provided many services and equipment items at modest cost-shares to ADFMs with severe disabilities that were also available at higher copayments to less seriously disabled ADFMs under TRICARE Basic.⁵ The 2001 Defense Authorization Act, however, effective April 1, 2001, eliminated the copayments for ADFMs under TRICARE Prime⁶ but not under PFPWD. As a result, PFPWD families can now buy many of the services and equipment they need under TRICARE Prime at

⁵In 1995, with TRICARE's introduction, some PFPWD services and equipment also became available under TRICARE Basic, although PFPWD patients were required until 1997 to obtain all services related to their disability from PFPWD. TRICARE—also referred to as TRICARE Basic—is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization, a preferred provider organization, and a fee-for-service benefit.

⁶TRICARE Prime, a health maintenance organization benefit, is one of three benefit options under DOD's health care program referred to as TRICARE Basic.

no cost. And, as some regional case managers have told us, PFPWD caseloads may decrease and the program may no longer be needed.

Data are not available on how many PFPWD participants are affected by the program's \$1,000 monthly benefit limit. Regional program managers we spoke with differed on whether the limit was keeping beneficiaries from obtaining needed services and thus should be increased. Some officials told us the limit has not kept pace with medical service and equipment cost increases because the limit has not changed materially in the last 15 years. However, other officials told us they are able to schedule services and buy equipment by spreading costs over several months so that the PFPWD \$1,000 monthly limit is rarely an obstacle. Some participants may use Medicaid to obtain services above the monthly limit and others may rely completely on Medicaid due to the \$1,000 monthly limit. Other officials told us that the recent TRICARE Prime copayment changes would cause PFPWD families to meet some of their needs under TRICARE Basic and thus reduce PFPWD's caseload costs. This could obviate the need to raise the limit. The effect of eliminating TRICARE Prime's copayments on PFPWD service use and caseloads may need to be reviewed before attempting to assess the monthly limit's adequacy.

Comparing ICMP-PEC's home care benefit—up to 24 hours of skilled nursing care per day, 7 days per week—and unlimited skilled nursing facility (SNF) coverage with Medicare and selected Medicaid programs showed that ICMP-PEC's benefits are more generous. Medicare's home health benefit is intermittent⁷ and its SNF coverage is limited to 100 days following at least a 3-day hospital stay. The selected Medicaid programs we reviewed cover unlimited SNF care, but in-home services may be limited, especially for persons over age 21. The FEHBP plans reviewed have limited in-home and SNF coverage, but each also offers extended coverage for patients with unusual medical needs who may qualify based on individual case-by-case assessments. Plan representatives could not elaborate on such coverage, citing the need for complete case information and examination by a plan physician. PFPWD services are comparable to Medicare services and also the reviewed Medicaid services available to those under age 21.⁸ Services available to patients over age 21, however,

⁷Skilled nursing care on an intermittent basis means services on fewer than 7 days per week or for fewer than 8 hours per day for periods of 21 days or fewer. There are no limits on the number of visits or length of coverage, and no copayments or deductibles apply.

⁸About 85 percent of PFPWD patients are under age 21.

are limited under Alabama’s Medicaid program and somewhat so under California’s Medicaid program—unlike Maryland’s program and PFPWD which provide the same services to patients regardless of age. For the plans we reviewed, FEHBP coverage for care needs, such as hearing aids and wheelchair maintenance, is less than PFPWD coverage for the same needs.

We are recommending that DOD clarify ICMP-PEC, explain how its legislative changes are to be implemented, and improve its case-by-case cost-data tracking. Also, DOD needs to develop procedures to facilitate the transfer of PFPWD cases from region to region and reassess PFPWD after the effects of eliminating TRICARE Prime copayments on its costs and caseload are known. In commenting on a draft of this report, DOD concurred with our recommendations.

Background

DOD’s health care program—TRICARE—provides health care services to active duty military members and their dependents and military retirees and their dependents. Health care for eligible beneficiaries is managed on a regional basis at military hospitals and clinics supplemented by contracted civilian services. Five Managed Care Support Contractors (MCSC) administer the TRICARE health benefit in 11 TRICARE regions in the contiguous United States through provider networks. TRICARE—also referred to as TRICARE Basic—is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization (TRICARE Prime), a preferred provider organization (TRICARE Extra), and a fee-for-service benefit (TRICARE Standard).⁹ Cost sharing varies among the three options from low per-service costs for active duty families under TRICARE Prime to a percentage of allowable charges under TRICARE Standard. (See appendix II for a list of TRICARE cost-shares, deductibles, and copayments.)

ICMP-PEC Program

In 1999, DOD implemented ICMP-PEC. The program was an outgrowth of DOD’s Home Health Demonstration (HHD) projects established to test DOD’s ability to provide home health care in lieu of hospital care to patients with exceptionally serious, long-term, costly, and incapacitating

⁹TRICARE Standard was formerly called the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS).

physical or mental conditions.¹⁰ ICMP-PEC provides qualifying patients with care and equipment not available under TRICARE Basic by waiving TRICARE Basic's restrictions on such services or supplies.¹¹ The National Defense Authorization Act for fiscal year 2000 (2000 Defense Authorization Act)¹² eliminated the program's original 365-day benefit limit and made ICMP-PEC first payer to Medicaid.¹³ The 2001 Defense Authorization Act imposed a \$100 million annual spending cap on ICMP-PEC.

ICMP-PEC requires that a qualifying patient be determined to be "custodial" under TRICARE or require continuing extensive services. A custodial patient must be disabled mentally or physically for a prolonged period; require assistance with the activities of daily living (ADL), which include eating, bathing, dressing, toileting, and transferring; not be under active medical, surgical, or psychiatric treatment that would reduce the disability such that the patient could function outside a protective, monitored, and controlled environment; and require a protected, monitored, or controlled environment whether in an institution or a home. Alternatively, a qualifying patient must have high TRICARE service costs in the year preceding his or her ICMP-PEC eligibility or require clinically appropriate services or supplies from various providers and be able to be treated more appropriately and cost effectively at a less intensive level of care under ICMP-PEC.¹⁴

Patients who qualify for ICMP-PEC predominantly receive skilled nursing services. Such services can only be furnished by a registered nurse,

¹⁰The first HHD project began in July 1986 for dependents of active duty service members and members who died in the service. The second HHD project began in July 1988 and expanded coverage to military retirees and dependents of retirees. For additional information, see *DOD Health Care: Further Testing and Evaluation of Case-Managed Home Care is Needed* (GAO/HRD-93-59, May 21, 1993) and *Evaluation of the Campus Home Health Care-Case Management Program*, Office of the Secretary of Defense, June 1992.

¹¹10 U.S.C. §1079(a)(17).

¹²P.L. 106-65, §703(b).

¹³Any Medicaid expenses incurred by ICMP-PEC beneficiaries are fully reimbursable by ICMP-PEC to the extent such services are available under ICMP-PEC.

¹⁴TMA's August 2001 proposed ICMP-PEC rule would eliminate as one of the qualifying criteria the alternative that a qualifying patient must have high TRICARE service costs in the year preceding ICMP-PEC eligibility or require clinically appropriate services or supplies from various providers.

licensed practical nurse, or licensed vocational nurse and are required to be performed under a physician's supervision. Once a patient is deemed custodial he or she can receive 1 hour per day of skilled nursing care in the home under TRICARE Basic. Through ICMP-PEC, up to an additional 23 hours per day in the home is available if medically necessary. As an alternative, skilled nursing care in a facility may be authorized through ICMP-PEC if medically necessary. ICMP-PEC does not cover assistance with ADLs. Cases undergo review periodically and, in particular, on a family's movement to another region.

MCSC program managers identify potentially eligible cases and, with regional lead agent concurrence, submit them to the TMA office in Colorado (TMA West), which until May 2001 had final acceptance or denial authority. The National Program Director, located at TMA headquarters in Falls Church, Virginia, has general oversight and program policy and procedure development responsibilities but had not been directly involved in final case decisions. In May 2001, however, final case decision responsibilities and functional program oversight were transferred to TMA headquarters.¹⁵

Also, over the past year TMA has been working to develop a final ICMP-PEC rule to implement legislative changes to ICMP-PEC made in fiscal years 2000 and 2001 and to concurrently amend the TRICARE operations and policy manuals. Both actions are expected to be completed by the end of 2001. The proposed rule was entered into the *Federal Register* on August 1, 2001, and TMA was accepting public comments until October 1, 2001. Once comments have been reviewed, the rule, as appropriate, will be amended, its contents translated into operating policies and procedures in the TRICARE manuals, and the information made available to regional program managers and lead agents. Subsequently, contract modifications incorporating the program changes will need to be drawn up and negotiated with the MCSCs who help administer ICMP-PEC.

PFPWD Program

PFPWD provides services and equipment to ADFMs who have moderate or severe mental retardation or serious physical disabilities.¹⁶ Prior to

¹⁵TMA West's Contracting Officer remains responsible for providing ICMP-PEC case files for independent peer review.

¹⁶The program originally did not have a separate name. It was named the Program for the Handicapped (PFTH) in 1977 and was renamed the Program for Persons with Disabilities (PFPWD) in 1997.

October 1997, PFPWD patients were required to obtain all services related to their disability from PFPWD and all other needed care from TRICARE Basic. Now, PFPWD patients may receive services related to their disability through TRICARE Basic. Currently, PFPWD requires that before PFPWD benefits are provided, a determination be made that the patient's needed care cannot, with the exception of Medicaid covered care, be met using other public resources and facilities. Examples of PFPWD qualifying disabilities are epilepsy, cerebral palsy, multiple sclerosis, muscular dystrophy, and hearing or vision loss. Services covered include speech and physical therapy, durable medical equipment (DME), transportation to and from medical appointments, and hearing aids. Upon the family's movement to another TRICARE region, the patient is required to reapply for program services there.

Beneficiaries are responsible for a cost-share each month they receive a service. The cost-share amount, ranging from \$25 to \$250, is based on the sponsor's rank (see appendix III). Also, the program has a monthly benefit cap of \$1,000 per family. Beneficiaries are responsible for costs beyond the limit. In families with more than one PFPWD participant, only the least expensive participant in a given month is subject to the monthly limit, while the family's other participants are not subject to the limit for that month nor a cost-share requirement.

Recent Legislative Changes

Recently, significant legislative changes were made to TRICARE Basic. As of April 1, 2001, copayments under TRICARE Prime were eliminated for active duty beneficiaries but not under PFPWD. Currently, about 67 percent of PFPWD claims are for persons enrolled in TRICARE Prime.

Also, Medicare-eligible uniformed services retirees age 65 and over and their spouses, dependents and survivors are entitled to TRICARE benefits as of October 1, 2001—referred to as TRICARE For Life (TFL).¹⁷ Eligible beneficiaries who receive care from Medicare providers will have TRICARE as their secondary payer. Also, those who qualify for ICMP-PEC will have access to benefits—such as up to 24 hours per day of skilled nursing care in the home—that are not covered by Medicare.

¹⁷Section 712(a)(2)(A) of the 2001 Defense Authorization Act requires that all Medicare-eligible beneficiaries be enrolled in Medicare Part B (which covers physician, outpatient hospital, laboratory and other services) to receive the TRICARE benefit.

Medicare

Medicare, the nation's largest federal health insurance program, provides health insurance to people age 65 and over and to those who have end-stage renal disease, (permanent kidney failure requiring regular dialysis or a transplant) and certain people with disabilities. There is a 24-month waiting period for Medicare coverage based on disability. Medicare part A covers inpatient hospital, SNF, certain home health, and hospice care. Enrollment in part A (Hospital Insurance) is automatic at age 65 for all workers who paid the hospital insurance payroll tax during their working years or whose spouse is covered. Beneficiaries generally pay no premium for part A coverage, but they are liable for required deductibles, coinsurance, and copayment amounts. Medicare-eligible beneficiaries may elect to purchase part B (Supplemental Medical Insurance), which covers physician, outpatient hospital, laboratory, and other services. Beneficiaries must pay a premium for part B coverage, currently \$50 per month, and are also responsible for part B deductibles, coinsurance, and copayments. Most of Medicare's 40 million beneficiaries are enrolled in both part A and part B.

Medicaid

Certain TRICARE beneficiaries are also eligible for Medicaid, a joint federal-state, means-tested entitlement program that provides medical assistance to certain individuals and families with low income and resources. Under broad federal guidelines, each state establishes its own eligibility standards, benefits package, and program administration. As a result, there are essentially 56 different Medicaid programs—one for each state, territory, and the District of Columbia. Nonetheless, under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, all state Medicaid programs are required to cover any service or item medically needed for qualifying persons under the age of 21. Also, Medicaid programs often cover a variety of supportive services for persons with long-term needs.

FEHBP

Established in 1959, FEHBP is an employer-sponsored program for federal civilian employees and annuitants and certain of their dependents. Participation is voluntary. The Office of Personnel Management (OPM) has overall administrative responsibility for contracting with private health insurance carriers and plans sponsored by federal employee and postal organizations. The contracts provide—for fixed, predetermined plan premiums—benefits that OPM judges affordable and appropriate for the needs of federal workers and retirees. The FEHBP law does not require plans to offer a particular benefit package, although OPM requires that they cover such services as child immunizations, cancer screening,

prescription drugs, mental health, and organ transplants. Plans are required to limit enrollees' annual out-of-pocket expenses for deductibles and coinsurance but can vary with regard to availability of high and low options, deductibles, coinsurance, and copayment requirements.

Number of Program Participants and Program Costs Differ Significantly

As of June 2001, there were a total of 38 participants in ICMP-PEC whose services for the fiscal year were projected to cost about \$6 million. Also, the care costs of 10 other participants from earlier HHD programs that preceded ICMP-PEC were transferred to ICMP-PEC. The projected costs for such services for this fiscal year are \$2.5 million. TMA managers lack the ability to track actual program costs during the year despite their efforts to improve data collection made during our review. Regarding PFPWD, for fiscal year 2000 there were 3,843 participants whose services cost about \$12 million.

ICMP-PEC Participant Data

Thirty patients are dependent children, 6 are dependent spouses, and 2 are retired military members. About 80 percent of the patients are less than age 22 and the rest are between 22 and 64 years of age.¹⁸ Thirty-six are receiving skilled nursing services in the home and 2 are receiving occupational and physical therapy. Demographic information was not available on the 10 patients transferred to the ICMP-PEC from the HHD. However, these patients were receiving skilled nursing and one of them was also receiving occupational and physical therapy. Early in our review we observed that TMA's ICMP-PEC records were incomplete, contained inconsistent data, and were not kept current. In July 2001, TMA officials described to us their recently installed ICMP-PEC data system aimed at addressing such problems. While significantly improving the automated compilation of needed data, still lacking is their ability to compile actual case-by-case cost data as it accrues during the fiscal year. Among other management uses such data are needed to track progress against ICMP-PEC's spending cap.

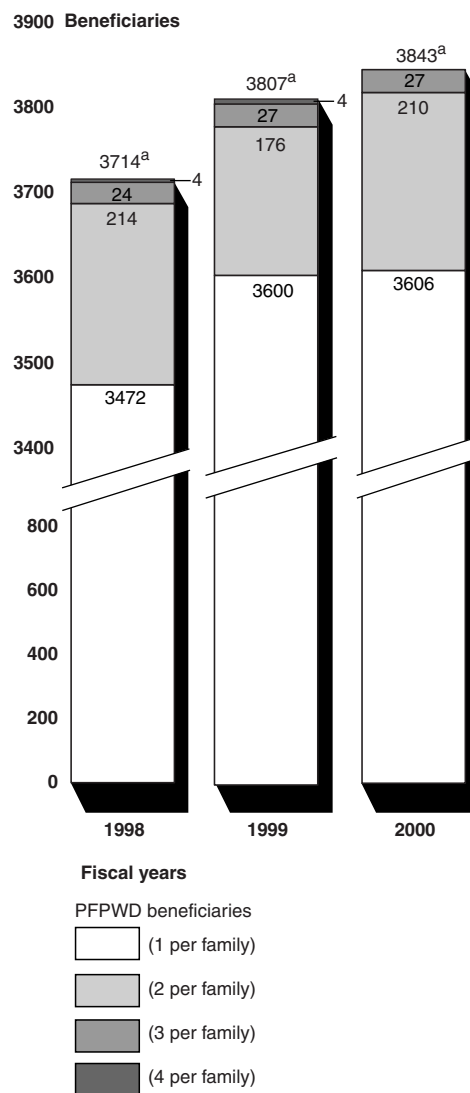
PFPWD Participants, Services, and Costs

For fiscal years 1998, 1999, and 2000 the annual number of PFPWD participants has ranged from about 3,714 to 3,843 (see figure 1). Most such participants have been dependents under age 21. Most services provided have been therapeutic in nature, such as medically supervised speech,

¹⁸ Ages were recorded for all but 1 patient.

language, and hearing therapy. Most participating families have one member in the program, but 2 percent to 3 percent of families have more than one member in the program.

Figure 1: Numbers of PFPWD Beneficiaries Grouped by Fiscal Year and Number of Participants per Family



^aFiscal year total.

Source: GAO analysis of PFPWD claims data provided by TMA.

Since fiscal year 1998, PFPWD total program costs have ranged from about \$11 million to \$12 million per fiscal year, with DOD paying about 85 percent of the service and equipment costs and the remaining potentially paid either out-of-pocket or by Medicaid, other health insurance, or other means (see table 1).

Table 1: PFPWD Program Costs and Estimated Beneficiary Costs by Fiscal Year

	Cost to DOD	Estimated beneficiary cost^a	Total costs
1998	\$9,436,918	\$1,906,206	\$11,343,124
1999	9,710,398	1,654,673	11,365,071
2000	10,389,500	1,538,434	11,927,934

^aData may not include beneficiary cost-shares above the \$1,000 monthly limit.

Source: September 2000 *TRICARE Statistical Phaseback Report* for fiscal year 1998 and March 2001 *TRICARE Statistical Phaseback Report* for fiscal years 1999 and 2000.

Programs Differ in Guidance; TRICARE Changes Will Affect Caseloads

ICMP-PEC has operated for about 3 years with frequent changes and without clear policy guidance, a situation that has led to confusion about the program's purpose, eligibility criteria, and benefits. The program's lack of clarity may further exacerbate such problems now that the age-65-and-over military retiree population has become entitled to participate.

PFPWD, on the other hand, has clearly defined regulations with specific eligibility and benefit criteria. Qualifying cases can be readily identified using program guidance. However, in April 2001, copayments were eliminated under TRICARE Prime,¹⁹ so PFPWD families may opt to obtain many services and equipment they now receive under PFPWD with a cost-share through TRICARE Prime for free. Thus, PFPWD's caseloads may decrease.

¹⁹Prescription medication copayments were not eliminated.

ICMP-PEC Purpose and Operating Rules Need Clarification Before Expected Caseload Hikes Occur

Among DOD and MCSC managers we interviewed, the general consensus is that ICMP-PEC's overall purpose is unclear and that it lacks clear policy guidance largely because it has been in a state of change since implementation. Also generally agreed is that ICMP-PEC lacks clearly defined eligibility criteria and benefits such that program specifics cannot be adequately communicated to potential participants. While a patient's access to such an expensive benefit needs to be carefully determined, the ICMP-PEC application process involves several clinical reviews of a patient's condition before final approval or denial and may be too complex and administratively burdensome. Recently enacted TRICARE changes entitling military retirees aged 65 and over and their dependents and survivors to lifetime DOD health benefits, including ICMP-PEC benefits, further underscore the need to address ICMP-PEC's problems before potential caseload increases occur. In that regard, DOD is working to complete ICMP-PEC's final rule and operating procedures, and efforts have recently begun to develop legislative proposals to improve ICMP-PEC.

Program Changes and Limited Policy Guidance

Since March 1999, when ICMP-PEC was first implemented, the program has been legislatively and administratively changed each year—and final regulations have yet to be promulgated. For example, the 2000 Defense Authorization Act eliminated the program's 365-day benefit limit.²⁰ This converted the program from one of temporary assistance while qualifying patients transitioned to other care resources, including Medicaid, to permanent assistance of potentially unlimited duration. The 2000 Defense Authorization Act made ICMP-PEC primary payer to Medicaid. This changed the program from one that relied on Medicaid and other public resources before providing services into a qualifying beneficiary's first resort for care. These changes had the potential for increasing ICMP-PEC's costs.²¹

In an effort to explain the new changes and how the program should operate, in March and November 1999 and March and April 2000, TMA issued informal guidance to regional program managers. However, DOD regional and MCSC officials told us that the successively changing guidance did not adequately address the program's lack of clear eligibility

²⁰P.L. 106-65, §703(b).

²¹The 2001 Defense Authorization Act did impose a \$100 million program spending cap. However, current spending is less than \$10 million, so the cap will likely constrain services only if the number of enrollees expands significantly.

criteria and benefits or issues that the legislative changes had raised, such as the effects of transforming the program into a long-term benefit. Eliminating the 365-day benefit limit, for example, potentially opened the program to unlimited care for those among the over-age-65 population who would qualify under TFL. MCSC officials also told us that they viewed the guidance as nonbinding because it was not the subject of a formal contract modification. According to regional program managers, the net effect of the program changes and unclear guidance is general confusion about the program's fundamental purpose. In seeking to provide further guidance on how legislative changes to the program are to be implemented, TMA's proposed rule sets forth, among other things, that ICMP-PEC's purpose is not to provide long-term care, thus reiterating TMA's interim guidance. But, under the proposed rule, ICMP-PEC's per-patient benefit would remain potentially unlimited and ICMP-PEC would remain first payer to Medicaid. Thus, the program would appear to continue to provide a potentially long-term care benefit contrary to the proposed rule's statement about ICMP-PEC's purpose. As mentioned, however, the proposed rule is subject to change based on public comment and subsequent translation into operating policies and procedures.

ICMP-PEC Eligibility and Benefits Are Unclear

Regional program managers told us that ICMP-PEC eligibility criteria are confusing and have not been specified to the level where they can readily identify patients that qualify for the program. For the most part, ICMP-PEC's custodial care definition is DOD's way of screening from TRICARE Basic, patients with high-cost, prolonged, nonremedial, disabling conditions. The definition generally requires that a patient must have a severe mental or physical disability and that the disability must be prolonged. Also, the patient must require assistance to support the essentials of daily living and not be under active medical, surgical, or psychiatric treatment that would reduce the disability such that the patient could function outside a protective, monitored, and controlled environment. Each case must be separately and comprehensively reviewed before care-level and duration decisions can be made. Some program managers told us that because the criteria are subjective and open to interpretation there is resulting confusion about which cases may qualify. Coupled with the multistep application reviews, this confusion may result in an ICMP-PEC caseload that is lower than the actual numbers of eligible patients.

Regional case managers also cited many instances in which TMA would approve cases for the program but then deny similar cases with no clear justification for the decisions. The TMA West officials responsible for approving and denying cases told us they agreed that the ICMP-PEC

criteria are too vague and need more specificity and that as a result their decision-making has been impeded.

Regional program managers also told us ICMP-PEC's benefits have not been clearly defined or set forth. They told us that, as a result, decisions about each eligible patient's services appear arbitrary. Decisions to assign different hours of skilled nursing care or to approve or deny other in-home services for apparently similar cases without reference to some commonly understood benefit criteria confuse regional program managers and beneficiaries about ICMP-PEC's case-by-case coverage. For example, a 1-year-old patient requiring 24-hour ventilator-related care was denied ICMP-PEC coverage by TMA West because the care was viewed as potentially temporary (meaning the patient likely would improve) because it would be needed for an estimated 5 to 10 years. In contrast, a 4-year-old patient requiring the same services was approved for 16 hours a day by TMA West, later increased to 24 hours, 2 days a month. The services were approved despite similar expectations that the patient would no longer need ventilator care after about 3 years.

Also, regional program officials told us that due to ICMP-PEC's eligibility and benefit ambiguities, they are unable to adequately explain its coverage to potential beneficiaries. Some officials questioned why they would attempt to inform potential clients about the program if they cannot answer their clients' most basic questions about it. As a result, they told us, ICMP-PEC is not well known to potential beneficiaries nor to their service providers. In this regard, TMA's proposed rule reiterates ICMP-PEC's custodial definition and, for the most part, reiterates the interim guidance with respect to eligibility criteria so that the current problems may persist. On the other hand, the proposed rule attempts to clarify ICMP-PEC's services with examples and more explicit service definitions, which may better equip regional program managers in understanding ICMP-PEC's coverage in the future.

ICMP-PEC Application Process Necessary but Burdensome

While access to such an expensive benefit as ICMP-PEC needs to be carefully determined, TMA and regional program managers told us that the current process is complex and burdensome. The ICMP-PEC application process is managed centrally by TMA, although some regional program managers told us they believe the process should be decentralized. Upon receipt of an ICMP-PEC application package, TMA preliminarily determines whether the case may be eligible, sends a letter to regional program managers authorizing 60 days of ICMP-PEC coverage, continues to review the case, and sends it for external peer review. Regional

program managers told us that 60 days is the minimum period for a TMA case decision and that many cases take longer.

Along with being administratively burdensome, regional program managers told us, the process is costly, requiring an estimated 20 to 40 hours at registered-nurse pay rates to complete the application alone. The estimates include the need to respond to frequent TMA requests for added case data such that regional program managers told us they often question TMA's ability to make the approval/denial decisions. While agreeing that the process is complex, TMA and peer review contractors, however, told us that many application packages provided by MCSC case managers lack sufficient clinical information needed for a thorough review.

TMA requests for added data are generally made after the patient's primary provider, regional MCSC medical director and case managers, and the lead agent's medical director and case managers have diagnosed the patient's condition, made their prognoses, and filed the application. After these reviews, TMA makes its separate review followed by a full, independent review by a peer-review organization. This review may be and has been, overturned by TMA upon its final case review. While acknowledging the importance of an effective eligibility process, some regional MCSC medical directors and case managers questioned the need for so many reviews, pointing to their redundancy and questioning their cost effectiveness and the value added to the process. These officials also told us that if decision-making were de-centralized in the regions—in much the way PFPWD operates—the approval process could be markedly shortened and streamlined. Other regional program officials, however, told us that because of the open-ended nature of ICMP-PEC's benefit and high per-case costs, managing eligibility centrally can improve control.

TFL's Potential Effects on ICMP-PEC Are Unknown

On October 1, 2001, the newly enacted TFL became effective. TFL entitles the estimated 1.4 million age-65-and-over military retirees and their dependents and survivors to DOD health care including ICMP-PEC. The TMA officials we interviewed also expect the new entitlement to increase ICMP-PEC's caseload and costs, but they told us that the number of ICMP-PEC eligibles and their care costs are difficult to reliably estimate and have not been determined.

In anticipation of TFL, TMA proposed an ICMP-PEC rule that would extend service priority to ADFMs before retirees and their dependents and survivors. Under the proposed rule, should current or projected service demand exceed available funding—currently capped at \$100 million—for the fiscal year, termination notices would be issued to affected

participants. The order of coverage termination would be non-ADFM patients from last to first authorized and then ADFM patients in the same order. The proposed rule is not expected to be complete until the end of calendar year 2001 followed by a period within which MCSC contract change orders will need to be negotiated.

In view of the program's current policy and definitional problems, however, DOD may face unforeseen financial risks and operational difficulties should it delay in addressing ICMP-PEC's problems. Meanwhile, efforts were recently begun to develop legislative proposals to restructure ICMP-PEC to address such problems, but proposal details are not yet available.

PFPWD Is Accessible but Changes May Reduce Caseloads

Regional program managers generally agreed that PFPWD is meeting its goal of financially assisting disabled ADFMs with their special health care service and equipment needs. Also general agreement exists that PFPWD eligibility and benefit criteria, for the most part, are clear and that the program is known to users and program administrators. Further, PFPWD's application process is relatively straightforward and, except for TMA's appeals and general oversight responsibilities, managed and operated at the regional level. The 2001 Defense Authorization Act eliminated copayments for TRICARE Prime but not for PFPWD participants, effective April 1, 2001. As a result, many services and much of the equipment that beneficiaries obtained under PFPWD with a cost-share can now be obtained under TRICARE Prime at no cost. Thus, PFPWD's caseloads may decrease.

Role Unchanged and Familiar to Users

PFPWD in various forms has been in operation for about 35 years. The need for the program sprang from the military's normal geographic reassignment of active duty families. Members with disabled children needing special services and equipment not available through the military health care system might obtain them through Medicaid but sometimes had difficulty obtaining them due to Medicaid's state-by-state residency and other eligibility requirements. Thus, PFPWD, in its earlier forms, was established to provide financial assistance for special services and equipment that Medicaid otherwise would have provided. Today, Medicaid residency requirements, eligibility factors such as income level, and benefits continue to vary widely across the states so that PFPWD remains an important option for active duty members with disabled children.

Regional officials told us that PFPWD administrators, providers, and beneficiaries are aware of the program and how it operates and fits within

Defined Eligibility and Benefits
and Straightforward
Application Process

TRICARE. They told us this is due to the program's many years of operations and efforts to educate potential beneficiaries about PFPWD's availability, eligibility criteria, and benefits. On the other hand, regional officials told us that some qualifying families may choose Medicaid instead of PFPWD because they believe that participating in PFPWD may cause the active duty member to be viewed as less deployable, thus limiting promotion potential. However, regional officials said that other families view participating in Medicaid as stigmatizing because it is considered a welfare program, and thus they choose PFPWD.

PFPWD is governed by rules and regulations that were last promulgated in October 1997 and that set forth the program's eligibility and benefit criteria. For example, the guidelines make clear that, except for Medicaid, public programs, such as those in schools, and other resources must be used when available before accessing PFPWD. In addition to reducing PFPWD costs, regional program managers told us this requirement causes their case managers to remain knowledgeable about the related resources in their jurisdictions so they can provide timely advice about service availability. These managers also told us that their case managers are able to identify qualifying PFPWD patients and access needed services and equipment through the program. Moreover, regional program managers told us that because PFPWD is well established, its eligibility criteria and benefits can be communicated to potential beneficiaries.

PFPWD's application process is designed to make case determinations quickly without successive levels of review. Once identified and physician-approved, a potential PFPWD case is promptly screened by case managers to determine if other public resources (with the exception of Medicaid) could be used; if not, the person is enrolled in the program. The average processing time for such cases is 2 to 4 weeks. Unless appealed to TMA, eligibility and benefit decisions are made at the regional level and are not subject to TMA or independent peer review. Case managers told us that some beneficiaries have one-time equipment or service needs, such as for a hearing aid, and leave and reenter the program intermittently. They told us they track such beneficiaries and can readily close and reopen their cases and not delay service delivery.

Case managers also told us that when PFPWD patients and their families move to different TRICARE regions, the receiving MCSC normally requires that the patient reapply there. While this has caused service delays and inconvenienced some patients, the receiving jurisdiction may have other public resources or services available to substitute for PFPWD services that the patient had been receiving in the previous jurisdiction. In this

regard, case managers told us they need to do a better job and formalize their communications with other region's MCSC case managers when PFPWD cases leave and enter their jurisdictions. Currently, there are no procedures requiring case managers to do so.

Likely Reduction of Caseloads With TRICARE Changes

A possible consequence of the 2001 National Defense Authorization Act is that qualified beneficiaries who obtained services and equipment under PFPWD with cost-shares can now obtain many of them for free under TRICARE Prime. Effective April 2001, active duty beneficiary copayments are no longer required under TRICARE Prime but still are under PFPWD. PFPWD's caseload may be reduced to only ADFMs needing services that are only obtainable under PFPWD and not TRICARE Prime such as hearing aids, assistive services such as interpreters for the deaf, and special education services for disabled patients (see appendix IV).

To illustrate, if a \$6,000 wheelchair were obtained under PFPWD, the participant would have a cost-share ranging from \$25 to \$250, depending on the active duty member's rank. An E-5, for example, would pay \$25 a month for the 6 months over which the \$6,000 cost could be prorated.²² Prior to April 2001, obtaining the same wheelchair under TRICARE Prime would have cost the family a 15 percent cost-share, or \$900. Today, obtaining the wheelchair under TRICARE Prime would cost the family nothing. Thus, PFPWD patients who can obtain the services and equipment they need through TRICARE Prime—about 70 percent of PFPWD's caseload—will likely do so at no cost.

Questions Remain About the Adequacy of PFPWD's Monthly Maximum

PFPWD has had a monthly benefit limit that has not changed materially in the last 15 years. Data are not available, however, on how many PFPWD participants are affected by the program's \$1,000 monthly benefit limit. Regional program managers we spoke with had differing views about whether the limit was keeping beneficiaries from obtaining needed services and thus should be increased. Some officials told us that the limit was not reflective of current higher medical service and equipment costs so that some beneficiaries may be reaching the limit. Other officials told us

²²Because the program has a \$1,000-per-month benefit limit, participants are allowed to prorate such equipment costs over as many months as the monthly limit and the program's prorating formula allows. The PFPWD prorating formula is used to calculate the longest period of time over which an item can be prorated. The allowable cost is divided by 1,000 and the quotient is multiplied by two. For example, a \$10,000 wheelchair may be prorated for a maximum of 20 months.

that the recent copayment changes to TRICARE Prime will reduce PFPWD caseload costs and may obviate the need to raise the limit. Still other regional program officials told us that they can schedule services and buy equipment to spread costs over several months so that the \$1,000 monthly limit is rarely an obstacle.

At issue in weighing the adequacy of PFPWD's monthly benefit are the questions—to what extent are participants incurring costs at or in excess of the monthly limit; to what extent are they using Medicaid and or other means to obtain services that exceed the limit; and how many otherwise eligible beneficiaries exclusively use Medicaid to avoid the \$1,000 benefit limit? Data to address such questions are currently unavailable.

When first established in 1967, the program's monthly benefit limit was \$350. In 1985, the limit was increased to \$1,000, where it has remained to this day. Some regional program officials told us that the limit has not kept pace with the rising medical goods and services costs. Such costs have increased by about 130 percent over the same period, which if applied to the current PFPWD monthly limit would increase it to about \$2,300.

Regional program managers told us that the elimination of TRICARE Prime copayments enables PFPWD participants to obtain many of their needed services and equipment under TRICARE Prime at no cost to themselves. For this reason, the managers said that the \$1,000 monthly limit may be sufficient to cover the services and equipment that are now obtainable only under PFPWD. However, they were unable to provide data to support that position.

Some regional program managers told us they have worked with the \$1,000 cap for many years and have become experienced in planning and scheduling services and equipment purchases so that needed care is delivered and the monthly cap is not exceeded. Because PFPWD equipment costs can be prorated at \$500 per month over the months needed to amortize the costs, the patient can use up to \$500 per month for other services such as therapies. For example, an \$8,000 wheelchair can be prorated over 16 months, leaving \$500 per month over that period for other services. A case manager told us that to ensure that costs were kept within a family's monthly cap, she could negotiate lower costs with the local providers, search for alternative providers, or consider purchasing the services under TRICARE Prime—which if done before April 1, 2001, would have entailed added beneficiary copayments. Currently, however, the example wheelchair and other services can likely be obtained under TRICARE Prime at no cost. As a result, none of the program managers we

spoke with could provide examples of PFPWD cases whose services were interrupted or who otherwise were adversely affected by the monthly limit.²³

Further experience with the effects of eliminating TRICARE Prime's copayments on PFPWD costs and caseloads may suggest that the services and equipment exclusively obtained under PFPWD could as appropriately be obtained under TRICARE Prime. If so, the need for PFPWD could become the issue.

ICMP-PEC and PFPWD Benefits Are Better Than or Comparable to Other Programs and Plans

Comparing ICMP-PEC's unlimited home health and SNF benefits with Medicare and Medicaid showed that ICMP-PEC's benefits are more generous.²⁴ Medicare provides limited home health and SNF benefits. And, while the state Medicaid programs we compared provide unlimited coverage for under-age-21 patients, older patients' benefits have varying limits. The FEHBP plans we reviewed had home care and SNF benefits that also have more limitations, but patients with special medical needs may qualify for extended coverage determined through individual case-by-case assessments. PFPWD services are comparable to those available under Medicare and to Medicaid services for patients under age 21 in the states reviewed.²⁵ Unlike PFPWD and one of the state Medicaid programs, two state Medicaid programs limit services for patients over age 21. FEHBP services for the same care needs for all ages were less available than PFPWD services.

Medicare has an intermittent in-home benefit and posthospital SNF benefit. Most ICMP-PEC cases need more than the intermittent care Medicare's home health benefit provides. ICMP-PEC's home benefit is up to 24 hours a day of skilled nursing care, 7 days a week.

²³In families with two or more PFPWD participants, the monthly limit only applies to the participant whose service or equipment costs for a given month are lowest among the family's participating members. The other members' costs for that month would not be subject to the monthly limit, but in subsequent months such members may be the lowest-cost user and be subject to the limit. Multiple PFPWD participants from the same family are about 6 percent of the current caseload.

²⁴ICMP-PEC's requirement that qualifying beneficiaries' conditions not be expected to improve may significantly affect the comparable number of beneficiaries eligible for the program. Moreover, those military beneficiaries with serious physical or mental disabilities that are expected to improve may receive in-home or SNF coverage under TRICARE Basic.

²⁵About 85 percent of PFPWD patients are under age 21.

Regarding SNF care, Medicare covers up to 100 days of such care for those needing daily skilled nursing or rehabilitative care following a hospital stay of at least 3 days. And, for the first 20 SNF care days, Medicare pays all the costs, but for the 21st through the 100th day, the patient is responsible for a daily copayment that currently equals about \$99. Even if ICMP-PEC patients were qualified for Medicare, which is the case under TFL beginning October 2001, their Medicare coverage would end after 100 days—while their ICMP-PEC SNF coverage would be unlimited.

Medicaid program benefits vary among states with respect to service type, duration, and limits, and the family's income and resources are taken into account in determining eligibility. Generally, Medicaid programs cover all necessary services for persons under age 21 and certain federally required services and state-selected options for persons over age 21. All Medicaid programs provide children a special entitlement to needed services through the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.²⁶ Established in 1967, EPSDT mandates that states cover any service or item medically needed to ameliorate a child's condition, regardless of whether the service or item is otherwise covered under the state Medicaid program.²⁷

ICMP-PEC's in-home skilled nursing benefit appears equal to or better than the three state Medicaid programs—California, Maryland, and Alabama—with which we compared it. California's Medicaid program includes two Home and Community Based Services (HCBS) waivers²⁸ that provide in-home skilled nursing services to medically fragile children and adults who would otherwise be receiving care in a licensed health care facility. In our view—and California Medicaid officials generally agreed—these patients were categorically most like ICMP-PEC patients. Qualifying pediatric patients may receive from 16 hours to 22 hours and adult patients

²⁶EPSDT requires that the patient's total family meet state Medicaid income and asset requirements.

²⁷*Children With Disabilities: Medicaid Can Offer Important Benefits and Services* (GAO/T-HEHS-00-152, July 12, 2000). The statutory requirements of EPSDT are in 42 U.S.C., Section 1396d(r).

²⁸One of the waivers, the Nursing Facility waiver, requires that the family meet state income and asset requirements whereas the other waiver, the Model waiver, only measures the patient's income against the requirements. Generally, Home and Community Based Services waivers allow states to develop and implement alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities, or intermediate-care facilities for persons with mental retardation.

up to 16 hours per day of licensed-nurse care in the home. Patients and providers can decide to take fewer than the available number of skilled nursing hours and apply the difference to such supplementary services as respite care or home health aides.

Since 1985, Maryland has had a Model HCBS waiver that targets medically fragile individuals including technology-dependent individuals who, before age 22, would otherwise be hospitalized and are certified as needing a hospital or nursing-home level of care. Under the waiver all medically needed services including up to 24 hours of skilled nursing care can be provided to enable medically fragile children to live and be cared for at home rather than in a hospital. Model waiver services include private duty nursing, home health aide assistance, and medical equipment and supplies. For persons over age 21 who meet the income, asset, and other criteria, ICMP-PEC patients would likely qualify for Maryland's Rare and Expensive Case Management Program (REM). REM patients also receive all the medically necessary care they need either at home or in a community setting but not in an SNF. Thus, Maryland's Medicaid program and ICMP-PEC services are the same in what they offer in each age group.

The Alabama Medicaid program does not have an HCBS waiver for a population similar to the ICMP-PEC cases. However, like ICMP-PEC, all medically necessary in-home skilled nursing services up to 24 hours per day would be provided through the Private Duty Nursing benefit for individuals under the age of 21. Unlike ICMP-PEC, however, patients over age 21 needing skilled nursing services would have to be admitted to a nursing facility for their care.

According to the three selected FEHBP plans' representatives and the documents they provided, patients with conditions like those of ICMP-PEC patients may receive in-home or SNF benefits, but such benefits are limited. For example, one plan reported that for qualified beneficiaries the plan would cover intermittent home health care and pay 100 percent of the first 30 visits. Subsequent visits would be covered with the patient's paying \$20 per visit. Also, a patient would be eligible for 100 days of SNF care per calendar year. Thus, ICMP-PEC's benefit is more extensive.

Each of the plans also has an extended benefit or case management option for caring for patients with unusual medical and condition-related needs. Under such an option, the plans generally

- determine the most effective way to provide services;

-
- may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative;
 - conduct an ongoing review of granted alternative benefits;
 - may withdraw an alternative at any time and resume regular contract benefits; and
 - offer or withdraw alternative benefits without OPM review under the normal disputed claims process.

Plan representatives told us that qualifying patients could be referred to case management for individual assessments of the most appropriate service venues, supplies; equipment; skill needs, if any; and coverage authorization. However, without complete case information and examination by a plan physician, the plan representatives could not elaborate on the extent nor on the duration of possible coverage referring to the need for case-by-case assessments.

Most PFPWD-type services, including therapies and equipment, are available under Medicare. Medicare does not cover hearing aids, however, and for DME, such as wheelchairs, it requires a 20 percent patient cost-share. Under PFPWD the cost-share would likely be less and the item's cost could be spread over a period of months, depending on its cost, to manage the purchase within PFPWD's monthly benefit cap.

In general, most states' Medicaid programs offer an array of services needed by children with special health care needs similar to those covered by PFPWD. Medicaid services in the three states we reviewed are comparable to PFPWD's services for patients under the age of 21. Such services offered at the states' option can include private duty nursing; case management; physical, occupational, or speech therapies; and prosthetic devices including hearing aids and DME. Officials in each state reported that the PFPWD example cases we provided, all of which involved persons under age 21, would be provided with virtually all the physical, occupational, and speech therapies; hearing aids; orthotics; and wheelchairs they now receive.

Services available to patients over age 21, however, are limited under Alabama's and California's Medicaid programs—unlike Maryland's program and PFPWD, which provide the same services to patients regardless of age. California, for example, limits some therapies for older patients, and Alabama does not provide hearing aids or prosthesis services.

The types of services available in the example PFPWD cases varied among the FEHBP plans we consulted. Unlike PFPWD, for example:

- The plans had considerable limitations in their speech, physical, and occupational therapy coverage. (For example, two plans restricted the number of therapy visits per year, while another plan only covered therapy lasting 2 months if, during that period, significant improvement was expected. None of the plans covered long-term therapy.)
- None of the plans covered hearing aids.
- The plans covered standard wheelchairs and replacements due to normal growth and development but not all plans covered maintenance and repairs.

Conclusions

Changes and challenges are on the horizon for DOD's supplemental disability programs. Currently, efforts are under way to revamp ICMP-PEC now that TFL became effective October 2001, and age-65-and-older military retirees, their dependents and survivors are eligible for TRICARE and ICMP-PEC. Also, PFPWD faces potential reductions in caseload due to the April 2001 elimination of copayments under TRICARE Prime. This is because many of the medical services and much of the equipment bought under PFPWD with a cost-share and a \$1,000-per-month benefit limit can now be gotten for free under TRICARE Prime—which may lead to questions about the need for PFPWD. Now, about 67 percent of PFPWD claims are from TRICARE Prime enrollees.

Currently, ICMP-PEC lacks a clearly enunciated purpose, well-defined eligibility criteria and benefits, and an efficient application process thereby impeding beneficiary access. Lead agent officials and MCSC representatives believe the program is too confusing to administer effectively and that it needs restructuring. A related problem is the lack of readily available case-by-case cost data needed to properly manage the program and track its spending limit under TFL. Clearly, DOD needs to clarify ICMP-PEC's purpose, eligibility criteria, benefits, and operating rules and disseminate the guidance to regional program managers who told us they do not sufficiently understand the program nor do they understand how it should be implemented. The need for such clarification is also made evident by the program's major legislative changes since its inception.

However, TMA's current proposed rule for ICMP-PEC does not clearly enunciate the program's purpose nor does it further clarify its eligibility criteria, so current problems may persist. The rule does attempt to clarify

ICMP-PEC's services and would extend service priority to ADFMs in anticipation of increased service demand now that retirees age 65 and over and their dependents and survivors are potentially eligible for the program due to TFL. Yet, the draft rule and its accompanying operating policies and procedures are not expected to be finalized until the end of 2001, whereupon contract change orders would need to be negotiated with MCSCs.

While PFPWD is an established program serving thousands of beneficiaries with clear eligibility criteria and benefits, certain actions would likely improve PFPWD's performance, including better communication among program managers when program participants leave and enter their respective jurisdictions to arrange for care continuity. Also, once enough is known about the effects on PFPWD of eliminating TRICARE Prime copayments, PFPWD's purpose and structure, including its cost-share and monthly limit may need to be reassessed and, if appropriate, modified.

Recommendations

To ensure that DOD's active duty and retired beneficiaries and dependents with seriously disabling conditions can readily access needed services and equipment, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to take the following actions aimed at improving ICMP-PEC:

- clarify ICMP-PEC's purpose, eligibility criteria, and service coverage and provide guidance to better equip regional program managers in administering the program and target groups in understanding it;
- provide guidance on how the legislative changes made to ICMP-PEC since its inception are to be implemented; and
- make needed improvements to TMA's ICMP-PEC records to ensure that they capture the actual case-by-case cost data needed to properly plan and manage the current program.

Also, we recommend that the Assistant Secretary of Defense for Health Affairs be directed to take the following actions to improve PFPWD:

- develop procedures for PFPWD program managers to communicate with one another across regions about active patients leaving and entering their respective jurisdictions to facilitate and expedite their reapplication for PFPWD, and

-
- reassess PFPWD's purpose and structure, including its cost-share and monthly benefit limit once the effects of eliminating TRICARE Prime copayments on PFPWD's cost and caseload are better known.

Agency Comments and Our Evaluation

In its comments on a draft of this report, DOD concurred with each of our recommendations and without providing specific details highlighted improvements planned or already in progress. DOD said, for example, that it has begun to clarify ICMP-PEC's legislative changes and eligibility criteria and to significantly streamline the program's administrative processes. Also, DOD said that, as we recommended, it was now devising methods to provide actual ICMP-PEC patient level cost data.

With respect to facilitating service continuation for PFPWD families who transfer to other regions, DOD said that it is considering a policy change that would require a MCSC gaining a PFPWD-eligible beneficiary to honor an existing PFPWD authorization issued by the losing MCSC. Also, DOD said it would design policy and operating procedures to implement the change. Lastly, DOD said that the entire PFPWD program is being reviewed for potential changes and that this review would be on-going to support future program changes. DOD also suggested technical report changes which we incorporated, as appropriate. DOD's comments are included in appendix V.

We are sending this report to the Secretary of Defense, relevant congressional committees, and others who are interested. Copies will be made available to others on request.

If you or your staff have any questions about this report, please contact me at (202) 512-7101. Other contacts and major contributors are included in appendix VI.

A handwritten signature in black ink that reads "Stephen P. Backhus". The signature is written in a cursive, flowing style.

Stephen P. Backhus
Director, Health Care—Veterans’
and Military Health Care Issues

List of Committees

The Honorable Carl Levin
Chairman
The Honorable John Warner
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Daniel K. Inouye
Chairman
The Honorable Ted Stevens
Ranking Minority Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Bob Stump
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Honorable Jerry Lewis
Chairman
The Honorable John P. Murtha
Ranking Minority Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Appendix I: Scope and Methodology

As agreed with the cognizant committees' offices, our objectives were to determine the number of ICMP-PEC and PFPWD participants and benefit costs; whether the programs are generally meeting their purposes, accessible to their target groups, and adequately administered; the extent to which PFPWD's monthly maximum benefit limit may affect beneficiaries' ability to obtain services; how the programs' benefits compare to Medicare and selected Medicaid and FEHBP plan benefits; and what program improvements may be needed.

We obtained and analyzed program data from TMA to determine the number of individuals receiving services in the two programs and the costs of those services. We reviewed available ICMP-PEC case files at TMA to obtain information on the services being provided, and from TMA, we obtained and analyzed PFPWD claims data from 1998 through February 2001.

To determine whether the programs are generally meeting their purposes, accessible to their target groups, and adequately administered, we reviewed program guidelines and discussed program coordination with TMA officials, MCSCs, program case managers, and military beneficiary advocacy groups.

We requested data from TMA to determine how PFPWD beneficiaries are affected by the monthly maximum benefit, how many participants use Medicaid or pay out of pocket for services above the limit, and the number that use Medicaid due to the \$1,000 monthly cap. However, TMA's databases do not contain information on the number of beneficiaries experiencing costs in excess of the \$1,000 monthly maximum limit or PFPWD participant's use of Medicaid. TMA program officials told us they were unaware of any database that could be used to address these issues.

To compare these programs' benefits with Medicare, Medicaid, and FEHBP plans, we (1) reviewed Medicare and Medicaid program requirements and eligibility criteria and (2) provided ICMP-PEC and PFPWD actual case examples without identifiers to selected Medicaid program officials in California, Maryland, and Alabama and FEHBP plan representatives in California and Alabama. The state Medicaid programs were chosen to reflect, respectively, higher, moderate, and lower state Medicaid spending and the resulting potential mix of available services. In each of the three Medicaid states, we selected one of the top three health maintenance organizations (HMO) with the highest number of enrollees. We also chose an FEHBP national fee-for-service plan that had the highest number of enrollees. We asked the Medicaid officials and FEHBP plan

representatives to provide a list of services for which the cases would qualify. The case examples included information on the patient's age and services currently received. We also interviewed the state Medicaid officials and the selected FEHBP plan representatives about the case examples and services, and we interviewed OPM representatives and obtained and reviewed FEHBP plans' brochures of covered services.

We also reviewed TMA's proposed ICMP-PEC rule which was published August 1, 2001, in the *Federal Register*. We conducted our work from December 2000 through August 2001 in accordance with generally accepted government auditing standards.

Appendix II: TRICARE Cost-Shares, Deductibles, and Copayments

Table 2: TRICARE Cost-Shares, Deductibles, and Copayments for Active Duty Family Members

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual deductible	None	\$150 per individual or \$300 per family for E-5 and above; \$50 per individual or \$100 per individual or for E-4 and below	\$150 per individual or \$300 per family for E-5 and above; \$50 per individual or \$100 per individual or for E-4 and below
Civilian outpatient visit	None	15 percent of negotiated fee	20 percent of allowable charge
Civilian inpatient visit	None	Greater of \$25 or \$10.85 per day	Greater of \$25 or \$10.85 per day
Civilian inpatient mental health	None	\$20 per day	\$20 per day

Note: Copayments under Prime were eliminated for active duty members as of April 1, 2001. Prescription medication copayments, however, were not eliminated.

Source: *TRICARE Standard Handbook*, May 19, 2000.

Table 3: TRICARE Cost-Shares, Deductibles, and Copayments for Retirees, Their Family Members, and Others

	TRICARE Prime	TRICARE Extra	TRICARE Standard (Champus)
Annual deductible	None	\$150 per individual or \$300 per family	\$150 per individual or \$300 per family
Annual enrollment fee	\$230 per individual \$460 per family	None	None
Civilian provider copayments: outpatient visit emergency care mental health visit	\$12 \$30 \$25 (\$17 for group visit)	20 percent of negotiated fees	25 percent of allowed charges
Civilian inpatient cost-share	\$11 per day (\$25 minimum charge per admission)	Lesser of \$250 per day or 25 percent of negotiated charges plus 20 percent of negotiated professional fees	Lesser of \$390 per day or 25 percent of billed charges plus 25 percent of allowed professional fees
Civilian inpatient mental health	\$40 per day	20 percent of institutional and negotiated professional charges	Lesser of \$144 per day or 25 percent of institutional and professional charges

Source: *TRICARE Standard Handbook*, May 19, 2000.

Appendix III: PFPWD Monthly Cost-Share Is Guided by Pay Grade

Pay grade	Cost-share amount
E-1 to E-5	\$25
E-6	30
E-7, O-1	35
E-8, O-2	40
E-9, W-1, W-2, O-3	45
W-3, W-4, O-4	50
W-5, O-5	65
O-6	75
O-7	100
O-8	150
O-9	200
O-10	250

Note: E=enlisted, W=warrant officer, and O=officer.

Source: *TRICARE Standard Handbook*, May 19, 2000.

Appendix IV: PFPWD Exclusive Benefits and PFPWD Benefits Also Available in TRICARE Basic

Some services and equipment available through PFPWD are also obtainable through TRICARE Basic, while other program services and equipment can be acquired only through PFPWD.

Table 4: PFPWD Exclusive Benefits and PFPWD Benefits Also Available in TRICARE Basic

PFPWD covered services and equipment	PFPWD services also covered in TRICARE Basic
Assistive services such as interpreters and translators for the deaf and readers for the blind	
Training to allow use of assistive technology or to acquire skills that are expected to reduce the disabling effects of a qualifying condition	
Durable medical equipment (DME) including wheelchairs and walkers	√
Equipment repair for DME; DME coverage includes fitting to accommodate the disability	√
Durable equipment, which is defined as a device or apparatus that does not qualify as DME but which is essential to the efficient arrest or reduction of functional loss resulting from a qualifying condition. This includes hearing aids.	
Equipment repair for durable equipment. This includes fitting to accommodate the disability.	
Institutional care for the purpose of providing the beneficiary with protective custody or training in a residential environment	
Orthotic devices as well as orthopedic braces and appliances	√
Prostheses including limbs, eyes, certain surgical implants, and some types of voice enhancement devices	√
Special education designed to accommodate the disabling effects of the qualifying condition (when appropriate public facilities are not available)	√ ^a
Transportation of patient and medical attendant to and from a provider in order to receive therapies or other authorized PFPWD services	
Medical or rehabilitative treatment, including physical therapy, occupational therapy, and speech therapy	√

^aSpecial education is provided under TRICARE Basic only in an institutional setting if not available from a public entity.

Source: GAO analysis based on information provided through (1) PFPWD Final Rule, *Federal Register*, June 30, 1997, (2) C.F.R. Title 32 (National Defense), Part 199.5, effective October 28, 1997, (3) *TRICARE/Champus Policy Manual* 6010.47-M, Chapters 1,7,8, June 25, 1999, (4) discussions and correspondence with the PFPWD program director, March through July 2001, and (5) TRICARE Conference, PFPWD briefing, Washington, D.C., June 2001.

Appendix V: Comments From the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

SEP 28 2001

Mr. Stephen P. Backhus
Director, Health Care-Veterans' and Military Health Care Issues
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the GAO draft report GAO-01-1096, 'DEFENSE HEALTH CARE: Disability Programs Need Improvement and Face Challenges Ahead', dated August 30, 2001 (GAO Code 290014). The Department appreciates the opportunity to comment on the draft report.

Please feel free to address any questions to my project officers on this matter, Ms. Mary Stockdale (functional) at (703) 681-3636 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Sincerely,

A handwritten signature in black ink that reads "J. Jarrett Clinton" with a stylized flourish at the end.

J. Jarrett Clinton, MD, MPH
Acting Assistant Secretary

Attachments:
As stated

GAO DRAFT REPORT DATED AUGUST 30, 2001
(GAO CODE 290014)

"DEFENSE HEALTH CARE: DISABILITY PROGRAMS
NEED IMPROVEMENTS AND FACE CHALLENGES
AHEAD"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to clarify ICMP-PEC's purpose, eligibility criteria, and service coverage and provide guidance to better equip regional program managers in administering the program and target groups in understanding it. (p. 37/Draft Report).

DOD RESPONSE: Concur. As discussed with GAO during the review, TMA has already begun initiating changes that will clarify eligibility requirements and significantly streamline the program's administrative processes.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to provide guidance on how the legislative changes made to ICMP-PEC since its inception are to be implemented. (p. 37/Draft Report).

DOD RESPONSE: Concur. The new proposed rule for the ICMP-PEC that was published in the Federal Register on August 1, 2001 incorporates all legislative changes imposed by the National Defense Authorization Acts for 2000 and 2001 and the Defense Appropriation Acts for 2000 and 2001. This includes lifting the 365-day coverage limit, establishing the ICMP-PEC as a primary payer to Medicaid and establishing the \$100 million annual expenditure cap. As discussed with the GAO during the review, TMA is now drafting corresponding modifications to its TRICARE Policy and Operations Manuals

RECOMMENDATION 3: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to make needed improvements to TMA's ICMP-PEC records to ensure they capture actual case-by-case cost data needed to properly plan and manage the current program. (p. 37/Draft Report)

DOD RESPONSE: Concur. As discussed during the review, the Department recently made major improvements to the program's record keeping, data gathering and reporting processes and has devised a comprehensive database to facilitate information management. Special ad hoc reporting processes are now being devised to provide actual patient-level cost data.

RECOMMENDATION 4: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to develop procedures for PFPWD program managers to communicate with one another across regions about active patients leaving and entering their respective jurisdictions to facilitate and expedite their reapplication for PFPWD. (p. 37/Draft Report).

DOD RESPONSE: Concur. A policy change has been proposed which will require a contractor gaining a PFPWD-eligible beneficiary to honor an existing PFPWD authorization issued by the losing contractor for the purchase of durable medical equipment or durable equipment. Additional operational policies and instructions will be developed in conjunction with program changes contained in the National Defense Authorization Act for Fiscal Year 2002.

RECOMMENDATION 5: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to reassess PFPWD's purpose and structure including its cost-share and monthly benefit limit once the effects of eliminating TRICARE Prime co-payments on PFPWD's cost and caseload are better known. (p. 37/Draft Report).

DOD RESPONSE: Concur. The entire PFPWD is being reviewed for potential changes that will be included with the National Defense Authorization Act for Fiscal Year 2002. Evaluation of program data will be an ongoing process to support future program changes.

Appendix VI: GAO Contacts and Staff Acknowledgments

GAO Contacts

Dan Brier (202) 512-6803
Lesia Mandzia (202) 512-7188

Staff Acknowledgments

Other major contributors to this report were Donald Morrison, Janice Raynor, Mary Reich, and Wayne Turowski.

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