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DEFENSE HEALTH CARE

Medicare Costs and Other Issues May Affect Uniformed Services Treatment Facilities' Future

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

Since fiscal year 1994, the Congress has appropriated nearly $1 billion for the Uniformed Services Treatment Facilities (USTF) to deliver health care to what now totals about 124,000 beneficiaries. In 1982, the Congress enacted legislation that designates 10 former Public Health Service hospitals now under civilian ownership as USTFs and makes them part of the Department of Defense's (DOD) health care system.[1] This arrangement with DOD has guaranteed the USTFs, in addition to their private health care business, a stable revenue source by enabling them to provide care to uniformed services beneficiaries.[2] The arrangement also has improved eligible USTF members' access to low-cost, comprehensive health care. The USTFs' deemed status will expire in September 1997 unless the Congress intervenes.[3]

In recent years, the Congress has grown concerned about the increased cost to treat USTF members, in part because some members retain dual eligibility and unrestricted access to such other government health care services as Medicare, CHAMPUS,[4] and DOD hospitals. As a result, in 1991, the Congress directed DOD to institute a managed care plan to reform the USTF program. The USTF managed care program has been in effect since October 1993. Even with this change, questions have arisen about the USTF

[1]The Military Construction Authorization Act of 1982, section 911 (42 U.S.C. 248c), deemed these facilities to be facilities of the uniformed services.

[2]The uniformed services include the Army, Navy, Marine Corps, Air Force, Coast Guard, and the Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration. USTFs provide care to active duty dependents and retirees of these uniformed services as well as to retired lighthouse keepers and retirees and dependents of the National Ocean Service.

[3]The National Defense Authorization Act of Fiscal Year 1996, P.L. 104-106, section 721. The Congress has periodically enacted delays in the termination of the deemed status since the program's inception in 1982.

[4]CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) is a fee-for-service health insurance program that pays for a substantial part of the health care that civilian hospitals, physicians, and others provide to non-active duty DOD beneficiaries.

program's future as DOD moves to implement its new nationwide managed care program, known as TRICARE.

DOD began to implement TRICARE in 1993 to improve beneficiary access to high-quality health care while containing costs. TRICARE calls for coordinating and managing beneficiary care on a regional basis using all available military hospitals and clinics, supplemented by contracted civilian services. DOD expects to have TRICARE fully implemented by September 1997.

At your request, we looked at issues regarding the USTFs' integration into TRICARE, namely

- whether unnecessary costs result from USTF members' use of other federally funded health care sources and
- what other issues need to be considered during congressional deliberations on reauthorizing the USTF program.

To do our work, we examined the legislative history of the USTFs and the Medicare and USTF laws. We reviewed DOD policies and regulations affecting the USTFs, and our prior studies on USTF operations as well as those conducted by the DOD Inspector General, DOD consultants, the Congressional Budget Office, and the Institute for Defense Analyses. We obtained and analyzed data from DOD; the USTFs; and the Health Care Financing Administration (HCFA), which administers Medicare, regarding USTF members' Medicare, military treatment facility, and CHAMPUS usage. Fiscal year 1994 was the only year, at the time of our work, for which sufficient data were available on the extent of USTF members' Medicare usage. We interviewed DOD, HCFA, and USTF officials regarding USTF program operations and the USTFs' future under TRICARE; unnecessary Medicare payments; and USTF members' use of military treatment facilities and CHAMPUS. We did our work from August 1995 through April 1996 in accordance with generally accepted government auditing standards. A more detailed discussion of our scope and methodology is in appendix I.

Results in Brief

In fiscal year 1994, over $9.5 million in unnecessary costs to the government resulted from USTF members' use of Medicare.[5] If the same Medicare usage occurs from the time the USTF managed care program began in fiscal year 1994 until current USTF agreements with DOD end in

[5]Medicare covers some medical services, such as end-stage renal disease treatment, that the USTFs do not. Payments for such services are not included in the unnecessary Medicare payment total.

September 1997, such unnecessary costs could approach $38 million. Some of these payments were made to USTF hospitals themselves and hospitals under contract with the USTFs—hospitals required to bill the USTFs for such care. Although DOD requires Medicare-eligible USTF members to agree on the enrollment form that they will not use Medicare, these beneficiaries are statutorily eligible for care under both programs. DOD does not have explicit statutory authority to disenroll USTF members for using Medicare or to prevent Medicare from paying any claims submitted for such care. Furthermore, under the current agreement between DOD and the USTFs, the unnecessary Medicare payments cannot be fully recovered. Although DOD has attempted to work with HCFA and the USTFs to address this continuing problem, they have been only partly successful. In contrast, DOD has been able to curb USTF members' use of military treatment facilities and CHAMPUS because DOD has the authority and controls in place to minimize such occurrences.

Other cost and equity issues will also likely affect forthcoming deliberations on the USTF program's reauthorization. One such issue is how to cost-effectively serve USTF members' health needs given DOD's TRICARE implementation and its mandate that the new system's costs be no greater than DOD's current costs under CHAMPUS and in military treatment facilities.[6] Recent reports have indicated that the USTFs may be more costly to the government. In 1996, for example, the Institute for Defense Analyses estimated that the USTF managed care program cost DOD $193 million more per year than what costs would be if the members had to rely for their care on the current military health services system (MHSS).

Another issue is how the USTFs should fit into TRICARE, under which DOD awards a single contract for an area's health care delivered outside military hospitals. Currently, the USTFs have a unique, noncompetitive contractual and operational relationship with DOD. At issue is whether the USTFs should retain that special relationship and, if so, what the cost and equity implications might be for TRICARE.

Background

Currently, 8.3 million people are eligible for medical care from the MHSS:[7] 1.7 million active duty members and 6.6 million non-active duty beneficiaries. As part of the MHSS, USTFs are permitted to enroll any of these beneficiaries, except for active duty members themselves, who

[6]The National Defense Authorization Act for Fiscal Year 1996, P.L. 104-106, section 714.

[7]Includes members of the Coast Guard and the Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration, who are also eligible for military health care.

generally must receive their care at military hospitals or clinics. At the beginning of fiscal year 1996, the USTFs had 124,012 members and an appropriated funding level of $339 million.[8] Table 1 lists the locations, enrollment, and appropriations for each of the USTFs.

Table 1: USTF Enrollment and Appropriation, FY 1996

USTF	Location	FY 1996 enrollment	FY 1996 appropriation
Bayley Seton Hospital	Staten Island, N.Y.	15,772	$53,236,085
Brighton Marine Public Health Care Center	Boston, Mass.	11,892	40,010,161
Johns Hopkins Medical Services Corporation	Baltimore, Md.	23,881	57,020,329
Lutheran Medical Center	Cleveland, Ohio	6,570	13,915,480
Martin's Point Health Care Center	Portland, Me.	18,795	41,340,896
Pacific Medical Center and Clinics	Seattle, Wash.	20,048	58,802,354
Sisters of Charity Hospitals[a]	Texas	27,054	75,022,395
Total		**124,012**	**$339,347,700**

[a]Sisters of Charity Hospitals operates three USTF facilities in Texas (St. John's Hospital, Nassau Bay; St. Joseph's Hospital, Houston; and St. Mary's Hospital, Port Arthur). Sisters of Charity recently sold its fourth USTF facility, St. Mary's Hospital, Galveston, to the University of Texas Medical Branch, and it is no longer a USTF.

The USTFs provide health care under individual participation agreements, which DOD negotiates with each facility on behalf of itself and the Departments of Health and Human Services and Transportation. DOD's USTF program provides only a part of each facility's total business because the facilities also provide services for private insurance, Medicare, and other patients. Beneficiaries who enroll in the USTF program agree on the application form not to use other DOD health care sources or the Medicare program.

In fiscal year 1994, at the Congress' direction, DOD implemented a USTF managed care program to control rising care costs. This program, which is similar to a health maintenance organization (HMO), is characterized by (1) the formation of provider networks to deliver a full spectrum of inpatient and outpatient care, (2) enrollment of beneficiaries, and (3) a

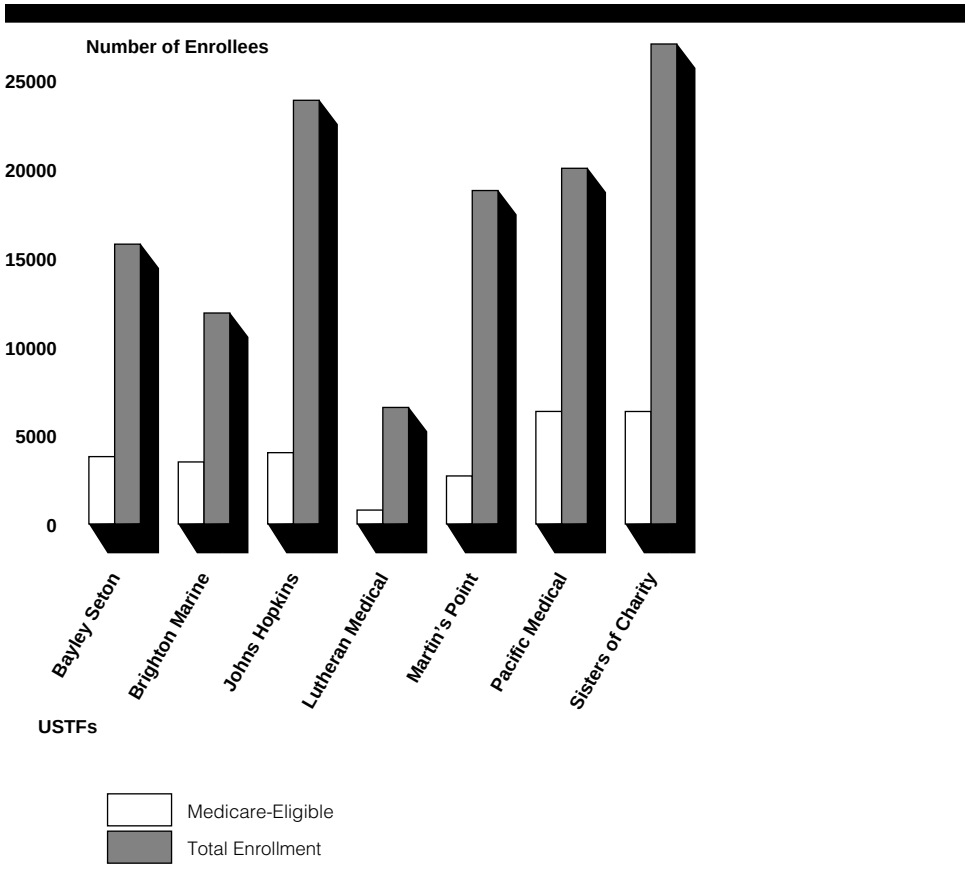
[8]In addition to DOD's covered beneficiaries, this appropriation includes amounts for the Department of Transportation's Coast Guard beneficiaries and the Department of Health and Human Services' Commissioned Corps beneficiaries of the Public Health Service and the National Oceanic and Atmospheric Administration.

capitated reimbursement system under which each USTF is paid a monthly sum for each enrolled member in return for the USTF's provision of all needed care for the member. Appendix II provides more detailed funding and enrollment information.

The capitation payments made to the USTFs are to cover all the medical care a member would need. Thus, if another government program (such as Medicare or CHAMPUS) is billed for any care a USTF member receives and the bill is paid, the government is paying unnecessarily for that care because it has already paid the USTF in advance for all USTF members' care. Similarly, if a USTF member receives care at a military hospital, the government incurs costs unnecessarily for care it has already paid for.

The USTFs offer their members the full CHAMPUS benefit package plus some additional preventive services not already covered by CHAMPUS. But unlike CHAMPUS, USTF members do not lose their participation rights when they reach age 65 and become Medicare-eligible. At the beginning of fiscal year 1996, 22 percent (about 27,000) of the USTF members were Medicare-eligible. Figure 1 shows the breakdown, by facility, of USTF Medicare-eligible members compared with all members.

Figure 1: Medicare-Eligible USTF Members Compared With Total Members, FY 1996



The MHSS is moving from a system of direct care in military facilities and CHAMPUS to TRICARE, DOD's nationwide managed care program. TRICARE implementation is aimed at improving access to high-quality care while containing cost growth. DOD's goal is to have TRICARE implemented nationwide by September 1997. TRICARE involves managing beneficiary care using all available military hospitals and clinics, supplemented by contracted civilian services. TRICARE features three benefit options, offering CHAMPUS-eligible beneficiaries two new additional health care choices: (1) TRICARE Standard, the current fee-for-service CHAMPUS program; (2) TRICARE Extra, a preferred provider option; and (3) TRICARE Prime, an HMO-like alternative that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. The USTF managed care program is

similar to TRICARE Prime. Appendix III contains details about TRICARE's three options.

The fiscal year 1996 National Defense Authorization Act contained a number of provisions relevant to DOD's future relationship with the USTFs. First, it made the participation agreements between the USTFs and DOD subject to the Federal Acquisition Regulation (FAR),[9] from which the USTFs had been previously exempt. Now DOD must seek full and open competition from all qualified managed care providers for the services previously procured on a sole source basis from the USTFs.[10] Second, the act directed DOD to submit a plan to the Congress addressing the USTFs' integration into TRICARE. Third, the act requires the USTFs to adopt TRICARE's enrollment fees and copayments after October 1, 1996, or the implementation of TRICARE in the USTF service area, whichever is later. In that regard, the act directed us to assess and report to the Congress the effects of adopting such fees and copayments on USTF operations, provided that the USTFs submitted actuarial estimates in support of their contention that the extension of such fees and copayments will have an adverse impact on the operation of the USTFs and the enrollment of participants.[11]

Unnecessary Costs Result From USTF Members' Use of Medicare

For fiscal year 1994, HCFA paid over $9.5 million for USTF members' use of Medicare services. If the same Medicare usage continues, such unnecessary costs could approach $38 million when the current USTF agreements with DOD end in September 1997. Unnecessary costs result when USTF members, for whose care DOD has prepaid the USTFs a monthly capitation payment, use Medicare. One reason for this is that federal statute does not bar USTF members from using both types of care. In other cases, members may use USTF providers who inappropriately bill Medicare. Recognizing this, HCFA has agreed to share its Medicare reimbursement data with DOD so that some cost recovery can be effected from the USTFs. But under the current DOD and USTF agreements, DOD cannot fully recover the unnecessary Medicare costs and to date has not recovered any of these costs. In contrast, DOD can prevent unnecessary payments from USTF members' use of military treatment facilities and CHAMPUS.

[9]Federal Acquisition Regulation, 48 C.F.R. Part 1.

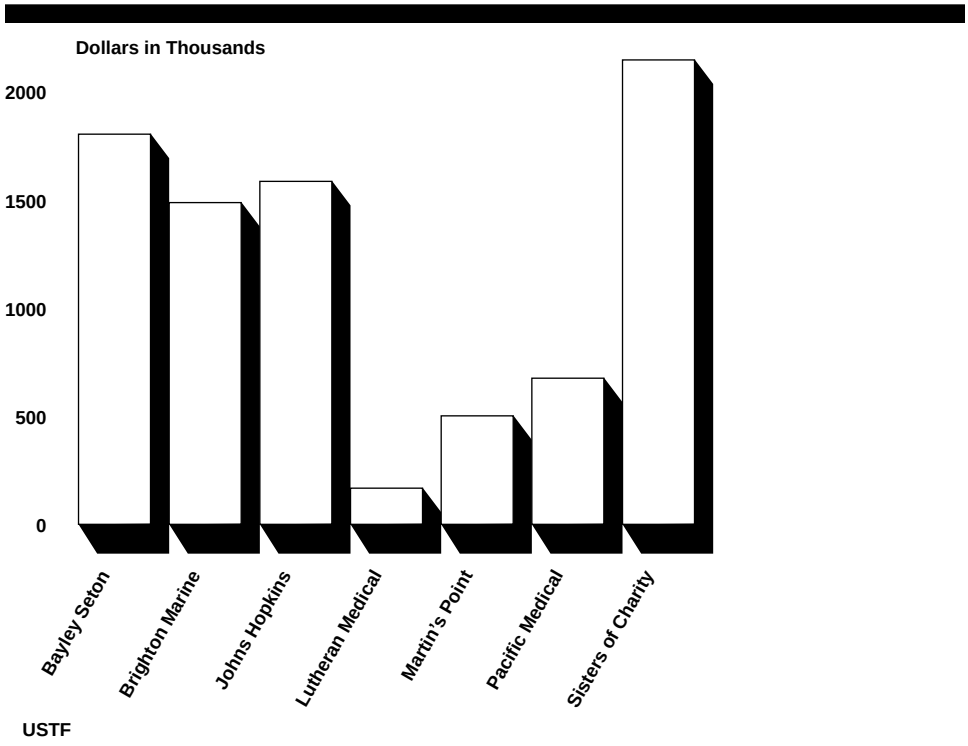
[10]The National Defense Authorization Act for Fiscal Year 1996 applies the requirements regarding competition to any new participation agreement between DOD and the USTFs upon the expiration of the current participation agreements (P.L. 104-106, section 724).

[11]See Defense Health Care: Effects of Mandated Cost Sharing on Uniformed Services Treatment Facilities Likely to Be Minor (GAO/HEHS-96-141, May 13, 1996).

Millions of Dollars Needlessly Paid for USTF Members' Medicare Use

The unnecessary Medicare payments totaling over $9.5 million made for USTF members' health care in fiscal year 1994 are shown in figure 2. The payments are aggregated by the USTF in which members were enrolled.

Figure 2: Unnecessary Medicare Payments Made for USTF Members, by Facility Membership, FY 1994

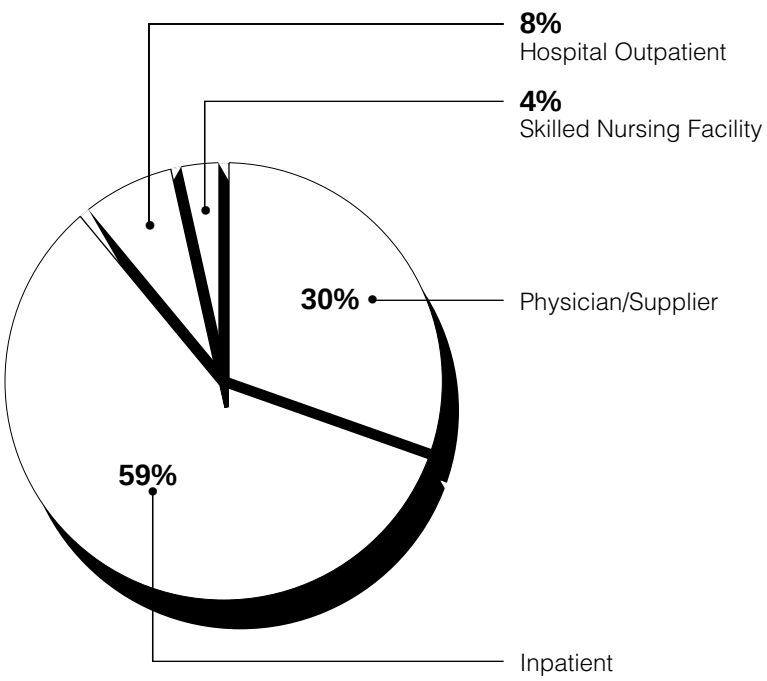


Notes: Sisters of Charity includes four hospitals.

This figure does not include $1.2 million in physician services for USTF members whose place of enrollment could not be verified.

These Medicare payments cover such medical services as care received in both inpatient and outpatient settings as well as physician services and skilled nursing facilities. Because Medicare covers some medical services that the USTFs do not, such as end-stage renal disease treatment and chiropractic care, we did not include such services in our analysis. For a more detailed description of our analysis, see appendix I. Figure 3 shows unnecessary Medicare payments for fiscal year 1994 by type of medical service.

Figure 3: Unnecessary Medicare Payments, by Service Category, FY 1994

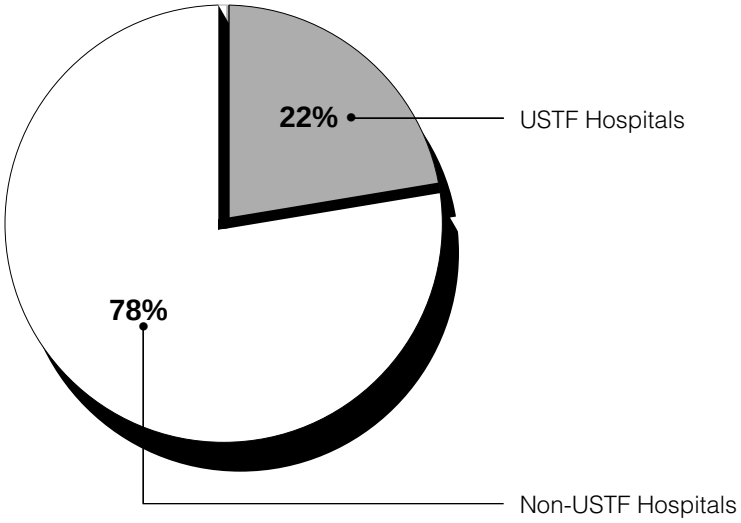


Note: Numbers add to more than 100 percent because of rounding.

As shown in figure 3, 67 percent, or $6.3 million, of the unnecessary Medicare payments were for inpatient and outpatient care. USTF members receive such care at USTF hospitals or at hospitals under contract to the USTFs. Although the hospitals under contract to the USTFs have agreed to bill the USTFs for medical services to USTF members, no control exists to prevent them, or the USTFs themselves, from billing Medicare if the member is also Medicare-eligible. In these cases, non-USTF hospitals have no knowledge that Medicare-eligible patients are USTF members unless the members specifically tell them. Our analysis showed that 78 percent of the payments were in this category. Conversely, 22 percent ($1.4 million) of the unnecessary Medicare payments for USTF members' inpatient and outpatient care were made to USTF hospitals, as shown in figure 4. At present, DOD is not aware of such inappropriate billings by USTF hospitals and their affiliates. Thus, we believe DOD needs to review the USTF entities'

billing practices to ensure that Medicare is not continuing to pay for such services.

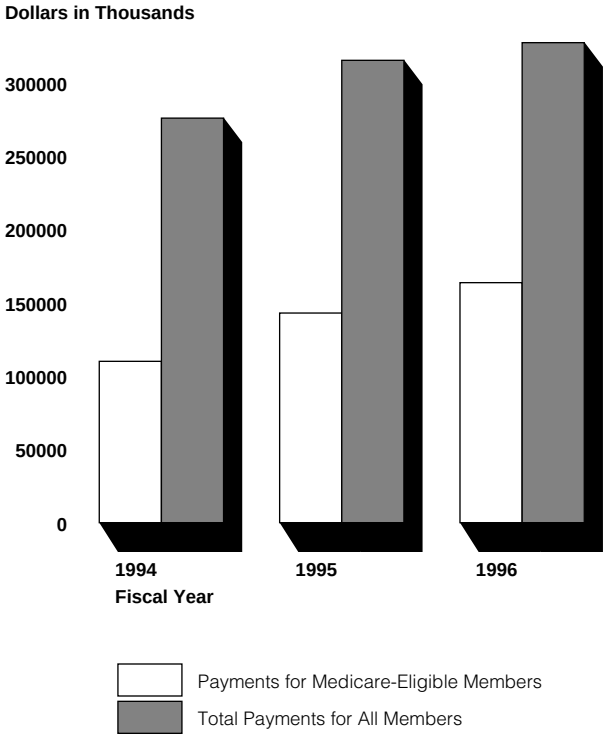
Figure 4: Percentage of Unnecessary Medicare Payments to USTF and Non-USTF Hospitals, FY 1994



Note: "USTF hospitals" includes hospitals under contract to USTFs.

Unless effective preventive controls are put in place, the unnecessary payments are likely to increase in magnitude. For fiscal years 1994, 1995, and 1996, the total number of USTF members aged 65 and over grew from 19,814 to 27,496—a 39-percent increase. Also, capitation payments for the USTF Medicare-eligible members continue to account for an increasing percentage of total capitation payments ranging from almost 40 percent in fiscal year 1994 to 50 percent in fiscal year 1996. Figure 5 shows the capitation payments paid to USTFs for fiscal years 1994, 1995, and 1996 for Medicare-eligible members compared with all members.

Figure 5: USTF Annual Capitation Payments for Medicare-Eligible and All Members, FY 1994-96



Note: Payment amounts for Medicare-eligible members are estimates based on capitation rates for Medicare-eligible members.

DOD and HCFA Lack Explicit Statutory Authority to Resolve Problem

Lacking explicit legislative authority, DOD and HCFA are limited in the actions they can take to prevent USTF members from using Medicare. DOD requires, for example, that USTF members sign a statement upon enrollment that they will refrain from using Medicare while a USTF member or be subject to disenrollment. But, since the USTF program's future is uncertain, DOD encourages Medicare-eligible members, on the USTF enrollment form, to continue paying their Medicare part B premiums to prevent penalties in the future.[12] Also, USTF officials told us that they advise their Medicare-eligible members not to use Medicare, but cannot control their actions.

[12]Medicare part B is a voluntary program financed by enrollee premiums and federal general revenues and covers physician and a variety of other health care services, such as laboratory and outpatient hospital services. If the recipient allows coverage to lapse or does not begin participation in part B immediately upon becoming Medicare-eligible, a penalty is assessed equal to 10 percent per year for each year the part B coverage is not taken.

DOD has requested that HCFA insert an automated screen into the USTF members' Medicare records to identify and block payments for Medicare use. However, HCFA believes it lacks the statutory authority to deny Medicare-eligible USTF members the right to use Medicare. Accordingly, HCFA cannot institute this simple, yet effective automated control that it now uses to prevent unnecessary Medicare fee-for-service payments for beneficiaries enrolled in Medicare-risk HMOs—a civilian equivalent of the USTFs. For these HMOs, HCFA inserts a screen into the members' Medicare records that alerts HCFA not to pay any Medicare claim that may be submitted because HCFA has prepaid the HMO. In such cases, the patient is responsible for paying for any unauthorized medical care obtained outside the HMO.

If a legislative change was made to permit HCFA to automatically screen[13] the records of Medicare-eligible USTF members, then members choosing to receive care from a Medicare provider outside the USTF network would bear the payment burden (except for emergency and authorized out-of-area care). Then, if a USTF provider inappropriately billed Medicare for a member's care, Medicare would send the bill to the USTF. Currently, without a screen, HCFA pays for care that DOD has already prepaid the USTFs to provide.

An alternative legislative course is also available. Currently, DOD does not have explicit statutory authority to disenroll a USTF member for using Medicare. If legislation was enacted requiring USTF members aged 65 and over to elect either to use Medicare or a USTF for all health care for a specified period of time, and if DOD was authorized to disenroll members who use Medicare in that period, DOD could promptly act to disenroll individuals found to have acted contrary to their USTF election. In such cases, the members would not be liable for the unnecessary Medicare costs but would lose their USTF eligibility while retaining their entitlements to Medicare and space-available care at military treatment facilities. Without such legislative authority, HCFA officials have made clear that any Medicare usage data they supply to DOD should not be used for an adverse purpose, such as member disenrollment.

After lengthy negotiations, DOD and HCFA have agreed to share data in an attempt to document the extent of Medicare usage. Using these data, DOD plans to recoup a portion of the unnecessary Medicare payments from the USTFs by reducing their future capitation payments. But the recoupment

[13]HCFA estimated that the one-time cost of changing its systems to screen USTF members would be $190,715. In discussing our draft report, HCFA officials told us that this estimate may need to be amended to include system maintenance costs, but they gave no new estimate.

will be based on a complex formula (see app. IV) negotiated between DOD and the USTFs that limits the risk to the USTFs. The costs incurred by Medicare will still be higher than the costs recouped by DOD. Also, because the formula reduces future USTF capitation payments based on Medicare claims from an earlier period, no provision exists for DOD to recoup unnecessary Medicare costs that may occur in fiscal year 1997, when the USTF participation agreements expire. Since the USTF managed care program began in October 1993, none of these unnecessary costs have been recovered from the USTFs.

DOD Has Curbed USTF Members' Use of Military Treatment Facilities and CHAMPUS

In contrast with Medicare, automated controls are in place to prevent military treatment facilities from providing care to USTF members. When a patient enters a military treatment facility for care, the admissions personnel check the patient's military identification number against data in the automated Defense Enrollment Eligibility Reporting System (DEERS). DEERS indicates whether the individual is enrolled in a USTF and thus ineligible for treatment at a military treatment facility. Thus, as long as the DEERS information is kept accurate and current, and the system is routinely checked, a military facility should know not to treat a USTF member. Our limited data match of 100 members' names at two locations found only one instance of military hospital use by a USTF member.

Concerning CHAMPUS, controls appear adequate to prevent unnecessary payments for health care services to USTF members. For every claim submitted, the CHAMPUS system automatically queries DEERS about eligibility. Thus, any medical claim submitted to CHAMPUS by a USTF member is rejected. Although we did not independently assess the CHAMPUS claims processing system, contractor audits of the system revealed few errors regarding eligibility.[14]

Other Cost and Equity Issues Likely to Affect the USTFs' Future

In addition to the unnecessary Medicare costs, other issues need to be addressed as the Congress deliberates the USTF program's reauthorization. One issue is how to most cost-effectively serve the health care needs of the current USTF members, given DOD's nationwide implementation of TRICARE and its mandate that it be no more costly than DOD's current costs under CHAMPUS and the military treatment facilities. Several congressional and DOD studies have shown that the USTF program may not be as cost-effective as CHAMPUS and other health care sources. And

[14]CHAMPUS contractors audit claims for payment errors every quarter. Included in the payment error category is eligibility determination.

questions of cost and equity have arisen with respect to the USTFs' prospective role as TRICARE providers.

Studies Document USTFs' Comparative Costliness

In a 1988 study,[15] we reported that USTFs were no more costly than comparable fee-for-service CHAMPUS providers. We recommended in subsequent testimony that in light of changes then being made to the USTF reimbursement method, the question should be periodically reevaluated.[16] Since then, the USTFs have changed to managed care, and CHAMPUS benefits have been scaled back in an effort to contain costs. Several subsequent studies have found that the USTFs now may be more costly than CHAMPUS and other health care sources.

A 1994 study by Lewin-VHI for DOD compared the cost-effectiveness of the USTF program with CHAMPUS and the military treatment facilities.[17] The study found that if the USTF program ended and its members had to rely for their care on CHAMPUS or military hospitals, DOD's costs could be reduced by an estimated $93 million to $146 million per year. Lewin-VHI also estimated that, for those aged 65 and over, USTF program costs were 10 times higher than what DOD's costs would be in the MHSS.[18] This is because the USTF managed care program provides to those aged 65 and over benefits that are not available in CHAMPUS and on a space-available-only basis in military treatment facilities. Moreover, the study concluded that to be budget neutral, the program should increase beneficiary cost sharing and impose enrollment fees for members under age 65, and ensure that all members receive all their care through the USTF.

Also in 1994, a congressionally mandated study by the Congressional Budget Office (CBO) addressed the USTFs' comparative cost-effectiveness with the MHSS and also with civilian HMOs.[19] Similar to Lewin-VHI's findings, the study estimated that, for those beneficiaries aged 65 and over, USTF

[15]Defense Health Care: Cost of Care at Selected Uniformed Services Treatment Facilities (GAO/HRD-88-67, Mar. 22, 1988).

[16]Costs of Care at Selected Uniformed Services Treatment Facilities (GAO/T-HRD-88-22, Sept. 28, 1988).

[17]Review of the USTF Managed Care Plan, submitted to the Assistant Secretary of Defense (Health Affairs) (Fairfax, Va.: Lewin-VHI, Apr. 26, 1994).

[18]Although, as estimated, DOD's costs would be reduced if the population aged 65 and over did not use USTFs, the total cost to the government might not change, because many of these individuals would switch to Medicare.

[19]CBO Memorandum: Evaluating the Uniformed Services Treatment Facilities (Washington, D.C.: CBO, June 1994).

program costs were eight times greater, or $95 million more per year, than what DOD's costs would be in the MHSS. CBO also estimated that the eight USTFs not located near military hospitals had costs 16 to 18 percent higher for caring for retirees and other beneficiaries under age 65 than what DOD's costs would be in the MHSS. This is because beneficiaries use CHAMPUS in areas not located near military treatment facilities, and CHAMPUS requires beneficiary cost sharing, which reduces the government's overall costs. CBO's work also suggested that USTF capitation rates were higher than the premiums of civilian HMOs.

Regarding the beneficiary cost-sharing findings of these studies, the fiscal year 1996 National Defense Authorization Act requires USTFs to adopt the uniform benefit cost shares and enrollment fees applicable to TRICARE after October 1, 1996, or the implementation of TRICARE in the USTF service area, whichever is later. The resulting higher beneficiary cost sharing may help lower DOD's overall costs for the USTF program.

A 1996 congressionally mandated study by the Institute for Defense Analyses also considered the cost-effectiveness issue.[20] The study estimated that the USTF program cost DOD over $193 million more per year than what costs would be if the members had to rely on the MHSS for their care. Considering overall government costs, the Institute estimated that the USTFs cost about $110 million more per year than what costs would be in the MHSS combined with Medicare coverage. Similar to the studies by Lewin-VHI and CBO, the study also estimated that, for those aged 65 and over, USTF program costs were eight times greater, or $115.5 million more per year, than what DOD's costs would be in the MHSS. Moreover, for those USTF members under age 65 who are active duty dependents, the study estimated that USTF program costs were 30 percent higher than what DOD's costs would be in the MHSS. The Institute also noted that high numbers of USTF members have private insurance coverage and may be receiving care outside the USTF, despite DOD's capitation payment to the USTF on their behalf to cover all of their care. The study results are currently under consideration by DOD and the affected parties.

USTFs' Inclusion in TRICARE Remains Undecided

DOD's policy has been that USTFs eventually would be made part of TRICARE on an equal footing with other contract providers.[21] With this policy, DOD's aim was to provide a level playing field for TRICARE's

[20]Summary of IDA's Evaluation of the Uniformed Services Family Health Plan (Washington, D.C.: Institute for Defense Analyses, Jan. 1996).

[21]60 Fed. Reg. 52090.

managed care programs and ensure beneficiary equity. The 1996 National Defense Authorization Act requires DOD to report to the Congress on how the USTFs could become TRICARE entities. In response, DOD formed a working group with USTF representatives and has drafted guiding principles for the transition.

Essentially, the guiding principles call for the USTFs to be distinct MHSS components; managed by TRICARE's regional lead agents; allowed to retain their currently enrolled members, including Medicare-eligible members and those who became Medicare-eligible while still USTF enrollees; and paid a per member capitation payment by DOD based on local health care market costs. In addition, the USTFs and DOD Health Affairs officials negotiated legislative language for the proposed fiscal year 1997 Defense Authorization Act that is now under consideration by the authorizing congressional committees. The legislation would essentially implement the guiding principles and specifically provide relief from FAR's competitive requirements as they pertain to the participation agreements so as to maintain DOD's current sole source contractual relationship with USTFs.

DOD Proposes That USTFs Retain Noncompetitive Status Under Tricare

DOD proposes that under TRICARE the USTFs should largely retain their current, noncompetitive status. Under this arrangement, the USTFs would be uniquely authorized to enroll Medicare-eligible beneficiaries aged 65 and over who would otherwise essentially lose their access to military health care under TRICARE.

Under TRICARE, civilian health care companies compete for each of the seven regional managed care support contracts under which they manage, within each designated area, all DOD beneficiaries' health care that is provided outside of the military treatment facilities. Each designated area has one managed care support contractor that, in turn, develops a network of providers within that area for the actual health care delivery. Under the proposed DOD plan, the USTFs would remain outside of this network of providers. Not only would the USTFs be allowed to keep their current enrollment of beneficiaries aged 65 and over, but they would be allowed to negotiate their capitation rates noncompetitively with DOD directly, whereas, under the TRICARE managed care support contracts, providers must compete.

USTF Enrollment of Medicare-Eligibles Creates Inequities

Along with the government's comparatively higher health care costs for USTF Medicare-eligible members, the USTF program allows a small number of beneficiaries to enjoy a benefit not now available to the majority of

military retirees. For example, USTFs enroll about 27,000 Medicare-eligible beneficiaries who receive DOD-funded care largely free to them. But DOD's other 1.2 million retirees aged 65 and over now rely—and will do so under TRICARE—on space-available access to military treatment facilities. Alternately, they may rely on Medicare, which does not cover such necessities as pharmaceuticals. TRICARE's goal of bringing as much CHAMPUS care as possible into military treatment facilities, thus reducing their resource availability, may further exacerbate the equity issue by squeezing out still more retirees who do not have access to such facilities.

The USTFs alternatively have proposed that they act as Medicare providers to treat individuals aged 65 and over and be reimbursed by HCFA, and that DOD's reduced capitation payment for these individuals should cover such added benefits as preventive, pharmaceutical, and optical services. Among other problems, however, such an arrangement (referred to as Option II),[22] would not remove the inequity issue in guaranteeing full health care coverage for only a fraction of DOD's older retiree community.

Conclusions

In recent years, the Congress has increasingly been concerned about the cost of the USTF program, partly because some members retain dual eligibility for other federal health care sources. Additionally, questions have arisen about the role that the USTFs should play as TRICARE providers. DOD is implementing its nationwide TRICARE program in the current environment of budget reductions and related attempts to control health care costs. Therefore, whether the USTFs are as cost-effective as alternative sources of care has become an issue.

In instances where DOD has clear authority to minimize USTF members' use of other potential health care sources, DOD has instituted controls that prevent unnecessary payments for these services. However, DOD does not have explicit legal authority to prevent unnecessary payments for health care to Medicare-eligible USTF members because of their dual eligibility. Accordingly, USTFs have relied on providers and members to not use Medicare, but this reliance has not proven effective as a control. As a result, unnecessary Medicare payments have been and continue to be

[22]Option II is a USTF proposal that would designate the USTFs as Medicare-risk HMOs and permit them to seek reimbursement from Medicare for Medicare-covered services provided to beneficiaries enrolled in the USTF health care program. In addition, this option would provide, for DOD beneficiaries, additional benefits such as pharmaceutical, optical, and preventive care services, which would supplement a beneficiary's Medicare benefits and require copayments identical to those required in TRICARE Prime. The 1996 National Defense Authorization Act directed DOD to address the feasibility of implementing Option II in its report to the Congress on its plan for integrating the USTFs into TRICARE.

made for services to USTF members. Unless action is taken, the magnitude of the problem will grow as the age of the USTF population advances. Although DOD has developed a method for recovering some of the capitation payments it has made to USTFs, this method allows for recovering only a portion of the money unnecessarily spent by the government. As yet, no money has been recovered.

In our view, DOD needs to reconsider its current plans to seek to retain its noncompetitive contractual relationship with the USTFs. In effect, with its current relationship, the USTFs have a business advantage relative to other, competitive TRICARE providers. Also, allowing the USTFs to continue to provide comprehensive health care for some Medicare-eligible members would be inequitable relative to the care the majority of such beneficiaries can obtain under TRICARE. This inequity would increase as the space-available care in military treatment facilities for TRICARE's beneficiaries aged 65 and over is further reduced. Rather, DOD needs to weigh the merits of having the USTFs compete on an equal footing with other TRICARE health care providers for care delivered outside the military facilities. At issue is what is the best, most cost-effective way to provide high-quality health care to uniformed services beneficiaries.

Matters for Congressional Consideration

To prevent unnecessary costs to the government from USTF members' Medicare use, the Congress should consider

- deeming USTFs Medicare-risk HMOs under the Social Security Act's section 1876(a)(3) for the limited purpose of allowing HCFA to identify and block payments for the costs of services incurred by dually eligible members or
- requiring Medicare-eligible members to elect whether to receive care from a USTF or under Medicare for a specified time period and authorizing the Secretary of Defense to disenroll USTF members who act contrary to their election not to use Medicare.

Also, the Congress should consider specifying in the authorizing legislation whether USTFs should continue as sole source contractors under TRICARE, and whether USTF members should be treated differently from all other DOD beneficiaries who receive medical services under DOD's managed care support contracts and direct care system.

Recommendations to the Secretary of Defense

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense, Health Affairs,

- pending action on the matters for congressional consideration in this report, to include, in all future USTF agreements, a method for directly and fully offsetting all unnecessary Medicare payments from the USTFs;
- to review USTF network providers who have inappropriately billed Medicare for USTF members' care and, as appropriate, require providers to reimburse Medicare for unnecessary payments and bill the USTFs for such costs; and
- to reconsider continuing the USTFs' sole source contractual relationship with DOD under TRICARE, including whether USTF members should be treated the same way all other DOD beneficiaries are treated under DOD's managed care support contracts and direct care system.

DOD and USTF Comments and Our Evaluation

We obtained comments on a draft of this report from DOD, USTF, and HCFA officials.

DOD officials stated that they agree with our recommendation to include, in all future USTF agreements, a method for directly and fully offsetting all unnecessary Medicare payments from the USTFs. They also fully agreed with our recommendation concerning inappropriate Medicare billings by USTF network providers and stated that the data match between DOD and HCFA will enable them to identify noncompliant USTF providers.

DOD officials emphasized that competition is important in the purchase of health care services and that providers' rates should be competitive and services' costs should be no greater than the costs of the TRICARE program. But, in responding to our recommendation, DOD officials declined to comment on the appropriateness of retaining a sole source contractual relationship with the USTFs under TRICARE.

We believe that DOD has the authority to reconsider its plan to maintain such relationships with the USTFs. Because DOD did not indicate its willingness to do so and in light of the legislation now pending in the Congress, we have also added to the report a matter for consideration of the Congress that in deliberating the USTFs' reauthorization it consider the fairness of the USTFs' continuing as sole source DOD contractors under TRICARE, including whether USTF members should be treated the same way all other DOD beneficiaries are treated under DOD's managed care support contracts and direct care system.

Furthermore, DOD officials acknowledged the inequity that exists because some Medicare-eligibles receive full medical care at USTFs, whereas the majority of such DOD beneficiaries must access care through military treatment facilities on a space-available basis. They said that they are pursuing an approach whereby Medicare would help pay for such beneficiaries' care in military treatment facilities to try to address this inequity.

DOD also suggested some technical changes to the report, which we incorporated as appropriate.

USTF officials expressed concern that the report implies that the USTFs are responsible for the unnecessary Medicare payments problem. They stated that they did not create the problem, have limited means to stop its occurrence, and have not been given the tools to control it. In addition, these officials stated that the USTFs are the only organizations that have acted to limit the government's exposure to unnecessary Medicare payments, but that the report is silent on this.

We disagree that the report assigns fault to the USTFs and state in the report that the problem results from the dual eligibility of USTF members who are aged 65 and over. While we agree that the USTFs have implemented some measures to help address the problem, such as developing guidelines in 1994 for handling affiliated providers that violate their agreement not to bill Medicare for USTF members' care, we did not discuss these measures because our analysis showed they do not prevent the problem from occurring.

Furthermore, USTF officials disagreed that they should be responsible for full reimbursement of their members' unnecessary Medicare payments. Because DOD's capitated USTF payments cover all the health care of members who actually use Medicare, we continue to believe that DOD should fully recover the unnecessary Medicare costs from the USTFs so the government does not pay twice for such care.

USTF officials disagreed with the findings of the Lewin, CBO, and Institute for Defense Analyses studies cited in our report, stating that these studies consider the USTFs' cost-effectiveness relative to CHAMPUS and DOD's direct care system costs, not the federal government's total costs. But under TRICARE, DOD has been required by congressional mandate to ensure that its costs under TRICARE not exceed what costs would have been under CHAMPUS and the direct care system. Thus, studies of the USTFs' costliness

relative to DOD's other system costs are directly relevant to whether and how the USTFs should be made a part of TRICARE. Also, our report points out that if the USTF population aged 65 and over were to leave the USTFs and switch to Medicare, the federal government's total costs for such beneficiaries might not change—except that the current overlapping Medicare and DOD costs for some such members would be eliminated.

Regarding USTF care for Medicare-eligible DOD beneficiaries, USTF officials stated that inequities exist throughout the MHSS, and our report did not discuss these other inequities. We agree that other inequities may exist in the MHSS, but this report specifically addressed the USTF program.

USTF officials stated that we distorted the competition issue and that when TRICARE is fully established, the USTFs will compete equally for DOD beneficiaries on the basis of their network design, care, quality, reputation, access, and value-added services. We disagree, and continue to believe that if the USTFs retain their noncompetitive contractual relationship with DOD under TRICARE, they will have a decided business advantage over other, competitive TRICARE providers.

In discussions with us, HCFA officials stated that identifying and blocking payments in the Medicare system for USTF members aged 65 and older is a reasonable solution to the unnecessary payment problem, but implementation details will have to be worked out. We agree.

HCFA officials also stated that our report alternatively suggests that the Congress consider enacting legislation requiring USTF members aged 65 and older to elect either USTF care or Medicare, and authorizing DOD to disenroll members who inappropriately use Medicare. The officials stated, however, that in negotiations with DOD regarding HCFA's providing DOD data on USTF members' Medicare use, DOD agreed that no member would be disenrolled on the basis of the released Medicare data. Nevertheless, we believe that the enactment of legislation expressly granting DOD authority to disenroll such USTF members would remove any current statutory impediments to DOD's using the HCFA-provided data for that purpose.

The HCFA officials stated that the report's estimated cost for adjusting their Medicare system to screen USTF members may need to be amended to include the costs of maintaining the process once in place. Although they provided no amended cost estimate, we have acknowledged this possibility in the report.

We are sending copies of this report to the Secretaries of Defense, Health and Human Services, Transportation, and Commerce; and the USTFs. We will make copies available to others upon request.

If you have any questions about this report, please call me on (202) 512-7111. Other GAO contacts and staff acknowledgments are listed in appendix V.

Stephen P. Backhus
Associate Director, Health Care Delivery
and Quality Issues

Contents

Abbreviations

CBO	Congressional Budget Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DEERS	Defense Enrollment Eligibility Reporting System
DOD	Department of Defense
FAR	Federal Acquisition Regulation
HCFA	Health Care Financing Administration
HMO	health maintenance organization
MHSS	Military Health Services System
USTF	Uniformed Services Treatment Facility

Scope and Methodology

In conducting our review, we examined USTF program documents obtained from DOD and the USTFs. We examined the legislative history of the USTFs and the Medicare and USTF statutes, and reviewed DOD policies and regulations affecting the USTFs. We interviewed USTF officials from three USTFs, the USTF Conference Group, officials from the Health Care Financing Administration (HCFA) responsible for the Medicare program, and DOD officials from Walter Reed Army Medical Center and Bethesda Naval Hospital.

We analyzed fiscal year 1994 Medicare part A and part B data relating to inpatient, outpatient, skilled nursing facility, and physician/supplier claims for USTF enrollees. We did not analyze data for home health aides and hospice claims because these services were not covered by the USTF program in fiscal year 1994. We also did not analyze data regarding durable medical equipment because the number of claims and dollar amount were small.

We matched fiscal year 1994 Medicare claims data to the USTF enrollment file to verify that the claims were for USTF enrollees. We eliminated claims from our analysis if the date of service was before the individual enrolled in the USTF program. We also eliminated claims for end-stage renal disease because Medicare is the primary payer for these claims. In addition, we eliminated chiropractic claims from the physician/supplier category since chiropractic care is not a covered benefit in the USTF program.

We could not verify that all the claims for outpatient and physician/supplier services occurred after the date of USTF program enrollment because they did not contain the name of the beneficiary. For physician/supplier services, we took the ratio of the Medicare payment amount incurred after USTF enrollment to the Medicare payment amount after matching the HCFA data to the USTF enrollment file and applied this ratio to the total Medicare payment amount for all fiscal year 1994 claims.

In addition, we obtained data from the USTFs listing USTF contracted hospitals and compared these data with the Medicare claims data to determine whether Medicare payments were made to USTF-contracted hospitals or other hospitals.

To get information on services USTF members received at military treatment facilities, we obtained a list of USTF members from DOD, which DOD personnel had entered into the military hospital's Composite Health

Care System at Walter Reed Army Medical Center and Bethesda Naval Hospital.

To obtain information on the CHAMPUS program, we reviewed contractor monitoring reports from the contractors responsible for monitoring the CHAMPUS fiscal intermediaries. We also reviewed pertinent sections of the CHAMPUS operations and automated data processing manuals.

We conducted work at the Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C.; Walter Reed Army Medical Center, Washington, D.C.; Bethesda Naval Hospital, Bethesda, Maryland; the Johns Hopkins USTF in Baltimore; the corporate headquarters of the Sisters of Charity, Houston; at two Sisters of Charity USTFs: St. Joseph's, Houston, and St. John's, Nassau Bay; and at the Pacific Medical Center USTF in Seattle. In addition, we interviewed officials from the USTF Conference Group in Baltimore, and from the Office of CHAMPUS in Aurora, Colorado.

USTF Program Information

Table II.1: Capitation Payments Made to USTFs, FY 1994-96

USTF	FY 1994	FY 1995	FY 1996[a]	Total
Bayley Seton	$29,042,942	$44,119,093	$11,871,802	$85,033,837
Brighton Marine	35,971,304	38,426,245	9,769,871	84,167,420
Johns Hopkins	44,184,621	51,487,006	13,699,693	109,371,320
Lutheran Medical	10,037,476	12,985,443	3,361,360	26,384,279
Martin's Point	37,095,034	38,793,141	10,003,219	85,891,394
Pacific Medical	49,539,661	57,604,882	14,515,423	121,659,966
Sisters of Charity	70,014,513	71,893,084	18,615,385	160,522,982
All facilities	$275,885,551	$315,308,894	$81,836,753	$673,031,198

Note: Capitation payments include those for all the uniformed services, including the Army, Navy, Marines Corps, Air Force, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

[a]Fiscal year 1996 data are for the first quarter only.

Table II.2: USTF Managed Care Program Enrollment by USTF Facility, FY 1994-96

USTF	FY 1994	FY 1995	FY 1996
Bayley Seton	8,574	13,858	15,772
Brighton Marine	10,290	11,411	11,892
Johns Hopkins	16,832	21,847	23,881
Lutheran Medical	3,878	6,001	6,570
Martin's Point	14,334	18,047	18,795
Pacific Medical	16,064	20,439	20,048
Sisters of Charity	24,720	26,903	27,054
All facilities	94,692	118,506	124,012

Table II.3: Fiscal Year 1996 USTF Enrollment and Percentage of Medicare-Eligible Members

USTF	FY 1996 enrollment	Percentage who are Medicare-eligible
Bayley Seton	15,772	24
Brighton Marine	11,892	29
Johns Hopkins	23,881	17
Lutheran Medical	6,570	12
Martin's Point	18,795	14
Pacific Medical	20,048	32
Sisters of Charity	27,054	23
All facilities	124,012	22

Table II.4: Allocation of USTF Managed Care Program Appropriations

USTF	FY 1994	FY 1995	FY 1996
Bayley Seton	$29,695,800	$45,600,000	$53,236,085
Brighton Marine	36,776,800	38,700,000	40,010,161
Johns Hopkins	45,290,300	52,000,000	57,020,329
Lutheran Medical	15,641,000	14,400,000	13,915,480
Martin's Point	42,300,500	39,200,000	41,340,896
Pacific Medical	49,539,600	59,000,000	58,802,354
Sisters of Charity	75,756,000	72,100,000	75,022,395
All facilities	$295,000,000	$321,000,000	$339,347,700

Notes: This table lists the budget ceiling DOD has established for each USTF program based on the total USTF appropriation.

Appropriations include those for the Army, Navy, Marine Corps, Air Force, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

Table II.5: USTF Operators

USTF	Operator
Bayley Seton	Sisters of Charity Health Care System
Brighton Marine	Allston-Brighton Aid & Health Group, Inc.
Johns Hopkins	Johns Hopkins Health Systems
Lutheran Medical	Fairview Health System
Martin's Point	Penobscot Bay Medical Association
Pacific Medical	Pacific Hospital Preservation Development Authority
Sisters of Charity	Sisters of Charity of the Incarnate Word

Note: The operators are the owners of the USTF facilities.

Background on TRICARE

Following years of demonstration programs that tested alternative health care delivery mechanisms, DOD designed TRICARE, a managed health care program. The program is intended to ensure a high-quality, consistent health care benefit, preserve choice of health care providers for beneficiaries, improve access to care, and contain health care costs. DOD began implementing TRICARE in 1993 and expects to complete implementation by September 1997.

TRICARE is significantly changing the military health care system. It offers beneficiaries alternatives to the current CHAMPUS program, such as the option of using a health maintenance organization (HMO) that will lower cost sharing when beneficiaries agree to limitations on their choice of physicians. To implement and administer the TRICARE program, DOD has reorganized its medical facilities into new health care regions and established a new administrative structure to oversee the delivery of health care within the regions. Military medical facilities are organized on a geographic basis into 12 health care regions, encompassing medical facilities from all three of the services. The number and service affiliation of the facilities vary among regions, as do the number of eligible beneficiaries within in each region's boundaries. A military medical center commander has been designated in each region as the lead agent, or health administrator, supported by a joint-service staff drawn from the region's military medical facilities and DOD medical program offices.

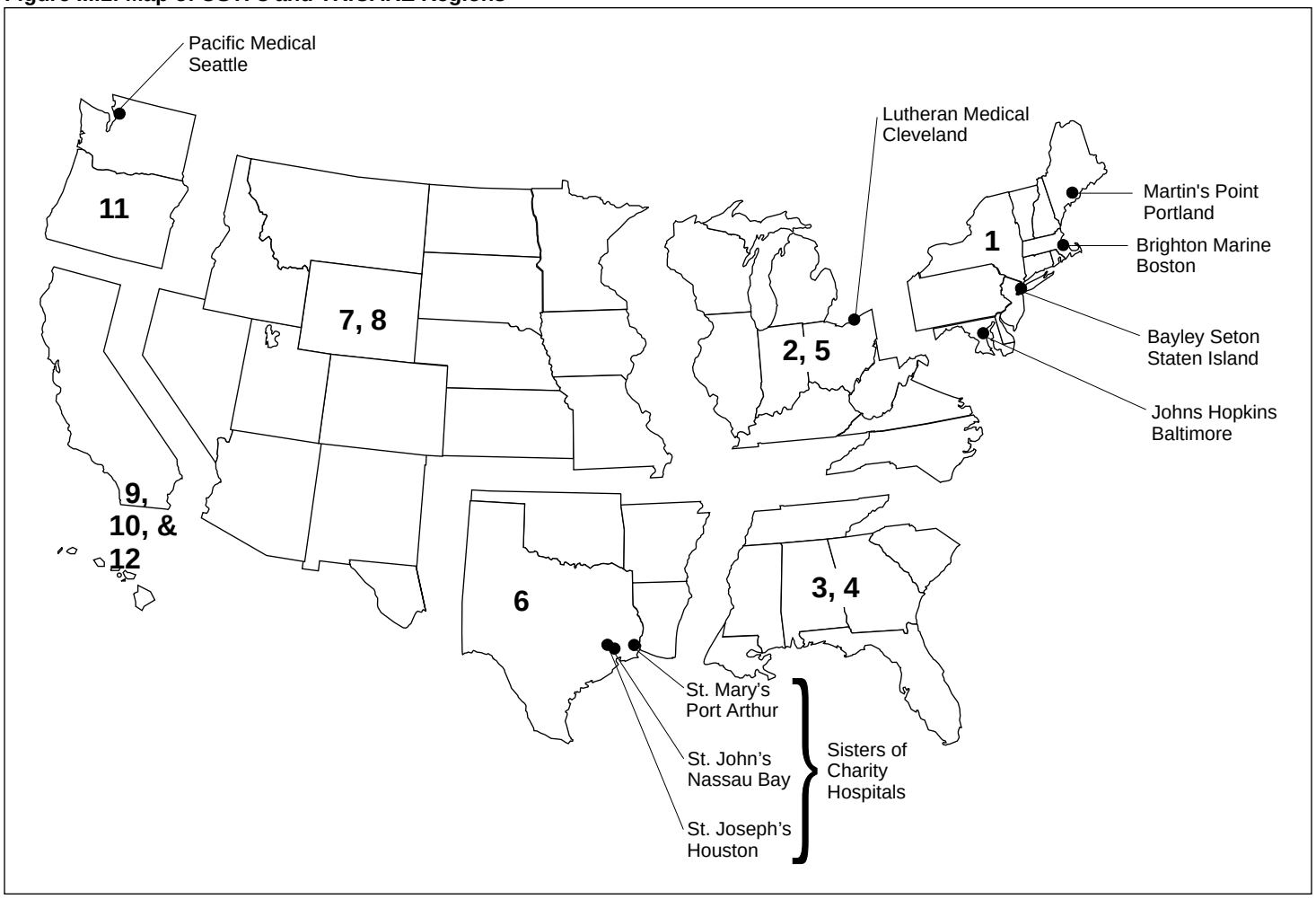
One significant feature that has been maintained from the demonstration programs is the use of contracted civilian health care providers to supplement the level and type of care provided by the Military Health Services System (MHSS) on a regional basis. DOD estimates that these contracts will cost about $17 billion over the 5-year contract period. TRICARE also incorporates several cost-control features of civilian managed care programs.

TRICARE features a triple-option benefit, offering beneficiaries eligible for CHAMPUS two new options for health care in addition to the CHAMPUS program. The options vary in the choices beneficiaries have in selecting their physicians and the amount beneficiaries are required to contribute toward the cost of the care they receive from civilian providers. The first option, TRICARE Standard, is the current fee-for-service CHAMPUS program. This option provides beneficiaries with the greatest freedom in selecting civilian physicians and requires the highest beneficiary cost share. The second option, TRICARE Extra, is a preferred provider option, through which beneficiaries receive a 5-percent discount on the Standard option

cost of care when they choose a medical provider from the contractor's network. The third option, TRICARE Prime, represents the greatest change in MHSS health care delivery. TRICARE Prime is an HMO-like alternative that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. Beneficiaries selecting this option must enroll annually in the program, agreeing to go through an assigned military or civilian primary care physician for all care. Low enrollment fees and copaymant features provide financial incentives for beneficiaries to select this option, the most highly managed of the three options.

See figure III.1, which shows the locations of the USTFs and the TRICARE regions.

Figure III.1: Map of USTFs and TRICARE Regions



Medicare Recoupment Formula

This appendix describes the formula negotiated between DOD and the USTFs to recover unnecessary Medicare payments made on behalf of USTF members. Under this recoupment formula, DOD would not recover the full amount of unnecessary Medicare payments. Rather, after the USTFs confirm the members' eligibility and verify the Medicare claims data, the formula converts the data to units—that is, the number of inpatient days and outpatient visits. The units are adjusted to reflect the difference between a beneficiary's experience under Medicare and in managed care. After removing outlier data such as catastrophic care cases, the formula assigns the remaining units a dollar value—$600 per inpatient day and $60 per outpatient visit. This total, rather than the total amount of unnecessary Medicare costs, is the dollar value base unnecessary payments subject to reimbursement. This base is then divided by the USTFs' capitation payments for their Medicare-eligible members, and the resulting percentage determines the dollar value base for which the USTFs are responsible. The USTFs are responsible for 100 percent of the derived base value up to 1 percent of the same year's capitation payments; 75 percent of the value between 1 and 4 percent; 50 percent of the value between 4 and 7 percent; and 25 percent of the value between 7 and 10 percent. The USTFs' liability is limited to 10 percent of the capitation payments.

Following is the detailed formula that would be used to determine the amount the USTFs would reimburse DOD for their members' use of Medicare.

1. Define the cost to the government.

The cost is the government cost associated with utilization of covered health care services by Medicare beneficiaries enrolled in the USTF managed care plan. The cost does not include the following:

- deductibles and copayments paid by the member;
- amounts not allowed by Medicare, such as charges in excess of the Medicare allowance;
- collection from third parties for deductibles and copayments as allowed; and
- payments to hospitals other than actual diagnosis related group payments, such as capital pass-through payments and indirect or direct medical education.

On the basis of the information DOD/USTFs provide, HCFA furnishes the USTFs with the names of Medicare beneficiaries with paid claims, the amount of

each claim, date of service, and Social Security number so the claims can be verified and eligibility confirmed.

2. Determine out-of-plan utilization based on units of service for inpatient days and outpatient physician visits during the first enrollment period.

On the basis of the information provided by HCFA, the USTFs calculate the number of inpatient days for each USTF member with Medicare coverage and the number of outpatient physician visits. (Outpatient visits include only those involving a physician. Lab tests, for example, are not counted unless they are part of the physician visit.) The USTFs furnish this information to DOD for review and comment.

3. Estimate utilization based on HMO experience.

The USTFs manage the care of their Medicare-eligible members. The utilization experience of USTF members should be substantially less than the utilization for nonenrolled Medicare beneficiaries. Thus, a USTF is responsible only for utilization that is consistent with managed care service. In 1989 the national average for hospital days per 1,000 members aged 65 and over was 2,930. For individuals enrolled in HMOs who were 65 and older, the utilization was 1,545 days, or 53 percent of the national experience. HMO members 65 and older had 7 outpatient physician visits per member per year, approximately 10 percent higher than the national average of 6.4 visits.

Therefore, the number of utilization units, calculated in step 2 under Medicare, is adjusted to reflect the difference between the beneficiary experience under Medicare and in an HMO. The number of inpatient units is multiplied by .53 to reflect this HMO experience. The number of outpatient physician visit units is multiplied by 1.1 to reflect this HMO experience. The sum of these two calculations is the number of units of unnecessary payments eligible for reimbursement.

4. Determine outliers and remove them from the total number of units of service eligible for reimbursement.

To protect the USTF from bearing the cost for outlier claims for non-managed-care services, the outlier claims are removed from the units eligible for reimbursement. The average inpatient utilization for an HMO member aged 65 and older is 1.545 hospital days per year. This number is multiplied by 3 to get 4.635 units per member per year as the outlier

threshold. Units above this threshold for each member are removed from the total number of inpatient units used to calculate the USTF reimbursement for unnecessary payments.

5. Determine the value of each unit of service and calculate the value of unnecessary payments.

Consistent with the individual reinsurance reimbursement, the number of inpatient units of service allowed by this methodology is multiplied by $600 and adjusted by the Medicare wage index. The number of outpatient physician units is multiplied by $60, and the sum of the two calculations is the dollar amount of unnecessary payments subject to reimbursement.

6. Allocation of unnecessary payments between DOD and the USTFs.

The USTF is responsible for only a portion of any unnecessary payments. The allocation is subject to a maximum dollar amount based on the capitation payments the USTF received during the enrollment period. The USTF is responsible for 100 percent of the value of the unnecessary payment amount up to 1 percent of its capitation payments for Medicare-eligible members. If the unnecessary payments amount is greater than 1 percent of the capitation payments but less than 4 percent, the USTF is responsible for 75 percent of this amount. If the amount is 4 percent but less than 7 percent, the USTF is responsible for 50 percent of this amount. If the amount is 7 percent of the capitation payments but less than 10 percent, the USTF will be responsible for 25 percent of this amount. The USTF is not responsible for the value of any unnecessary payments beyond 10 percent of the capitation payments for its Medicare-eligible members.

The following example illustrates this allocation band methodology:

(1) USTF has 2,000 Medicare-eligible members.

(2) The average Medicare capitation payment is $6,000 per member per year.

(3) The total of annual capitation payments for Medicare-eligible members is $12,000,000.

(4) Unnecessary payments are calculated to be $1.0 million on the basis of this methodology.

(5) The share of unnecessary payments allocated to the USTF is $40,000, or 25 percent, as shown in table IV.1.

Table IV.1: USTF Share of Unnecessary Payments

Unnecessary payments as a percentage of capitation payment	Percentage of unnecessary payment USTF is responsible for	USTF share of unnecessary payment
0 - 1%	100%	$120,000
1% - 4%	75%	$270,000
4% - 7%	50%	$180,000
7% - 10%	25%	$40,000

Any unnecessary costs in excess of the amount determined by this methodology are not the responsibility of the USTF.

7. Recoupment of USTF portion of unnecessary payment reimbursement.

At the beginning of the second enrollment period after the calculation of unnecessary payments is made, DOD adjusts the payments made to the USTF to reflect this amount. At the beginning of the second enrollment period, the number of Medicare-eligible members is determined by age and gender. The projected annual capitation payments are calculated by multiplying the age/gender capitation rates by the number of Medicare-eligible individuals. The recoupment amount, determined through the above methodology, is divided by the projected annual capitation payments to the USTF. The capitation payment for each Medicare-eligible individual is reduced by this percentage. For example, if the USTF enrolled 2,000 Medicare-eligibles with an average capitation payment of $6,000, the projected annual payment for these members will be $12 million. If the payment amount due, based on the above methodology, is $610,000, the monthly capitation payment for each individual is reduced by 5.083 percent for the 12 months in the contract year. The value of the unnecessary payment amount is determined for each contract year. The amount of potential reduction in the capitation payments will vary depending on the actual amount of unnecessary payments, calculated by this methodology, in each enrollment period.

Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Carolyn Kirby and Sigrid McGinty, Senior Evaluators; Jean Chase, Evaluator; Robert DeRoy, Assistant Director; Stefanie Weldon, Senior Attorney; and Pamela Tumler, Communications Analyst.

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