United States General Accounting Office

GAO

Report to Congressional Committees

July 2003

DEFENSE HEALTH CARE

Oversight of the TRICARE Civilian Provider Network Should Be Improved

GAO-03-928

July 2003

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Highlights

Highlights of GAO-03-928, a report to congressional committees

DEFENSE HEALTH CARE

Oversight of the TRICARE Civilian Provider Network Should Be Improved

Why GAO Did This Study

Testifying before Congress in 2002, military beneficiary groups described problems accessing care from TRICARE's civilian medical providers. Providers also testified on their dissatisfaction with the TRICARE program, specifying low reimbursement rates and administrative burdens.

The Bob Stump National Defense Authorization Act of 2003 required GAO to review the oversight of the TRICARE network of civilian providers. Specifically, GAO describes how the Department of Defense (DOD) oversees the adequacy of the civilian provider network, evaluates DOD's oversight of the civilian provider network, and describes the factors that have been reported to contribute to network inadequacy.

GAO analyzed TRICARE Prime—the managed care component of TRICARE. To describe and evaluate DOD's oversight, GAO reviewed and analyzed information from reports on network adequacy and interviewed DOD and contractor officials in 5 of 11 TRICARE regions.

What GAO Recommends

GAO recommends that DOD improve its oversight of the civilian provider network by ensuring sufficient information is reported and by exploring options for evaluating beneficiary complaints and improving provider survey data. DOD concurred with the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-03-928.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marjorie Kanof at (202) 512-7101.

What GAO Found

For the 8.7 million TRICARE beneficiaries, DOD relies on the civilian provider network to supplement health care delivered by its military treatment facilities. To ensure the adequacy of the civilian provider network, DOD has standards for the number and mix of providers, both primary care and specialists, necessary to satisfy TRICARE Prime beneficiaries' needs. In addition, DOD has standards for appointment wait, office wait, and travel times to ensure that TRICARE Prime beneficiaries have timely access to care. DOD has delegated oversight of the civilian provider network to the local level through regional TRICARE lead agents.

DOD's ability to effectively oversee the TRICARE civilian provider network is hindered in several ways. First, the measurement used to determine if there is a sufficient number and mix of providers in a geographic area does not always account for the total number of beneficiaries who may seek care or the availability of providers. This may result in an underestimation of the number of providers needed in an area. Second, incomplete contractor reporting on access to care makes it difficult for DOD to assess compliance with these standards. Finally, DOD does not systematically collect and analyze beneficiary complaints, which might assist in identifying inadequacies in the civilian provider network. However, DOD has tools, such as surveys of network providers and automated reporting systems which, while not designed specifically for monitoring the civilian provider network, could, if modified, improve DOD's ability to oversee the network.

DOD and its contractors have reported that a lack of providers in certain geographic locations, low reimbursement rates, and administrative requirements contribute to potential civilian provider network inadequacy. DOD and contractors have reported long-standing provider shortages in some geographic areas. In areas where DOD determines that access to care is severely impaired, DOD has the authority to increase reimbursement rates. Since 2002, DOD has used its reimbursement authority to increase rates in Alaska and Idaho in an attempt to entice more providers to join the network. DOD officials told us that the contractors have achieved some success in recruiting additional providers by using this authority. Additionally, civilian providers have expressed concerns that TRICARE's reimbursement rates are generally too low and administrative requirements too cumbersome. However, while reimbursement rates and administrative requirements may have created provider dissatisfaction, it is not clear how much this has affected civilian provider network adequacy except in limited geographic locations, because the information contractors provide to DOD is not sufficient to measure network adequacy.

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Abbreviations

ATC	Access To Care Project
DOD	Department of Defense
EWRAS	Enterprise Wide Referral and Authorization System
HCSDB	Health Care Survey of DOD Beneficiaries
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MOAA	Military Officers Association of America
MTF	military treatment facility
NCQA	National Committee for Quality Assurance
PCM	primary care manager
TMA	TRICARE Management Activity

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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

July 31, 2003

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

The Honorable Duncan L. Hunter
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The primary mission of TRICARE, the Department of Defense's (DOD) health care system, is to provide care for eligible active duty personnel, retirees, and dependents. These beneficiaries, currently numbering more than 8.7 million, can receive their care through military hospitals and clinics called military treatment facilities (MTFs) or through TRICARE's civilian provider network. The civilian provider network is developed by managed care support contractors and is designed to complement the availability of care offered by MTFs.[1]

DOD faces new challenges in ensuring that the TRICARE civilian provider network can provide adequate access to care that complements the capabilities of MTFs. In 2003, DOD intends to award new contracts for the delivery of care in the civilian provider network because the current contracts will expire. As a result, the providers who choose to participate in the network may change, while those who remain will operate under new policies and procedures. During this transition, DOD is still responsible for ensuring that the civilian provider network provides adequate access to care, even if beneficiaries must change providers.

[1]MTFs supply most of the health care services TRICARE beneficiaries receive. The military health system was funded at about $26.4 billion for fiscal year 2003. Approximately 20 percent of this amount, $5.2 billion, was budgeted for the TRICARE civilian provider network.

TRICARE also faces beneficiary and provider dissatisfaction with the existing civilian provider network. During April 2002 testimony before the Subcommittee on Personnel of the House Armed Services Committee, beneficiary groups described problems with access to care from TRICARE's civilian providers. Also, providers testified about their dissatisfaction with the TRICARE program, specifying low reimbursement rates and administrative burdens.

In response to these concerns, the Bob Stump National Defense Authorization Act of 2003 required that we review DOD's oversight of the adequacy of the TRICARE civilian provider network.[2] As agreed with the committees of jurisdiction we focused on DOD's oversight and did not assess the adequacy of the network. Also, we analyzed TRICARE Prime, the managed care component of the TRICARE health delivery system. Specifically, we agreed to (1) describe how DOD oversees the adequacy of the civilian provider network, (2) evaluate DOD's oversight of the adequacy of the civilian provider network, (3) describe the factors that have been reported to contribute to network inadequacy, and (4) describe how the new contracts might affect network adequacy. We testified before the Subcommittee on Total Force of the House Committee on Armed Services on March 27, 2003, about our findings at that time.[3]

To describe and evaluate DOD's oversight of the TRICARE civilian provider network, we reviewed and analyzed information from five network adequacy reports submitted between June and October of 2002. We reviewed at least one report from each of the contractors who develop and maintain the network of providers to augment the care provided by MTFs. We also interviewed DOD regional officials, known as lead agents, and MTF officials from 5 of 11 TRICARE regions. In addition, we interviewed officials from each of the four contractors. As part of our assessment of DOD's oversight, we reviewed surveys of beneficiaries and providers, as well as DOD data collection initiatives that could be used by DOD to oversee its civilian provider network. We did not validate the data in the surveys or collection initiatives. We also interviewed officials at TRICARE Management Activity (TMA) in Falls Church, Va., the office with responsibility for ensuring that DOD health policy is implemented, and

[2]Pub. L. No. 107-314, § 712, 116 Stat. 2458, 2588 (2002). See also, H.R. Rep. No. 107-436.

[3]U.S. General Accounting Office, *Defense Health Care: Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weaknesses*, GAO-03-592T (Washington, D.C.: Mar. 27, 2003).

officials at TMA-West, the office that carries out contracting functions, including monitoring the civilian contracts and writing the requests for proposals for the future contracts. To describe factors that may contribute to network inadequacy, we interviewed DOD, contractor, and professional health association officials. In addition, we met with groups representing TRICARE beneficiaries to discuss their concerns. Finally, we reviewed DOD's request for proposals for the new health care contracts and interviewed DOD and contractor officials to determine how the new contracts might affect network adequacy. Appendix I contains more details about our scope and methodology. We conducted our work from June 2002 through July 2003 in accordance with generally accepted government auditing standards.

Results in Brief

To oversee the adequacy of the civilian provider network, DOD has standards that are designed to ensure that the network has a sufficient number and mix of providers, both primary care and specialists, to satisfy TRICARE Prime beneficiaries' needs. In addition, DOD has standards for appointment wait, office wait, and travel times that are designed to ensure that TRICARE Prime beneficiaries have adequate access to care. DOD has delegated oversight of the civilian provider network to lead agents, who are responsible for ensuring that these standards have been met.

DOD's ability to effectively oversee the TRICARE civilian provider network is hindered in several ways. First, the measurement used to determine if there is a sufficient number of providers for the beneficiaries in an area does not always account for the actual number of beneficiaries who may seek care or the availability of providers. In some cases, this may result in an underestimation of the number of providers needed in an area. Second, incomplete contractor reporting on access to care makes it difficult for DOD to assess compliance with these standards. Finally, DOD does not systematically collect and analyze beneficiary complaints, which might assist in identifying inadequacies in the TRICARE civilian provider network. However, DOD has surveys of TRICARE beneficiaries and network providers and automated reporting systems on appointments and referrals that, while not designed specifically for monitoring the civilian provider network, could provide information and potentially improve DOD's ability to oversee the civilian provider network.

DOD and its contractors have reported three factors that may contribute to potential civilian provider network inadequacy: lack of providers in certain geographic locations, low reimbursement rates, and administrative requirements. DOD and contractors have reported long-standing provider

shortages in some geographic areas because providers in certain areas may refuse to join any network. In areas where DOD determines that access to care is severely impaired, DOD has the authority to increase reimbursement rates. Since 2002, DOD has used this authority to increase reimbursement rates in Alaska and Idaho in an attempt to remedy such provider shortages. DOD told us that the contractors have achieved some success in recruiting additional providers by using this authority. Additionally, civilian providers have expressed concerns about TRICARE's reimbursement rates being too low and administrative requirements being too cumbersome. However, while reimbursement rates and administrative requirements may have created dissatisfaction among providers, it is not clear that these factors have resulted in insufficient numbers of providers in the civilian network because the information contractors provide to DOD is not sufficient to measure network adequacy.

The new contracts, which DOD expects to award during the summer of 2003, may result in improved civilian provider network participation by addressing some network providers' concerns about administrative requirements. For example, the new contracts may simplify requirements for provider credentialing and referrals, two administrative procedures providers have complained about. However, according to contractors, the new contracts may also create requirements that could discourage provider participation, such as the new requirement that all network claims submitted by civilian providers be filed electronically. Currently, only about 25 percent of such claims are submitted electronically.

We are recommending that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to improve DOD's oversight of the civilian provider network by ensuring sufficient information is reported to assess network adequacy and by exploring options for evaluating beneficiary complaints and improving provider survey data. In commenting on a draft of this report, DOD concurred with the report's recommendations.

Background

TRICARE has three options for its eligible beneficiaries:

- TRICARE Prime, a program in which beneficiaries enroll and receive care in a managed network similar to a health maintenance organization;
- TRICARE Extra, a program in which beneficiaries receive care from a network of preferred providers; and
- TRICARE Standard, a fee-for-service program that requires no network use.

The programs vary according to the amount beneficiaries must contribute toward the cost of their care and according to the choices beneficiaries have in selecting providers. In TRICARE Prime,[4] the program in which active duty personnel generally must participate, the beneficiaries must select a primary care manager (PCM)[5] who either provides care or authorizes referrals to specialists. Most beneficiaries who enroll in TRICARE Prime select their PCMs from MTFs, while other enrollees select their PCMs from the civilian provider network. Regardless of their status—military or civilian—PCMs may refer Prime beneficiaries to providers in either MTFs or TRICARE's civilian provider network.[6]

Both TRICARE Extra and TRICARE Standard require copayments, but beneficiaries do not enroll with or have their care managed by PCMs. Beneficiaries choosing TRICARE Extra use the same civilian provider network available to those in TRICARE Prime, and beneficiaries choosing TRICARE Standard are not required to use providers in any network. TRICARE Extra and Standard beneficiaries may receive care at an MTF when space is available.

The Office of the Assistant Secretary of Defense for Health Affairs (Health Affairs) establishes TRICARE policy and has overall responsibility for the program. TMA, under Health Affairs, is responsible for awarding and monitoring the TRICARE contracts. DOD has delegated oversight of the civilian provider network to regional TRICARE lead agents. The lead agent for each region coordinates the services provided by MTFs and civilian network providers. The lead agents respond to direction from Health Affairs, but report directly to their respective Surgeons General. In overseeing the network, lead agents have staff assigned to MTFs to provide the local interaction with contractor representatives and respond to beneficiary complaints as needed and report back to the lead agent.

[4]Out of more than 8.7 million eligible beneficiaries, nearly half are enrolled in TRICARE Prime.

[5]A primary care manager is a provider or team of providers at an MTF or a provider in the civilian network to whom a beneficiary is assigned for primary care services when he or she enrolls in TRICARE Prime. Enrolled beneficiaries agree to initially seek all nonemergency, nonmental health care services from these providers.

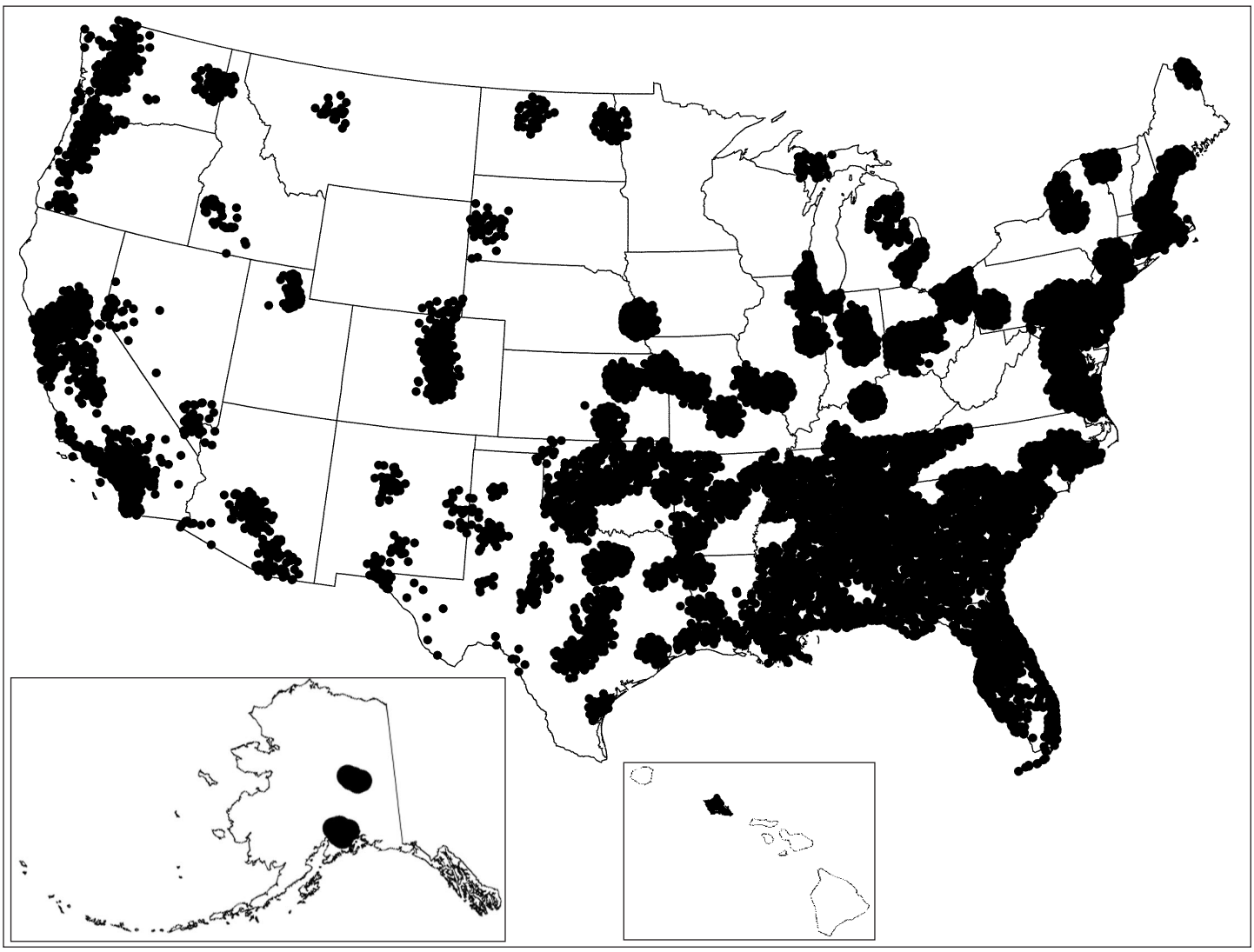
[6]DOD's policy is to optimize the use of the MTF. Accordingly, when a referral for specialty care is made by a civilian PCM, the MTF retains the "right of first refusal" to accommodate the beneficiary within the MTF or refer the beneficiary to the civilian provider network for the needed medical care.

Currently, DOD employs four civilian health care companies or contractors that are responsible for developing and maintaining the civilian provider network that complements the care delivered by MTFs. The contractors recruit civilian providers into a network of PCMs and specialists who provide care to beneficiaries enrolled in TRICARE Prime. Contractors are required to establish and maintain the network of civilian providers in the following locations: all catchment areas,[7] base realignment and closure sites,[8] other contract-specified areas, and noncatchment areas where a contractor deems it cost effective. These locations are called prime service areas. In the remaining areas, a network is not required. (See fig. 1.)

[7]Catchment areas are geographic areas determined by the Assistant Secretary of Defense for Health Affairs that are defined by five-digit zip codes, usually within an approximate 40-mile radius of MTFs with inpatient care.

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

Figure 1: Areas of the United States with a TRICARE Network of Civilian Providers



Source: DOD.

Note: Shaded areas represent zip codes in which there was a TRICARE network of civilian providers as of May 2003.

This network of civilian providers also serves as the network of preferred providers for beneficiaries who use TRICARE Extra. In 2002, contractors reported that the civilian provider network included about 37,000 PCMs and 134,000 specialists.

The contractors are also responsible for ensuring adequate access to health care, referring and authorizing beneficiaries for health care, educating providers and beneficiaries about TRICARE benefits, ensuring that providers are credentialed, and processing claims. In their network agreements with civilian providers, contractors establish reimbursement rates and certain requirements for submitting claims. Reimbursement rates cannot be greater than Medicare rates unless DOD authorizes a higher rate.

DOD's four contractors manage the delivery of care to beneficiaries in 11 TRICARE regions. DOD is currently analyzing proposals to award new civilian health care contracts, and when they are awarded in 2003, DOD will reorganize the 11 regions into 3—North, South, and West—with a single contract for each region. Contractors will be responsible for developing a new civilian provider network that will become operational in April 2004. Under these new contracts DOD will continue to emphasize maximizing the role of MTFs in providing care. See appendix II for maps depicting the current and future regions.

DOD Has Standards for Network Adequacy and Requires Contractors' Compliance

DOD has standards intended to ensure that its civilian provider network enhances and supports the capabilities of the MTFs in providing care to millions of TRICARE Prime beneficiaries. DOD requires that contractors have a sufficient number and mix of providers, both primary care and specialists, to satisfy the needs of beneficiaries enrolled in the Prime option. Specifically, it is the responsibility of the contractors to ensure that each prime service area in the network has at least one full-time equivalent PCM for every 2,000 TRICARE Prime enrollees and one full-time equivalent provider (both PCMs and specialists) for every 1,200 TRICARE Prime enrollees.[9]

[9]In addition, all four contractors generally follow the Graduate Medical Education National Advisory Committee recommendation for determining the specialty mix requirements for their network.

In addition, DOD has access-to-care standards that are designed to ensure that Prime beneficiaries receive timely care from providers.[10] Under these standards

- appointment wait times shall not exceed 24 hours for urgent care, 1 week for routine care, or 4 weeks for well-patient and specialty care;
- office wait times shall not exceed 30 minutes for nonemergency care; and
- travel times shall not exceed 30 minutes for routine care and 1 hour for specialty care.[11]

Lead agents are responsible for ensuring that the civilian provider network meets these standards so that all TRICARE Prime beneficiaries in their region have adequate access to health care. To do so, lead agents told us they use network adequacy reports that contractors provide each quarter as the primary tool to oversee the network. According to DOD's operations manual, these reports are to contain information on the status of the network, such as the number and type of specialists; data on adherence to the access standards; a list of civilian and military primary care managers; and the number of their enrollees. The reports may also contain information on steps contractors have taken to address any network inadequacies.

However, because the reporting requirements do not specify a standard process for collecting information on network adequacy, contractors vary in how they obtain this information. For example, lead agents told us that one contractor conducts visits of providers' offices to review appointment wait times, while another contractor uses an automated appointment tracking system to collect this information.

Lead agents told us they also rely on beneficiary complaints to oversee the adequacy of the civilian provider network. Beneficiaries may complain directly to DOD, the contractor, lead agent, or MTF. DOD officials said that when they receive a beneficiary complaint, they direct the complaint to either the contractor, lead agent, or MTF, depending on the subject of the complaint.

[10]DOD does not specify access standards for eligible beneficiaries who do not enroll in TRICARE Prime. However, DOD requires that contractors provide information and/or assist all beneficiaries—regardless of which option they choose—in finding a participating provider in their area.

[11]32 C.F.R. § 199.17(p)(5)(i), (ii), (iv) and (v) (2002).

In addition to these tools, lead agents periodically monitor contractor compliance by reviewing performance related to specific contract requirements, including requirements related to network adequacy. Lead agents also told us they periodically schedule reviews of special issues related to network adequacy, such as conducting telephone surveys of providers to determine whether they are accepting TRICARE Prime patients. In addition, lead agents stated they meet regularly with MTF and contractor representatives to discuss network adequacy.

If lead agents determine that the network is inadequate, the lead agents or TMA may issue enforcement actions to encourage contractors to address deficiencies in their region. However, lead agents told us that few enforcement actions have been issued. During our review, three enforcement actions related to network adequacy were open for the five regions we visited.[12] Lead agents said they prefer to address deficiencies informally rather than take formal actions, particularly in areas where they do not believe the contractor can correct the deficiency because of local market conditions. For example, rather than taking a formal enforcement action, one lead agent worked with the contractor to arrange for a specialist from one area to travel to another area periodically.

DOD's Oversight of the Civilian Provider Network Has Weaknesses, But Additional Tools May Help

DOD's ability to effectively oversee the TRICARE civilian provider network is hindered by (1) flaws in its required provider-to-beneficiary ratios, (2) incomplete reporting on beneficiaries' access to providers, and (3) the absence of a systematic assessment of complaints. Although DOD has required the network to meet established ratios of providers to beneficiaries, the ratios may underestimate the number of providers needed in an area. Similarly, although DOD has certain requirements governing Prime beneficiary access to available providers, the information reported to DOD on this access is often incomplete—making it difficult to assess compliance with the requirements. Finally, when beneficiaries complain about availability or access in the network, these complaints can be directed to different DOD entities, with no guarantee that the complaints will be compiled and analyzed in the aggregate to identify possible trends or patterns and correct network problems. However, DOD has existing surveys and automated reporting systems that, while not

[12]All three enforcement actions were for lack of available providers in certain geographical areas. For example, there were shortfalls of orthopedic surgeons and neurosurgeons in Spokane, Washington.

designed specifically for monitoring the civilian provider network, could provide valuable information and potentially improve DOD's ability to oversee the civilian provider network.

Provider-to-Beneficiary Ratios May Not Account for Actual Number of Beneficiaries or Availability of Providers

The provider-to-beneficiary ratios contractors report to DOD for a prime service area do not always accurately reflect the potential health care workload for that area or the provider capability to deliver the care. In some cases, the provider-to-beneficiary ratios underestimate the number of providers, particularly specialists, needed in an area. This underestimation occurs because in calculating the ratios, some contractors do not include the total number of Prime enrollees within the area. Instead, in some areas contractors base their ratio calculations on the total number of beneficiaries enrolled with civilian PCMs and do not count beneficiaries enrolled with PCMs in MTFs. The ratio is most likely to result in an underestimation of the need for providers in areas in which the MTF is a clinic or small hospital with a limited availability of specialists. For example, the Air Force clinic at Grand Forks, N. Dak. has few specialists on staff and must rely on the civilian provider network for a large proportion of specialist care. In fiscal year 2002, 90 percent of its specialist appointments were referred to the network. In contrast, a large MTF, such as Wright Patterson Medical Center in Dayton, Ohio, has many specialist providers on staff and referred only 2 percent of its specialty appointments to the civilian provider network during fiscal year 2002. Incorporating MTF provider capability and the total number of Prime enrollees into the network assessment would give DOD a more complete and accurate assessment of the adequacy of the network for a geographical area.

Moreover, in reporting whether the network meets the established ratios, contractors do not make the same assumptions about the level of participation on the part of civilian network providers. Contractors generally assume that between 10 to 20 percent of their providers' practices are dedicated to TRICARE Prime beneficiaries. Therefore, if a contractor assumes 20 percent of all providers' practices are dedicated to TRICARE Prime rather than 10 percent, the contractor will need half as many providers in the network in order to meet the prescribed ratio standard. These assumptions may or may not be accurate, and the assumptions have a significant effect on the number of providers required in the network.

Information Reported on Access Standards Was Incomplete

In the network adequacy reports we reviewed, the contractors did not always report all the information required by DOD to assess compliance with the access standards. Specifically, for the network adequacy reports we reviewed from 5 of the 11 TRICARE regions, we found that contractors reported less than half of the required information on access standards for appointment wait, office wait, and travel times. Some contractors reported more information than others, but none reported all the required access information. Contractors said they had difficulties in capturing and reporting information to demonstrate compliance with the access standards. They stated that it was not practical or feasible to document every appointment and office wait time because some beneficiaries make their own appointments directly and provider offices are spread throughout the geographic area.

Beneficiary Complaints Are Not Systematically Collected and Evaluated

Most of the DOD lead agents we interviewed told us that because information on access standards is not fully reported, they monitor compliance with the access standards by reviewing beneficiary complaints. Lead agents and contractors said such complaints may include a beneficiary's inability to get an appointment, having to drive long distances for care, or a provider not accepting new TRICARE Prime patients. Because beneficiary complaints are received through numerous venues, often handled informally on a case-by-case basis, and not centrally evaluated, it is difficult for DOD to assess the extent of any systemic access problems. Separately, TMA has a database of complaints that includes some complaints about access to care. TMA has received these complaints either directly, through DOD's beneficiary survey, or from letters sent by beneficiaries to their congressional representatives. However, the usefulness of the database is limited because it does not capture complaints sent to MTFs, lead agents, or contractors.

While contractor and lead agent officials told us they have received few complaints about network access problems, this small number of complaints could indicate either an overall satisfaction with care or a general lack of knowledge about how or to whom to complain. Additionally, a small number of complaints, particularly when spread among many sources, limits DOD's ability to identify any specific trends of systemic problems related to network adequacy within TRICARE.

The next generation of contracts, called TNEX, may result in a more structured approach to collecting complaint information when implemented in 2004. Under TNEX, the civilian provider network must be accredited in each region by a nationally recognized accrediting

organization, such as the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). These organizations typically require procedures for addressing beneficiary complaints. For example, NCQA guidance requires procedures for registering, responding to, and investigating complaints. It also requires documentation of actions taken to address complaints. JCAHO guidance has similar requirements. Such procedures could provide DOD with a basic structure that in turn could lead to a more systematic means of collecting and evaluating complaint data at the prime service area and regional levels.

Potential Network Oversight Tools

DOD has some tools that, while not designed specifically for monitoring the civilian provider network, could be useful for oversight. For example, the Health Care Survey of DOD Beneficiaries (HCSDB) could be used as a source of information for overseeing civilian provider network adequacy at the national level.[13] This quarterly survey contains specific questions on all beneficiaries' experiences related to access to care.[14] For example, our analysis of the 2000 HCSDB data for all Prime beneficiaries receiving care from civilian providers indicates that over one-third of these beneficiaries waited more than DOD's standard of 1 day for access to a provider for an illness or an injury. However, the survey's sample design does not generally allow for assessing the adequacy of the civilian provider network in most prime service areas and the survey's response rate of 35 percent further limits its usefulness.[15]

In addition to DOD's beneficiary survey, contractors conduct surveys of providers that could assist in DOD's oversight of the civilian provider network. These surveys are intended to assess providers' satisfaction with contractors' performance and other TRICARE requirements. However,

[13]This survey was required by the National Defense Authorization Act for Fiscal Year 1993, Pub. L. No. 102-484, § 724, 106 Stat. 2315, 2440 (1992).

[14]These questions ask how many days a beneficiary had to wait to see a provider for regular or routine care and how long they had to wait to receive treatment for an injury or illness, among other things. Also, DOD recently added questions to the survey specifically aimed at beneficiaries receiving care from civilian providers. These questions ask how difficult it was to obtain care and locate a doctor, and whether a civilian provider had left the network.

[15]Even though DOD samples 180,000 beneficiaries annually, the 35 percent response rate reduces the sample to about 63,000. As a result the survey estimates may be biased if those who responded to the survey are not representative of the entire surveyed population.

these surveys have very low response rates, ranging from 4 to 19 percent, and in some cases they reflect unrepresentative samples of providers. For example, one contractor surveyed only those providers who participated in a contractor-sponsored seminar. Also, we found considerable variation among the survey instruments, with some assessing provider satisfaction more thoroughly than others. Despite these weaknesses, if improved, the surveys could reveal concerns providers may have about participating in the TRICARE network. This in turn could help DOD address these concerns and mitigate problems that might affect the adequacy of the network.

In addition to these existing surveys, DOD is piloting two initiatives for collecting information on meeting access standards that could help in the oversight of network adequacy. The first, the Enterprise Wide Referral and Authorization System (EWRAS), which is currently being tested in the Washington D.C. area, captures information on specialty care appointments in MTFs and information on some specialty care appointments in the civilian provider network. DOD officials said they expect EWRAS to be fully implemented in Spring 2004. The second initiative, the Access to Care (ATC) Project, gathers information on appointments and specialty referrals at or originating from MTFs. Specifically, it captures data on whether beneficiaries had a referral, declined an appointment that was available, cancelled an appointment, or left without being seen. It also records the average number of days between when the appointment was made and when the beneficiary was seen, as well as clinic cancellations and future appointments. This information can help indicate the extent to which MTFs are meeting the appointment wait-time access standards. Although the ATC Project is currently being piloted at four MTFs, a similar system, if modified to accommodate the requirements of the contractors for the civilian provider network, could provide valuable information on appointment wait time standards—information that is necessary for overseeing the adequacy of the network.

DOD and Contractors Report Three Factors That May Contribute to Civilian Provider Network Inadequacy

DOD and its contractors have reported three factors that may contribute to potential civilian provider network inadequacy: lack of providers in certain geographic locations, low reimbursement rates, and administrative requirements. First, DOD and contractors have reported regional shortages for certain types of specialists in rural areas. For example, they reported shortages for endocrinologists in the Upper Peninsula of Michigan, dermatologists in New Mexico, and neurologists and allergists in Mountain Home, Idaho. Additionally, in these instances, TRICARE officials

and contractors have reported difficulties in recruiting providers into the TRICARE Prime network because in some areas providers, notably specialists, will not join managed care programs. For example, contractor network data indicate that there have been long-standing specialist shortages in TRICARE in areas such as Alaska or eastern New Mexico, where the lead agent stated that the providers in those locations have repeatedly refused to join any managed care network.

There are certain geographic locations in which DOD has confirmed shortages of providers and has raised TRICARE's reimbursement rates as a means of remedying such shortages. Although by statute DOD generally cannot pay TRICARE network providers more than they would be paid under the Medicare fee schedule,[16] DOD may make payments of up to 115 percent of the Medicare fee to ensure the availability of an adequate number of qualified healthcare providers.[17] In 2000, DOD increased reimbursement rates in rural Alaska in an attempt to entice more providers to join the network. Similarly, in 2002, DOD increased reimbursement rates for the rest of Alaska, and in 2003, DOD increased the rates for selected specialists in Idaho to address documented network shortcomings. These three instances are the only times DOD has used its authority to pay above the Medicare rate in order to address local area provider shortages,[18] and the increases have had mixed success. In 2001, for instance, we found that the 2000 rate increase in rural Alaska had not increased provider participation.[19] On the other hand, DOD officials told us that with the 2002 increase in Alaska and the 2003 increase in Idaho, contractors were experiencing some success in recruiting providers in those areas. According to DOD officials, for example, six neurosurgeons in Boise, Idaho agreed to join the network, eliminating the neurosurgeon shortfall in that prime service area. In Alaska, DOD officials reported that

[16]10 U.S.C. § 1079(h)(1) (2000).

[17]10 U.S.C. § 1097b (2000).

[18]DOD officials told us that all requests received by Health Affairs to increase rates have been approved. Additionally, there are two other instances in which DOD increased its reimbursement rates above Medicare's, but these increases did not address local area shortages. In 1997, DOD increased national reimbursement rates for obstetrical care. In April 2002, DOD adopted a policy that will authorize a 10 percent bonus payment to selected TRICARE providers working in medically underserved areas as defined by the Health Resources and Services Administration, consistent with Medicare payment policy. DOD plans to implement the bonus payment in July 2003.

[19]U.S. General Accounting Office, *Defense Health Care: Across-the-Board Physician Rate Increase Would Be Costly and Unnecessary*, GAO-01-620 (Washington, D.C.: May 24, 2001).

since the reimbursement rate increased, providers for radiology, thoracic surgery, pediatrics, and other specialties have stated they will participate in TRICARE.

The general levels of TRICARE's reimbursement rates are another factor that DOD and contractor officials told us may contribute to civilian provider network inadequacy. Specifically, according to contractor officials, civilian network providers have expressed concerns about the decline in Medicare fees in 2002 and the potential for further reductions, which they have said will affect their participation in the network. In addition, there have been reported instances in which groups of providers have banded together and refused to accept TRICARE Prime patients due to their concerns with low reimbursement rates. One contractor identified low reimbursement rates as the most frequent cause of provider dissatisfaction. In addition to provider complaints, beneficiary advocacy groups, such as the Military Officers Association of America (MOAA), have cited instances of providers refusing care to beneficiaries because of low reimbursement rates. However, while TRICARE's reimbursement rates may have created dissatisfaction among providers, it is not clear how much this has affected civilian provider network adequacy except in limited geographic locations, because the information contractors provide to DOD is not sufficient to measure network adequacy. Additionally, there are indications that reimbursement rates have little influence on providers' decisions to leave the TRICARE network. Data from one contractor indicated that out of the 2,156 providers who left the network between June 2001 and May 2002, 900 providers cited reasons for leaving and only 10 percent of these cited reimbursement rates as a reason for leaving the network.

Contractors report that providers have also expressed dissatisfaction with some TRICARE administrative requirements, such as credentialing and preauthorizations and referrals—but the effect of these requirements on civilian provider network adequacy is also unclear. For example, many providers have complained about TRICARE's credentialing requirements. In TRICARE, a provider must get recredentialed every 2 years, compared to every 3 years for the private sector. Providers have said that this places cumbersome administrative requirements on them.

Another widely reported concern about TRICARE administrative requirements relates to preauthorization and referral requirements. Civilian PCM providers are required to get preauthorizations from MTFs before referring patients for care. While preauthorization is a standard managed care practice, providers complain that obtaining

preauthorization adversely affects the quality of care provided to beneficiaries because it takes too much time. In addition, civilian PCMs have expressed concern that they cannot refer beneficiaries to the specialist of their choice because of MTFs' "right of first refusal" that gives an MTF discretion to care for the beneficiary or refer the care to a civilian provider. Nevertheless, there are not direct data confirming that administrative burdens translate into widespread civilian provider network inadequacies. Further, when reviewing one contractor's survey of providers who left the network, we found that only 1 percent of providers responding cited administrative burdens as a factor.

New Contracts May Address Some Network Concerns, But May Create Others

DOD's new contracts for providing civilian health care, called TNEX, may address some network concerns raised by providers and beneficiaries, but may create other areas of concern. Because the new contracts had not yet been finalized as of June 2003, the specific mechanisms DOD and the contractors will use to ensure network adequacy are not known. Under TNEX, DOD plans to retain the requirement that the civilian provider network complement the clinical services provided by MTFs; the access standards for appointment and office wait times, as well as travel-time standards; and the periodic reporting on the adequacy of the network. However, the requirement to use provider-to-beneficiary ratios to measure network adequacy will be eliminated, although such ratios may be used during the network accreditation process.

Further, TNEX contains a provision intended to encourage contractors to develop an adequate civilian provider network. This provision states that at least 96 percent of contractor referrals shall be to a MTF or network provider with an appointment available within the access standards. Failure to achieve the 96 percent standard will affect contractors financially.

TNEX may reduce the administrative burden related to provider credentialing and patient referrals. Currently, civilian network providers must follow TRICARE-specific requirements for credentialing. In contrast, TNEX will allow network providers to be credentialed through a nationally recognized accrediting organization. DOD officials stated this approach is more in line with industry practices. Patient referral procedures will also change under TNEX. Referral requirements will be reduced, but the MTFs will still retain the right of first refusal.

On the other hand, TNEX may be creating a new administrative concern for contractors and providers by requiring that all network claims

submitted by civilian providers be filed electronically.[20] In fiscal year 2002, only 25 percent of processed claims were submitted electronically.[21] Contractors stated that such a requirement could discourage providers from joining or staying in the network because providers may not be willing to modify their systems to submit electronic claims for a small volume of TRICARE beneficiaries. DOD states that electronic filing will reduce claims-processing costs.

Conclusions

DOD spends over $5 billion a year for health care delivered by the network of civilian providers to complement care provided in the MTFs; however, DOD has exercised limited oversight of the adequacy of the civilian provider network. The information DOD relies on to assess the network does not always accurately reflect the actual numbers of beneficiaries or availability of providers. Further, the contractors do not report comprehensive data on the network's compliance with DOD's access standards, which are key benchmarks in assessing network adequacy. This information will be important as DOD oversees the transition to the new health care delivery contracts.

Incorporating data on the numbers and types of providers in the MTFs and the total number of beneficiaries enrolled in TRICARE Prime would give DOD a more accurate and comprehensive report of the potential workload the civilian provider network faces in a prime service area and the adequacy of the number of PCMs and specialists to deliver that care. Similarly, more thorough reporting on beneficiaries' access to care within the standard time frames and development of a more systematic means of collecting and evaluating complaint data would help DOD's oversight of the ability of the civilian provider network to deliver timely care to beneficiaries. Further, with improvements in response rates and provider representation, the civilian provider satisfaction surveys could also be useful in identifying actions DOD and the contractors could take to address provider concerns and ensure network stability.

[20]The Health Insurance Portability and Accountability Act of 1996 included provisions for the establishment of standards and requirements for the electronic transmission of health information. Pub. L. No. 104-191, § 262, 110 Stat. 1936, 2021. Effective October 16, 2003, Medicare claims generally must be submitted electronically.

[21]This percentage does not include pharmacy claims or claims for care provided to Medicare-eligible beneficiaries under TRICARE For Life.

Recommendations for Executive Action

To improve DOD's oversight of the civilian provider network, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to

- ensure that MTF capabilities and all enrolled Prime beneficiaries in prime service areas are accounted for when assessing and documenting the adequacy of the civilian provider network;
- ensure that the information reported on the required access standards is sufficient and reliable;
- explore ways to ensure that beneficiary complaints are systematically evaluated and used to oversee the civilian provider network; and
- explore options for improving the civilian provider surveys so that the results of the surveys could be useful to DOD and the contractors in identifying civilian provider concerns and developing actions that might mitigate concerns and help ensure the adequacy of the civilian provider network.

Agency Comments and Our Evaluation

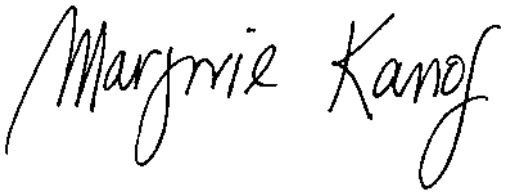
DOD provided written comments on a draft of this report. (See app. III.) DOD concurred with the report's recommendations.

In its written comments, DOD stressed that strong oversight of the civilian provider network is necessary and should be continuously monitored for improvements. DOD said that the implementation of TNEX will address many of the points raised in our report. DOD said TNEX will enhance the reporting of information about network adequacy as well as provide powerful financial incentives for contractors to optimize the direct care system, maximize the extent of civilian provider networks, and achieve the highest level of beneficiary satisfaction. However, since the TNEX contracts have not been finalized as of July 2003, it is too early to assess whether the contracts will result in improved oversight.

In its written comments DOD also said that the report title might mislead some into concluding that we found the TRICARE network to be inadequate. As we noted in the draft report, we did not assess the adequacy of the civilian provider network but focused our work on DOD's oversight of the network. We believe the title of the report reflects that focus.

DOD also provided technical comments, which we incorporated into the report as appropriate.

We are sending copies of this report to the Secretary of Defense, appropriate congressional committees, and other interested parties. Copies will also be made available to others upon request. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov. If you or your staff have questions about this report, please contact me at (202) 512-7101. Other contacts and staff acknowledgments are listed in appendix IV.



Marjorie E. Kanof
Director, Health Care—Clinical
and Military Health Care Issues

Appendix I: Scope and Methodology

To describe and evaluate DOD's oversight of the adequacy of the civilian provider network, we reviewed and analyzed the information in the quarterly network adequacy reports submitted by each contractor. We identified the requirements for the content of these adequacy reports based upon the general requirements in the TRICARE Operations Manual and the additional requirements in contractors' Best and Final Offers. We reviewed the contents of five of the contractors' quarterly network adequacy reports, submitted between June 2002 and October 2002, and compared them to the applicable reporting requirements. Each report was evaluated for compliance regarding the provider-to-beneficiary ratios and the access-to-care standards.

Because DOD has delegated the oversight of the network to the regional lead agents, we discussed civilian provider network oversight with officials in 5 of the 11 TRICARE regions—Northeast, Mid-Atlantic, Heartland, Central, and Northwest. To discuss network management, we interviewed officials from the four contractors—HealthNet, Humana, Sierra, and TriWest—that are responsible for developing and maintaining the provider network that augments care provided by DOD's MTFs. Because concerns regarding network adequacy may also be identified at the local level, we met with lead agent and contractor officials at MTFs in each of the regions we visited. Finally, we interviewed officials at TMA in Falls Church, Va., the office that is responsible for ensuring that DOD health policy is implemented, and officials at TMA-West in Aurora, Colo., the office that carries out contracting functions, including monitoring the civilian contracts and writing the request for proposals for the future contracts.

As part of our assessment of DOD's oversight, we also reviewed surveys of beneficiaries and providers, as well as DOD data collection initiatives as potential tools for overseeing DOD's civilian provider network, but did not validate the data in the surveys or collection initiatives. Using annual data from the 2000 HCSDB, we analyzed beneficiaries' responses to access-to-care questions for those who were enrolled in Prime and received most of their health care in the civilian provider network. We examined the results of access-to-care questions based on whether or not these beneficiaries were seen within the TRICARE access-to-care standards. Because we included only Prime beneficiaries who received care in the civilian provider network, our analysis of access to care does not reflect the entire survey sample. To examine the provider surveys as potential oversight tools, we obtained and reviewed each contractor's 2001 provider survey and assessed the survey's response rate, sample selection, and the

instrument itself. We also discussed DOD initiatives underway and being tested with cognizant officials to assess their potential as oversight tools.

To describe factors that may contribute to network inadequacy, we interviewed and obtained documentation from DOD and contractor officials regarding current network inadequacies, including their location, duration, and the type of specialty needed. We also obtained provider termination reports from three of the four contractors,[1] which described providers' reasons for leaving the network. To further explore DOD's response to civilian provider concerns regarding rates, we interviewed DOD officials on the use of their authority to raise reimbursement rates. We also interviewed officials from the American Medical Association, The Military Coalition, the MOAA, the National Association for Uniformed Services, and the National Veteran's Alliance to supplement data on the possible causes of network inadequacy.

Finally, we reviewed DOD's request for proposals for the future contracts and interviewed DOD and contractor officials to describe how the new contracts might affect network adequacy.

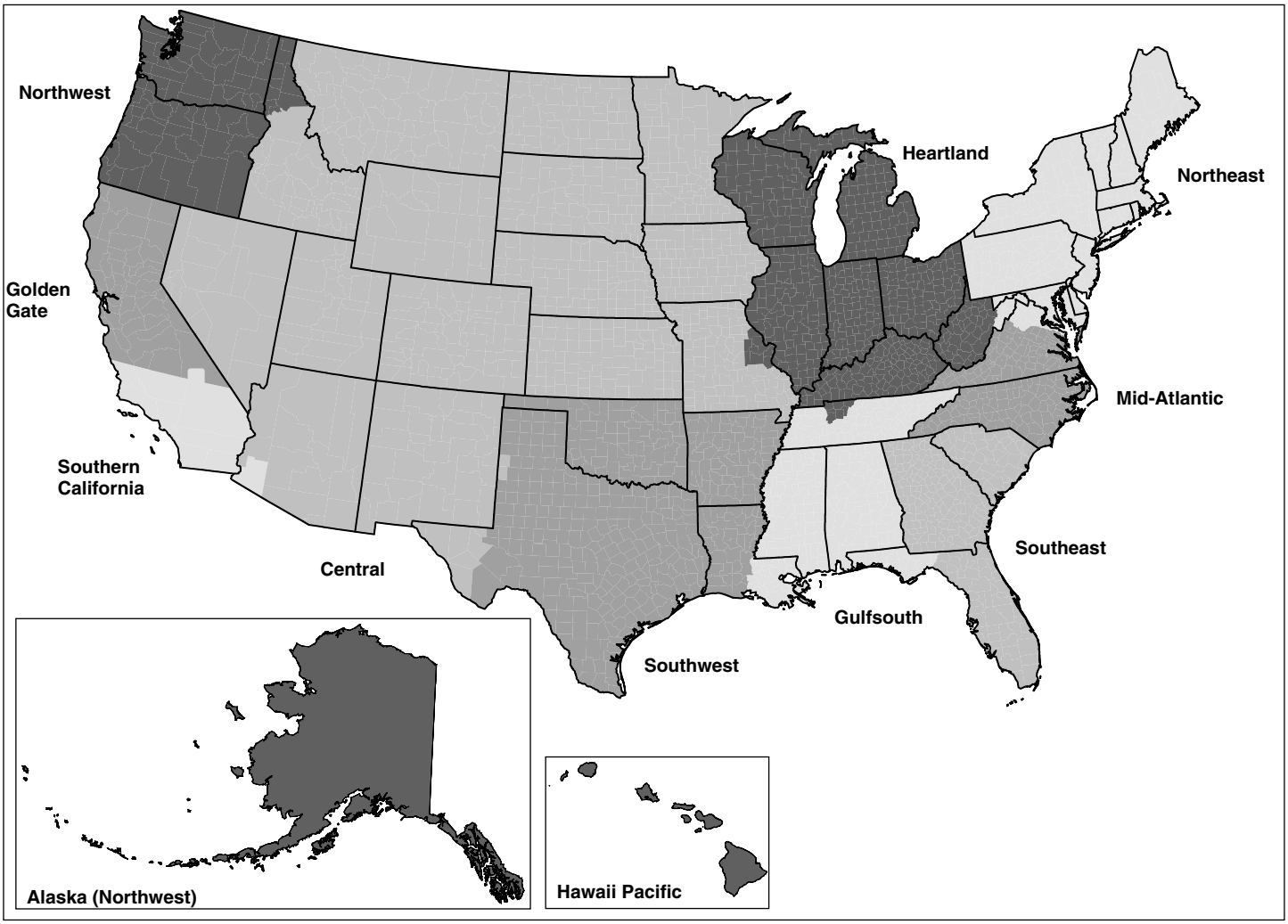
We conducted our work from June 2002 through July 2003 in accordance with generally accepted government auditing standards.

[1]One contractor does not collect data on provider terminations.

Appendix II: Comparison of Current and Future TRICARE Regions

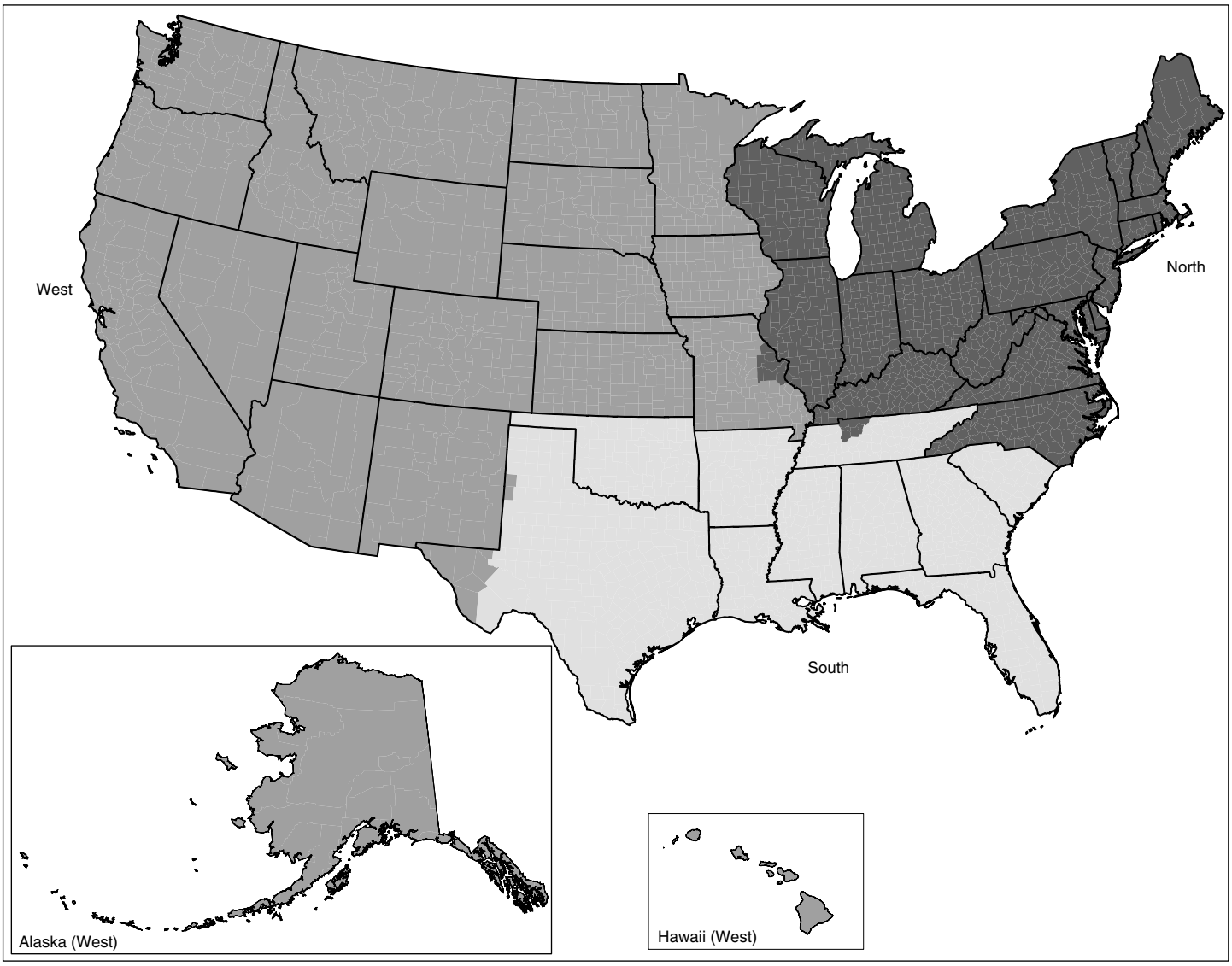
The shaded areas in figure 2 represent the 11 current TRICARE geographic regions. The shaded areas in figure 3 represent the 3 planned TRICARE geographic regions under the TNEX contracts expected to be awarded in 2003.

Figure 2: Current TRICARE Regions



Source: DOD.

Figure 3: Future TRICARE Regions After TNEX Implementation



Source: DOD.

Appendix III: Comments from the Department of Defense

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

JUL 28 2003

Ms. Marjorie E. Kanof
Director, Health Care-Clinical and Military Health Care Issues
U.S. General Accounting Office
441 G Street, N.W., Washington D.C. 20548

Dear Ms. Kanof:

This is the Department of Defense (DoD) response to the Draft Report, GAO-03-928 "DEFENSE HEALTH CARE: Oversight of the TRICARE Civilian Provider Network Should Be Improved." dated July 2, 2003 (GAO Code 290203).

Thank you for the opportunity to review and comment on this draft report. Access to healthcare is one of my highest priorities. We appreciate your review and recommendations for improvements in measuring and monitoring of network adequacy that would result in demonstrated enhancements to our current efforts. We are very pleased to note that GAO did not uncover any specific instances of inadequate networks that had not already been identified and addressed by the Lead Agents, the managed care support contractors, and TRICARE Management Activity staff.

The implementation of the next generation of TRICARE contracts (T-Nex) will address many of the points raised in your report. T-Nex will enhance the reporting of information about network adequacy as well as powerful financial incentives for contractors to optimize the direct care system, maximize the extent of civilian provider networks, and achieve the highest level of beneficiary satisfaction. Taken together these enhances will ensure the highest quality and access for TRICARE beneficiaries.

Overall, although I concur with the findings of the audit, improvements are already being implemented by my office. Strong oversight of the civilian provider networks is necessary and should be continuously monitored for improvements. A number of initiatives are being considered with the intent of improving beneficiary access to the civilian networks. Detailed DoD comments on the report recommendations are provided in the enclosure. Also provided are several technical comments for your consideration to strengthen the report.

Although oversight can and will be improved, I do find the title of the report misleading in that it might lead some to conclude that GAO finds TRICARE networks inadequate in some respects, which is not the case. Access problems for TRICARE beneficiaries are rare and typically relate to a lack of specialty providers in a rural area rather than a TRICARE unique problem. Finally, I believe that our current approach to assuring network adequacy is working, but I endorse your suggestions for improving it. Our approach under T-Nex will mirror GAO's recommendations.

Please feel free to address any questions to my project officer on this matter, Mr. Michael Talisnik, TMA/Regional Operations at (703) 681-0064 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-3492.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

GAO DRAFT REPORT – DATED JULY 2, 2003
(GAO CODE 290203)

"DEFENSE HEALTH CARE: OVERSIGHT OF THE TRICARE CIVILIAN PROVIDER NETWORK SHOULD BE IMPROVED"

DEPARTMENT OF DEFENSE COMMENTS

RECOMMENDATION 1: Ensure that MTF capabilities and all enrolled Prime beneficiaries in Prime service areas are accounted for when assessing and documenting the adequacy of the civilian provider network.

RESPONSE: Concur. Under T-Nex, the next generation of TRICARE contracts, the contractor will be required to ensure that the adequacy of the network shall be sufficient in number, mix, and geographic distribution to provide the TRICARE benefit for all Prime enrollees and to complement the MTF. As noted below, any instance of network inadequacy must be reported, together with a corrective action plan, within 24 hours.

The report identifies a theoretical possibility that failure to consider the needs of MTF enrollees for civilian specialty care could result in network shortcomings. There are current variations across the country in the methods used by our contractors to compute the sizing of the civilian network. Local monitoring is occurring with Lead Agent and contractors working together to address any network shortages. While GAO did not identify any actual shortages arising from this, we have included a provision in upcoming contracts to avoid any possibility of this occurring.

RECOMMENDATION 2: Ensure that the information reported on the required access standards is sufficient and reliable.

RESPONSE: Concur. Under current contract requirements, the contractors are required to report every quarter on the adequacy of the networks and that TRICARE's access standards are being met by civilian providers. There is local variation in our ability to collect all information about every healthcare visit. However, Lead Agents and contractors actively monitor network adequacy and act promptly to correct any deficiencies.

Under T-Nex, the contractor is required to inform the Government within 24 hours of any instance of network inadequacy relative to the Prime and/or Extra service areas and shall submit a corrective action plan with each notice of an instance of network inadequacy. Network inadequacy is defined as any failure to meet the access standards.

Additionally, as indicated in the report, the Government has included a performance guarantee clause in the contract requirement stipulating a monthly report for referrals failing the access standard. These reports will give additional insight as to whether access standards are being met.

RECOMMENDATION 3: Explore ways to ensure that beneficiary complaints are systematically evaluated and used to oversee the civilian provider network.

RESPONSE: Concur. The Department has been collecting data since April 2001 concerning the volume of beneficiary calls to the TRICARE Information Center, as well as written correspondence. This information is sorted into various categories (such as Region, Eligibility, Enrollment Status, and Issue to name a few). We are currently working to enhance our own data collection process (to expand beyond just being limited to complaints) so we can identify trends, problems et cetera and are proactive rather than reactive. A working group will be established soon to identify existing data, set collection criteria, compile the results in a usable format and periodically provide trend analysis to decision makers to assist in their management of the health care plan.

RECOMMENDATION 4: Explore options for improving the civilian provider surveys so that the results of the surveys could be useful to DoD and the contractors in identifying civilian provider concerns and developing actions that might mitigate concerns and help ensure the adequacy of the civilian provider network.

RESPONSE: Concur. The Department recognizes the potential value in soliciting civilian provider concerns. Currently, DoD is conducting first time provider and employee surveys focused solely within the Direct Care system. DoD expects results from these surveys this calendar year. In addition, under T-Nex contractors will be eligible for performance award fees based on beneficiary and MTF Commander satisfaction. A key component is ensuring that the network is adequate.

Upon review of the results of these surveys, to include a determination of the usefulness of the instruments, findings and the response rates, DoD will decide whether or not to conduct similar surveys within the Purchased Care system.

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contacts

Kristi Peterson, (202) 512-7951
Allan Richardson, (404) 679-1863

Acknowledgments

In addition to those named above, contributors to this report were Louise Duhamel, Marc Feuerberg, Krister Friday, Gay Hee Lee, John Oh, and Marie Stetser.

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