

Tricare officials give top priority to keeping today's roster of physicians in the program.

Are There Enough Doctors in the House?

LAST April, a dozen family practice physicians near Little Rock AFB, Ark., were ready to drop out of Tricare Prime, the military's managed care network. Dr. Alan R. Storeygard, the group's chairman, told a Congressional panel that Tricare reimbursements were too low and hassles too great.

For example, he noted, Tricare required a primary care doctor to get Tricare's permission before referring a patient to a specialist. This not only slowed down the doctor's work but also added \$25,000 a year to administrative costs.

Today, Storeygard and his colleagues remain in the Tricare network but only because Health Net Federal Services, one of the Tricare support contractors, made extraordinary concessions.

After Storeygard testified, Health Net's executives agreed not only to raise reimbursements but to suspend preauthorization screens—for these doctors alone—in 2003. Health Net officials called it a pilot program seeking to find out whether Tricare can be more efficient by trusting the judgment of doctors with histories of responsible referrals.

Maybe, but the special handling of Storeygard's doctors underscores what has become a high priority for Tricare: keeping physicians satisfied. Members of Congress, Tricare leaders, and managed care contractors agree it's a more important task now, for several reasons:

- Medicare reimbursements, to which Tricare physician fees are tied, fell 5.5 percent in January 2002. The rate was set to fall another 4.4 percent this month, but

By Tom Philpott

Congress instead was scrambling to raise reimbursements as part of last minute negotiations for add-ons to a Fiscal 2003 spending measure. If passed, the increase would ease Tricare officials' worries that more doctors could leave the network or freeze the number of Tricare patients they agree to see.

■ Tricare plans to reorganize on the basis of new managed care support contracts. Today's setup has 12 regions under seven contracts and four contractors. It will shrink to three regions, three contracts, and three contractors. Keeping provider networks robust during the transition is key to sustaining quality care and beneficiary satisfaction.

■ The new contracts set tougher standards for providers. Some current contractors say these new standards are unreasonable and will force more physicians to leave the Prime networks.

■ Roughly 1.9 million Tricare beneficiaries under age 65 rely not on Prime but Tricare Standard, the fee-for-service plan formerly called CHAMPUS. A grassroots beneficiary group claims that the Tricare Standard benefit has diminished because of higher out-of-pocket costs and lack of physicians willing to accept Standard. Tricare leaders have agreed to take a closer look.

Now, Congress has asked the General Accounting Office to study physician "stability" under Tricare and present its report sometime this month.

Tricare already has authority to raise physician reimbursements to ensure access, said Steve Lillie, director of program development for the Tricare Management Activity in Falls Church, Va. However, the tactic has been used sparingly. In February 2000, Tricare bumped fees 28 percent above Medicare levels for physicians in rural Alaska. The special rates remain in effect today.

Moreover, when Medicare several years ago cut fees for surgery services by 10 percent, Tricare declined to apply the cut to obstetrician fees, given that the military beneficiary population tends to be younger.

Tricare also has authority to raise fees as much as 15 percent above the Tricare maximum allowable charge to bring a doctor with specific skills into a network. That authority has not yet been used at all.

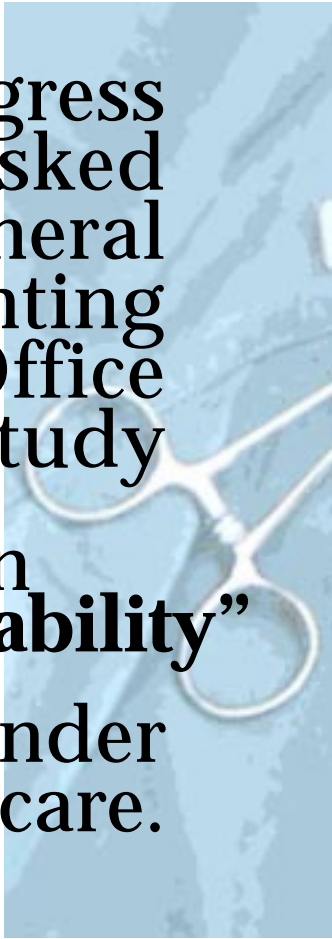
Finally, a support contractor can at any time refer a patient to a physician outside of the network if his specialty is required. This does happen on occasion.

High "Noise Factor"

Support contractors say annual network physician turnover ranges from two to five percent, a rate better than what is found in most managed care programs. On the surface, these numbers seem to suggest overall satisfaction with fees, but it's an example of statistics hiding the real story, according to physicians, patient advocates, and even some network executives.

"I can tell you the noise factor in the provider community has grown more intense," said Paul Gilbertson, Health Net's chief operating officer. His boss, Health Net president James E. Woys, told Congress last year, "We may not have many providers who are turning over in our network [but] we're having more and more providers who are unwilling to accept new patients because of [reimbursement] rates."

That concerns Tricare's Lillie. Doctors in the network need to be willing to accept new patients, he said. Other-



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wise, some beneficiaries—for example, members and families transferring into an area—will not have the access to the care that network enrollment should guarantee.

Health Net is one of four companies in the business of building and managing networks of civilian hospitals and doctors to treat military beneficiaries. The others are Humana Military Healthcare Services, Sierra Military Health Services Inc., and TriWest Healthcare Alliance.

Last year, the cost of the private Tricare contracts hit \$7.2 billion, a figure that eclipsed the \$4 billion spent on the military's direct care system of base hospitals, clinics, and combat medical units.

Lawmakers say that they still get far too many complaints about civilian-provided health care, given the amount of money spent on the Tricare system. The complaints come not only from beneficiaries who can't find physicians willing to accept Tricare but also from physicians concerned about low fees and needless administrative hassles.

"Physician participation is generally adequate," said Rep. John McHugh (R-N.Y.) during hearings last year. "But my dad used to say, 'If you put one foot in a bucket of ice water, and another foot in a bucket of boiling water, on average, you're comfortable.'"

Such concern has also crept into the thinking of Health Net's Woys. "Our network is fairly stable now," he observed. "I am concerned about the future." The incidence of network doctors clamping strict limits on numbers of Tricare patients continues to rise, he said.

In the view of Woys, doctors need "a certain level of

revenue to pay office expenses [and] continue to provide quality care. If it means they have to adjust the mix of [payers], that's probably good business practice."

The Medicare Drag

Tricare physician and hospital fees are tied to Medicare rates, which, unless Congress passes the last-minute increase, will have fallen a combined 10 percent over the last two years. The trouble is that physician costs—for rent, equipment, staff, and malpractice insurance—continue to rise.

In 2002, news outlets began publishing accounts of doctors turning away Medicare patients. Aggravating the fee problem for Tricare, in particular, is that many network physicians are paid less than the Medicare fees because of discount deals signed with Tricare contractors.

Tolerance for discounts is disappearing, say support contractors, as Tricare physician fees, already among the lowest in the nation, fall farther because of the Medicare connection.

David R. Nelson serves as president of Sierra Military Health Services, the Tricare support contractor for the northeast United States. He said every contractor has to perform a delicate balancing act, maximizing discounts while ensuring full patient access to health care.

However, noted Nelson, providers "are less inclined to give a discount off a rate they find unacceptable to begin with."

Support contractors have seen the physician discounts evaporate as contracts come up for renewal. More and more doctors such as Storeygard find reimbursements below Medicare rate to be unacceptable.

"When we went out in '97, '98 to build a system, providers were willing to grant, say, 10 to 15 percent discounts off of the Tricare reimbursements," Nelson said. Since then, many network physicians have renegotiated deals with smaller or no discounts.

With Tricare, physicians worry not only about low fees but also greater administrative headaches tied to tough credentialing standards or the preauthorization requirements.

"With Medicare," said Storeygard, "if you need to refer someone, you just refer them. They see the specialist, they get the test." It keeps administrative costs low and speeds care.

Moreover, it reduces malpractice exposure. "If you have to slow down the process of getting somebody treated, and they have an adverse outcome, you're the doctor involved," said Storeygard. "So the quicker you can get somebody seen, the better."

Fortunately, the troubling fall in doctor fees has been accompanied by alleviation of other major Tricare headaches. One of these was the speed at which Tricare processes claims. This was a big deal only a few years ago. Now, said Storeygard, doctors in his group see Tricare payments arrive almost as quickly as it takes to get reimbursed by Medicare.

"Tricare has made tremendous strides in the past couple of years in speed and accuracy of payment," said David J. Baker, president of Humana Military Healthcare Services.

Tricare and support contractors say they have worked to become less intrusive but that Tricare is inherently more complex than other managed care networks. The reason for this is the "parallel delivery system"—the

outside network for managed care supports a sophisticated military direct care system.

More Hassles?

Next-generation Tricare contracts will provide no relief from current fee structures, said Woys. More troubling, however, are "additional requirements we think increase the hassle factor for providers and probably will decrease participation in the Tricare program," he said.

The new features would require:

- Network physicians and providers to file all of their claims electronically.

- Specialists to promptly give referring physicians legible copies of discharge summaries or postoperative reports within 24 hours for urgent care cases and for routine cases, 10 working days.

Both are admirable goals, said Woys, but Tricare leaders are wrong to make them "absolute requirements." If these features are enforced, he warned, a lot of doctors will leave or decline to join Tricare networks.

"Tricare is less than five percent of patients for many physicians in our networks," said Gilbertson of Health Net. "We don't have the clout [to dictate such terms to doctors that] the government believes we have."

Electronic claims are cheaper than paper, said Woys, and the government is right to try to drive costs down and perhaps to make outside record keeping compatible with the department's new computer-based medical records system.

"Unfortunately, we don't control providers' practices enough to dictate how they submit their claims," he said.

Mike Carroll, a Tricare policy official who helped to shape the new contracts, said he's heard the arguments and is unimpressed. He said providers can make the transition with ease and begin saving money quickly. Moreover, the major support contractors will have authority to "demonstrate some real initiative" and buy their reluctant physicians the hardware and training needed to file claims electronically.

Woys retorted that Medicare for seven years has pressed for 100 percent electronic filing but has only reached 83 percent. He asked, How can Tricare expect to move to 100 percent immediately?

However, Carroll said proposed deadlines for reports to providers who refer patients "really comes down to protecting patients." The longer it takes to get a report, the longer care is delayed.

Unprecedented Demand

One support contractor, however, called the proposed 10-working-days standard "absolutely without precedent in American health care delivery." He said he took an informal poll of network providers and learned that, if the deadline is rigorously enforced, the "business decision" will be to leave the network.

Failure to meet the 10-day deadline would bring the offending specialist a \$100 fine from Tricare. Because support contractors would be responsible for those penalties, they will try to pass them on or will become more intrusive with specialty providers to avoid the fine.

"That's when the provider will say, 'This is enough. This program isn't for me,'" claimed Woys.

Nelson, at Sierra, agreed that Tricare contract officials need a reality check. "We are not the 800-pound gorilla



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that Medicare is,” Nelson said. “Tricare may represent less than two percent of a hospital’s admissions for an entire year, so for us to go into Johns Hopkins [Hospital in Baltimore] and say we have to have all postop reports back to our preferring providers within 10 days—that’s just not an industry norm, nor is Johns Hopkins ever going to comply.”

Humana’s Baker said he doesn’t believe an exodus of physicians is at hand, particularly among the network’s primary care providers. If fees stay low, he said, most of the turnover will be among specialists. However, he said, “if a specialist leaves, and a Prime member had a long-standing relationship for some sort of chronic condition, ... well, if it happens once I’m concerned.”

The complaint about limited access to doctors has become more common among Tricare Standard users. With Medicare rates on the decline, physicians operating outside a network become less willing to accept Tricare fees. Networks can lure providers with the promise of patient volume, Woys said. For Tricare Standard beneficiaries, he said, “there’s no one in the middle” fighting for them.

By design, out-of-pocket costs under Standard are higher. Prime patients (retirees, not active duty) pay a \$230 annual enrollment fee for individual coverage or \$460 for a family. Retirees and their dependents also have co-payments for physician visits or lab tests.

Standard users (including active duty family members) pay a \$300 annual deductible and then 20 or 25 percent of the Tricare rate, for, respectively, active duty dependents or retirees. The annual deductible is less for lower ranks. They also can face an additional 15 percent

charge if doctors or hospitals refuse to accept Tricare maximum allowable charges.

Yet almost two million beneficiaries use Standard. Reasons vary. Many live too far from a base or Tricare network to enroll in Prime. Others want the freedom to choose their doctors. Many retirees have other health insurance and use Standard only as backup insurance.

White Paper Charges

Last year’s “white paper,” written by Standard users who call themselves the Military Retiree Grass Roots Group, said there has been a steady decline in doctors who will accept Standard patients. So, in effect, the one big advantage of Standard—physician choice—is disappearing.

“We have tens of thousands of people who agree with us,” said retired Army Col. John M. Vann, a principal author of the white paper. It was hand delivered to every member of Congress last summer. Tricare officials disagreed with much of the report but said it spurred debate about the decline of the Standard benefit.

One physician group that won’t accept Tricare assignments is Wayne Family Practice Associates of Jesup, Ga., 25 miles from Ft. Stewart. Gwenell Lightsey, office manager for the five physicians, said the group will treat military beneficiaries but only if they pay for care themselves. Then the practice will help patients file claims with Tricare Standard.

By law, no provider can charge Tricare beneficiaries more than 115 percent of the Tricare maximum allowable charge rate. Still, that extra 15 percent on top of a 25 percent cost share for retirees or 20 percent for active duty family members can leave significant out-of-pocket costs. Tricare beneficiaries can pay up to \$3,000 out of pocket.

Even charging 15 percent above the Tricare maximum allowable charge, Lightsey said, “ends up costing us financially to see Tricare patients.”

Tricare officials concede that, while they focused on establishing Prime networks, they paid too little attention to problems facing Standard users. Disparity in out-of-pocket costs became more obvious after Tricare Prime improved and service elderly gained Tricare for Life and Tricare Senior Pharmacy benefits in 2001.

Doctors accepted Tricare rates for 98 percent of Standard claims filed last year, said Lillie. “That doesn’t measure whether a patient can find a doctor or not,” he conceded.

Tricare is committed to doing a better job tracking Prime and Standard access problems. It will gather more information routinely from support contractors and regional management teams. Officials will talk more often with physician groups.

“The clear desire on the part of leadership,” said Lillie, “is to try to find out what’s going on.”

That is the intent of Congress, too. Congressional staffers recently promised to address this year two critical issues: provider reimbursement fees and access to doctors for Standard patients. ■

Tom Philpott, the editor of “Military Update,” lives in the Washington, D.C., area. His most recent article for Air Force Magazine, “Principi’s Honor,” appeared in the October 2002 Issue.