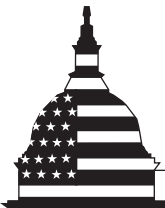


June 2011

DEFENSE HEALTH CARE

Access to Civilian Providers under TRICARE Standard and Extra



G A O

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Why GAO Did This Study

The Department of Defense (DOD) provides health care through its TRICARE program, which is managed by the TRICARE Management Activity (TMA). TRICARE offers three basic options. Beneficiaries who choose TRICARE Prime, an option that uses civilian provider networks, must enroll. TRICARE beneficiaries who do not enroll in this option may obtain care from nonnetwork providers under TRICARE Standard or from network providers under TRICARE Extra.

The National Defense Authorization Act for Fiscal Year 2008 directed GAO to evaluate various aspects of beneficiaries' access to care under the TRICARE Standard and Extra options. This report examines (1) impediments to TRICARE Standard and Extra beneficiaries' access to civilian health care and mental health care providers and TMA's actions to address the impediments; (2) TMA's efforts to monitor access to civilian providers for TRICARE Standard and Extra beneficiaries; (3) how TMA informs network and nonnetwork civilian providers about TRICARE Standard and Extra; and (4) how TMA informs TRICARE Standard and Extra beneficiaries about their options. To address these objectives, GAO reviewed and analyzed TMA and TRICARE contractor data and documents. GAO also interviewed TMA officials, including those in its regional offices, as well as its contractors.

DEFENSE HEALTH CARE

Access to Civilian Providers under TRICARE Standard and Extra

What GAO Found

Reimbursement rates and provider shortages have been cited as the main impediments that hinder TRICARE Standard and Extra beneficiaries' access to civilian health care and mental health care providers. Providers' concern about TRICARE's reimbursement rates—which are generally set at Medicare rates—has been a long-standing issue and has more recently been cited as the primary reason civilian providers will not accept TRICARE Standard and Extra beneficiaries as patients, according to TMA's surveys of civilian providers. TMA can increase reimbursement rates in certain instances, such as when it determines that access to care is being affected by the level of reimbursement. Shortages of certain provider specialties, such as mental health care providers, at the national and local levels may also impede access, but these shortages are not specific to the TRICARE program and also affect the general population. As a result, there are limitations as to what TMA can do to address them.

TMA has primarily used feedback mechanisms, including surveys of beneficiaries and civilian providers, to gauge TRICARE Standard and Extra beneficiaries' access to civilian providers. More recently, in February 2010, in recognition that TRICARE has had no established measures for monitoring the availability of civilian network and nonnetwork providers for these beneficiaries, TMA directed the TRICARE Regional Offices to develop a model to help identify geographic areas where they may experience access problems. GAO's review of the initial models found their methodology to be reasonable. However, because the regional models were recently developed, it is too early to determine their effectiveness.

TMA's contractors educate civilian providers about TRICARE program requirements, policies, and procedures. Contractors also conduct outreach to increase providers' awareness of the program, and while TMA's provider survey results indicate that civilian providers are generally aware of the program, this does not necessarily signify that providers have an accurate understanding of the TRICARE program and its options.

Similarly, TMA's contractors educate beneficiaries on all of the TRICARE options and maintain directories of network providers to facilitate beneficiaries' access to care. When the new TRICARE contracts are implemented, TMA will also require its contractors to include information on nonnetwork providers in their provider directories.

In commenting on a draft of this report, DOD concurred with GAO's overall findings.

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Abbreviations

BRAC	Base Realignment and Closure
CPT	current procedural terminology
DOD	Department of Defense
NDAA	National Defense Authorization Act
PPACA	Patient Protection and Affordable Care Act
TMA	TRICARE Management Activity

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

June 2, 2011

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

The Honorable Howard P. “Buck” McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

In fiscal year 2010, the Department of Defense (DOD) offered health care to almost 9.7 million eligible beneficiaries through its TRICARE program.¹ Under TRICARE, beneficiaries may choose among three basic options—TRICARE Prime (a managed care option), TRICARE Extra (a preferred provider organization option), and TRICARE Standard (a fee-for-service option).² TRICARE is different from other health care plans because not all of the options require eligible beneficiaries to enroll to use their benefits. Beneficiaries who choose TRICARE Prime are required to enroll in this option. Beneficiaries who decide not to use TRICARE Prime may still obtain health care through the TRICARE program by using either the TRICARE Standard or Extra options, or they may choose not to use their TRICARE benefits at all.³ Consequently, DOD does not have complete information on which beneficiaries intend to use their benefits, and it

¹Eligible beneficiaries include active duty personnel and their dependents, medically eligible Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors.

²The TRICARE program also offers other options, including TRICARE Reserve Select and TRICARE for Life. TRICARE Reserve Select is a premium-based health plan that qualified Reserve and National Guard members may purchase, with care options that are similar to those of TRICARE Standard and Extra. TRICARE beneficiaries who are eligible for Medicare and enroll in Part B are eligible to receive care under TRICARE for Life.

³Eligible beneficiaries may choose not to use TRICARE if, for example, they are covered by another health care plan.

cannot accurately predict the health care demands of beneficiaries who have not enrolled, including how to ensure adequate access to care.

Under TRICARE, beneficiaries can obtain care either from providers at military hospitals and clinics, referred to as military treatment facilities, or from civilian providers. DOD's TRICARE Management Activity (TMA), which oversees the program, contracts with managed care support contractors (contractors) to develop networks of civilian providers and to perform other customer service functions, such as processing claims and assisting beneficiaries with finding providers. Contractors are required to establish adequate networks of civilian providers to serve all TRICARE beneficiaries regardless of enrollment status in geographic areas called Prime Service Areas.⁴ Contractors use estimates of the number of TRICARE users, among other factors, to develop provider networks and ensure adequate access to care for beneficiaries. Although some network providers may be located outside of Prime Service Areas, contractors are not required to develop networks in these areas (which we refer to as non-Prime Service Areas).

All beneficiaries may obtain care at military treatment facilities, although priority is given to active duty personnel and then to beneficiaries enrolled in TRICARE Prime. Beneficiaries who enroll in TRICARE Prime can also obtain care from the civilian providers who have joined the provider network established by the TRICARE contractors—referred to as network providers.⁵ Beneficiaries who do not enroll in TRICARE Prime may receive care either from network providers, in which case they are considered to be using TRICARE Extra, or from nonnetwork providers (those outside the network), in which case they are considered to be using TRICARE Standard. The choices that beneficiaries have in selecting TRICARE options and providers vary depending on their location. Beneficiaries living in Prime Service Areas can choose between TRICARE Prime, TRICARE Standard, and TRICARE Extra. Beneficiaries living in non-Prime

⁴Prime Service Areas are geographic areas determined by the Assistant Secretary of Defense for Health Affairs and are defined by a set of 5-digit zip codes, usually within an approximate 40-mile radius of a military inpatient treatment facility. The managed care support contracts also require the contractors to develop civilian provider networks at all Base Realignment and Closure (BRAC) sites, which are military installations that have been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure.

⁵A network provider is a provider who has a contractual relationship with the TRICARE regional contractors to provide care at a negotiated rate.

Service Areas can choose between TRICARE Standard and TRICARE Extra. According to a TMA official, about 19 percent of beneficiaries eligible for TRICARE Standard and Extra resided in non-Prime Service Areas in fiscal year 2010.

Since TRICARE's inception in 1995, beneficiaries using the TRICARE Standard and Extra options have reported difficulties finding civilian providers who will accept them as patients. In response to these concerns, the National Defense Authorization Act (NDAA) for Fiscal Year 2004 directed DOD to monitor access to care for TRICARE beneficiaries who were not enrolled in TRICARE Prime through a multiyear survey of civilian providers.⁶ According to TMA, which administered the survey, results indicated that nationally, about 81 percent of physicians who were accepting new patients would accept TRICARE beneficiaries as patients, although the results varied by state and by provider specialty. The act also directed us to review the processes, procedures, and analysis used by DOD to determine the adequacy of the number of network and nonnetwork civilian providers and the actions DOD has taken to ensure access to care for beneficiaries who were not enrolled in TRICARE Prime. In December 2006, we reported that TMA and its contractors used various methods to monitor access to care, and these methods indicated that access was generally sufficient for users of TRICARE Standard and Extra.⁷

Nonetheless, beneficiaries using the TRICARE Standard and Extra options have continued to express concerns about access to civilian providers. To better understand the adequacy of access to care for this population, the NDAA for Fiscal Year 2008 directed DOD to conduct two surveys⁸—another multiyear survey of civilian providers as well as a multiyear survey of beneficiaries, which includes nonenrolled beneficiaries who were eligible to use the TRICARE Standard and TRICARE Extra options as well as TRICARE Reserve Select—an option similar to TRICARE Standard and Extra that is available to certain members of the Reserves and National Guard. The NDAA for Fiscal Year 2008 directed us to review these surveys, and in March 2010, we reported that the methodology for DOD's surveys of

⁶See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532-34 (2003) and S. Rep. No. 108-46, at 330 (2003).

⁷GAO, *Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option*. [GAO-07-48](#) (Washington, D.C.: Dec. 22, 2006).

⁸See Pub. L. No. 110-181, § 711(a), 122 Stat. 3, 190-91.

civilian providers and nonenrolled beneficiaries was sound, and we provided an analysis of the first year's results for each of the surveys.⁹

Furthermore, access to mental health care providers is of particular concern for all TRICARE beneficiaries, including those who use TRICARE Standard and Extra, because the exposure to combat and the stress of deployment and redeployment have increased beneficiaries' demand for mental health services. From fiscal year 2006 through 2010, TRICARE Standard and Extra beneficiaries' visits to civilian mental health care providers increased over 27 percent. A June 2007 report by DOD's Task Force on Mental Health stated that TRICARE's provider networks have been tasked with providing an increasing volume and proportion of mental health services for families and retirees.¹⁰ In assessing the oversight of the mental health network at one location, the task force discovered that out of 100 network mental health providers contacted from a list on the contractor's Web site, only 3 would accept new TRICARE patients.

The NDAA for Fiscal Year 2008 directed us to evaluate issues related to TRICARE Standard and Extra beneficiaries' access to health care and mental health care, including the identification of access impediments and education and outreach efforts directed at civilian providers and these beneficiaries. This report identifies and examines: (1) the impediments to TRICARE Standard and Extra beneficiaries' access to civilian health care and mental health care providers and TMA's actions to address the impediments; (2) TMA's efforts to monitor access to civilian providers for TRICARE Standard and Extra beneficiaries; (3) how TMA informs network and nonnetwork civilian providers about TRICARE Standard and Extra; and (4) how TMA informs TRICARE Standard and Extra beneficiaries about their options and facilitates their access to network and nonnetwork civilian providers.

To address these objectives, we met with officials in each of the three TRICARE Regional Offices (North, South, and West) and with officials for each of the three contractors to discuss access impediments in their respective regions, how access to network and nonnetwork providers is

⁹GAO, *Defense Health Care: 2008 Access to Care Surveys Indicate Some Problems, but Beneficiary Satisfaction Is Similar to Other Health Plans*, GAO-10-402 (Washington, D.C.; Mar. 31, 2010).

¹⁰Department of Defense, Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (Falls Church, Va., June 2007).

monitored, and their efforts to educate civilian providers and TRICARE Standard and Extra beneficiaries. We also interviewed TMA officials responsible for program operations, medical benefits and reimbursement, contract performance evaluation, contract management, data quality, communication and customer service, and program analysis and evaluation. We also obtained documentation on the contractors' performance in meeting network adequacy and education related requirements. Lastly, we met with representatives of military beneficiary organizations as well as two national provider organizations to obtain their perspectives about access to civilian providers for TRICARE Standard and Extra beneficiaries.

To identify and examine impediments to TRICARE Standard and Extra beneficiaries' access to civilian health care and mental health care providers and TMA's actions to address them, we obtained and reviewed relevant reports and studies. Specifically, we reviewed TMA's reported results from its multiyear survey of civilian providers, conducted from 2005 through 2007, as well as the first 2 years of its subsequent surveys of these providers during fiscal years 2008 and 2009. We assessed the reliability of these data by speaking with knowledgeable officials and reviewing related documentation, and we determined that the survey results were sufficiently reliable for the purposes of this report. We also reviewed a 2008 report prepared by CNA¹¹ on the current participation of civilian providers in the TRICARE program. To examine how TMA addresses access impediments, we reviewed TMA's reimbursement policies, studies that assessed TRICARE's reimbursement rates, TMA's procedures for increasing reimbursement rates, and TMA's procedures for offering bonus payments to physicians in areas identified as having physician shortages. We obtained TMA's reported data on adjustments to reimbursement rates that it issued between January 2002 and January 2011. However, we did not assess the appropriateness of TMA's decision to make these adjustments or the extent to which these adjustments improved civilian providers' acceptance of TRICARE beneficiaries as patients. Additionally, we reviewed DOD's 2009 Report to Congress: Access to Mental Health Services, and spoke with TMA and contractor officials about access to mental health care and actions to improve access.

¹¹CNA is a nonprofit research organization that operates the Center for Naval Analyses and the Institute for Public Research.

To identify and examine the mechanisms that TMA uses to monitor TRICARE Standard and Extra beneficiaries' access to civilian providers, we reviewed various efforts, including feedback mechanisms, that TMA and its contractors use to solicit and gauge beneficiaries' concerns, including difficulties with access to civilian providers. These feedback mechanisms included TMA's surveys of civilian providers and nonenrolled beneficiaries (TRICARE Standard, TRICARE Extra, and TRICARE Reserve Select), as well as data collected on beneficiaries' inquiries and complaints by TMA and its contractors during either fiscal or calendar years 2008 through 2010. We spoke with TMA officials and obtained information from its contractors about the reliability of their data on beneficiaries' inquiries and determined them to be sufficiently reliable for the purpose of our report, but we did not independently verify these data. We also reviewed TMA's 2010 memorandum that directed the TRICARE Regional Offices to implement a new approach for monitoring access to civilian providers under the TRICARE Standard and Extra options, and we obtained and reviewed information about each regional office's monitoring methodology.

To identify and examine how TMA informs network and nonnetwork civilian providers and beneficiaries about TRICARE Standard and Extra and how it facilitates access to civilian providers, we reviewed TMA's requirements of its contractors as related to educating providers and beneficiaries in each TRICARE region under the second generation of TRICARE managed care support contracts (contracts).¹² We also reviewed each contractor's marketing and education plans to identify their specific education efforts. Additionally, we obtained and reviewed TRICARE provider and beneficiary educational materials to gain an understanding of the information that TMA and the contractors use to educate providers and beneficiaries. However, we did not assess the quality and effectiveness of TMA's or the contractors' education efforts and materials. Finally, we reviewed TMA's 2010 memorandum and related documentation regarding TMA's effort to facilitate access to care through provider directories for TRICARE Standard and Extra beneficiaries.

¹²The contracts included in our review are the second generation of TRICARE contracts. The implementation period for these contracts was set to end on March 31, 2010, with the third generation of contracts to begin implementation on April 1, 2010. However, this timeline was delayed due to bid protests on two of the three contracts.

We conducted this performance audit from July 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

In fiscal year 2010, DOD offered health care to almost 9.7 million eligible beneficiaries through its TRICARE program. TRICARE is organized into three regions, and within these regions, beneficiaries may obtain health care from either providers at military treatment facilities or civilian providers.

TRICARE's Benefit Options

TRICARE provides three basic options for its non-Medicare-eligible beneficiary population. These options vary according to TRICARE beneficiary enrollment requirements, the choices TRICARE beneficiaries have in selecting civilian and military treatment facility providers and the amount TRICARE beneficiaries must contribute towards the cost of their care. (See table 1.)

Table 1: Summary of TRICARE's Basic Options

TRICARE option	Description
TRICARE Prime	Beneficiaries who choose to use this managed care option must enroll. All active duty servicemembers are required to use TRICARE Prime, but other TRICARE eligible (i.e., non-active duty) beneficiaries may choose to use this option and must enroll to do so. TRICARE Prime enrollees may pay an annual enrollment fee ^a and receive most of their care from providers at military treatment facilities, augmented by network providers who have agreed to meet specific standards for appointment wait times among other requirements. TRICARE Prime offers lower out-of-pocket costs than the other TRICARE options.
TRICARE Standard	TRICARE beneficiaries who choose not to enroll in TRICARE Prime may obtain health care from nonnetwork providers. Under this option, beneficiaries must pay an annual deductible and cost-shares, which vary among active duty dependents and retirees and their dependents. There is no annual enrollment fee.
TRICARE Extra	Similar to TRICARE Standard, beneficiaries do not have to enroll or pay an annual enrollment fee for TRICARE Extra. Under this option, beneficiaries may obtain care from a TRICARE network civilian provider for lower cost-shares (about 5 percentage points less) than they would have if they saw nonnetwork providers under the TRICARE Standard option.

Source: GAO summary of the Department of Defense's TRICARE documentation.

Note: All beneficiaries may obtain care at military treatment facilities although priority is given to any active-duty personnel and then to TRICARE Prime enrollees.

^aThere is no annual enrollment fee for active duty servicemembers and their dependents. However, retirees and their dependents under 65 years must pay an annual enrollment fee.

TRICARE also offers other options, including TRICARE Reserve Select, a premium-based health plan that certain Reserve and National Guard servicemembers may purchase. Under TRICARE Reserve Select, beneficiaries may obtain health care from either nonnetwork or network providers, similar to beneficiaries using TRICARE Standard or Extra, respectively, and pay lower cost-shares for using network providers.

TRICARE Regional Structure and Contracts

TRICARE is a regionally structured program that is organized into three main regions—North, South, and West. (See fig. 1 for the location of the three regions.) TMA manages civilian health care in each of these regions through contractors. As of March 2011, the second generation of TRICARE contracts were in operation, and TMA was in the process of awarding the third generation of contracts.

Figure 1: Location of TRICARE Regions



Source: GAO analysis of TRICARE data.

The contractors are required to establish and maintain adequate networks of civilian providers within designated locations referred to as Prime Service Areas. In these areas, civilian provider networks are required to be large enough to provide access for all TRICARE beneficiaries, regardless of enrollment status or Medicare eligibility. These civilian provider networks are also required to meet specific access standards for TRICARE Prime beneficiaries—such as for travel times or wait times.¹³ However the access standards do not apply to beneficiaries using options other than TRICARE Prime, such as TRICARE Standard or Extra. The contractors are also responsible for helping TRICARE beneficiaries locate providers and for informing and educating TRICARE beneficiaries and providers on all aspects of the TRICARE program. In addition, they provide customer service to any TRICARE beneficiary who requests assistance, regardless of their enrollment status.

TMA has a TRICARE Regional Office in each region that helps to manage health care delivery. These offices are responsible for overseeing the contractors, including monitoring network quality and adequacy and customer-satisfaction outcomes. Similar to the contractors' efforts, these offices provide customer service to all TRICARE beneficiaries who request assistance, regardless of their enrollment status.

TRICARE Network and Nonnetwork Civilian Providers

Civilian providers must be TRICARE-authorized to be reimbursed for care under the program.¹⁴ Such authorization requires a provider to be licensed by their state, accredited by a national organization, if one exists, and meet other standards of the medical community. There are two types of authorized civilian providers—network and nonnetwork providers, and both types of providers may accept TRICARE beneficiaries as patients on a case-by-case basis, regardless of enrollment status.

¹³The TRICARE Prime option has five access-to-care standards that address the following: (1) travel time, (2) appointment wait time, (3) availability and accessibility of emergency services, (4) composition of network specialists, and (5) office wait time. See 32 C.F.R. § 199.17(p)(5) (2010).

¹⁴TRICARE beneficiaries who choose to receive medical care from providers who are not TRICARE-authorized are responsible for all billed charges. Civilian providers consist of primary care physicians, specialists, certified clinical social workers, certified psychiatric nurse specialists, clinical psychologists, certified marriage and family therapists, pastoral counselors, mental health counselors, and psychiatrists.

-
- **Network providers** are TRICARE-authorized providers who enter into a contract with the regional contractor to provide care to TRICARE beneficiaries and agree to accept TRICARE reimbursement rates as payment in full.¹⁵ By law, TRICARE reimbursement rates for civilian providers are generally limited to Medicare rates, but network providers may agree to accept lower reimbursements as a condition of network membership.¹⁶ Network providers are not obligated to accept all TRICARE beneficiaries seeking care. For example, network providers may decline to accept TRICARE beneficiaries as patients because their practices do not have sufficient capacity or for other reasons.¹⁷
 - **Nonnetwork providers** are TRICARE-authorized providers who have not entered into a contractual agreement with a contractor to provide care to TRICARE beneficiaries. Nonnetwork providers may accept the TRICARE reimbursement rate as payment in full or they may charge up to 15 percent above the reimbursement amount. The beneficiary is responsible for paying the extra amount billed in addition to the required cost-shares.

Beneficiaries' Use of TRICARE

Claims data from fiscal years 2006 through 2010 show that overall TRICARE claims paid to civilian providers have increased by more than 50 percent, even though the eligible population increased by less than 6 percent.¹⁸ (See table 2.)

¹⁵Network providers also undergo a formal credentialing process through the contractor. Credentialing includes a review of the provider's training, educational degrees, licensure, practice history, etc.

¹⁶Beginning in fiscal year 1991, in an effort to control escalating health care costs, Congress instructed DOD to gradually lower its reimbursement rates for individual civilian providers to mirror those paid by Medicare. Congress specified that reductions were not to exceed 15 percent in a given year. See 10 U.S.C. §§ 1079(h), 1086(f).

¹⁷For example, network providers may determine that only a set amount of their practice—such as 10 or 20 percent—will be allocated to TRICARE patients. When this percentage is met, providers may decline to accept any new TRICARE patients.

¹⁸Claims analyzed were for services provided in an office or other setting outside of an institution. Claims for services rendered at hospitals, military treatment facilities, and other institutions were excluded. TRICARE for Life claims were excluded as well as claims for medical supplies and from chiropractors and pharmacies.

Table 2: TRICARE-eligible Beneficiaries and Claims Paid to Civilian Providers for Fiscal Years 2006 through 2010

Fiscal year	TRICARE-eligible beneficiaries (million)^a	TRICARE claims paid to civilian providers (million)
2006	9.19	19.29
2007	9.22	21.31
2008	9.39	24.02
2009	9.58	26.97
2010	9.69	29.60 ^b
Total percentage change from fiscal year 2006 to 2010	5.4 percent	53.4 percent

Source: GAO analysis of TRICARE Management Activity (TMA) data.

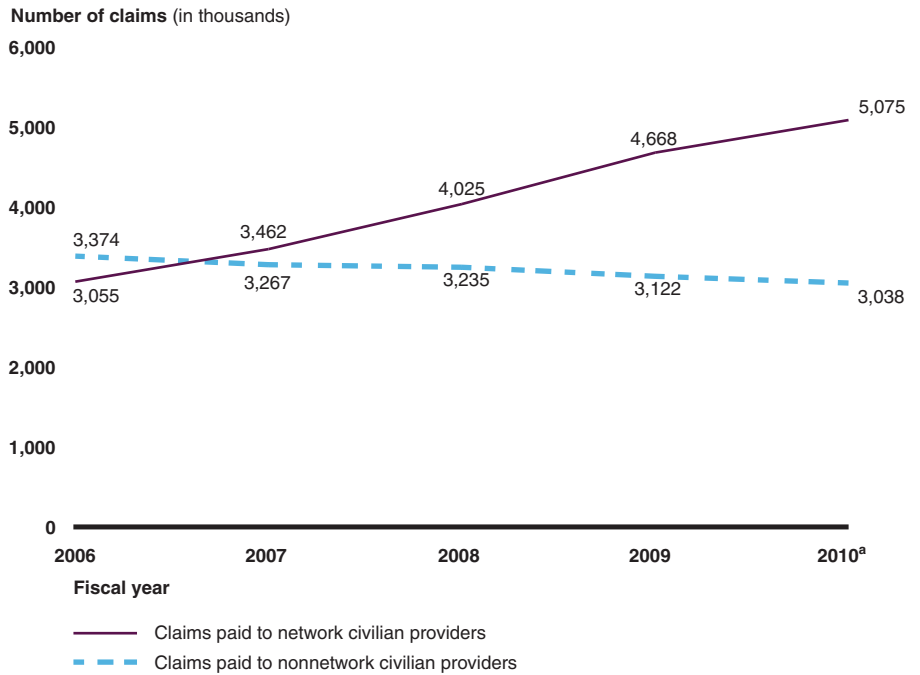
Note: Claims were for services provided in an office or other setting outside of an institution. Claims for services rendered at hospitals, military treatment facilities, and other institutions were excluded. TRICARE for Life claims were excluded as well as claims for medical supplies and from chiropractors and pharmacies.

^aEligible beneficiaries include active duty personnel and their dependents, medically eligible Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors.

^bFiscal year 2010 data are incomplete as TMA allows claims to be submitted up to 1 year after care was provided.

Between fiscal years 2006 through 2010, TRICARE Standard and Extra beneficiaries' use of network providers—as measured by the number of claims paid to network providers—has increased significantly, while their use of nonnetwork providers—as measured by the number of claims paid to nonnetwork providers—has slightly decreased. (See fig. 2.) Specifically, their use of network providers has increased more than 66 percent between fiscal years 2006 and 2010, compared to about a 10 percent decrease in the use of nonnetwork providers over the same time period.

Figure 2: TRICARE Standard and Extra Beneficiaries' Claims Paid to Network and Nonnetwork Civilian Providers for Fiscal Years 2006 Through 2010



Source: GAO analysis of TRICARE Management Activity (TMA) data.

Note: Claims analyzed were for services provided in an office or other setting outside of an institution. Claims for services rendered at hospitals, military treatment facilities, and other institutions were excluded. TRICARE for Life claims were excluded as well as claims for medical supplies and from chiropractors and pharmacies.

^aFiscal year 2010 data are incomplete as TMA allows claims to be submitted up to 1 year after care was provided.

Reimbursement Rates and Provider Shortages Hinder Access to Civilian Providers; TMA Can Increase Reimbursement Rates When Needed, but Has Only Limited Means to Address Shortages

Reimbursement rates have been cited as the primary impediment that hinders beneficiaries' access to civilian health care and mental health care providers under TRICARE Standard and Extra. TMA can increase reimbursement rates in certain circumstances when a need has been demonstrated. Although national and local shortages of certain types of providers have also been cited as an impediment to TRICARE Standard and Extra beneficiaries' access to civilian providers, TMA is limited in its ability to address this impediment as it affects the general population and not just TRICARE beneficiaries. Additionally, beneficiaries' access to mental health care is affected by provider shortages and other issues and is of particular concern because the stress of deployment and redeployment has increased the demand for these services.

Reimbursement Rates Have Been Cited as the Primary Impediment to Beneficiaries' Access to Civilian Providers under TRICARE Standard and Extra, and TMA Can Adjust Them When a Need is Demonstrated

Since TRICARE was implemented in 1995, some civilian providers—both network and nonnetwork—have expressed concerns about TRICARE's reimbursement rates. For example, in 2006, we reported that both network and nonnetwork civilian providers said that TRICARE's reimbursement rates tended to be lower than those of other health plans, and as a result, some of these providers had been unwilling to accept TRICARE Standard and Extra beneficiaries as patients.¹⁹ More recent studies by TMA and others have cited TRICARE's reimbursement rates as the primary reason civilian providers may be unwilling to accept these beneficiaries as patients, for example:

- TMA's first multiyear survey of civilian providers (2005 through 2007) showed that TRICARE's reimbursement rates were the primary reason cited by providers for not accepting TRICARE Standard and Extra beneficiaries as new patients.²⁰
- Similarly, results from the first 2 years (2008 and 2009) of TMA's second multiyear provider survey showed that the responding providers cited TRICARE's reimbursement rates as one of the primary reasons that they

¹⁹See [GAO-07-48](#).

²⁰TMA's first multiyear survey of civilian providers had approximately 18,000, 18,900, and 19,000 responses in 2005, 2006, and 2007 respectively, for an eligible physician response rate of about 50 percent each year.

would not accept new TRICARE patients even though they would accept new Medicare patients.²¹

- In a 2008 study on civilian providers' acceptance of TRICARE Standard and Extra beneficiaries, CNA reported that the medical society officials and physicians they interviewed cited low reimbursement as the primary reason for limiting their acceptance of TRICARE beneficiaries as patients.²² The providers who were interviewed as part of this study noted that while they could accept more TRICARE beneficiaries as patients, there are services for which the reimbursement was so low that accepting more TRICARE beneficiaries as patients hurt rather than helped them.

In addition to these studies, officials from each of the TRICARE Regional Offices and two of the contractors, as well as a national provider organization, told us that reimbursement rates were civilian providers' primary concern about TRICARE.

Concerns about TRICARE's reimbursement rates—which generally mirror the Medicare program's physician fee schedule²³—have increased by the

²¹The first 2 years of TMA's second multiyear survey of civilian providers had 19,309 responses in 2008 and 19,812 responses in 2009 for a 2-year adjusted response rate of 39 percent. TRICARE's reimbursement rates, along with a lack of awareness of the TRICARE program were tied for the most-cited reasons by providers who were accepting new Medicare patients, but would not accept new TRICARE patients over all regions surveyed.

²²Levy, Robert A., and Gabay, Mary, *Some Additional Findings Related to the Acceptance by Civilian Providers of TRICARE Standard*, CNA Research Memorandum D0019101.A2/Final (November 2008). TMA tasked CNA to examine the current participation of civilian providers in the TRICARE program, focusing on potential reasons that may inhibit many of these providers from accepting TRICARE Standard and Extra beneficiaries as patients.

²³Beginning in fiscal year 1991, in an effort to control escalating health care costs, Congress instructed DOD to gradually lower its reimbursement rates for individual civilian providers to mirror those paid by Medicare. Congress specified that reductions were not to exceed 15 percent in a given year. See 10 U.S.C. §§ 1079(h), 1086(f). As of March 2011, the transition to Medicare rates was nearly complete, and reimbursement rates for only 43 services remain higher than Medicare reimbursement rates. (See app. I for a list of these services.)

uncertainty surrounding the annual update to these Medicare fees.²⁴ All of the contractors expressed concerns about the proposed decreases to Medicare rates and how that would affect providers' acceptance of TRICARE patients. One contractor told us that providers already were expressing concerns about the Medicare rate decreases and that some providers said they would no longer accept TRICARE beneficiaries as patients if the rates were reduced. Furthermore, as of September 2010, this contractor noted that one provider had stopped accepting TRICARE beneficiaries as patients because of concerns about potential Medicare reimbursement reductions.

TMA has the authority to adjust TRICARE reimbursement rates under certain conditions to increase beneficiaries' access to civilian providers, and has done so in some instances. In response to various concerns about providers' willingness to accept TRICARE patients, TMA contracted with a consulting firm to conduct a number of studies about TRICARE reimbursement rates, and some of these studies have resulted in increases to reimbursement amounts for certain procedures. (See app. II for a summary of the studies.) For example, in response to civilian obstetric providers' concerns about TRICARE reimbursement rates, TMA conducted an analysis of historical TRICARE claims data and made nationwide changes to its physician payment rates for obstetric care in 2006.²⁵ These changes included an additional payment for ultrasounds for uncomplicated pregnancies that is likely to result in overall higher payments for civilian physicians who perform one or more ultrasounds during the course of pregnancy.

TMA also has the authority to adjust reimbursement rates through the use of waivers in areas where it determines that the rates have had a negative impact on TRICARE beneficiaries' access to civilian providers. TMA can

²⁴The Medicare physician fee schedule is updated annually by the sustainable growth rate system, with the intent of limiting the total growth in Medicare spending for physician services over time. Because of rapid growth in Medicare spending for physician services, the sustainable growth rate has called for fee reductions since 2002. However, congressional action has temporarily averted such fee reductions for 2003 through 2011. Although under current law, Medicare's fees to physicians are scheduled to be reduced by about 29.5 percent in 2012, Congress has considered ways to repeal or replace the sustainable growth rate system for a number of years. See 42 U.S.C. § 1395w-4(d).

²⁵For more information on TMA's changes to its physician payment rates for obstetric care, see GAO, *TRICARE: Changes to Access Policies and Payment Rates for Services Provided by Civilian Obstetricians*, [GAO-07-941R](#) (Washington, D.C.: July 31, 2007).

issue three types of reimbursement waivers, depending on the type of adjustment that is needed:

- Locality waivers may be used to increase rates for specific medical services in specific areas where access to civilian providers has been severely impaired and are applicable to both network and nonnetwork providers.²⁶
- Network waivers may be used to increase reimbursement rates for network providers up to 15 percent above the TRICARE reimbursement rate in an effort to ensure an adequate number and mix of primary and specialty care network civilian providers in a specific location.²⁷
- TMA can restore TRICARE reimbursement rates in specific localities to the levels that existed before a reduction was made to align TRICARE reimbursement rates with Medicare rates for both network and nonnetwork providers.²⁸

Waivers can be requested by providers, beneficiaries, contractors, military treatment facilities, or TRICARE Regional Office directors, although all requests must be submitted through the TRICARE Regional Office directors. Individuals may apply for waivers by submitting written requests to the TRICARE Regional Offices. These requests must contain specific justifications to support the claim that access problems are related to low reimbursement rates and must include information such as the number of providers and TRICARE-eligible beneficiaries in a location, the availability of military treatment facility providers, geographic characteristics, and the cost-effectiveness of granting the waiver. Ultimately, the TRICARE Regional Office director reviews and analyzes the requests. If the TRICARE Regional Office director agrees with the request, they make a recommendation to the Director of TMA that the waiver request be approved. Each analysis is tailored to the specific concerns outlined in the waiver requests. Once implemented, waivers remain in effect indefinitely or until TMA officials determine they are no longer needed.

²⁶32 C.F.R. § 199.14(j)(1)(iv)(D) (2010). According to a TMA official, TMA usually defines a locality using one or more zip codes.

²⁷32 C.F.R. § 199.14(j)(1)(iv)(E) (2010).

²⁸32 C.F.R. § 199.14(j)(1)(iv)(C) (2010).

As shown in table 3, the total number of waivers has increased from 15 to 24 since we last reported on TMA's use of waivers in 2006. (See app. III for more details about the waivers.) Additionally, 13 of the 24 waivers are for locations in Alaska. (See app. IV for more information about access-to-care issues in Alaska.)

Table 3: TRICARE Reimbursement Waivers in August 2006 and January 2011

Type of waiver	Number of waivers in place as of August 2006	Number of waivers in place as of January 2011
Locality waiver	7	16
Network waiver	6	8
Waiving reimbursement rate reductions ^a	2	0
Total	15	24

Source: GAO analysis of TRICARE Management Activity (TMA) data.

^aTMA has authority to restore TRICARE reimbursement rates in specific localities to the levels that existed before a reduction was made to align TRICARE reimbursement rates with Medicare rates. The two waivers that were in place in 2006 were for Alaska and were discontinued when a demonstration project, implemented in 2007, increased TRICARE's reimbursement rates so that on average, they matched those of the Department of Veterans Affairs.

Other than assessing the effectiveness of a specific rate adjustment in Alaska, TMA has not conducted analyses to determine if its rate adjustments or the use of waivers have increased beneficiaries' access to civilian providers. Nonetheless, officials told us that using the waivers has proved to be successful by maintaining the stability of the provider networks and by increasing the size of the networks in some areas.

National and Local Shortages of Certain Provider Specialties Impede Beneficiaries' Access to Civilian Providers, and TMA Is Limited in Its Ability to Address Them

Another main impediment to TRICARE beneficiaries' access to civilian providers is a shortage of certain provider specialties, both at the national and local levels. However, TMA is limited in its ability to address provider shortages because this impediment affects the entire health care delivery system and is not specific to the TRICARE program.

National and Local Shortages of Certain Provider Specialties Impede Access

Although the number of civilian providers accepting TRICARE has increased over the years,²⁹ access to civilian providers remains a concern due to national and local shortages of certain provider specialties. These shortages limit access for the general population, including all TRICARE beneficiaries regardless of enrollment status. Several organizations have reported on national provider work-force shortages in primary care as well as in a number of specialties.³⁰ For example, the Association of American Medical Colleges reported national shortages in provider specialties such as anesthesiology, dermatology, and psychiatry. Additionally, the contractors and regional office officials we met with told us that they were particularly concerned about the national shortage of child psychiatrists.

In addition to national shortages, TRICARE beneficiaries' access to civilian providers also may be impeded in certain locations where there are insufficient numbers and types of civilian providers to cover the local demand for health care. According to the contractors, each TRICARE region had areas with civilian provider shortages, for example:

- In TRICARE's West region, a Prime Service Area in northern California had provider shortages in 21 different provider specialties, including allergists and obstetricians as well as psychologists and psychiatrists. According to this region's contractor, either there were no providers located in the area or the providers located in the area were already contracted as TRICARE network providers.
- In TRICARE's South region, the contractor identified locations in Texas, Louisiana, and Florida in which there were limited numbers of specialists and mental health providers. For example, according to this contractor, Del Rio, Texas has no providers in several specialties including dermatology, allergy, and psychiatry.
- Likewise, in TRICARE's North region, the contractor stated that there are mountainous areas, such as parts of West Virginia, and remote areas, such as western North Carolina, in which there are provider shortages.

²⁹According to TMA, from fiscal year 2006 to 2009, 44,000 additional civilian providers (network and nonnetwork) accepted TRICARE (a more than 13 percent increase).

³⁰See for example: Institute of Medicine, *Hospital-Based Emergency Care: At the Breaking Point*, (Washington, D.C.: The National Academies Press, 2006), and Center for Workforce Studies, Association of American Medical Colleges, *Recent Studies and Reports on Physician Shortages in the U.S.* (November 2010).

Consequently, the general population, including TRICARE beneficiaries, has to drive longer distances to obtain certain types of specialty care.

TMA is Limited in How it Can Address Provider Shortages

TMA has attempted to address civilian provider shortages, but because these shortages are not specific to the TRICARE program, there are limitations in what TMA can do. One step TMA has taken is the adoption of a bonus payment system that mirrors the one used by Medicare for certain provider shortage areas.³¹ Under Medicare, providers who provide services to beneficiaries located in Health Professional Shortage Areas—geographic areas that the Department of Health and Human Services has identified as having shortages of primary health, dental, or mental health care providers—receive 10 percent bonus payments.³² Beginning in June 2003, TMA began offering providers a 10 percent bonus payment for services rendered in these same locations. TMA estimated that from fiscal year 2007 through the third quarter of fiscal year 2010, more than 20,000 individual providers received these payments.

Currently, civilian providers must include a specific code on every TRICARE claim they submit to obtain the additional payment. However, TMA officials noted that some providers may not be receiving this bonus because they do not include the specific code on their claims. TMA officials noted the process will become easier once the third generation of managed care support contracts is implemented. Once this occurs, the contractors will rely on the Centers for Medicare & Medicaid Services' public database of zip codes to determine a provider's eligibility for these bonus payments instead of requiring the provider to include a code on each claim. TMA officials estimated that this change will result in an additional \$150,000 in bonus payments each year for TRICARE claims.

³¹TMA has the authority to implement bonus payment programs for physicians in areas determined to be medically underserved areas by the Department of Health and Human Services for Medicare purposes. TMA is generally required to make the bonus payments in the same amounts as authorized for Medicare. See 32 C.F.R. § 199.14(j)(2) (2010).

³²See 42 U.S.C. § 1395l(m). Health Professional Shortage Areas include both urban and rural areas. For example, Fulton County, Georgia, (which could be considered an urban area) contains 90 Health Professional Shortage Areas because it lacks primary and mental health care providers. Likewise, the state of Alaska (which is predominantly considered to be a rural area) contains 141 Health Professional Shortage Areas that lack primary and mental health care providers.

TRICARE Beneficiaries' Access to Mental Health Care Is Affected by Provider Shortages and Other Issues

Access to mental health care is a concern for all TRICARE beneficiaries, and it has been affected by provider shortages and other issues, including providers' lack of knowledge about combat related issues, providers' concerns about reimbursement rates, and providers' lack of awareness about TRICARE. A 2007 report by the American Psychological Association noted that shortages of mental health providers specifically trained in military issues and the challenge associated with modifying the military culture so that mental health services are less stigmatized are impediments to TRICARE beneficiaries' access to mental health care.³³ Furthermore, the report discusses that even where mental health providers are available, it can be difficult to find psychiatrists and other mental health providers with specific familiarity of TRICARE beneficiaries' mental health conditions such as post-traumatic stress disorder and deployment issues. This can be frustrating for TRICARE beneficiaries who seek mental health care only to discover that providers cannot relate to their specific concerns.

Over the years, Congress has required DOD to report on TRICARE beneficiaries' access to mental health care providers. Specifically, the NDAA for Fiscal Year 2008 required DOD to report on the adequacy of access to mental health services under the TRICARE program. In 2009, DOD reported that it believed access to mental health care providers for TRICARE beneficiaries was adequate due to a dramatic increase in both inpatient and outpatient mental health care provided in 2008.³⁴ DOD also cited increases in the numbers of mental health providers from May 2007 to May 2009 in both the direct care system of military treatment facilities (1,952) and in the civilian provider network (10,220), while acknowledging that there may still be some areas where access to mental health care providers is inadequate. However, in the same report, DOD noted that TRICARE Standard and Extra beneficiaries reported more problems finding civilian mental health care providers than beneficiaries who use other health care coverage, and that psychiatrists have the lowest

³³American Psychological Association, Presidential Task Force on Military Deployment Services for Youth, Families and Service Members, *The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report* (Feb. 18, 2007).

³⁴Department of Defense, *Report to Congress: Access to Mental Health Services* (Sept. 9, 2009).

acceptance rates of new TRICARE Standard and Extra beneficiaries compared with other providers.³⁵

In its 2009 *Access to Mental Health Services* report, DOD noted that two reasons most cited by civilian mental health providers, including psychiatrists, for not accepting new TRICARE patients were “not aware of TRICARE” and “reimbursement.” DOD also reported that TMA would increase outreach to mental health providers in selected locations to improve awareness of the program. In addition to the increased outreach, DOD also reported two initiatives designed to enhance beneficiaries’ access to mental health care—the Telemental Health Program and the TRICARE Assistance Program. The Telemental Health Program³⁶ connects TRICARE beneficiaries in one office to civilian mental health providers in another medical office through an audiovisual link. The TRICARE Assistance Program³⁷ is a Web-based program that enables certain beneficiaries to contact licensed civilian counselors 24 hours a day for short-term, nonmedical issues.³⁸ Also, in recognition that mental health is an issue of concern for its beneficiaries, each of the TRICARE Regional Offices and contractors has established staff positions that focus specifically on mental health issues, including access to care.

More recently, the NDAA for fiscal year 2010 required DOD to report on the appropriate number of personnel to meet the mental health care needs of servicemembers, retired members, and dependents and to develop and implement a plan to significantly increase the number of DOD military and

³⁵According to the first 2 years of TMA’s second round of provider surveys, less than 46 percent of responding psychiatrists who were accepting any new patients would accept new nonenrolled beneficiaries, compared to almost 69 percent of responding primary care providers and almost 72 percent of responding specialist providers.

³⁶TMA’s Telemental Health Program, which began on August 1, 2009, uses medically supervised, secure audio-visual conferencing to link beneficiaries in one location with mental health care providers in another. These providers can evaluate, treat, and refer patients as necessary by video.

³⁷TMA’s TRICARE Assistance Program, which began on August 1, 2009, allows eligible beneficiaries to access licensed counselors for nonmedical issues including stress management and deployment issues.

³⁸These beneficiaries include active duty family members and those using TRICARE Reserve Select.

civilian mental health personnel, among other requirements.³⁹ In response to this requirement, DOD reported in February 2011 that it has identified criteria for the military services to use in determining the appropriate number of mental health personnel needed to meet the needs of their beneficiaries.⁴⁰ However, DOD also noted that the military services are still testing and validating these criteria to determine how effective they would be in gauging adequate mental health staffing numbers. Therefore, although DOD reported increases in the number of mental health providers employed at military treatment facilities or contracted to join TRICARE's network of providers, it did not specifically estimate the appropriate number of mental health care providers needed. DOD also reported that initiatives are under way to increase the number of mental health providers in military treatment facilities, including increasing the number of Public Health Service providers serving in military treatment facilities as well as recruitment and retention incentives. These initiatives, if successfully implemented, could reduce the demand for civilian mental health providers in those locations.

³⁹The law also required the Secretary of Defense to assess the feasibility of establishing one or more military mental health specialties for officers or enlisted servicemembers and required the secretary of each military department to increase the authorized number of active-duty mental health personnel by at least 25 percent. See Pub. L. No. 111-84, § 714, 123 Stat. 2190, 2381-82 (2009).

⁴⁰DOD, *Mental Health Personnel Required to Meet Mental Health Care Needs of Service Members, Retired Members, and Dependents; Report to Congress* (Feb. 1, 2011).

Although TMA Has Typically Used Feedback Mechanisms to Gauge TRICARE Standard and Extra Beneficiaries' Access to Civilian Providers, It Is Developing a New Method for Monitoring Access

TMA and its contractors have used various feedback mechanisms, such as surveys, to gauge beneficiaries' access to care under TRICARE Standard and Extra. More recently, TMA officials have taken steps to develop a model to help identify geographic areas where beneficiaries that use TRICARE Standard and Extra may experience access problems. However, because this initiative is still evolving, it is too early to determine its effectiveness.

TMA Has Primarily Relied on Feedback Mechanisms to Gauge Beneficiaries' Access to Civilian Providers under TRICARE Standard and Extra

TMA has primarily relied on feedback to gauge beneficiaries' access to civilian providers under TRICARE Standard and Extra, as historically, access to care has only been routinely monitored for beneficiaries enrolled in TRICARE Prime, the only option with access standards.⁴¹ These feedback mechanisms have included surveys of civilian health care (including mental health care) providers as well as surveys of nonenrolled beneficiaries who are eligible to use the TRICARE Standard and Extra options as well as TRICARE Reserve Select. Additionally, TMA and its contractors use feedback from beneficiaries' inquiries and complaints to help identify problems with access, among other issues.

In fiscal year 2005, TMA implemented its first multiyear survey of civilian providers (network and nonnetwork) as required by the NDAA 2004. TMA's survey was supposed to assess beneficiaries' access to civilian providers under the TRICARE Standard and Extra options by determining whether civilian providers would accept these beneficiaries as new patients. In 2006, we reported on TMA's survey methodology, among other issues, and reported that it was sound and statistically valid. TMA's results

⁴¹Contractors have only been required to monitor access to care for TRICARE Prime beneficiaries. To do this, contractors are to determine the adequacy of civilian provider networks. Although TRICARE Prime is the only option with required access-to-care standards, network adequacy may also affect nonenrolled beneficiaries who use network providers. (See app. V for information on network adequacy requirements which are used to gauge access to care.)

for this first multiyear survey of civilian providers, which was fielded through 2007, showed that about 8 of 10 physicians and behavioral health providers accepted TRICARE beneficiaries as new patients, if they accepted any patients at all.⁴² However, while these results appear favorable, as we reported in 2006, there is no benchmark with which to compare them.

Subsequently, the NDAA 2008 required TMA to conduct two multiyear surveys—one of civilian providers and one of nonenrolled beneficiaries—to determine the adequacy of access to health care and mental health care for these beneficiaries. In March 2010, we reported⁴³ that the methodology for both of TMA’s surveys was sound and generally addressed the methodological requirements outlined in the law.⁴⁴ TMA has completed the first 2 years (2008 and 2009) of these surveys.

TMA and its contractors also use feedback collected from beneficiaries’ inquiries and complaints to identify and gauge potential problem areas, including issues with access to care. However, this type of feedback is not representative because not every beneficiary who has a question or complaint will contact TMA or its contractors. TMA uses its Assistance Reporting Tool to collect and analyze information on the beneficiary inquiries that it receives, including inquiries on access to care from beneficiaries who use TRICARE Standard and Extra.⁴⁵ During fiscal years 2008 through 2010, data from the Assistance Reporting Tool showed that only about 5 percent of closed cases on all TRICARE-related beneficiary inquiries and complaints were from TRICARE Standard and Extra beneficiaries. Further, of the total inquiries and complaints received from

⁴²TMA’s reported results showed that on average, 92 percent of civilian providers were accepting any new patients.

⁴³See [GAO-10-402](#).

⁴⁴The law also directed DOD to give high priority to locations having high concentrations of Selected Reserve servicemembers, which would likely result in surveying beneficiaries who may be under the TRICARE Reserve Select option. However, TMA did not give a high priority to locations with high concentrations of Selected Reserve members. Instead, for both of its surveys, TMA randomly selected areas to produce results that can be generalized to the populations from which the survey samples were drawn. TMA plans to cover the entire United States at the end of the 4-year survey period, which will include any locations with higher concentrations of Selected Reserve servicemembers.

⁴⁵The Assistance Reporting Tool does not include information reported to the contractors. Implemented in 2001, this tool is used by customer service staff in TRICARE program offices, military treatment facilities, and the uniformed services.

these beneficiaries, TMA reported that 313 cases were access-to-care related (2 percent).

The contractors separately receive feedback from beneficiaries through some or all of the following methods: (1) telephone, (2) e-mail, (3) in-person at a TRICARE Service Center, or (4) in writing. Each contractor collects and reports information on their beneficiary feedback differently. In reviewing contractors' data on beneficiary inquiries or complaints received, we found:

- During fiscal year 2009, TMA's contractor in the North region reported receiving 11,176 (less than 1 percent) access-to-care inquiries out of a total of more than 5 million inquiries. This contractor does not categorize its inquiries by TRICARE option, but does collect and categorize inquiries specific to access-to-care concerns. In fiscal year 2010, the contractor received 3,642 access-to-care inquiries (less than 1 percent) out of a total of more than 5 million inquiries.
- TMA's contractor in the South region reported that during calendar year 2009, it received a total of 7,785 complaints. Of these, 175 (2 percent) were submitted by TRICARE Standard and Extra beneficiaries. While access to care did not represent a top reason for their complaints in 2009, this contractor reported that 15 of the complaints received were related to beneficiary appointment and wait times. This contractor also reported that it received a total of 7,927 complaints in calendar year 2010. Of these, 134 (about 2 percent) were submitted by TRICARE Standard and Extra beneficiaries, and only 14 of the 134 complaints were specific to beneficiary appointment and wait times.
- Finally, data submitted to us by TMA's contractor in the West region showed that it received a total of 809 grievances from TRICARE beneficiaries between January 2008 and December 2010. Of these, TRICARE Standard and Extra beneficiaries submitted 83 inquiries (about 10 percent), and about 2 percent of the 83 inquiries were specific to provider appointment wait times.

TMA Has Initiated Steps to Establish a Method for Routinely Monitoring Access to Civilian Providers for TRICARE Standard and Extra Beneficiaries

TMA has recently initiated steps to establish an approach to routinely monitor beneficiaries' access to both network and nonnetwork providers under the TRICARE Standard and Extra options. (The new approach will also apply to beneficiaries using the TRICARE Reserve Select option.) In recognition that the military health system had no established measures for determining the adequacy of network and nonnetwork providers for these beneficiaries, in February 2010, TMA's Office of Policy and Operations directed the TRICARE Regional Offices to develop a model to identify geographic areas where they may experience access problems as well as areas of provider shortages for the general population. The model is intended to help the TRICARE Regional Offices and their contractors identify geographic areas where additional efforts to increase access to civilian providers may be warranted.

To implement this approach, TMA recommended that each regional office adapt and standardize the model that had originally been developed by its West regional office in 2008. This model applies a specific provider-to-beneficiary ratio based on the Graduate Medical Education National Advisory Committee's recommended standards for health care services⁴⁶ to different provider specialties to determine whether there are sufficient numbers and types of providers for the nonenrolled beneficiary population in certain locations. To identify locations for analysis, West regional office officials used zip codes to identify locations with populations of 500 or more nonenrolled beneficiaries. According to officials in the West regional office, they then identified the network and nonnetwork providers who practiced and had previously accepted a TRICARE patient in these same locations and applied a specific provider-to-beneficiary ratio against each provider specialty included in the model for the locations assessed. Each regional office has developed a model that generally follows the same methodology and includes similar data as the West regional office's model, although variations exist. For example, while one regional office includes provider data that represents 15 provider specialties, another regional office includes 40 provider specialties in its model. Officials at one regional office told us they have plans to update their model to reflect changes in the beneficiary population, and an official at another regional office said that staff were already in the process of updating their model, which may include additional provider demographic factors.

⁴⁶The Graduate Medical Education National Advisory Committee projected the need for and supply of physicians and other providers and developed guidelines for the geographic distribution of physicians.

TMA directed each TRICARE Regional Office to apply the model at least semiannually beginning on May 1, 2010. According to officials in TMA's South region, they plan to apply the model semi-annually as directed while TMA's regional offices in the North and West apply the model as needed. More specifically, since TMA's office in the North region implemented the model, it has assessed 20 locations, and now applies the model as needed in response to specific concerns. Meanwhile, officials from TMA's office in the West region told us that they initially applied the model to over 50 locations and that they now apply the model as needed, such as in response to a specific inquiry about access to care in a particular location. Officials in the North regional office noted that their model's data are used in conjunction with other indicators to assess if further analysis of civilian provider availability is needed. Officials in the West region said that they plan to reach out to providers in the community or use the contractor to help recruit additional providers to the TRICARE network if the model identifies an area that is short of their targeted number of providers in a given specialty.

Based on our review of each regional office's initial approach, we found this methodology to be reasonable. However, because the regional models were recently developed, it is too early to determine their effectiveness. And, while the regional offices provided us with examples of their models, they did not provide documentation of how they applied a provider-to-beneficiary ratio as criteria to determine the adequacy of access in these locations or any documentation of their results, although they told us that they did not identify any access problems.

TMA's Contractors Educate Civilian Providers about TRICARE and Surveys Indicate That Providers Are Generally Aware of the Program

TMA's contractors educate civilian providers about TRICARE program requirements, policies, and procedures. Contractors also conduct outreach to increase providers' awareness of TRICARE, and TMA's provider survey results indicate providers are generally aware of the program. However, providers' awareness of TRICARE does not necessarily signify that they have an accurate understanding of it.

TMA's Contractors Inform Network and Nonnetwork Providers about TRICARE

Under the second generation of TRICARE contracts, TMA's contractors are required to conduct activities to help ensure that providers—both network and nonnetwork—are aware of TRICARE program requirements, policies, and procedures in their respective regions. To accomplish this, the contractors are required to have active provider education programs. In addition, each contractor must submit an annual marketing and education plan to TMA's Communications and Customer Service office that outlines its methods for educating providers based on contractual requirements. All contractors include details in these plans about their efforts to satisfy requirements to distribute regular bulletins and newsletters as well as educate new network providers, such as through orientation sessions or with a Welcome Tool Kit.⁴⁷

The contractors' marketing and education plans also identify provider education efforts that vary across the regions. These efforts vary because contractors have some flexibility in how they achieve outcomes and because the contractors may include additional performance standards in their contracts.⁴⁸ Under the second generation of TRICARE contracts, contractors have added performance standards related to provider education. For example, one contractor must visit high-volume network and nonnetwork providers in its region annually, while another contractor must conduct annual seminars for the network and nonnetwork providers in its Prime Service Areas.⁴⁹ TMA reported that each contractor had fulfilled its provider education requirements as of December 2010.

All of the contractors also make TRICARE education resources available to providers. Many of these resources are available on the contractors'

⁴⁷Welcome Tool Kits are distributed to new providers who join the contractor's developed network, and may include reference charts, the *TRICARE Provider Handbook*, and a welcome letter.

⁴⁸The second generation of managed care support contracts are performance-based contracts. A performance-based contract includes certain performance standards that those offerors submitting bids must achieve if selected for the contract or they may be subject to certain penalties. In their bids for the contract, offerors may also submit additional performance standards for incorporation into the contract where the request for proposal does not have a minimum standard. Under these managed care support contracts, contractors have different requirements related to provider education due to contractors' submission of additional performance standards during the solicitation period.

⁴⁹While these examples are unique to these contractors' contracts, all three contractors may offer these resources to the providers in their regions.

Web sites and include the *TRICARE Provider Handbook*⁵⁰ as well as quick reference charts that include information on provider resources and TRICARE covered benefits and services, among other topics. One contractor hosts electronic seminars on its Web site that allow providers to learn about the TRICARE program at their convenience. Another contractor has developed a reference chart that details the Prime, Standard, and Extra benefit options and has mailed it to both network and nonnetwork providers in its region who have accepted TRICARE beneficiaries as patients.

In addition, all of the contractors have conducted outreach activities to promote or increase providers' awareness of TRICARE. This has included participating in provider events with local, state, or national groups, including physician associations, medical societies, military treatment facilities, and military associations. Contractors told us that while at these events, they answer providers' questions about the program, distribute TRICARE materials, and encourage providers to join the regional TRICARE network. All of the contractors have also participated in events specific to behavioral health care. Contractors said that these events allow them the opportunity to discuss behavioral health issues that may particularly affect military servicemembers and their families, such as suicide and post-traumatic stress disorder, with providers. The contractors also use social media⁵¹ to highlight TRICARE information for providers, including resources and program news and changes. For example, one contractor used its Twitter account to provide a link to information on how to become a network or TRICARE-authorized provider in its region. Additionally, two of the TRICARE Regional Offices as well as two contractors have specifically conducted outreach related to either encouraging network and nonnetwork providers to accept TRICARE beneficiaries as patients or thanking them for doing so. For example, in January 2011, one contractor mailed letters to nonnetwork providers, encouraging them to support TRICARE beneficiaries by joining the network.

⁵⁰TMA developed the *TRICARE Provider Handbook* and updates it annually to inform providers about basic and important information about TRICARE and emphasize key operational aspects of the program and program options. The handbook assists providers in coordinating care for TRICARE beneficiaries, and contains information about specific TRICARE programs, policies, and procedures. Any TRICARE program changes and updates may be communicated periodically through the *TRICARE Provider News* publications.

⁵¹Social media refers to services that enable individuals to publicly create, share, and discuss information. These services include Facebook and Twitter.

Results of TMA's Provider Surveys Indicate a General Awareness of TRICARE, but May Not Necessarily Signify an Accurate Understanding of the Program

Although TMA's provider surveys indicate a general awareness of the program, these results may not signify an accurate understanding of TRICARE. Survey results from TMA's first multiyear survey (2005 through 2007) of civilian providers (network and nonnetwork) indicated that 87 percent of providers on average were aware of TRICARE. TMA's second multiyear survey of civilian providers (network and nonnetwork),⁵² which has completed 2 years (2008 and 2009) of its 4-year cycle, similarly asked whether providers were aware of the TRICARE program. Although the results of this survey are not generalizable,⁵³ TMA's results show that, of those providers who responded, 87 percent on average were aware of the program.⁵⁴

Although TMA's survey results indicate that providers were generally aware of TRICARE, this does not necessarily mean that providers had an accurate understanding of the program's options and its requirements. For example, representatives of an association representing current and former servicemembers told us that providers do not always understand the differences between the TRICARE Standard and TRICARE Prime options. Similarly, in a November 2008 report, CNA stated that the providers they interviewed were often confused about the differences between TRICARE Standard and TRICARE Prime.⁵⁵ One provider, a former president of a local medical society, said many providers are under the misconception that TRICARE Standard is the same as TRICARE Prime and that when providers have had bad experiences with TRICARE Prime, which generally pays network providers less than Medicare, they end up refusing to accept any TRICARE patients because they "don't want to deal with" a health maintenance organization. This lack of understanding is not always easy to remedy. According to the contractors, because many

⁵²TMA's second civilian provider survey (2008 and 2009) was fielded as two versions. The first version was fielded to physicians, including psychiatrists. The second version was fielded to nonphysician mental health providers, including: (1) certified marriage and family therapists, (2) mental health counselors, (3) pastoral counselors, (4) certified psychiatric nurse specialists, (5) clinical psychologists, and (6) certified clinical social workers.

⁵³TMA's consultant conducted analyses of the responses to determine whether they could be generalized to the populations surveyed and found that their responses could not be generalized. As each survey year's results are cumulative, the results may be generalizable at the end of the 4-year survey period.

⁵⁴The result reported above is from responses to the physician survey.

⁵⁵Levy, Robert A., and Gabay, Mary, *Some Additional Findings Related to the Acceptance by Civilian Providers of TRICARE Standard* (Nov. 2008, p. 4, 29-30).

providers have relatively low volumes of TRICARE patients, it can be challenging to encourage them to take advantage of the available TRICARE education resources or to remain current on updates and changes to the program. In 2009, the average percentage of Prime Service Areas civilian providers' and non-Prime Service Areas civilian providers' TRICARE patient population (under any option) was 5.14 percent and 3.42 percent, respectively.

TMA's Contractors Educate Beneficiaries on All TRICARE Options and Provide Information on Network Providers; New Contracts Will Also Require Information about Nonnetwork Providers

Under the second generation of TRICARE contracts, TMA's contractors have beneficiary education programs that contain information on all of the TRICARE options; contractors also maintain directories of network providers. Under its third generation of contracts, TMA will also require contractors to include information on nonnetwork providers in their directories.

TMA's Contractors Educate Beneficiaries on all TRICARE Options

Under the second generation of TRICARE contracts, TMA's contractors have established beneficiary education programs that contain information on all of the TRICARE options, including Standard and Extra. To meet its beneficiary education requirements, each contractor must submit an annual marketing and education plan to TMA's Communications and Customer Service office that outlines the contractor's methods for educating beneficiaries based on its contractual requirements. For example, the contractor may include details in its marketing and education plan about intentions to distribute required beneficiary newsletters and handbooks, which include information on TRICARE's options and covered services. These plans also specify how the contractors are to provide required weekly one-hour TRICARE briefings to audiences specified by the commanders of their regional military treatment facilities. TMA reported that each of the contractors had fulfilled its beneficiary education requirements as of December 2010.

TMA has only one beneficiary education requirement targeted to TRICARE Standard and Extra beneficiaries: contractors must provide these beneficiaries with the annual *TRICARE Standard Health Matters* newsletter. The 2010 *TRICARE Standard Health Matters* newsletter included articles on topics such as waiving cost-sharing for certain preventive services under TRICARE Standard and Extra. In 2010, the contractors mailed this newsletter to approximately 1.1 million TRICARE Standard and Extra households and made it available electronically through e-mail and their Web sites.⁵⁶ Additionally, for the first time, in summer 2010 TMA developed a second *TRICARE Standard Health Matters* newsletter for TRICARE Standard and Extra beneficiaries in an electronic format as an additional resource to fill any possible information gaps to beneficiaries. The contractors then e-mailed the electronic newsletter to beneficiaries and posted it to their Web sites.⁵⁷ This electronic newsletter included articles on topics such as how beneficiaries may save money by using TRICARE Extra and how they can stay informed about TRICARE. Two of the contractors told us that it is difficult to communicate with TRICARE Standard and Extra beneficiaries because they do not necessarily have ready access to the beneficiaries' residential or e-mail addresses as these beneficiaries are not required to enroll. This lack of information can make communicating with these beneficiaries challenging, and as a result, TRICARE Standard and Extra beneficiaries may not receive all the available information on their TRICARE benefit. A TMA official noted that TMA is not considering making the additional electronic newsletter a requirement of the third generation of TRICARE contracts, although the contractors may use it to communicate with beneficiaries.

All of the contractors also make additional TRICARE education resources available to beneficiaries. Many of these resources are available on their

⁵⁶TMA's Communications and Customer Service annually provides the contractors with a mail file that includes the residential addresses of TRICARE Standard beneficiaries for the purpose of mailing the annual newsletter. TRICARE Extra beneficiaries are included in this list because they are the same as TRICARE Standard beneficiaries except that they choose to obtain health care from network providers.

⁵⁷Although TRICARE Standard and Extra beneficiaries are not required to enroll, these beneficiaries can sign-up for e-mail alerts that deliver the latest TRICARE information. According to a TMA official, the contractors may also collect beneficiaries' e-mail addresses and use these e-mail addresses to communicate with beneficiaries.

Web sites, and may include the *TRICARE Standard Handbook*⁵⁸ and brochures that explain the different TRICARE options and costs to beneficiaries, among other topics. For example, one contractor makes games available on its Web site, which enables beneficiaries to interactively learn about the TRICARE program. Another contractor posts its own monthly newsletter to its Web site, through which beneficiaries receive information about TRICARE, including its different options, and activities specific to its region. Meanwhile, the third contractor has developed several different fact sheets for beneficiaries that summarize key TRICARE program elements in short, easy-to-read formats.

Each of the three contractors also conducts outreach to enhance beneficiaries' awareness of TRICARE. For example, each of the contractors has attended events hosted by organizations such as the Military Officers Association of America, the Enlisted Association of the National Guard of the United States, the National Military Family Association, the Military Health System, and the Adjutants General Association of the United States. Contractors stated that while at these events they can share TRICARE information with attendees. One contractor also noted that while at these events it addresses beneficiaries' concerns and directs them to further resources. Contractors also use social media to communicate with beneficiaries and provide information on different TRICARE topics, including (1) benefits, (2) resources, and (3) health campaigns. For instance, one contractor used its Facebook page to clarify whether TRICARE Standard beneficiaries needed primary care managers to coordinate their referrals. Another contractor included information on Facebook about how beneficiaries could access information about their TRICARE benefit.

⁵⁸The *TRICARE Standard Handbook* has been developed to guide TRICARE beneficiaries in using the Standard and Extra options. It explains the different types of TRICARE providers and outlines services covered under TRICARE Standard and Extra as well as costs and requirements.

Contractors Provide Directories of Network Providers to Facilitate Access to Care; New Contracts Will Also Require Information on Nonnetwork Providers

To facilitate beneficiaries' access to care, TMA requires its contractors to maintain directories of TRICARE-authorized network providers. These directories are to include current information (updated within 30 days) about each network provider, including specialty, address, and telephone number. The contractors are required to make their directories readily accessible to all beneficiaries, and as a result, all of the contractors' Web sites have online provider directories. Under the second generation of TRICARE contracts, TMA does not require its contractors to provide similar information on nonnetwork providers. However, beneficiaries may contact the TRICARE Regional Offices or the contractors for assistance in locating a network or nonnetwork provider. Two of the contractors said they currently collect information on nonnetwork providers who have accepted TRICARE beneficiaries and can use this information to assist beneficiaries in locating a nonnetwork provider. Beneficiaries can also use TMA's TRICARE Web site, which refers beneficiaries to the American Medical Association's provider directory and the *Yellow Pages*, to find a nonnetwork provider. However, these online resources do not indicate whether a provider is TRICARE-authorized or has accepted TRICARE patients in the past.

TMA recognized that its Web site asked beneficiaries to "start from square one" to identify a TRICARE-authorized nonnetwork provider. Although it is not a routine practice for insurance companies to identify nonnetwork providers in their online directories, in February 2010, TMA's Deputy Chief of TRICARE Policy and Operations recommended (through a memo) that TMA establish an online search tool on its Web site to enable beneficiaries to identify both network and nonnetwork providers no later than May 1, 2010. However, TMA noted that it did not have sufficient data to develop this online search tool. Instead, TMA officials decided that under the third generation of TRICARE contracts, each contractor would be responsible for creating an online provider directory for its region that would include information for beneficiaries on TRICARE-authorized providers, both network and nonnetwork.

Agency Comments

We received comments on a draft of this report from DOD. (See app. VI.) DOD concurred with our overall findings and provided technical comments, which we incorporated where appropriate.

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. The report is also available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VII.

A handwritten signature in black ink that reads "Randall B. Williamson". The signature is written in a cursive style with a large initial "R".

Randall B. Williamson
Director, Health Care

Appendix I: TRICARE Reimbursement Rates That Remain Higher than Medicare Reimbursement Rates

Beginning in fiscal year 1991, in an effort to control escalating costs, Congress instructed the Department of Defense (DOD) to gradually lower its reimbursement rates for individual civilian providers to mirror those paid by Medicare.¹ Congress specified that reductions were not to exceed 15 percent in a given year. As of March 2011, there were seven nonmaternity procedures or services for which reimbursement remains higher under TRICARE than Medicare. (See table 4.)

Table 4: TRICARE Reimbursement Rates That Remain Higher than Medicare Reimbursement Rates for Nonmaternity Procedures and Services

CPT code ^a	Procedure or service performed	Ratio of TRICARE to Medicare reimbursement
36591	Collection of blood specimen from a completely implantable venous access device	1.017
38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic	1.152
38241	Bone marrow or blood-derived peripheral stem cell transplantation; autologous	1.155
86901	Blood typing; Rh (D)	1.810
92953	Temporary transcutaneous pacing	1.210
99173	Screening test of visual acuity, quantitative, bilateral	3.466
99359	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; each additional 30 minutes	1.076

Source: TRICARE Management Activity and the American Medical Association.

^aCurrent procedural terminology is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers.

Additionally, beginning in 1998, the TRICARE Management Activity (TMA) established a policy that its reimbursement rates for some maternity services and procedures must be set at the higher of the current Medicare fee or the 1997 Medicare fee.² As a result, the TRICARE reimbursement rates for 36 maternity services and procedures are higher than Medicare. (See table 5.)

¹See 10 U.S.C. §§ 1079(h), 1086(f).

²According to a TMA official, this TRICARE policy was established in 1998 because Medicare decreased the maternity rates by 10 percent that year. The official also noted that TMA determined this 10 percent decrease would jeopardize access and decided that the rates should not fall below the 1997 levels.

**Appendix I: TRICARE Reimbursement Rates
That Remain Higher than Medicare
Reimbursement Rates**

Table 5: TRICARE Reimbursement Rates That Remain Higher than Medicare Reimbursement Rates for Maternity Procedures and Services

CPT code^a	Procedure or service performed	Ratio of TRICARE to Medicare reimbursement
58300	Insertion of intrauterine device	1.038
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	1.070
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)	1.015
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	1.118
58970	Follicle puncture for oocyte retrieval, any method	1.004
59012	Cordocentesis (intrauterine), any method	1.200
59020	Fetal contraction stress test	1.327
59025	Fetal non-stress test	1.055
59030	Fetal scalp blood sampling	1.487
59050	Fetal monitoring during labor by consulting physician (e.g., non-attending physician) with written report; supervision and interpretation	1.400
59051	Fetal monitoring during labor by consulting physician (e.g. non-attending physician) with written report; interpretation only	1.285
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy	1.127
59140	Surgical treatment of ectopic pregnancy; cervical, with evacuation	1.093
59160	Curettage, postpartum	1.136
59320	Cerclage of cervix, during pregnancy; vaginal	1.178
59325	Cerclage of cervix, during pregnancy; abdominal	1.296
59350	Hysterorrhaphy of ruptured uterus	1.276
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	1.318
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	1.135
59412	External cephalic version, with or without tocolysis	1.307
59414	Delivery of placenta (separate procedure)	1.397
59514	Cesarean delivery only	1.361
59515	Cesarean delivery only; including postpartum care	1.087
59525	Subtotal or total hysterectomy after cesarean delivery	1.032
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	1.239
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	1.093
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	1.373
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	1.098
59840	Induced abortion, by dilation and curettage	1.237

**Appendix I: TRICARE Reimbursement Rates
That Remain Higher than Medicare
Reimbursement Rates**

CPT code^a	Procedure or service performed	Ratio of TRICARE to Medicare reimbursement
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines	1.160
59851	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	1.042
59852	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines; with hysterectomy (failed intra-amniotic injection)	1.125
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g. laminaria), including hospital admission and visits, delivery of fetus and secundines	1.010
59856	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g. laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation	1.060
59857	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g. laminaria), including hospital admission and visits, delivery of fetus and secundines; with hysterotomy (failed-medical evacuation)	1.229
59866	Multifetal pregnancy reduction(s)	1.365

Source: TRICARE Management Activity and the American Medical Association.

^aCurrent procedural terminology is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers.

Appendix II: TMA's Studies on TRICARE Reimbursement Rates

TMA contracted with a health-policy research and consulting firm to conduct a number of studies about specific TRICARE reimbursement rates. Some of these studies resulted in changes to the TRICARE reimbursement rates for certain procedures. A brief description of these studies is provided below.

Studies of Reimbursement Rates for Specific Maternity/Delivery Procedures, 2006 through 2011¹

Starting in 2006, TMA's consultant has conducted annual comparisons of TRICARE's reimbursement rates for certain maternity/delivery procedures with Medicaid² reimbursement rates on a state-by-state basis. Any reimbursement rates that were found to be below the Medicaid level of payment have been increased.

- For 2006, TMA found that for at least one procedure, the Medicaid rates in 12 states were higher than TRICARE reimbursement rates.³
- For 2007, TMA found that for at least one procedure, the Medicaid rates in 11 states were higher than TRICARE reimbursement rates.⁴
- For 2008, TMA found that for at least one procedure, the Medicaid rates in 18 states were higher than TRICARE reimbursement rates.⁵

¹See the 2011 report at Kennell, D., Witsberger, C., Doukeris, C., *Information on Maternity CMACs for 2011 (Task Order No. 3005-001)*, Kennell and Associates, Inc. (Feb. 1, 2011). This report contains summaries of all previous analyses beginning in 2006.

²Medicaid is the joint federal-state program that provides health care coverage for certain low-income individuals.

³TMA's consultant reviewed data from 47 states (all except Tennessee, Delaware, and Rhode Island). A state was identified as having TRICARE reimbursement rates below Medicaid if the TRICARE reimbursement rate in any locality was below the Medicaid rate for any of 6 specific maternity/delivery current procedural terminology (CPT) codes. For any state where at least 1 of these 6 TRICARE reimbursement rates were below the Medicaid rate, the rates for 14 CPT codes (the 6 specific codes plus 8 others) were set at the greater of the TRICARE reimbursement rate or the Medicaid rate.

⁴TMA's consultant reviewed data from the 12 states identified in 2006, as well as Idaho, Oklahoma, Virginia, North Carolina, Maryland, Alabama, Vermont, Utah, Kentucky, New Hampshire, and Illinois.

⁵For the 2008, 2009, 2010, and 2011 studies, TMA's consultant reviewed data from all states except Tennessee.

- For 2009, TMA found that for at least one procedure, the Medicaid rates in 19 states were higher than TRICARE reimbursement rates.
- For 2010, TMA found that for at least one procedure, the Medicaid rates in the same 19 states were higher than TRICARE reimbursement rates.
- For 2011, TMA found that 3 of the 19 states from 2010 no longer met the criteria of having at least one maternity/delivery procedure with TRICARE reimbursement rates lower than Medicaid. As a result, for at least one procedure, the Medicaid rates in 16 states were higher than TRICARE reimbursement rates.

**Comparison of Commercial, Medicaid, and TRICARE
Reimbursement Rates for Selected Medical Specialties, April 2009⁶**

TMA's consultant compared specific TRICARE reimbursement rates with reimbursement rates from Medicaid and commercial insurers. For the comparison with Medicaid rates, it identified commonly used procedures for 13 medical specialties⁷ and compared TRICARE's reimbursement rates for these procedures with Medicaid's fee-for-service rates in 49 states.⁸ Overall, the median value of the 2009 Medicaid rates in the 49 states was about 18 percent lower than TRICARE's reimbursement rates. In 24 states, the TRICARE reimbursement rates exceeded the state Medicaid program rates for the 13 medical specialties reviewed. Conversely, the study found that in 3 states—New Mexico, Arizona, and Wyoming—Medicaid rates, on average, exceeded the TRICARE reimbursement rates for these 13 specialties. For the comparison with commercial rates, TMA's consultant analyzed reimbursement amounts for 12 medical specialties⁹ in 15

⁶Kennell, D., Brooks, A., Witsberger, C., Cottrell, L., Caney, K., *Comparison of Commercial, Medicaid, and TRICARE Reimbursement Rates for Physicians (Task Order 1005-009)*, Kennell and Associates, Inc. (Apr. 22, 2009).

⁷In order to capture differences between different types of physicians, TMA's consultant examined 13 specialties that provide the vast majority of physician services to TRICARE beneficiaries. The 13 specialties were (1) general and family practice providers, (2) pediatricians, (3) internists, (4) obstetricians/gynecologists, (5) psychiatrists, (6) psychologists, (7) cardiologists, (8) orthopedic surgeons, (9) radiologists, (10) general surgeons, (11) gastroenterologists, (12) physical medicine specialists, and (13) ophthalmologists.

⁸Tennessee was not included as it did not have a Medicaid fee-for-service program.

⁹There was insufficient commercial data to analyze rates for obstetricians.

geographic market areas¹⁰ and found that commercial rates were higher than TRICARE reimbursement rates for these 12 specialties in almost all of the geographic market areas analyzed.

Review of TRICARE Reimbursement Rates for Pediatric Vaccines and Immunizations, January 2009¹¹

TMA's consultant studied TRICARE's reimbursement rates for selected pediatric immunizations and vaccines to determine whether TRICARE's reimbursement amounts were below the cost that pediatricians must pay to acquire these vaccines.¹² It analyzed 15 vaccine codes (which often have more than one type of vaccine product associated with them) and found that for each of the vaccine codes, TRICARE's reimbursement rates exceeded the average acquisition cost paid by pediatric providers for at least one of the vaccine products. Overall, in 2007 TRICARE's reimbursement rates exceeded the average acquisition cost for the 15 vaccine codes by 30 percent (when weighted by volume). The study also noted that some pediatricians may pay more than the average acquisition price, and some network pediatricians may receive TRICARE reimbursement rates below the average acquisition cost if they have agreed to reimbursement discounts as a condition of belonging to the TRICARE provider network.¹³ The study also compared TRICARE's reimbursement rates to those of Medicare and Medicaid. The study noted that TRICARE uses the same vaccine prices and administration prices as Medicare for vaccine codes for which Medicare sets a price (which is mostly at 106 percent of the average sales price of the vaccine as of 2005—determined by the Centers for Medicare & Medicaid Services). For those vaccines for which Medicare does not have a set price, TRICARE reimbursement rates are set at 95 percent of average wholesale price—which is essentially a “list price” set by the manufacturer. When compared

¹⁰The geographic market areas were equally distributed among the three TRICARE regions: two high-volume TRICARE markets and three smaller markets in each region.

¹¹Kennell, D., Brooks, A., Witsberger, C., *TRICARE Reimbursement of Pediatric Vaccines and Immunizations (Task Order No. 1005-005)*, Kennell and Associates, Inc. (Jan. 14, 2009).

¹²At the time of the study, TRICARE reimbursed providers for pediatric vaccines in two components: (1) a reimbursement for the vaccine and (2) a separate amount (in many cases) for the administration of the vaccine.

¹³Network providers may agree to accept lower reimbursements as a condition of network participation.

to Medicaid's rates, TRICARE's reimbursement rate for the administration of a vaccine or immunization was higher than Medicaid's in every state in 2008.¹⁴

Analysis of TRICARE Payment Rates for Maternity/Delivery Services, Evaluation and Management Services, and Pediatric Immunizations, March 2006¹⁵

TMA's consultant compared TRICARE's reimbursement rates for 14 specific maternity/delivery services and a pediatrician office visit¹⁶ with Medicaid¹⁷ and commercial payment rates.¹⁸ It found the following:

- For these specific maternity/delivery services, TRICARE's reimbursement rates were higher than Medicaid rates in 35 of the 45 states reviewed. Additionally, in 27 of the 35 states, the Medicaid payment rate for deliveries was less than 90 percent of TRICARE's reimbursement rates. TRICARE's reimbursement rates for deliveries were less than the median commercial rates in all but one of the 50 markets studied (they were equivalent in the remaining market). Overall, the median commercial rates for deliveries were 24 percent higher than TRICARE's reimbursement rates in 2005.

¹⁴According to the study, TRICARE payments for pediatric vaccines could not be compared to Medicaid payments because pediatric vaccines were typically supplied free to pediatricians by states and/or the Centers for Disease Control and Prevention's Vaccines for Children program. The Vaccines for Children program provides free vaccines to enrolled public and private providers for recommended immunizations for children who are Medicaid-eligible, uninsured, on Medicaid, American Indian/Alaska Native, or underinsured by having insurance that does not cover routine immunizations. When a pediatrician receives Vaccines for Children products free, he or she is usually paid an administration fee by most Medicaid programs which generally ranges between \$3 and \$10, with most states paying between \$4 and \$6. TRICARE's 2008 reimbursement rate for this same service is \$20.57.

¹⁵Kennell and Associates, Inc., *Analysis of TRICARE Payment Rates for Maternity/Delivery Services, Evaluation and Management Services, and Pediatric Immunizations* (Mar. 30, 2006).

¹⁶The study examined the 14 maternity/delivery CPT codes with the highest number of TRICARE purchased care uses, as well as the most frequently billed CPT code under TRICARE used by pediatricians—a mid-level office visit for an established patient.

¹⁷The study examined the 2006 state Medicaid rates for 45 states. According to the study, Tennessee and Delaware did not have fee-for-service Medicaid programs at the time of the study, and Massachusetts, Rhode Island, and Kansas' data were unavailable.

¹⁸The study examined the median commercial rates for September 2005 in the 50 areas with the highest number of TRICARE purchased care deliveries in fiscal year 2005.

- For pediatric care, TRICARE's reimbursement rate for a mid-level office visit for an established patient (the most commonly billed code by pediatricians) was higher than the state Medicaid reimbursement rate in 41 of the 45 states in 2005.¹⁹ However, the median commercial reimbursement rates were 10 percent higher than TRICARE's reimbursement rates in the 50 TRICARE markets examined.
- TRICARE's reimbursement for pediatric vaccines and injectable drugs generally appeared to be reasonable when derived from Medicare pricing, based on an analysis of private sector costs, average wholesale prices, and average sales prices for top volume CPT codes. However, TRICARE's reimbursement rate for the pediatric and adolescent dose of the hepatitis A vaccine was found to be 22 percent lower than estimated private sector costs to obtain the vaccine in 2005. Specifically, the TRICARE reimbursement rate for this vaccine dose was \$22.64, while pediatricians were paying between \$27.41 and \$30.37 for the vaccine. Based on the results of this study, TMA used its general authority to deviate from Medicare rates (upon which TRICARE rates are based),²⁰ and starting May 1, 2006, TMA instructed the contractors to reimburse pediatric hepatitis A vaccines nationally at a new reimbursement rate of \$30.40.

¹⁹Three of the four states in which the Medicaid rates exceeded TRICARE's reimbursement rates for this service were states that also had higher Medicaid rates for maternity/delivery services. The fourth state had Medicaid rates that were roughly equal to TRICARE's reimbursement rate for this service.

²⁰See 10 U.S.C. §§ 1079(h)(1), 1086(f).

Appendix III: TMA's Use of Waivers

TMA has the authority to increase TRICARE reimbursement rates for network and nonnetwork civilian providers to ensure that all beneficiaries, including TRICARE Standard and Extra beneficiaries, have adequate access to civilian providers. TMA's authorities include: (1) issuing locality waivers that increase rates for specific procedures in specific localities,¹ (2) issuing network waivers that increase some network civilian providers' reimbursements,² and (3) restoring TRICARE reimbursement rates in specific localities to the levels that existed before a reduction was made to align TRICARE reimbursement rates with Medicare rates for both network and nonnetwork providers.³

Locality waivers may be used to increase rates for specific medical services in specific areas where access to civilian providers has been severely impaired. The resulting rate increase would be applied to both network and nonnetwork civilian providers for the medical services identified in the areas where access is impaired. A total of 17 applications for locality waivers have been submitted to TMA between January 2002 and January 2011. TMA approved 16 of these waivers. (See table 6.)

¹32 C.F.R. § 199.14(j)(1)(iv)(D) (2010). According to a TMA official, TMA usually defines a locality using one or more zip codes.

²32 C.F.R. § 199.14(j)(1)(iv)(E) (2010).

³32 C.F.R. § 199.14(j)(1)(iv)(C) (2010).

Table 6: Applications for Locality Waivers and Approval Results

Date submitted	Affected location	Affected services	Amount of increase requested	Outcome
1/23/03	Juneau, Alaska	All gynecological procedures or services delivered by one provider	600 percent ^a	3/26/03—Approved for nonroutine gynecological procedures or services
8/01/04	Fairbanks, Alaska	All inpatient internal medicine procedures or services delivered by providers employed by Fairbanks Memorial Hospital	Veterans Affairs rates	10/28/04—Approved
6/08/05	Anchorage, Alaska	All medical procedures or services delivered by perinatologists	40 percent	11/21/05—Approved for perinatologists who are participating providers ^b 11/21/07—Decreased the rate to 35 percent as a result of an increase in overall TRICARE reimbursement rates in Alaska
6/08/05	Fairbanks, Alaska	Four medical procedures or services delivered by two plastic surgeons	Veterans Affairs rates	5/18/06—Approved to increase rates to the rate paid by the Veterans Affairs for professional services provided by plastic surgeons in Alaska
3/03/05	Puerto Rico ^c	All medical procedures or services delivered by neurosurgeons	40 percent	10/26/05—Approved
Annual study ^d (originally requested on 10/19/05)	Multiple states ^e	14 obstetrical procedures or services	Medicaid reimbursement amounts	3/01/10—Approved
2/23/06	Fairbanks, Alaska	All anesthesia or pain management and treatment services delivered by anesthesiologists	200 percent	6/02/06—Approved to increase rates by 252 percent ^f
7/17/06 ^g	Puerto Rico ^c	Medical procedures or services delivered by perinatologists, orthopedists, and pediatric urologists	Various: 310 percent for perinatologists; 300 percent for orthopedists; and 162 percent for pediatric urologists	Denied because the request did not meet the requirements for a locality waiver
7/01/06 ^g	All of Alaska	All medical procedures or services	Veterans Affairs rates	1/01/07—Approved
8/07/06 ^g	Fairbanks, Alaska	Three services delivered by a pulmonologist	Veterans Affairs rates	12/13/06—Approved
5/24/07 ^g	Juneau, Alaska	All orthopedic and physical medicine rehabilitation at Juneau Bone & Joint Center	15 percent	8/06/07—Approved

Appendix III: TMA's Use of Waivers

Date submitted	Affected location	Affected services	Amount of increase requested	Outcome
12/18/07 ^g	Key West, Florida	All psychiatric services in the code range of 90800 through 90899 delivered by two providers	50 percent	1/07/08—Approved for patients 18 and under within the 33040 zip code
4/16/08 ^g	Puerto Rico ^c	All medically indicated bilateral breast reduction surgeries delivered by surgeons	\$2,600 (bilateral procedure)	6/19/08—Approved
8/22/08 ^g	Juneau, Alaska	Orthopedic and physical medicine/rehabilitation services at Juneau Bone & Joint Center	35 percent	9/05/08—Approved
5/05/09 ^g	Anchorage/Palmer, Alaska	Neurosurgical services for three provider groups	250 percent	7/14/09—Approved
8/20/09 ^g	Anchorage area, Alaska	Pain management services for four provider groups in and around the Anchorage area	217 percent	11/17/09—Approved
11/13/09 ^g	All of Alaska	Certain rheumatology, orthopedics, and otolaryngology services	Various: 125 percent for rheumatologists; between 150 and 175 percent for orthopedists; and 175 percent for otolaryngologists	12/30/09—Approved for certain rheumatology, orthopedics, and otolaryngology services provided by the 14 practices which have signed letters of intent to provide these services, as well as any other practices which sign a letter of intent to provide these services

Source: GAO analysis of TRICARE Management Activity (TMA) data.

^aRequest did not include a specific increase amount. The approved waiver was for the lesser of billed charges or 600 percent of the TRICARE reimbursement rate.

^bParticipating providers submit claims for reimbursement and accept the TRICARE reimbursement rate as payment in full.

^cThe TRICARE Regional Offices are not responsible for managing TRICARE in Puerto Rico because it operates under a different contract than what is used for the three TRICARE regions.

^dWhen reviewing the need for this rate adjustment, TMA annually compares TRICARE reimbursement rates with Medicaid rates in states for which data are available. The 19 states listed were identified as needing a rate adjustment based on this analysis. The first of these waivers was approved in 2006 and included only 12 states. Each year when the TRICARE reimbursement rates are adjusted, TMA intends to similarly determine where this adjustment is needed.

^eThe states are Alabama, Arizona, Connecticut, Georgia, Massachusetts, Montana, Nebraska, New Mexico, New York, North Dakota, Oregon, Pennsylvania, South Carolina, South Dakota, Vermont, Virginia, Washington, West Virginia, and Wyoming.

^fBecause the TRICARE reimbursement rate changed during the period between the application and the approval of this waiver, TMA raised the percentage of the increase.

^gAccording to TMA, these dates are the dates the waiver submission was assigned or received by TMA to better reflect when TMA started to take action on the request.

Network waivers are used to increase reimbursement rates for network providers up to 15 percent above the TRICARE reimbursement rate in an effort to ensure an adequate number and mix of primary and specialty care network civilian providers in a specific location. Between January 2002 and January 2011, 13 applications for network waivers have been submitted to TMA. Of these, eight network waivers have been approved by TMA and five have been denied. (See table 7.)

Table 7: Applications for Network Waivers and Approval Results

Date submitted	Affected location	Affected services	Amount of increase requested	Outcome
1/29/02	Fredericksburg, Virginia	33 varied medical procedures or services, encompassing various specialties	28 percent ^a	Denied—Application did not substantiate an access-to-care problem
3/07/02	Great Falls, Montana	All medical procedures or services delivered by a specific clinic representing 32 specialties	200 percent ^a	Denied—Application did not directly request a network waiver and increase could be handled under TRICARE Prime Remote ^b
8/13/02	Idaho	All medical procedures and services	15 percent	1/15/03—Approved for nine specialties in the Mountain Home Air Force Base Prime Service Area
12/20/02	Bozeman, Montana	All obstetrical or gynecological medical procedures or services	15 percent	Denied—Increase available under TRICARE Prime Remote ^b
4/08/03	Cheyenne, Wyoming	Three newborn inpatient medical procedures or services	To match civilian insurers' rates	7/16/03—Approved increase to 15 percent above TRICARE reimbursement rates
2/03 and 3/03	Watertown, New York, Norwich, Connecticut	Deliveries provided by nurse midwives in New York and emergency gynecological services in Connecticut	Not specified	Denied—Incomplete application package submitted
9/26/03	Ft. Leonard Wood and Springfield, Missouri	All medical procedures and services delivered by network providers	15 percent	12/24/03—Approved for 11 specialties in Ft. Leonard Wood Prime Service Area. Denied for Springfield
1/05/05	Delta Junction and Tok, Alaska	All primary care medical procedures and services	15 percent	3/30/05—Approved for nonmental health medical care services, excluding laboratory services

Appendix III: TMA's Use of Waivers

Date submitted	Affected location	Affected services	Amount of increase requested	Outcome
6/10/05	Norfolk, Virginia	All medical procedures and services for three specialties delivered by a group of pediatric specialists	15 percent	7/08/05—Approved
3/06/06	Rapid City, South Dakota	All obstetrical or gynecological services delivered by a group of specialists	Not specified	5/16/2006—Approved a 15 percent increase for one group of obstetricians and gynecologists
2/16/07 ^c	Ellsworth Air Force Base, South Dakota	Evaluation and management codes for orthopedic and rheumatology services by the Black Hills Orthopedic and Spine Center	15 percent	7/13/07—Approved
2/26/07 ^c	Fort Bliss, Texas	Ophthalmology services provided by Southwest Retina Consultants	15 percent	Denied because the documentation was not sufficient to support and justify the waiver
1/04/10 ^c	Hawaii	Inpatient neonatal and pediatric services by providers at Kapiolani Medical Specialists	15 percent	2/25/10—Approved

Source: GAO analysis of TRICARE Management Activity (TMA) data.

^aAccording to TMA, the waiver requesters did not understand that the maximum network waiver is 15 percent over TRICARE reimbursement rates. If the waiver had been granted it would have been limited to 115 percent of the TRICARE reimbursement rate.

^bTRICARE Prime Remote is a specialized version of TRICARE Prime available for active duty members when they are assigned to duty stations in areas not served by the military health care system. Under this program, civilian network providers can be reimbursed up to 15 percent above the TRICARE reimbursement rate. Family members who reside with servicemembers who are enrolled in TRICARE Prime Remote are eligible to enroll in and receive care under TRICARE Prime Remote for Active Duty Family Members.

^cAccording to TMA, these dates are the dates the waiver submission was assigned or received by TMA to better reflect when TMA started to take action on the request.

TMA can also use its authority to restore TRICARE reimbursement rates in specific localities to the levels that existed before a reduction was made to align TRICARE rates with Medicare rates. On two occasions previously, TMA has used this authority in Alaska to encourage both network and nonnetwork civilian providers to accept TRICARE beneficiaries as patients in an effort to ensure adequate access to care. In 2000, TMA used this waiver authority to uniformly increase reimbursement rates for network and nonnetwork civilian providers in rural Alaska, and in 2002, TMA implemented this same waiver for network and nonnetwork civilian providers in Anchorage. However, in 2007 TMA implemented a demonstration project in Alaska that increased reimbursement rates to match those of the Department of Veterans Affairs. As a result, the waivers implemented under this authority were ended. As of January 2011, TMA did not have any waivers of reimbursement rate reductions in place.

Appendix IV: Access-to-Care Concerns in Alaska

Access to health care in Alaska is hindered by unique impediments due to its geographically remote location and small population base, which has resulted in some of the highest costs for providing services in the country. To identify and examine the unique access concerns for Alaska, we reviewed the *Interagency Access to Health Care in Alaska Task Force Report to Congress*. We also spoke with TMA officials and a representative of the Alaska State Medical Association to obtain their views on the unique access challenges in this state.

Federal health programs¹ are the leading payer of health care services to Alaska citizens, constituting approximately 31 percent of total health care expenditures in the state in 2006.² In 2010, the Department of Health and Human Services reported that about 14 percent of the population in Alaska had received health care from either DOD's TRICARE program or from the Veterans Health Administration.³ According to a 2009 study by the Alaska Center for Rural Health, Alaska has a shortage of providers that has been further impacted by its remoteness, harsh climate, and scarce training resources.⁴ Workforce shortages in urban areas range from a complete lack of certain specialists in Fairbanks and other towns, to a relative shortage of primary care providers and many specialists in Anchorage. Moreover, rural areas have far more difficulty attracting qualified candidates than more heavily populated areas, such as Anchorage or Fairbanks. TRICARE officials have identified this overall shortage of providers and providers' reluctance to accept TRICARE reimbursement rates as the main impediments to TRICARE beneficiaries' access to civilian providers in Alaska—regardless of which option they use.

Alaska is part of TRICARE's West region, and until recently, Alaska was the only state for which TMA administered and managed TRICARE

¹The federal responsibility for health care in Alaska includes, but is not limited to, providing or funding health care to users of the Indian Health Service, Medicare, Medicaid, TRICARE, and Veterans Health Administration.

²See Sebelius, Kathleen, Secretary of Health and Human Services, *Report to Congress of the Interagency Access to Health Care in Alaska Task Force* (Sept. 17, 2010, p. 19).

³Alaska ranks first in the nation in the percent of population receiving TRICARE or Veterans Health Administration paid services. The national average is about 4 percent of the population. See *Report to Congress of the Interagency Access to Health Care in Alaska Task Force* (Sept. 17, 2010, p.19).

⁴Alaska Center for Rural Health, Alaska's AHEC Institute of Social and Economic Research, *2009 Alaska Health Workforce Vacancy Study* (December 2009).

directly as well as being the only state that did not have Prime Service Areas with networks of civilian providers.⁵ In a November 2010 *Federal Register* notice, DOD announced that the responsibility for administering and managing TRICARE in Alaska would transfer from TMA to the contractor for the West region.⁶ Additionally, the notice required the contractor to develop networks of civilian providers in two Prime Service Areas to be established around the military treatment facilities located at Fort Wainwright and Eielson Air Force Base, near Fairbanks, Alaska. This transition of responsibility took place in January 2011, and TMA expects these Prime Service Areas to be developed by July 2011. Additionally, the West region contractor noted that it expects to receive authorization to develop a third Prime Service Area around Elmendorf Air Force Base in Anchorage in late summer 2011.

TMA has taken actions to address TRICARE beneficiaries' access to civilian providers in Alaska by (1) increasing TRICARE's reimbursement rates through the use of waivers and a demonstration project and (2) participating in a federal task force on the delivery of health care in Alaska. Specifically, in areas where access is impaired, TMA has increased reimbursement rates to encourage civilian providers to accept TRICARE beneficiaries through TMA's reimbursement waivers. Of the 24 waivers in place as of January 2011, 13 are for locations in Alaska.

In addition, TMA began a demonstration project in Alaska in February 2007—originally expected to end in December 2009—that raised reimbursement rates for physicians and other noninstitutional professional providers so that on average, they matched those of the Department of Veterans Affairs. Specifically, TRICARE's 2007 reimbursement rates were increased approximately 35 percent.⁷ In July 2009, TMA conducted a preliminary assessment of the demonstration project and found mixed results. Specifically, TMA's analysis determined that three of seven measures of access to care indicated that access had improved since the beginning of the project, while the other four measures

⁵TRICARE administration and management in each of the other 49 states was overseen by one of three regional contractors.

⁶See 75 Fed. Reg. 67,695 (Nov. 3, 2010).

⁷TMA calculated that, on average, the Department of Veterans Affairs reimbursement rates were 35 percent higher than TRICARE's rates in 2006, and 73 percent higher than Medicare's rates in Alaska. The 13 reimbursement waivers in Alaska are in addition to the demonstration project rate increases.

did not show an improvement in access.⁸ Despite this inconclusive assessment, TMA officials in the West region said that the demonstration project and the use of waivers have increased access to care, as the number of providers accepting TRICARE's reimbursement rates increased. According to these officials, the number of providers that have accepted TRICARE's reimbursement rate went from under 300 before the demonstration project to almost 800, as of July 2010. Although DOD has recognized that there have been mixed results on the effectiveness of the demonstration project, it extended the demonstration project through December 31, 2012.

Finally, in recognition that Alaska has unique health care challenges, Congress established the Interagency Access to Care in Alaska Task Force to review how federal agencies with responsibility for health care services in Alaska are meeting the needs of Alaskans.⁹ The Task Force consisted of members from the following: DOD (including TMA), the Department of Veterans Affairs and its Veterans Health Administration, the Department of Health and Human Services and its Centers for Medicare & Medicaid Services and Indian Health Service, and the U.S. Coast Guard. In September 2010, the Task Force issued its report recommending that, among other things, federal agencies providing health care reimbursement in Alaska should support current projects to develop a budget-neutral, uniform provider reimbursement rate for similar services for Medicare, TRICARE, and the Veterans Health Administration.¹⁰ According to TMA officials, TMA is currently reviewing the Task Force's recommendations to develop options within the framework of current law and regulations. However, the full implementation of the recommendations will be under the direction of the Secretary of Health and Human Services.

⁸The seven measures included: (1) the number of unique beneficiaries who received civilian care; (2) the number of unique civilian physicians who saw a TRICARE beneficiary; (3) the number of services (visits and other services) received by TRICARE patients; (4) the number of civilian emergency room visits; (5) the number of visits and admissions by Alaska residents outside of Alaska (prior to 2007, many beneficiaries had to be sent outside of Alaska for services because physicians would not treat them in Alaska); (6) the number of TRICARE waivers granted for active-duty servicemembers; and (7) survey information on whether physicians are willing to accept TRICARE Standard patients (this indicator of access is based on results of TMA surveys). These seven measures were developed in discussions with TMA and TRICARE Regional Office officials.

⁹See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10501(b), 124 Stat. 119, 993-94 (2010) (adding section 5104 to PPACA).

¹⁰See *Report to Congress of the Interagency Access to Health Care in Alaska Task Force* (Sept. 17, 2010).

Appendix V: Network Adequacy Reporting Requirement of Contractors under the Second Generation of TRICARE Contracts

Under the second generation of contracts, TMA's contractors have been required to develop and maintain adequate networks of providers, which are to meet the needs of all TRICARE beneficiaries within Prime Service Areas.¹ In doing so, each contractor uses a different methodology for determining the number of providers needed. Contractors are also required to develop their own systems to continuously monitor and evaluate network adequacy and to submit routine reports to TMA on the status of their provider networks in accordance with contract requirements. Specifically, TMA requires its contractors to submit monthly and quarterly reports on network inadequacy and network adequacy, respectively, and to submit corrective action plans for each instance of network inadequacy.

- The monthly report on network inadequacy must include information on each instance in which a beneficiary enrolled in TRICARE Prime is being referred to: (1) a provider outside of TMA's time or distance standards² or (2) a nonnetwork provider. According to TMA officials, network inadequacies may occur because of provider shortages; in such instances, contractors are not held accountable for not meeting access standards. However, other network inadequacies, particularly referrals to nonnetwork providers, may also be due to other factors, such as network providers not accepting new patients or beneficiaries' not wanting to wait for available appointments with network providers who are unable to provide an appointment within TMA's access standards. According to a TMA official, none of the contractors have been cited for not meeting TMA's time and distance standards or for referrals to nonnetwork providers under the second generation of TRICARE contracts.

¹TMA defines an "adequate network" as one that ensures that all access standards are continuously maintained in all TRICARE Prime Service Areas for the delivery of health care under TRICARE Prime and Extra.

²Among others, these time and distance standards set allowable travel and appointment wait times. Specifically, under normal circumstances, travel time may not exceed 30 minutes from home to primary care delivery site, or 1 hour from home for specialty care, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. Additionally, the wait time for an appointment for well-patient visits or specialty care referrals shall not exceed 4 weeks; for a routine visit, the wait time for an appointment shall not exceed 1 week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours. Office waiting times in nonemergency circumstances must not exceed 30 minutes, except when emergency care is being provided to patients and disrupts the normal schedule. See 32 C.F.R. § 199.17(p)(5) (2010).

**Appendix V: Network Adequacy Reporting
Requirement of Contractors under the Second
Generation of TRICARE Contracts**

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- Contractors' quarterly reports include: (1) the total number of network providers by specialty, (2) the number of additions and deletions to the network by specialty, and (3) actions to contract with additional providers in areas lacking networks to meet access standards, among other things.

Appendix VI: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

MAY 23 2011

HEALTH AFFAIRS

Mr. Randall B. Williamson
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

This is the Department of Defense response to the Government Accountability Office (GAO) draft report, DEFENSE HEALTH CARE: Access to Civilian Providers Under TRICARE Standard and Extra (GAO-11-500, Code #290858).

Thank you for the opportunity to review and provide comments on the subject draft report. We have carefully reviewed the draft report and concur with the report as written. Technical comments are attached to address portions of your report.

We sincerely thank the GAO for their thorough review and analysis of issues regarding access to civilian providers under TRICARE Standard and Extra.

My points of contact on this effort are Mr. Mark Ellis (Functional) and Mr. Gunther Zimmerman (TRICARE Management Activity Audit Liaison). Mr. Ellis may be reached at (703) 681-0039, and Mr. Zimmerman may be reached at (703) 681-4365.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan Woodson for", is written over a horizontal line.

Jonathan Woodson, M.D.

Attachment:
As stated

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Jennie F. Apter; Kaitlin Coffey; Jeff Mayhew; Lisa Motley; C. Jenna Sondhelm; and Suzanne Worth made major contributions to this report.

Related GAO Products

Defense Health Care: 2008 Access to Care Surveys Indicate Some Problems, but Beneficiary Satisfaction Is Similar to Other Health Plans. [GAO-10-402](#). Washington, D.C.: March 31, 2010.

TRICARE: Changes to Access Policies and Payment Rates for Services Provided by Civilian Obstetricians. [GAO-07-941R](#). Washington, D.C.: July 31, 2007.

Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option. [GAO-07-48](#). Washington, D.C.: December 22, 2006.

Defense Health Care: Oversight of the TRICARE Civilian Provider Network Should Be Improved. [GAO-03-928](#). Washington, D.C.: July 31, 2003.

Defense Health Care: Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weaknesses. [GAO-03-592T](#). Washington, D.C.: March 27, 2003.

Defense Health Care: Across-the-Board Physician Rate Increase Would be Costly and Unnecessary. [GAO-01-620](#). Washington, D.C.: May 24, 2001.

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