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DEFENSE HEALTH CARE

Reimbursement Rates Appropriately Set; Other Problems Concern Physicians

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The Honorable Strom Thurmond
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Floyd D. Spence
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on National Security
House of Representatives

In response to escalating health care costs, the Congress urged the Department of Defense (DOD), beginning with the DOD Appropriations Act for Fiscal Year 1991 (P.L. 101-511), to gradually lower reimbursement rates paid to civilian physicians under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for medical care provided to active duty dependents and retirees and their dependents.[1] These adjustments were to be based on comparisons with the rates established under another nationwide federal health program—the Department of Health and Human Services' (HHS) Medicare program. Previously, many of the rates paid under CHAMPUS, a DOD-administered fee-for-service type program, were significantly higher than those paid for identical services under Medicare.[2] As DOD has implemented its payment revisions, however, some physicians have complained that the CHAMPUS maximum allowable charge (CMAC) is too low—particularly for obstetric and pediatric rates.

Under DOD's new managed care program called TRICARE, CMAC rates represent DOD's maximum physician reimbursement level. Under TRICARE, civilian physicians—some of whom join the TRICARE network—are used to supplement care provided in military treatment facilities.

[1]This act specified that reductions were not to exceed 15 percent in a given year.

[2]CHAMPUS payments were previously based on a yearly calculation of the 80th percentile of physicians' actual charges statewide. Using this approach, CHAMPUS reimbursement rates were, in many cases, significantly higher—50 percent higher, on average—than those paid for identical treatment under the Medicare program.

The National Defense Authorization Act for Fiscal Year 1998 (P.L. 105-85, Nov. 18, 1997) directed that we study the adequacy of the maximum allowable charges for physicians established under the CHAMPUS program and the effect of such charges on physician participation in CHAMPUS. In response to this mandate, we examined (1) whether DOD's methodology for setting CMAC rates complies with statutory requirements[3] and how current CMAC rates compare with Medicare rates for similar services, (2) the basis for physicians' concerns about CMAC rates and how these concerns affect physicians' willingness to treat military beneficiaries, (3) the basis for other concerns physicians have about TRICARE that could also affect their willingness to treat military beneficiaries, and (4) how balance billing limits are being enforced.[4]

To examine these issues, we reviewed documentation explaining DOD's methodology for setting CMAC rates and contracted with a consulting firm that provides actuarial services to evaluate the methodology's compliance with U.S. Code requirements. To compare CMAC and Medicare rates, we obtained rates for specific high-volume procedures at four locations: Abilene, Texas; Jacksonville, Florida; Ozark, Alabama; and San Diego, California. Each of these locations has military treatment facilities; together, they represent a mix of urban and rural areas as well as different degrees of health maintenance organization (HMO) penetration. To determine how reimbursement levels and other administrative factors affect physicians' decisions to treat military beneficiaries, we interviewed physician and beneficiary advocacy groups as well as members of medical societies in each of the four selected locations. In addition, we interviewed DOD and its managed care support contractors (MCSC), who help administer the TRICARE program, to obtain information on the extent and difficulty of balance billing enforcement. For a further description of the scope and methodology of our work, see appendix I. We conducted our review between March 1997 and January 1998 in accordance with generally accepted government auditing standards.

Results in Brief

The methodology used by DOD to transition CMAC rates to the Medicare level of payment complies with statutory requirements and generally conforms with accepted actuarial practice. These adjustments will result in DOD saving about three-quarters of a billion dollars in fiscal year 1998 in health care expenditures. As of the most recent available CMAC rate

[3]Statutory requirements are established under section 1079(h) of title 10, U.S.C.

[4]Physicians who do not join the TRICARE network are allowed to charge the beneficiary an additional fee, or "balance bill," up to 15 percent above the allowed CMAC rate.

adjustment in March 1997, 80 percent of CMAC rates nationwide were at the same level as Medicare, with about 20 percent higher and less than 1 percent below the Medicare level of payment. Also, the CMAC rates at each of the four locations we selected were generally consistent with Medicare rates.

While physicians' initial concerns about low obstetric and pediatric rates have been addressed by DOD, current physician complaints about reimbursement levels are focused on the discounted CMAC rates paid to network physicians under DOD's TRICARE program. Because most CMAC rates are now equivalent to Medicare rates, the discounted CMAC rates that TRICARE network physicians agree to accept are typically below the Medicare level of payment. Some physicians told us that they considered the discounts unacceptable, and as a result, they would not join the TRICARE network but would continue to treat military beneficiaries as nonnetwork physicians. We found that the discount rates physicians were willing to accept in each of the four locations were largely dependent on local health care market factors such as the degree of HMO penetration and the dependence of local physicians on the military beneficiary population.

Physicians we met with also expressed concerns about administrative "hassles," which included untimely reimbursement, lack of fee schedules with which to verify reimbursement accuracy, a slow preauthorization process to approve medical treatment, and unreliable customer telephone service—all of which contributed to their frustration with the TRICARE program. In many cases, physicians said that while they would be willing to accept discounted CMAC rates, the administrative impediments provided significant disincentives to joining the TRICARE network. Although they continue to treat military beneficiaries as nonnetwork physicians, some physicians told us that, out of frustration, they dropped out of the network, and others decided not to join. DOD and MCSC officials acknowledged these complaints and are making efforts to address them and alleviate physicians' concerns. It is too soon, however, to determine the effectiveness of these efforts.

DOD and MCSC officials told us that they were aware of only a very small number of balance billing infractions—all of which had been easily resolved. However, MCSC officials told us that although they adjudicate the claim and pay the physician, they cannot ensure that physicians are not balance billing beneficiaries more than 15 percent above the allowed CMAC rate because they do not receive notice of any subsequent bill that the physician may send the beneficiary. While the MCSCs attempt to educate

beneficiaries about balance billing limits, the explanation of benefits statement does not include information on the balance billing limits—information that would notify the beneficiary and the physician of the maximum balance billing amount. Medicare, which has the same balance billing limit, sends notice of balance billing limitations on the statements it provides to beneficiaries and physicians.

Background

DOD's primary medical mission is to maintain the health of 1.6 million active duty service personnel and to provide health care during military operations. Also, DOD offers health care to 6.6 million non-active duty beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. Most care is provided in about 115 hospitals and 470 clinics worldwide—collectively referred to as military treatment facilities (MTF)—operated by the Army, Navy, and Air Force. The DOD direct care system is supplemented by care that is mostly paid for by DOD but is provided by civilian physicians under the CHAMPUS program. DOD is currently transitioning to a nationwide managed care program called TRICARE, under which the CHAMPUS program is now offered as one of three health care options called TRICARE Standard.

In response to the rapid escalation of CHAMPUS costs in the 1980s, the Congress urged DOD, beginning with the Appropriations Act for Fiscal Year 1991 (P.L. 101-511), that physician payments under CHAMPUS be gradually brought in line with payments under Medicare, with reductions not to exceed 15 percent in a given year. Starting with the DOD Appropriations Act for Fiscal Year 1993 (P.L. 102-396), the Congress also enacted provisions (1) directing DOD, through regulations, to limit beneficiaries' out-of-pocket costs through balance billing limits and (2) authorizing waivers to "freeze" CMAC rates at current levels if DOD determines that further rate reductions would impair beneficiaries' adequate access to health care. DOD set balance billing limits for nonparticipating physicians at 115 percent of CMAC, which is the same limitation used for the Medicare program. By basing physician reimbursement on the Medicare fee schedule, DOD estimates that beneficiaries will save about $155 million in out-of-pocket costs in fiscal year 1998.

To further contain rising health care costs, the Congress directed DOD in the National Defense Authorization Act for Fiscal Year 1994 (P.L. 103-160) to prescribe and implement a nationwide managed health care benefit program modeled on HMOs. Drawing from its experience with demonstrations of alternative health care delivery approaches, DOD

designed TRICARE. As a triple-option benefit program, TRICARE is designed to give beneficiaries a choice among an HMO, a preferred provider organization (PPO), and a fee-for-service benefit. The HMO option, called TRICARE Prime, is the only option for which beneficiaries must enroll. TRICARE Extra is the PPO option, and TRICARE Standard is the fee-for-service option, which remains identical in structure to the previous CHAMPUS program. Regional MCSCs help administer the TRICARE program. The MCSCs' many responsibilities include claims processing, customer service, and developing and maintaining an adequate network of civilian physicians.

CMAC rates serve as the maximum level of reimbursement under each of TRICARE's three options. To treat military beneficiaries under the Prime and Extra options, civilian physicians must join a network through the MCSC. The MCSC individually contracts with physicians or physician groups at a negotiated reimbursement rate, which is usually discounted from the CMAC rate. Network physicians are reimbursed at their negotiated rate regardless of whether they are providing care to enrollees under Prime or nonenrollees under the Extra option. Network physicians must accept their negotiated rate as payment in full. Physicians who do not join the network may still provide care to military beneficiaries under TRICARE Standard, for which they are reimbursed up to the full CMAC rate. Under this option, physicians may choose, on a case-by-case basis, whether to participate on a claim, that is, accept the CMAC rate as payment in full, less any applicable copayment. By law, physicians who decide not to participate on a particular claim under TRICARE Standard will receive the full CMAC rate and can balance bill the beneficiary for up to an additional 15 percent above that rate.

CMAC Methodology Complies With Statutory Requirements as the Transition Nears Completion

The methodology DOD uses to set and transition CMAC rates to the Medicare level of payment complies with statutory requirements established under section 1079(h) of title 10 U.S.C. and generally conforms with accepted actuarial practice. Since 1991, DOD has annually adjusted and set CMAC rates on the basis of the Medicare fee schedule, which will result in a savings of about $770 million in fiscal year 1998. The methodology used to adjust CMAC rates is described in appendix II.

As of March 1997, the most recent available CMAC rate update, approximately 80 percent of the national CMAC rates were at the same level as Medicare and about 20 percent were higher than Medicare because the transition for these rates is not yet complete. Only the rates for 61 of about

7,000 procedures—less than 1 percent—were below the Medicare level of payment. DOD has proposed a new rule (62 Fed. Reg. 61058 (1997)) to increase the payment amounts for the 61 procedures to the Medicare fee schedule amounts. The proposed rule is expected to be finalized in March 1998 after comments are received and analyzed. See appendix III for a list of these procedures.

While CMAC rates are initially set at the national level, adjustments are made for each procedure code for 225 different localities within the United States.[5] The locality-adjusted CMAC rates are the rates actually used to reimburse physicians. We found that the selected high-volume CMAC rates at each of the four locations were generally consistent with Medicare rates.

Initial Reimbursement Complaints Addressed, but Network Discounts Now Concern Physicians

DOD began using CMAC rates to reimburse civilian physicians on May 1, 1992. During the initial CMAC transition process to the Medicare level of payment, some physicians expressed concern about the low level of payment for certain obstetric and pediatric procedures, but payment levels for these procedures have since been addressed by DOD and HHS' Health Care Financing Administration (HCFA). Current physician complaints about the CMAC level of reimbursement are primarily directed at the discounted CMAC rates paid to TRICARE network physicians under the Prime and Extra options rather than the full CMAC rate used to reimburse nonnetwork physicians under the Standard option. DOD reports that the vast majority of physicians who accept military beneficiaries as patients under the Standard option agree to accept the CMAC rate as payment in full for their services and do not balance bill for additional payment.

DOD Addressed Initial Complaints About Obstetric and Pediatric CMAC Rates

During the transition of CMAC rates, physicians initially complained about the CMAC reimbursement levels for obstetric and pediatric procedures. In response to complaints about obstetric rates, HCFA reexamined and adjusted the Medicare fee schedule's obstetric cost components and increased the reimbursement rates for some obstetrical delivery procedures. DOD, in turn, made corresponding adjustments to obstetric fees during its yearly CMAC revision.

DOD did not, however, adjust pediatric rates. Physicians argued that CMAC rates for pediatric procedures should not be set at the same levels as services provided to adults because physician costs for caring for children

[5]Beginning with the 1998 update, adjustments will be made for 89 localities, consistent with Medicare.

are higher. To determine the validity of this concern, DOD commissioned a study, which concluded that only 12.3 percent of all payments would be for services for which there is a higher cost for children, and 56.2 percent of all payments would be for services for which there is a lower cost for children. The study found that 31.5 percent of payments were the same for children and adults. Consequently, DOD concluded that no payment differential was needed. According to the actuaries, DOD's decision conforms with common insurance industry practice.

Physician Complaints Now Focused on Discounted CMAC Rates

Because most CMAC rates are equivalent to Medicare rates, the discounted CMAC rates that TRICARE network physicians agree to accept are typically below the Medicare level of payment. The American Medical Association and some medical society members we interviewed told us that they considered the discounted CMAC rates network physicians were being asked to accept by the MCSCs to be too low, but that the full CMAC rate paid under Standard, though not desirable, is acceptable. Because of this, some physicians told us that they would not join the TRICARE network but would continue to see military beneficiaries under the Standard option. In the four locations, we found that the differences in the discounted CMAC rates physicians are willing to accept depend largely upon local health care market conditions such as the degree of HMO penetration as well as the dependence of the local physicians on the military beneficiary population. Physicians whose practices include a large percentage of military beneficiaries are more likely to join the network and accept the discounted rates offered by the MCSCs to maintain their patient base.

For example, in Ozark, Alabama, one of the two rural, low-HMO-penetration locations we selected, the median discount rate physicians were willing to accept to maintain their patient base was 10 percent. In Abilene, Texas, the other rural, low-HMO-penetration location we visited, most physicians said that they did not need to join the network to maintain their patient base, and consequently, many of those who did agree to join did so only on the condition that their fee would not be discounted. In each of these locations, DOD and MCSC officials told us that the local physicians also tended to be unfamiliar with and averse to managed care. In contrast, however, network physicians in the two urban, high-HMO-penetration locations—San Diego, California, and Jacksonville, Florida—accepted higher median discounts of 15 and 20 percent, respectively.

According to the actuaries, in areas with significant competition among managed care plans such as the states of Florida, California, Minnesota,

and Massachusetts, physician reimbursement is approaching the Medicare level of payment, and in some of these areas, typical reimbursement is based on 80 percent of the Medicare level of payment. Likewise, a study conducted by Milliman and Robertson concluded that HMO reimbursement rates are approaching those of the Medicare fee schedule in many states.[6] For example, an analysis of HMO payments as a percentage of Medicare showed that HMOs in California pay at 105 percent of Medicare and those in Florida pay at 95 percent of Medicare, on average.

Despite Complaints, DOD Reports High Participation Levels

DOD reported in April 1997 a physician participation rate of 86 percent for the TRICARE Standard option, based on an analysis of claims submitted from July 1995 through June 1996. This participation rate means that the vast majority of physicians accepted the allowed charges as payment in full and did not balance bill beneficiaries for services rendered. As a safeguard to ensure participation, DOD also monitors participation for individual procedures for each locality during the yearly CMAC update process. If participation on claims falls below 60 percent for a particular procedure for which there are at least 50 claims, DOD uses a waiver to automatically "freeze" the rate for that procedure at the current level with no downward adjustments for that year. During 1997, 167 automatic waivers for physician payments were in effect, which represents less than 1 percent of the approximately 1.6 million locality-specific CMAC rates. Waivers can also be requested through written petitions. To date, DOD has received about 20 waiver petitions but has approved only 1 on the basis of the information provided.

Administrative Problems Contribute to Physicians' Frustration With TRICARE

Our discussions with physician groups, physicians, and physician office staff revealed considerable concern with several other aspects of TRICARE administration—all of which negatively affected their opinion of the program. The administrative concerns range from slow claims payment to unreliable customer telephone service. And while these concerns resulted in some physicians dropping out of the network or not joining, these physicians told us that they continue to treat military beneficiaries as nonnetwork physicians under the Standard option. DOD and MCSC officials acknowledged these complaints and told us they are in the process of addressing them. Consequently, the success of these efforts will not be known for some time.

[6]Mark Crane, "How Low Can Fees Go?" Medical Economics (Apr. 7, 1997), pp. 26-38. Milliman and Robertson is a firm of actuaries and consultants who assist health care payers and providers such as hospitals, insurance companies, HMOs, PPOs, government agencies, and support institutions.

Physicians Complain About Slow Claims Processing

Slow reimbursement was a common physician complaint about TRICARE and, when combined with discounted payment levels, has resulted in some physicians dropping out of the TRICARE network and others choosing not to join. During the start-up phase of health care delivery, the MCSCs for the four selected locations experienced to varying degrees some problems regionwide in meeting their contractual timeliness requirement that 75 percent of claims be processed within 21 days, primarily because of higher-than-expected claims volume.

To begin meeting claims processing timeliness standards, the MCSC for Abilene, Texas, told us it closed its understaffed claims processing center for DOD's Southwest region and subcontracted with a company that specializes in claims processing to clear a backlog of about 200,000 claims. In addition, it sent a team of claims adjudicators to Abilene to resolve physicians' individual claims. The MCSC's claims processing center for the regions encompassing Ozark, Alabama, and Jacksonville, Florida, hired an additional 200 staff to adjudicate the larger-than-expected workload. The MCSC responsible for these regions also told us that it has teams of claims processors that can be sent to specific locations when needed.

Although the MCSCs for the four locations reported to DOD that they are now meeting the contractual claims processing requirements, physicians in all four locations still complained to us about slow and cumbersome reimbursement. Physicians and their office staffs told us they spend considerable time refiling and appealing TRICARE claims as a result of denials and partial payments. Physicians and their office staffs also complained that there seem to be no distinct or specific TRICARE requirements on how a treatment should be coded on a claim to receive payment. DOD and MCSC officials responded that although the MCSCs use national Current Procedural Terminology coding standards, some of the coding confusion is due to the use of Claim Check, a software program that DOD requires all MCSCs to use for claims review. Claim Check performs an initial claim review and edits the procedure codes to eliminate nonreimbursable and duplicate procedures to prevent overpayment. According to DOD, all Claim Check determinations are considered final and, as such, are not appealable. These edits may result in the denial or recoding of submitted procedure codes, which may cause physicians to receive lower-than-expected payments. DOD and MCSC officials also said that payments are delayed for other reasons, such as the lack of preauthorization for treatment. To help remedy this, MCSC officials told us that they are conducting educational seminars on proper claims submission techniques for physicians and their office staffs.

Physicians Lack Fee Schedules Necessary to Verify Reimbursement Accuracy

Contributing to physicians' discouragement with the TRICARE program is that they are not routinely provided with fee schedules, and as a result, they do not always know what they should be paid. MCSC officials responded that physicians can request fee information up front for their high-use procedures and that CMAC rates are available on the Internet.[7] They also told us that physicians may request fee information for specific procedures through a toll-free customer service telephone line. In addition, fee information can be purchased from the federal government in hard copy for $75 or as an electronic file for $152. These sources contain over 1.6 million CMAC rates—representing approximately 7,000 procedure codes for each of the 225 localities.[8] However, some physician offices may be unwilling to pay these prices for information they believe should be provided by the MCSC or DOD—especially since physicians would only be interested in the rates for their specific locality. Furthermore, we were told by physician office staff that not every physician's office has access to the Internet and that repeatedly requesting specific fees by telephone is time consuming.

Preauthorization Delays and Customer Service Problems Add to Physician Frustration With the Program

Physicians complained that other administrative problems, such as slow preauthorizations for care and unreliable customer service telephone lines, have also resulted in increased paperwork and staff time, which is not cost-effective. Physicians at each of the locations we examined cited the slow and paperwork-intensive preauthorization process, which is used to approve certain types of care for reimbursement. Some of the physicians told us they have had to delay treatment to obtain preauthorization, and some said that they went ahead and treated patients who, in their opinion, needed immediate attention, thereby running the risk of not being reimbursed for their services.

DOD and MCSC officials responded that the preauthorization process takes time because it is a two-level review. The local MTF must review the request to determine whether the care could be provided within that facility, then MCSC officials must perform a medical necessity review. MCSC officials also stated that incomplete information could require resubmission and thus a delayed determination. Recognizing physicians' concerns, MCSC officials are working on ways to streamline and improve

[7]Locality-specific CMAC rates are available on the Internet via the TRICARE Support Office home page at http://www.ochampus.mil.

[8]The hard copy file of CMAC rates can be obtained from the Defense Technical Information Center. The electronic file is available from the U.S. Department of Commerce's National Technical Information Center.

the preauthorization process. For example, in Ozark, Alabama, local MCSC personnel rerouted preauthorization requests to first obtain the medical necessity decision, thus giving the MTF staff information necessary to make a faster determination as to whether the care could be provided at the MTF. And in Abilene, Texas, a team of military and MCSC officials evaluated the preauthorization process. Their review resulted in the retraining of civilian network physicians and their staffs on a case-by-case basis to ensure complete initial submissions of patient identification and clinical data.

Some physicians also complained that their office staffs spent inordinate amounts of time trying to get through to customer service on the telephone, and once connected, they had a long wait for a representative. In one location, some office staff told us that they called the customer service line repeatedly over a 2-day period trying to get through to a representative. Other office staff told us that they typically stayed on hold 30 to 45 minutes for a representative after being connected. The MCSC told us they are trying various approaches to address these problems. For example, the MCSC for Abilene, Texas, responded that the telephone system at the TRICARE Service Center had been improved by adding more telephone lines, modifying the automated telephone menu, and streamlining the rerouting process. The MCSC in San Diego, California, installed an additional toll-free telephone line dedicated solely for physician use, and the MCSC for Ozark, Alabama, and Jacksonville, Florida, more than doubled the staff at its central telephone center.

DOD Lacks Information on the Extent of Balance Billing Infractions

On the basis of congressional direction, DOD limited beneficiaries' out-of-pocket costs by setting balance billing limits for nonparticipating physicians at 115 percent of the CMAC rate, which is the same limitation used for the Medicare program. This provision became effective for all care provided on and after November 1, 1993. An infraction of this requirement will result in a physician possibly losing his or her status as a TRICARE authorized provider.[9] DOD has proposed a new rule (62 Fed. Reg. 61058 (1997)) that noncompliant physicians also be excluded from other federal health care and benefit programs such as Medicare and Medicaid.[10] According to a recent DOD analysis of claims submitted under the

[9]Pharmacies, ambulance companies, independent laboratories, and portable X-ray companies are currently exempt from the 115 percent limitation. However, DOD has proposed a new rule (62 Fed. Reg. 61058 (1997)) to extend balance billing limit authority to these noninstitutional, nonprofessional providers. A beneficiary may also request a waiver of the 115-percent requirement if the beneficiary is willing to pay the full billed charge for a particular physician.

[10]Currently, all physicians who have been convicted of defrauding other federal health care or benefit programs are automatically excluded from TRICARE.

TRICARE Standard option, physicians who did not participate balance billed for 14 percent of claims filed during the period of July 1, 1995, through June 30, 1996. For these nonparticipating claims, beneficiaries saved approximately $78.6 million dollars as a result of balance billing limits.

DOD and MCSC officials told us they were aware of only a very small number of balance billing infractions—all of which were easily resolved. However, MCSC officials told us that after adjudicating the claim and paying the physician, they did not receive notice of any bill the physician may have subsequently sent to the beneficiary. Consequently, the MCSC does not know whether physicians are balance billing beneficiaries in excess of the 115 percent limit unless beneficiaries complain. While the MCSCs have attempted to educate beneficiaries about balance billing limits through briefings and written materials such as benefit booklets, the explanation of benefits statement, which contains information on claim adjudication, does not contain information on the balance billing limits for TRICARE Standard claims submitted by nonparticipating physicians. Including this information on the explanation of benefits statements for both beneficiaries and physicians, as Medicare does, would educate both parties about the amount that can be balance billed.

For the few cases in which beneficiaries notified DOD and the MCSCs that physician charges exceeded the balance billing limits, DOD and the MCSCs reported that these excess charges were due to either billing mistakes or ignorance of procedures rather than deliberate intent. Each of the MCSCs has procedures in place on how to resolve excessive balance billing through a series of notifications to the physician and the beneficiary. To date, all of the identified infractions have been easily resolved, and, according to DOD officials, no physicians have been sanctioned under TRICARE for excessive balance billing practices.

Conclusions

By lowering CMAC rates to levels comparable to rates paid under the Medicare program, DOD will save nearly three-quarters of a billion dollars in fiscal year 1998 in health care expenditures. And throughout the nearly complete transition process, DOD has appropriately set and adjusted CMAC rates in compliance with statutory requirements using a methodology that also generally complies with accepted actuarial practice.

Although physicians complained about the level of reimbursement under TRICARE, their complaints are focused on the discounted rates paid to

network physicians under TRICARE Prime and Extra—rates that are typically lower than Medicare. However, it is the combination of low payments and administrative impediments associated with untimely payments and slow authorizations for treatment that has negatively affected many physicians' opinions of the TRICARE program. Furthermore, when physicians are reimbursed, they do not always know how much to expect or whether they are being paid correctly because written or published fee schedules are not routinely furnished by the MCSCs.

While most of the physicians we spoke with continue to treat military beneficiaries, addressing physicians' concerns is crucial to the development and maintenance of TRICARE networks. Because of administrative and cost issues, physicians are becoming disillusioned with the program. Although DOD and MCSCs are addressing these problems, if they are not resolved, DOD could face increasing problems in the future attracting the number of physicians necessary to ensure that beneficiaries have adequate access to care.

While balance billing limits under the Standard option are intended to protect beneficiaries from excessive out-of-pocket costs, DOD, MCSCs, and beneficiaries do not always know when physicians charge above the 115 percent limit. Although the MCSCs attempt to educate beneficiaries on balance billing limits, this information could be easily communicated by following Medicare's practice of including balance billing information on explanation of benefits statements sent to both the beneficiaries and physicians.

Recommendations

To improve the administration of the TRICARE program, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to

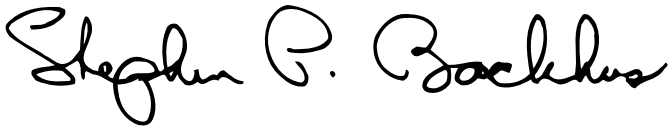
- require MCSCs to provide to physicians written or published locality-specific fee schedules after each yearly CMAC update to help eliminate confusion about CMAC reimbursement rate amounts and
- require MCSCs to notify beneficiaries and physicians of balance billing limits on the explanation of benefits statements for all TRICARE Standard claims submitted by nonparticipating physicians.

Agency Comments and Our Evaluation

In commenting on a draft of our report, the Deputy Assistant Secretary of Defense (Health Services Financing) concurred with our findings and stated that the draft fairly and thoroughly addresses a complex set of issues related to the reimbursement of physicians. In response to our first recommendation, DOD agreed to seek additional, cost-effective methods to ensure that all physicians have access to accurate, timely information about CMAC rates. In response to our second recommendation, DOD agreed to develop balance billing information statements for inclusion on the explanation of benefits forms. We incorporated several technical revisions as suggested by DOD. DOD's comments are presented in their entirety in appendix IV.

As agreed with your offices, we are sending copies of this report to the Secretary of Defense and will make copies available to others upon request.

Please contact me on (202) 512-7101 or Michael T. Blair, Jr., Assistant Director, on (404) 679-1944 if you or your staff have any questions concerning this report. Other major contributors to this report include Cynthia M. Fagnoni, Associate Director; Bonnie W. Anderson, Evaluator-in-Charge; Jonathan Ratner, Senior Health Economist; and Dayna K. Shah, Assistant General Counsel.



Stephen P. Backhus
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Military Health Care Issues

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Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMAC	CHAMPUS maximum allowable charge
DOD	Department of Defense
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
MCSC	managed care support contractor
MEI	Medicare Economic Index
MTF	military treatment facility
PPO	preferred provider organization

Scope and Methodology

To evaluate the compliance of DOD's rate-setting methodology with statutory requirements, we obtained assistance from an actuarial consulting firm. It reviewed documentation of the methodology used in developing CHAMPUS maximum allowable charges (CMAC) along with the requirements of section 1079(h) of title 10, U.S.C. In addition to assessing compliance, the actuary made a determination of whether DOD's methodology is generally consistent with accepted actuarial practice and reviewed and provided observations on DOD's approach for setting pediatric rates. We reviewed and discussed with DOD officials the changes made to obstetric procedure fees by the Health Care Financing Administration (HCFA).

We obtained information from DOD officials regarding the status of the CMAC transition process. To determine whether reimbursement levels differed between CMAC and Medicare rates, we compared a number of high-volume procedures for the following four selected locations: (1) Abilene, Texas; (2) Jacksonville, Florida; (3) Ozark, Alabama; and (4) San Diego, California. In addition, we obtained the discounted rates paid to network physicians in each of the four locations. We used specific criteria to select the locations to ensure that they were representative of the various health care markets where military beneficiaries reside, within regions with the most extensive TRICARE experience. Our selection criteria included the level of HMO penetration, whether the area was rural or urban, the military facility branch of service, and the size and mix of the beneficiary population. These four locations also served as the focus for our evaluation of physician complaints and balance billing enforcement. We selected the high-volume procedures on the basis of an analysis of claim data for each location for the time period of July 1995 through June 1996. For each location, we used the top five high-use specialties in addition to obstetrics and pediatrics for a total of seven specialties. For each specialty, we then used the top procedures on the basis of the frequency, or volume, of claims received for the service. For each procedure, we calculated the CMAC rate as a percentage of Medicare.

To determine the basis of physician complaints about CMAC rates and to identify other physician complaints about TRICARE, we spoke with members of the local medical societies for each of the four locations. To obtain an overall perspective of physician concerns, we met with officials from the American Medical Association. We also interviewed officials from the National Military Family Association and The Retired Officers Association. To determine whether and how physicians' concerns were being addressed, we interviewed local military and MCSC officials for each

of the locations as well as DOD officials at the Office of the Assistant Secretary of Defense for Health Affairs. We also reviewed DOD's physician participation report to determine the extent to which physicians were willing to accept the CMAC rate as full payment. We discussed the report's methodology with DOD officials along with DOD's use of participation rates to waive rate reductions for procedures in locations where participation is low.

To determine the extent and difficulty of balance billing enforcement, we interviewed the local military and MCSC officials for the four locations. We met with officials at the TRICARE Support Office to discuss the methods of enforcement and the extent of infractions. We also met with officials at HCFA to determine how they enforce Medicare's balance billing limits.

We performed our work between March 1997 and January 1998 in accordance with generally accepted government auditing standards.

Methodology for Setting CMAC Rates

CMAC rates for a particular year are calculated using actual charge data submitted on DOD claims for service dates during a 12-month period starting July 1 and ending June 30. A national prevailing charge for each procedure is then calculated at the 80th percentile of these actual billed charges.[11] For each procedure, the previous year's national CMAC is then compared with the lesser of the current-year prevailing charge or the current-year Medicare fee schedule amount. Depending on the outcome, one of the following three scenarios applies:

- If the current-year prevailing charge is lower than the Medicare fee schedule amount, the prevailing charge becomes the new CMAC rate.
- If the current-year prevailing charge is above the Medicare amount, the previous year's CMAC is cut the lesser of 15 percent or the amount necessary to reach the Medicare amount, and thus becomes the new CMAC rate.
- If the previous year's CMAC is below the Medicare amount, it is updated by the Medicare Economic Index (MEI),[12] either in full or by the amount necessary to reach the Medicare level of payment.

After CMAC rates are calculated at the national level, locality-specific adjustments are made for each procedure code.

[11]The National Defense Authorization Act for Fiscal Year 1998 (P.L. 105-85, Nov. 18, 1997) changed statutory requirements for setting CMAC rates. As a result, DOD will be able to simplify the process and establish rates based on the Medicare fee schedule.

[12]The MEI is a measure of annual growth in physician practice costs as well as general earning trends in the economy.

1997 National CMAC Reimbursement Rates That Are Lower Than Medicare's Rates

Procedure code	Procedure	1997 Medicare fee	1997 CMAC rate	Ratio of CMAC to Medicare
10040	Acne surgery	$57.53	$40.24	0.70
11954	Therapy for contour defects	122.74	108.67	0.89
15788	Chemical peel of face	139.16	104.04	0.75
16025	Burn treatment	89.97	80.48	0.89
16030	Burn treatment	102.70	91.98	0.90
17360	Skin peel therapy	64.46	40.24	0.62
20500	Injection of sinus tract	50.16	44.26	0.88
20615	Treatment of bone cyst	87.83	86.23	0.98
24220	Injection for elbow X ray	59.61	52.56	0.88
28234	Incision of foot tendon	188.22	160.96	0.86
29740	Wedging of cast	60.09	33.48	0.56
30400	Reconstruction of nose	811.14	647.44	0.80
46500	Injection into hemorrhoids	73.03	57.49	0.79
46900	Destruction of anal lesions	86.42	68.98	0.80
51720	Treatment of bladder lesion	94.10	74.73	0.79
53600	Dilate urethra stricture	60.19	47.41	0.79
53601	Dilate urethra stricture	49.92	43.69	0.88
53661	Dilation of urethra	38.51	34.49	0.90
54160	Circumcision	167.87	124.49	0.74
57150	Treat vaginal infection	30.08	29.94	1.00
59051	Interpret fetal monitor	55.46	51.00	0.92
59430	Care after delivery	98.44	56.98	0.58
66830	Removal of lens lesion	623.52	614.94	0.99
66983	Remove cataract, insert lens	807.79	628.32	0.78
69000	Drain external ear lesion	68.15	57.49	0.84
69401	Inflate middle ear canal	35.13	33.99	0.97
80101	Lab procedure	20.20	17.30	0.86
80438	Lab procedure	71.52	68.76	0.96
82775	Lab procedure	30.90	25.39	0.82
83840	Lab procedure	23.94	13.20	0.55
83898	Lab procedure	39.91	30.15	0.76
84600	Lab procedure	23.57	22.01	0.93
85576	Lab procedure	31.51	25.67	0.81

(continued)

Procedure code	Procedure	1997 Medicare fee	1997 CMAC rate	Ratio of CMAC to Medicare
86353	Lab procedure	71.90	56.59	0.79
88261	Lab procedure	259.26	238.01	0.92
88285	Lab procedure	27.86	15.40	0.55
90835	Special interview	107.43	100.44	0.93
90842	Psychotherapy: 75-80 minutes	137.76	137.70	1.00
92015	Refraction	23.30	21.62	0.93
92100	Serial tonometry exams	37.35	33.34	0.89
92130	Water provocation tonometry	42.40	33.48	0.79
96440	Chemotherapy, intracavitary	103.00	69.05	0.67
96542	Chemotherapy injection	85.36	62.42	0.73
96913	Photo-chemotherapy	47.05	38.03	0.81
99186	Total body hypothermia	75.14	54.06	0.72
99355	Prolonged service, office	87.74	78.03	0.89
99357	Prolonged service, inpatient	84.55	78.03	0.92
99375	Care plan oversight	76.41	67.63	0.89
99381	Preventive visit, new, infant	81.27	59.77	0.74
99382	Preventive visit, new, age 1-4	92.98	70.63	0.76
99383	Preventive visit, new, age 5-11	92.98	89.76	0.97
99384	Preventive visit, new, age 12-17	104.68	92.37	0.88
99386	Preventive visit, new, age 40-64	119.95	117.30	0.98
99391	Preventive visit, established, infant	69.90	49.99	0.72
99392	Preventive visit, established, age 1-4	81.27	57.22	0.70
99393	Preventive visit, established, age 5-11	81.27	71.40	0.88
99394	Preventive visit, established, age 12-17	92.98	81.60	0.88
99395	Preventive visit, established, age 18-39	87.22	86.70	0.99
99396	Preventive visit, established, age 40-64	97.92	86.93	0.89

(continued)

Procedure code	Procedure	1997 Medicare fee	1997 CMAC rate	Ratio of CMAC to Medicare
99401	Preventive counseling, individual	31.14	25.50	0.82
99432	Newborn care, not in hospital	86.15	66.30	0.77

Comments From the Department of Defense

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

9 FEB 1998

Mr. Stephen P. Backhus
Director, Veterans' Affairs
and Military Health Care Issues
Health, Education, and Human Services Division
US General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "DEFENSE HEALTH CARE: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians," dated January 27, 1998 (GAO Code 101603/OSD Case 1524).

DoD concurs with the report. The report fairly and thoroughly addresses a complex set of issues related to the reimbursement of physicians and other health care providers.

DoD provided minor technical comments on the draft report directly to GAO staff. DoD's position on the two recommendations provided in the report is enclosed. My point of contact for this action is Steve Lillie, (703) 695-3350.

Sincerely,

for

Diana G. Tabler
Deputy Assistant Secretary
(Health Services Financing)

Enclosure:
As stated

GAO DRAFT REPORT – DATED JANUARY 27, 1998
(GAO CODE 101603) OSD CASE 1524

"DEFENSE HEALTH CARE: REIMBURSEMENT RATES APPROPRIATELY SET; OTHER PROBLEMS CONCERN PHYSICIANS"

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATIONS

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to require managed care support contractors (MCSCs) to provide physicians written or published locality-specific fee schedules after each yearly CHAMPUS maximum allowable charge (CMAC) update to help eliminate confusion about CMAC reimbursement rate amounts. (p. 19/GAO Draft Report)

DoD RESPONSE: Concur. DoD currently makes updated rate information available on the Internet. We will seek additional, cost effective methods to assure that all physicians have access to accurate, timely information, and that they are informed about CMAC rates.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to require MCSCs to notify beneficiaries and physicians of balance billing limits on the explanation of benefits statement for all TRICARE Standard claims submitted by nonparticipating physicians.
(p. 20/GAO Draft Report)

DoD RESPONSE: Concur. DoD will develop information statements for inclusion on the explanation of benefits for nonparticipating claims. It is likely that only generic statements will be possible. This is because (1) bills for multiple services are often submitted on the same claim; (2) balance billing limitations may come into play for some services on the claims and not for others; (3) space limitations prevent presentation of an extensive "footnote" on the Explanation of Benefits listing each item from the claim and its disposition regarding balance billing.

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