REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2 - I-08

Subject: Acceptance of TRICARE Health Insurance

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Referred to: Reference Committee J
(Jack J. Beller, MD, Chair)

At the 2007 Interim Meeting, the House of Delegates adopted Substitute Resolution 714, "Acceptance of TRICARE Health Insurance." The second resolve of Substitute Resolution 714 (I-07) asks that our American Medical Association (AMA) report back at the 2008 Interim Meeting on issues regarding TRICARE in light of the increased numbers of new veterans and their families. The Board of Trustees assigned the requested study to the Council on Medical Service.

This report provides background on the military and veterans health systems, examines TRICARE contracting and physician payment issues, spotlights issues associated with mental health, describes recent activity to improve the military and veterans health systems, summarizes relevant AMA policy and activity, and presents policy recommendations.

BACKGROUND ON THE MILITARY AND VETERANS HEALTH SYSTEMS

Since October 2001, roughly 1.64 million US troops have deployed as part of Operation Enduring Freedom (OEF, Afghanistan) and Operation Iraqi Freedom (OIF, Iraq). This surge in active duty service members has prompted concern over whether the primary federal health systems that directly provide health care and coverage to these personnel are able to meet the increase in demand and provide quality health care, including mental health services. The health care programs that have a primary purpose to provide health care and coverage to members of the military, veterans and their families are operated through the Department of Defense (DoD) and the Department of Veterans Affairs (VA).

DoD oversees TRICARE (formerly CHAMPUS), the health plan of the Military Health System, which provides health care to active duty service members and their families and to military retirees and their eligible family members, as well as to certain survivors. TRICARE and the rest of the DoD health system is different from and should not to be confused with the VA health system. The VA covers veterans and their eligible family members, who constitute a very small minority of total beneficiaries, and has entirely different eligibility criteria, benefits packages, and financing structures than the DoD and TRICARE.

The Veterans Health Administration (VHA) directly provides a range of services, including inpatient and outpatient care; long-term care; pharmacy and mental health in its 153 medical centers, 731 community-based outpatient clinics, 135 nursing homes, 209 readjustment counseling centers (Vet Centers) and 47 domiciliaries. In 2007, the VHA provided health care services to 5.5 million patients. Eligibility and enrollment in the VHA is limited to eight priority groups of veterans, categorized on the basis of disability rating, income, wars fought, Purple Heart recipient

status, Prisoner of War (POW) status and other factors. The Secretary of the VA determines each year whether the agency's medical budget can support providing health care to veterans in all priority groups. If the budget cannot support services for all priority groups, VA health care is provided to the highest priority groups first. The VA provides health care to many low-income veterans who would otherwise be uninsured. Spouses and dependents of veterans may be eligible for the Civilian Health and Medical Program of the VA (CHAMPVA) if they are not eligible for TRICARE. Under CHAMPVA, the VA shares the cost of covered health care services and supplies with beneficiaries.

Approximately 9.2 million beneficiaries worldwide are eligible for TRICARE. The overall user rate in the program, which includes both direct and purchased care, was 79.6 percent in FY 2007. In FY 2007, there were approximately 1.1 million inpatient admissions, and roughly 90 million outpatient visits. The estimated fiscal year 2008 budget for the Unified Medical Program – which includes TRICARE and other DoD health programs, and funds for construction of military medical facilities – is $42.6 billion. Of that amount, $12.34 billion is allocated to care purchased from the private sector and approximately $20 billion (including overhead and administration costs) on care provided directly in 63 military inpatient hospitals and medical centers, 413 ambulatory medical clinics and 413 dental clinics.

TRICARE offers enrollees three main options for coverage. The majority of eligible TRICARE beneficiaries are enrolled in TRICARE Prime, the option that resembles a health maintenance organization (HMO). TRICARE Prime offers lower out-of-pocket costs than any other TRICARE option. Active duty service members and activated National Guard or Reserve Members must enroll in one of the TRICARE Prime options. Other TRICARE beneficiaries can choose to enroll either in a TRICARE Prime option or another TRICARE health plan option, such as TRICARE Extra and TRICARE Standard. Whereas TRICARE Extra is the preferred-provider option (PPO) within TRICARE, TRICARE Standard is often referred to as the military equivalent of a fee-for-service plan.

For Medicare-eligible beneficiaries, TRICARE offers wrap-around coverage with TRICARE For Life. TRICARE Reserve Select is available to most members of the Selected Reserves once their coverage associated with active duty expires. Other options are also available to qualifying beneficiaries that offer coverage that blends the benefits available under TRICARE Prime, Standard and Extra, and include TRICARE Prime Remote and the Uniformed Services Family Health Plan. In cases in which TRICARE beneficiaries are eligible for Medicaid, Medicaid can be coordinated with TRICARE if the needs of a Medicaid-eligible family member exceed the limits of TRICARE coverage. DoD has also launched an e-prescribing initiative, and has published its formulary electronically as a key first step.

In recent years, civilian providers have been accessed more frequently by TRICARE beneficiaries for outpatient care as a growing proportion of the DoD population is no longer predominately located on bases where there are military clinics and hospitals available. For example, during long deployments, families of active duty personnel are increasingly choosing to live close to other family members, who may not live near any military base. This trend toward increased civilian provider access is also partly due to military base closures and the increasing number of reservists participating in TRICARE.

The diversity and geographic distribution of returning OEF/OIF veterans, military personnel and retirees have also led to a need for the DoD and the VA to increasingly coordinate with

community-based providers to deliver essential health services to veterans and military personnel. Such providers can include centers that offer counseling and other services to veterans. These collaborative efforts will only augment the capacity of TRICARE, the rest of the DoD health system and the VA to ensure military personnel and veterans have access to quality health care.

TRICARE CONTRACTING AND PAYMENT ISSUES

Substitute Resolution 714 (I-07) cited physician concern regarding TRICARE physician payment rates and contractor operations, including claims processing. Such concerns with TRICARE contributed to a leveling of the number of TRICARE civilian providers in fiscal year 2007, after years of steady increases. Despite physician concerns with claims processing, TRICARE cites in its FY 2008 evaluation that, over the past six years, it exceeded its goal of processing 95% of clean claims within 30 days.

In recent years, the TRICARE Management Activity (TMA) has made significant changes to its program administration and contracting. As a result, many argue that today's TRICARE looks and functions much differently from the program as first implemented. Most notably, TMA consolidated the number of domestic TRICARE contracts and regions from twelve to three. The three TRICARE regions - TRICARE West, TRICARE North and TRICARE South - are each led by TRICARE Regional Directors who manage region-wide contracts that purchase health care from civilian providers and administrative services for TRICARE beneficiaries. The TRICARE Regional Offices are responsible for coordinating the integration of this commercial health care with care provided at hospitals and clinics on military bases to ensure beneficiaries receive timely, clinically appropriate treatment. These region-wide contracts are competitively bid. Currently, TriWest Healthcare Alliance is the regional contractor for TRICARE West, Health Net Federal Services is the TRICARE North regional contractor, and Humana Military Healthcare Services is the TRICARE South regional contractor. TRICARE regional contractors establish provider networks and carry out other administrative and customer service activities, including processing claims, authorizing care, and communicating and distributing educational information to beneficiaries and providers.

Physicians and some military associations have also noted the need for TRICARE and its contractors to improve coordination of care for its beneficiaries. Notably, it has been reported that there have been difficulties in transferring patient information between military treatment facilities and civilian providers. Beneficiaries have also reported difficulties in obtaining appointments and referrals in TRICARE Prime. In addition, TRICARE Prime enrollees have reported problems in coordinating care between TRICARE regions, due mainly to the process of care authorization when beneficiaries travel outside their home region. Coordinating TRICARE benefits for those living overseas is also an ongoing issue.

Continued physician dissatisfaction with TRICARE is also related to low and unstable payment rates. Federal statute (10 U.S.C. 1079) requires that TRICARE payment levels be aligned with Medicare's fee schedule "to the extent practicable." Similar to the Medicare billing limit, federal law and regulation (P.L. 102-396; 32 CFR 199.14) also prohibit physicians from billing for more than 115% of charges authorized by a DoD fee schedule. However, if payment rates to physicians in certain specialties and geographic areas are proven to severely limit access, the Director of TMA has waiver authority to increase the rates on a case-by-case basis. In terms of waivers by specialty, waivers have been approved for obstetrical or gynecological medical procedures or services in

several locales. Broader waivers have also been approved for various locations in Alaska; Mountain Home, ID; and Ft. Leonard Wood, MO.

MENTAL HEALTH AND TRICARE

Current concerns with TRICARE contracting and physician payment are likely to be exacerbated by the increasing demand for mental health services among beneficiaries. Roughly 300,000 US military personnel who have deployed to Iraq or Afghanistan have post-traumatic stress disorder (PTSD) or severe depression. The costs associated with the prevalence of these conditions likely range between $4 to $6 billion over two years, resulting from the costs of medical care, forgone productivity and suicide. In addition, approximately 20% of the 1.64 million veterans of Iraq and Afghanistan (nearly 320,000 veterans) incur probable traumatic brain injury (TBI) during deployment. The DoD defines TBI as "a traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of one of the following clinical signs immediately following the event: any period of loss of or a decreased level of consciousness; any loss of memory for events immediately before or after the injury; any alteration in mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.); neurological deficits (weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia, etc.) that may or may not be transient; and intracranial lesion." Due to the comprehensiveness of the definition of TBI, cases of TBI can range in their severity from mild to severe. The projected cost of all cases of TBI diagnosed through June 2007 range from $600 million to $800 million in a single year.

Studies to date have shown severe gaps in the access, delivery and quality of mental health services for service members. According to a study by RAND Corporation, 53% of service members with PTSD or depression accessed a provider in the past year. Of those, only about half received "minimally adequate" treatment. This gap between the need for and use of mental health services stems from several factors, such as availability of providers, wait times, concerns regarding confidentiality and stigma.

To respond to increasing demand for mental health services, the DoD established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury in 2007. The DoD has also expanded its mental health screening guidance for deploying troops, and improved its Mental Health Self-Assessment Program. In addition to these efforts, recent reports of the DoD, RAND Corporation and others suggest that increasing payment rates may be necessary to improve access to mental health services. If the access to and quality of mental health services is improved, it has been estimated that evidence-based care for PTSD and major depression could lead to savings as much as $1.7 billion, or $1,063 per returning veteran.

RECENT ACTIVITY RELATED TO TRICARE AND MILITARY HEALTH CARE

The conditions reported at Walter Reed Army Medical Center, coupled with the volume of soldiers returning from Iraq and Afghanistan, has made the issue of providing quality health care to returning service members and veterans a national priority. Realizing that improvements must be made to the health care delivery systems that provide necessary services to military personnel, various task forces and commissions have been charged with analyzing the current state of military health care and developing recommendations to improve access to and quality of care. Closely following the press coverage and findings of the conditions at Walter Reed, the President's Commission on Care for America's Wounded Warriors was established by executive order. In July

2007, the Commission released its final report, which offered six recommendations that primarily focused on improving care and expediting treatment and delivery of services; strengthening support for and improving communication with patients and their families; restructuring the disability and compensation systems; aggressively preventing and treating post-traumatic stress disorder and traumatic brain injury; and strongly supporting Walter Reed. At the 2008 Annual Meeting, the House of Delegates adopted the recommendations of Board of Trustees Report 6, which proposed that our AMA support the recommendations of the President's Commission (Policy H-510.989, AMA Policy Database).

The National Defense Authorization Acts for fiscal years 2006 and 2007, which have been enacted into law, also established task forces within the DoD to examine both the future of military health care and the current status of access to and quality of mental health services. Both task forces submitted their final reports in 2007. The final report of the DoD Task Force on the Future of Military Health Care directed the DoD to implement twelve recommendations on a variety of military health issues, including long-term sustainability of the military health system. The recommendations included restructuring the TMA to prioritize its acquisition role; implementing best practices from the public and private sectors regarding health care purchasing and reexamining requirements in existing purchased care contracts; and promoting the appropriate use of health care resources through case and disease management programs. The final report of the DoD Task Force on Mental Health proposed several recommendations to improve access to and quality of mental health services provided to members of the Armed Forces and the DoD. The recommendations underscored the need to ensure a full continuum of mental health care; improve access to and increase the number of mental health providers, including in TRICARE networks; and providing sufficient resources to mental health services. These recommendations were reinforced by recent findings of RAND Corporation and others.

RELATED AMA POLICY AND ADVOCACY

AMA policy has historically supported providing service members and veterans with improved access to and quality of health care services. Policies D-510.996 and D-510.994 call for the AMA to use its influence to expedite quality medical care, including mental health care, for all military personnel and their families by developing a national initiative and strategies to utilize civilian health resources to complement the federal health care systems. Policy H-510.995 supports providing the VA with sufficient funding to allow its hospitals and clinics to provide proper care to veterans. Policy H-40.962[2] supports the elimination of price controls and encourages competition among health plan choices in TRICARE. Policies H-510.990 and H-510.991 advocate for alternative approaches to providing quality health care to veterans, including increasing VHA flexibility to provide services, and an option similar to the Federal Employees Health Benefit Program (FEHBP). Policies H-40.969[1,3] and H-385.921 support increased and sufficient physician payment rates under TRICARE. Policy D-40.997 stresses the importance of providing physicians with necessary information regarding TRICARE to assist in their contracting decisions, including that related to contractor operations and physician payment. Policies H-510.989 and D-510.994 support the recommendations of the President's Commission on Care for America's Wounded Warriors and advocate working with medical societies and other entities to implement the Commission's recommendations.

At its meeting in March 2008, the Council on Medical Service met with Major General Elder Granger, MD, Deputy Director and Program Executive Officer of the TRICARE Management Activity, to discuss issues relating to contracting and payment, and explore ways to improve the

access of service members, veterans and their families to quality health care. The Council emphasized that physicians still encounter problems with TRICARE contractors, especially with respect to claims processing, and that TRICARE payment rates have become an issue for some physician practices.

The AMA also meets with TRICARE representatives each year to discuss the results of TRICARE's annual survey of civilian physician acceptance of TRICARE patients. The survey measures physician awareness of TRICARE, the percentage of physicians accepting new TRICARE patients among those accepting any new patients, and the disparity in civilian physician acceptance of TRICARE by geographic area and other factors. During the 2008 meeting, it was noted that an increased exchange of information between the AMA and TRICARE, regarding areas in which there are shortages of physicians accepting TRICARE patients, would serve to facilitate improved beneficiary access to necessary health care services.

DISCUSSION

Since its inception, TRICARE has contributed to improving health care access and choice for its beneficiaries—active duty personnel, reservists, military retirees and their families. However, despite reported high satisfaction rates among physicians and beneficiaries with TRICARE and improvements that have been made to the program in terms of its contracting and physician payment, the Council believes important concerns remain with respect to access to and coordination of care, beneficiary and physician education, and physician payment. TRICARE needs to increasingly respond to the geographic diversity of its beneficiaries and model its physician networks and payment levels accordingly to ensure adequate and sustainable physician participation in the program. TRICARE also needs to strengthen and adequately support its networks of mental health providers to respond to the increasing demand for mental health services. The Council notes that physicians have historically provided care to the military population in gratitude for their service to this country, oftentimes at a financial loss. Although payment levels for physicians can be increased on a case-by-case basis, the Council notes sustainable physician participation requires a sustainable physician payment system.

The Council believes information regarding TRICARE and recent improvements to and changes in its operations and contracting can be of value to physicians, including non-network physicians, those contemplating participation in TRICARE and those already participating in TRICARE. To improve the awareness of physicians regarding these changes and improvements in TRICARE, the Council believes that not only does the DoD need to improve its physician education programs, including those for non-network physicians, but that state and specialty societies can play a key role in communicating this information to their members.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed.

1. That our American Medical Association reaffirm Policies H-40.969[1,3] and H-385.921, which support increased and sufficient physician payment rates under TRICARE. (Reaffirm HOD Policy)

2. That our AMA encourage state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. (Directive to Take Action)

3. That our AMA encourage the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. (Directive to Take Action)

4. That our AMA encourage the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. (Directive to Take Action)

5. That our AMA strongly urge the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. (Directive to Take Action)

6. That our AMA strongly urge the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payment for vaccines reflect the published CDC retail list price for vaccines. (Directive to Take Action)

Fiscal note: Staff cost estimated to be less than $500 to implement.

References for this report are available from the AMA Division of Socioeconomic Policy Development.