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Subject: *TRICARE: Changes to Access Policies and Payment Rates for Services Provided by Civilian Obstetricians*

About 111,000 women covered by the Department of Defense's (DOD) TRICARE program gave birth during 2006.¹ During their pregnancies, about half of these women received obstetric care from physicians and other providers practicing at military hospitals and clinics called military treatment facilities (MTF), while half received their care from civilian physicians and other civilian providers.² In recent years, the use of civilian obstetric care has increased among TRICARE beneficiaries. In 2004, 51 percent of TRICARE beneficiaries delivered their babies at civilian hospitals; by 2006, 54 percent delivered at civilian hospitals. However, through 2005, some TRICARE beneficiaries reported difficulties obtaining obstetric care from civilian physicians.³

At the same time, some civilian physicians contended that TRICARE payment rates for obstetric care were too low.⁴ TRICARE reimburses physicians for most obstetric care using two global payments, one for uncomplicated vaginal delivery and the other for uncomplicated cesarean delivery, each of which is a single amount that covers a defined set of related services. In the case of obstetrics, these global payments cover a woman's prenatal visits, the physician's assistance at delivery of the baby, and postnatal care after the delivery of the baby.

¹TRICARE offered health care to approximately 9.1 million active duty personnel, retirees, and their dependents in 2006.

²Obstetrics is the branch of medicine that addresses the care of women during pregnancy, childbirth, and the recuperative period following delivery. In addition to obstetricians, other physicians may provide obstetric care. In this report, we generally refer to physicians as the providers of obstetric care, but obstetric care may also be delivered by other types of providers such as nurse midwives and nurse practitioners.

³In general, TRICARE beneficiaries have shifted to civilian providers for outpatient care in recent years. From fiscal year 2004 to fiscal year 2006, use of civilian providers increased from 37 percent to 43 percent of total outpatient care provided. The trend toward increasing use of civilian providers may partially reflect changes in TRICARE beneficiaries' place of residence. Because of military base closures and shifts in the mix of TRICARE beneficiaries (such as additional reservists and their family members) the percentage of TRICARE beneficiaries who lived near an MTF declined between 2000 and 2006 from 55 percent to 48 percent.

⁴In fiscal year 2006, TRICARE paid \$82 million to civilian physicians for outpatient obstetric care, which represented about 4 percent of the program's total outpatient payments of \$1.9 billion to civilian physicians that year. The total TRICARE budget for fiscal year 2006 was about \$39 billion.

Under the TRICARE program, which is administered by DOD's TRICARE Management Activity (TMA), beneficiaries may obtain care through three different options. Beneficiaries enrolled in TRICARE's HMO-like option, called TRICARE Prime, generally obtain health care from physicians at an MTF. TRICARE Prime beneficiaries also may obtain care from a network civilian physician when the MTF does not have sufficient capacity to provide care. Beneficiaries who have not enrolled in Prime receive care under TRICARE Extra or TRICARE Standard.⁵ These options allow beneficiaries to receive care either from civilian physicians who belong to the TRICARE network or from civilian nonnetwork physicians, who do not belong to the TRICARE network but have agreed to accept TRICARE beneficiaries as patients on a case-by-case basis. TRICARE Extra and Standard beneficiaries may also receive care from a physician at an MTF on a space-as-available basis.

TRICARE's civilian provider networks are developed by three managed care support contractors. Each managed care support contractor is responsible for the delivery of care to TRICARE beneficiaries in one of three geographic locations—North, South, and West. The managed care support contractors, among other things, establish targets for the number of physicians required to ensure a sufficient supply of providers to TRICARE patients in civilian provider networks. In developing these targets, each contractor estimates the percentage of each physician's practice that will likely be made up of TRICARE patients. The contractors also monitor progress in meeting targets to ensure network adequacy and periodically make adjustments to the targets to account for changes that occur in the availability of civilian physicians and demands for care of TRICARE beneficiaries.⁶

The National Defense Authorization Act (NDAA) for Fiscal Year 2006 directed us to evaluate the effectiveness of DOD's TRICARE program in achieving adequate access for beneficiaries to high-quality obstetric care.⁷ As discussed with the committees of jurisdiction, this report (1) describes changes TRICARE has made to obstetric coverage policy and payment rates since late 2003 to address concerns about access to civilian outpatient obstetric care and about the adequacy of payments to civilian physicians for obstetric care and (2) examines the extent to which TRICARE's managed care support contractors achieved targeted numbers of obstetric care providers in their civilian provider networks in 2005 and 2006, and potential implications for access to care. In addition, we provide information on the change in TRICARE payment rates for obstetric care compared to inflation; this information is shown in enclosure I.

⁵When TRICARE beneficiaries who have not enrolled in Prime choose to receive care from a network physician, they do so under the rules of TRICARE Extra, which resembles a preferred provider organization. In contrast, TRICARE Standard resembles a traditional fee-for-service program. Nonenrolled TRICARE beneficiaries cannot be categorized as belonging to either Extra or Standard because each time they seek care, they can choose to see a network or nonnetwork civilian physician, and this choice determines whether they receive coverage under Extra or Standard.

⁶The managed care support contractors have a financial incentive to ensure that they develop and maintain an adequate supply of physicians in the civilian provider network. TMA requires, on a monthly basis, that not less than 96 percent of all referrals of TRICARE beneficiaries who reside within 40 miles of an MTF be made to a physician at an MTF or a physician in the civilian provider network. If this standard is not met, TMA imposes a monetary penalty that reduces its payment to the contractor.

⁷See Pub. L. No. 109-163, § 734, 119 Stat. 3136, 3353-55.

To provide information on TRICARE changes to policies regarding access to obstetric care and payment rates, we reviewed relevant coverage and payment policies implemented in late 2003 through 2006. We interviewed officials from TMA, the office with responsibility for ensuring that DOD health policy is implemented for the TRICARE program. We also interviewed representatives of the American College of Obstetricians and Gynecologists and the National Military Family Association.⁸

To provide information on the extent to which TRICARE's managed care contractors met targets for the number of obstetricians⁹ in their civilian provider networks, and implications for access to care, we analyzed data provided by the managed care support contractors for TMA-defined service areas called prime service areas (PSA).¹⁰ The managed care support contractors provided us with periodic reports on the targeted and actual number of network obstetricians participating in the civilian provider networks during 2005 and 2006. For each reporting period, in each PSA, we determined whether the actual number of network obstetricians fell short of the targeted number of network obstetricians by one or more. Across the entire reporting period of calendar years 2005 and 2006, we identified the number of PSAs that had fewer obstetricians than were targeted for four or more reporting periods. We considered these PSAs to have "frequently fallen short" of the targets set by the managed care contractors. We also interviewed representatives of the three managed care support contractors, the American College of Obstetricians and Gynecologists, and the National Military Family Association about TRICARE beneficiaries' access to obstetric care during 2006.

Our analysis of the number of obstetricians participating in TRICARE's civilian provider networks was limited by the data available. We asked the managed care support contractors to provide monthly data for January, April, July, and October 2005 and 2006. The North and West regions' managed care support contractors provided periodic data reports for calendar year 2005 and most of calendar year 2006, while the South region managed care support contractor provided monthly data as we requested. The North region was unable to report until March 2005, which resulted in slightly different reporting periods for the North and West regions. The data provided by the managed care support contractors were sufficient to illustrate the extent to which each of the three managed care contractors met its own targets for the number of network obstetricians during the period for which data were provided, which generally covered early calendar year 2005 through late calendar year 2006.

Through our review of relevant documentation and discussions with TMA officials and representatives of managed care support contractors, we determined that the data presented in this report were sufficiently reliable for our purposes. We did not assess the soundness of TRICARE's policy changes, nor did we evaluate the criteria used by the managed care support contractors for determining the targeted number of network obstetricians. Although we did not verify the managed care support contractors' data on the number of network

⁸The American College of Obstetrics and Gynecologists is a national professional society that represents 90 percent of U.S. board-certified obstetrician-gynecologists. The National Military Family Association represents members of the armed forces and their families.

⁹TRICARE's managed care support contractors set targets for specialists in obstetrics and gynecology, which may include providers other than obstetricians.

¹⁰PSAs typically include a 40-mile radius around MTFs and thus can include multiple counties. PSAs are also established for other areas where TMA has determined that networks would be cost effective.

obstetricians, we reviewed the data for implausible values and internal consistency. Because TMA made several changes to its payment rates for obstetric care that took effect during 2006, at the time of our review data were not yet available to draw conclusions about the effect of these changes on beneficiaries' access to civilian obstetric care.¹¹

We conducted our work from December 2006 through June 2007 in accordance with generally accepted government auditing standards.

Results in Brief

Since late 2003, TMA has made several changes aimed at addressing concerns about TRICARE beneficiaries' access to civilian obstetric care. TMA's nationwide changes began in late 2003; the most recent changes took effect in 2006. In late 2003, TMA loosened controls over access to civilian obstetric care nationwide by permitting TRICARE Extra and Standard beneficiaries to obtain obstetric care from civilian physicians without first receiving approval from the local MTF. In 2006, TMA made two nationwide changes to its physician payment rates for obstetric care. First, TMA began paying separately for maternity ultrasounds—outside of TRICARE's two global payments for obstetric care—performed during an uncomplicated pregnancy, which is likely to result in increased total payments to physicians.¹² Second, TMA increased payment rates for obstetric care in geographic areas where TRICARE payment rates were lower than the Medicaid payment rates for obstetrics, to match the Medicaid payment rates.¹³ In addition, in response to localized concerns about severe physician shortages, TMA increased payment rates for specialized obstetric care in Alaska and raised payment rates for obstetric care in a South Dakota PSA to improve access and network capacity in these locations.

In 2005 and 2006, managed care support contractors met most of the targets—77 percent—they set for numbers of obstetricians in TRICARE's regionally based networks. Of the 175 PSAs in the civilian provider networks, 24 PSAs (14 percent) fell short of obstetrician supply targets for four or more reporting periods during 2005 and 2006, while another 16 PSAs (9 percent) fell short of these targets for one to three quarters. The contractors' achievement in meeting the majority of their targets in 2005 and 2006 serves as an indicator that access was not likely a problem for most TRICARE beneficiaries seeking obstetric care. However, we could not be conclusive about access from these data alone because of other factors that can influence access. For example, in PSAs where targets were consistently met, access could have been a problem if the contractors overestimated the percentage of TRICARE patients that network civilian obstetricians were willing to treat. Conversely, in PSAs that frequently fell short of established targets, network civilian obstetricians may have been

¹¹TRICARE claims data offer information about trends in service use and the number of physicians providing care to TRICARE beneficiaries, but complete data have a lag time of about 1 year behind program changes as physicians and other providers may take up to 1 year to submit claims for payment. Only after claims are submitted for payment are the records of service use and physician participation included in the claims database.

¹²Ultrasound is a type of imaging used by health professionals in many types of examinations and procedures. A standard maternity ultrasound creates a picture that helps a provider determine a baby's gestational age and evaluate a baby's growth and development.

¹³Medicaid is the joint federal-state program that provides health care coverage for certain low-income individuals. In fiscal year 2005, the last year for which data were available, about 60 million low-income children, families, and aged or disabled individuals were covered by Medicaid.

willing to absorb more TRICARE patients than had been estimated by the contractors. Representatives of the American College of Obstetricians and Gynecologists and the National Military Family Association told us that they had not heard significant concerns from their members in 2006 about the adequacy of TRICARE's payment rates for obstetric care or access to civilian obstetricians. In commenting on a draft of this report, DOD agreed with our findings.

Background

To supplement health care provided in MTFs, TMA requires managed care support contractors to develop civilian provider networks. To accomplish this, managed care support contractors develop comprehensive network plans that include physician targets for each specialty, including the number of obstetric care providers required for each PSA. A key factor for civilian obstetricians in deciding whether to participate in TRICARE has been the payment rate for obstetric care, which has undergone significant changes over the past decade as part of an overall effort to reduce military health care costs. In geographic locations where the TRICARE program is experiencing shortages of providers or access to health care is severely impaired, TMA has the authority to approve payment rate increases to encourage civilian physicians and other providers to participate in TRICARE.

TRICARE Provisions for Extra and Standard Beneficiaries to Use Civilian Care

TRICARE Standard is designed to provide TRICARE beneficiaries maximum flexibility in selecting civilian providers. Under Standard, TRICARE beneficiaries may obtain care from TRICARE-authorized nonnetwork civilian providers of their choice.¹⁴ TRICARE beneficiaries using this option do not need a referral for most specialty care. Network civilian physicians enter a contractual agreement with the regional managed care support contractors to provide health care to TRICARE beneficiaries. However, network civilian physicians do not have to accept all TRICARE beneficiaries seeking care if the physician's practice does not have sufficient capacity. Nonnetwork civilian physicians do not have a contractual agreement with a managed care support contractor, and may accept TRICARE beneficiaries as patients on a case-by-case basis. They also have the option of charging up to 15 percent more than the TRICARE payment rate. The beneficiary must pay the additional 15 percent, along with their required copayments.

TMA Oversight of TRICARE Program

TMA, in DOD's Office of the Assistant Secretary of Defense for Health Affairs, establishes TRICARE policy and payment rates for services. To help administer the program, TMA uses managed care support contractors to develop networks of civilian providers and perform other customer service functions, such as claims processing. Currently, there is one managed care support contractor for each of TRICARE's three regions.¹⁵ For each PSA within the regions, managed care support contractors are required to maintain civilian provider networks that are large enough to provide access to care for all TRICARE beneficiaries living in the area. To do so, each contractor, using its own methodology, determines the number of

¹⁴For more information about access to civilian health care providers for TRICARE beneficiaries who have not enrolled in Prime see GAO, *Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option*, [GAO-07-48](#) (Washington, D.C.: Dec. 22, 2006).

¹⁵Each TRICARE region has about the same number of TRICARE beneficiaries.

civilian physicians required for each PSA in its region, based on the number of TRICARE beneficiaries in the PSA and other factors, such as the estimated percentage of each physician's practice likely to be made up of TRICARE patients.¹⁶ Separate targets are set for each specialty, including obstetrics, and these targets along with other information on the network size are updated by the contractors in monthly or quarterly reports.

For each region, TMA has established a TRICARE regional office and has designated the office directors as health plan managers for their regions with responsibilities for monitoring provider network adequacy, overseeing the managed care support contractors, and monitoring customer satisfaction. In 2006, about 9,600 obstetricians participated in TRICARE's civilian provider network, representing about 26 percent of all civilian obstetricians in the United States.¹⁷

TRICARE Payment Structure for Civilian Obstetric Care

TMA pays civilian physicians for most obstetric care using global obstetric payments. Under a global payment, physicians are not reimbursed separately for every office visit or individual service provided. Rather, the physician receives one payment for a defined set of related services. TRICARE's most frequently used global obstetric payments include payment for prenatal care, the physician's attendance at delivery, and postnatal care.¹⁸ Although TMA also pays physicians for obstetric care through 59 other billing codes, approximately 68 percent of TRICARE's obstetric payments are made under the 2 billing codes that we refer to as global payments—the payments for the set of obstetric services related to uncomplicated vaginal deliveries and the set of services related to uncomplicated cesarean deliveries. The other 59 billing codes used to reimburse for obstetric care are for such obstetric-related services as amniocentesis, a diagnostic procedure sometimes performed during pregnancy, or delivery-only services for cases in which the physician does not provide prenatal or postnatal care.

TRICARE's payment rates for obstetric care have been in transition for over a decade. In the early 1990s, under DOD's former health care program, DOD's payment rates to civilian physicians were based on historical charges—an annual calculation of physicians' charges for services claimed the previous year.¹⁹ Using this approach, DOD's payment rates were, on average, 50 percent higher than those paid for identical treatment under the Medicare

¹⁶In developing civilian provider networks, managed care support contractors also consider historical medical needs, availability of existing services in MTFs, and the availability of civilian providers to deliver care within the PSAs.

¹⁷According to the 2005 *Area Resource File* published by the National Center for Health Workforce Analysis, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services, in 2004 there were about 37,200 civilian obstetricians in the United States. The *Area Resource File* provides data on county-level demographics and health systems.

¹⁸Hospitals bill TRICARE separately for the hospital stay.

¹⁹DOD replaced its Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which had been administered as a fee-for-service type health care program, with TRICARE, a triple-option benefit type program, in 1994. CHAMPUS payments were based on an annual calculation of the 80th percentile of physicians' charges statewide.

program.²⁰ Beginning with fiscal year 1991, in response to concerns about rising costs of military health care, Congress required that DOD's physician payments gradually be brought in line with payment rates under the physician fee schedule for the Medicare program. Each year, the payment rate for a particular service was to be reduced by no more than 15 percent of the amount allowed during the previous year for that service.²¹

As DOD implemented these payment revisions, however, civilian obstetricians expressed concerns that the revised payment rates were too low. In response, in July 1998, TMA returned payment rates for obstetric billing codes to 1997 levels after having reduced those rates earlier in the year. TMA then decided to freeze obstetric payment rates at 1997 levels until Medicare payment rates for obstetric care caught up to TRICARE's 1997 payment rates.

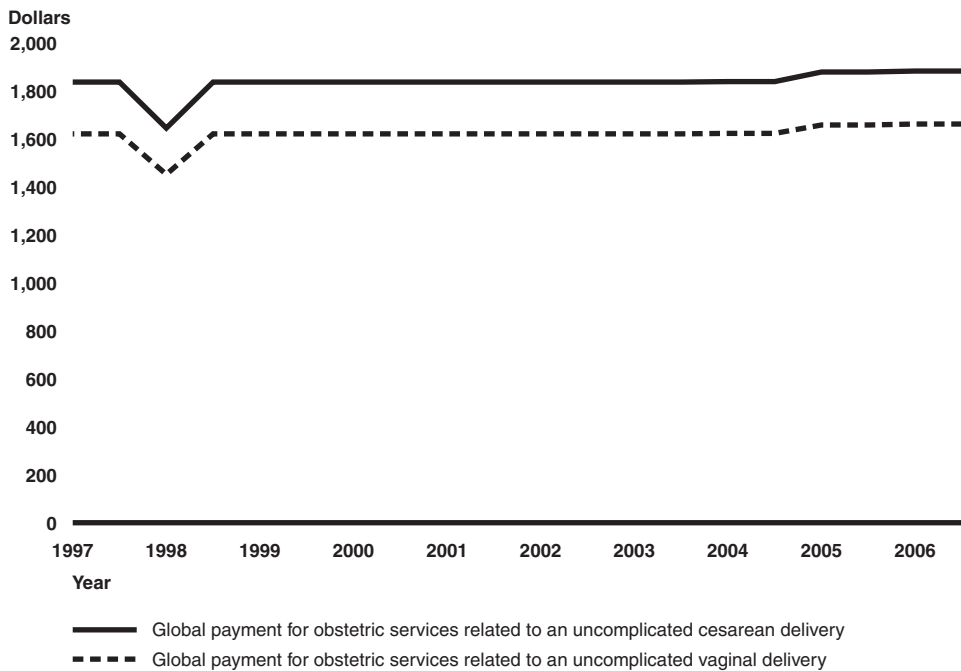
Thus, TMA allowed inflation to gradually reduce the value of TRICARE's obstetric payments.²² As shown in figure 1, from July 1998 through 2006, TRICARE's global payments for the set of services related to uncomplicated vaginal deliveries and uncomplicated cesarean deliveries have remained relatively constant at about \$1,600 and \$1,800, respectively.

²⁰DOD is now required by law to follow Medicare's reimbursement rules to the extent practicable. See 10 U.S.C. § 1079(j)(2). Since 1992, Medicare—the federal program that pays for health care services and items on behalf of more than 42 million elderly and disabled beneficiaries—has paid physicians using a fee schedule with payment rates for more than 7,000 services. The physician community is involved in setting the relative differences in payment rates for these services, including payment rates for services not commonly used by the Medicare population, such as obstetric care.

²¹See Department of Defense Appropriations Act for Fiscal Year 1991, Pub. L. No. 101-511, § 8012, 104 Stat. 1856, 1877 (1990). This provision was codified at 10 U.S.C. § 1079(h).

²²By 2006, 30 of the 61 obstetric billing codes were still paid at TRICARE's 1997 payment rate levels.

Figure 1: Payment Rates for TRICARE’s Most Frequently Used Billing Codes for Obstetric Services, Known as Global Payments, 1997 through 2006



Source: GAO analysis of TRICARE payment data.

Note: In 2006, the two global obstetric payments represented 68 percent of TRICARE’s total physician payments for obstetric care. This figure shows that TRICARE’s global payments for obstetric care services have remained relatively constant since July 1998, when TMA restored payment rates to 1997 levels in response to physicians’ concerns that payment rates were too low.

TMA Has Authority to Adjust Payment Rates under Certain Conditions

TMA has the authority to adjust TRICARE payment rates under certain conditions to increase beneficiaries’ access to care. Under TMA’s locality-based waiver authorities, TMA may approve increases in TRICARE’s payment rates for both network and nonnetwork providers in locations where access to care is impaired. For example, TMA may approve payment rate increases for network providers when it has determined that it is necessary and cost effective to approve higher rates to ensure an adequate number and mix of qualified health care physicians in a specific locality. In such instances, payment rates can be raised to a maximum of 115 percent of rates set in the TRICARE physician fee schedule.²³ TRICARE payment rates for specific services can also be adjusted for both network and nonnetwork providers in localities where access to care has been severely impaired.²⁴ In such instances, one method that may be used to establish the higher payment rates is to adopt the payment rates of other government health care programs, such as Medicaid. If this method is used, TMA would

²³See 10 U.S.C. § 1097b(a); 32 C.F.R. §199.14(j)(1)(iv)(E).

²⁴See 10 U.S.C. § 1079(h)(5); 32 C.F.R. § 199.14(j)(1)(iv)(D).

adopt the applicable state Medicaid rate if TRICARE's payment rate is lower in a specific location.²⁵

Recent Changes Loosened a Restriction on Access to Civilian Obstetric Care and Increased Some Obstetric Payment Rates

Since late 2003, TMA has made several changes aimed at addressing concerns about TRICARE beneficiaries' access to civilian obstetric care. One change loosened a restriction on access to civilian providers of obstetric care, and other changes raised payment rates for obstetric care in some geographic areas and for specific obstetric services.

In December 2003, in response to provisions in the NDAs for fiscal years 2001 and 2002, TRICARE loosened restrictions on Standard and Extra beneficiaries' access to civilian obstetricians and other civilian providers of obstetric care.²⁶ Prior to that time, Standard and Extra beneficiaries who resided within a 40-mile radius of an MTF had been expected to receive their obstetric care from military physicians at the local MTF. Civilian obstetric care was permitted for those beneficiaries only when the beneficiary lived more than 40 miles from the MTF or when the local MTF provided a written statement of nonavailability, stating that the MTF did not have sufficient capacity to provide obstetric care. This limitation caused concern among some Standard and Extra beneficiaries who received other medical care from civilian physicians. On December 28, 2003, TMA revised its regulations to allow Standard and Extra beneficiaries who lived within a 40-mile radius of an MTF to access obstetric care from civilian physicians without first obtaining a nonavailability statement.²⁷

Payment changes include the following:

- *TRICARE changed the way it paid for obstetric ultrasounds.* Effective April 1, 2006, to help address concerns among civilian obstetricians about payment rates for obstetric care, TMA began paying for ultrasounds related to uncomplicated pregnancies outside the global obstetric payment. This additional payment is likely to result in overall higher payments for physicians who perform one or more ultrasounds during the course of pregnancy.²⁸ Prior to this change, TRICARE included ultrasounds performed for uncomplicated pregnancies in the global obstetric payment.²⁹ However, after an analysis of historical TRICARE claims data, TMA officials determined that the global obstetric payment was not sufficient to cover the physicians' payments for ultrasounds, and that its policy to include ultrasounds in the global

²⁵Medicaid payment rates are consistent across all geographic areas within a state, whereas TRICARE rates are locality based. There are 89 TRICARE payment rate localities for the United States and Puerto Rico.

²⁶See Pub. L. No. 106-398, § 728, 114 Stat. 1654, 1654A-189 (2000); Pub. L. No. 107-107, § 735, 115 Stat. 1012, 1171-72 (2001).

²⁷TRICARE's Prime enrollees are not affected by this change. They are expected to receive obstetric care from physicians at the local MTF, unless the local MTF lacks sufficient capacity, in which case enrollees are referred to civilian physicians for care.

²⁸TMA estimated that program costs would increase by about \$1.5 million annually as a result of this change.

²⁹TRICARE's policy has always been to pay separately—outside the global obstetric payment—for ultrasounds performed during complicated pregnancies.

obstetric payment may have inadvertently discouraged physicians from doing as many ultrasounds as might be needed.³⁰

- *TRICARE matched state Medicaid payment rates for physician-provided obstetric care.* Effective May 1, 2006, TMA increased payment rates for obstetric care to ensure that TRICARE's payment rates were at least equal to Medicaid payment rates in each state. For a locality to qualify for increased obstetric payment rates under this policy change, TRICARE had to have been paying an amount below the state's Medicaid payment rate.³¹ Specifically, TMA identified states where at least one locality was below the state's Medicaid payment rate for any of the six most frequently billed codes for obstetric care. In those localities, TMA increased TRICARE payment rates to match the state's Medicaid payment rates for a broader range of obstetric care that includes services provided under 14 billing codes.³² For 2006, this policy affected TRICARE's payment rates in 12 states, primarily in the West region, as shown in figure 2. Under this change, TRICARE's payments for the 14 obstetric billing codes increased an average of 19 percent in the affected states.^{33, 34}

³⁰We did not review TMA's analysis of the claims data.

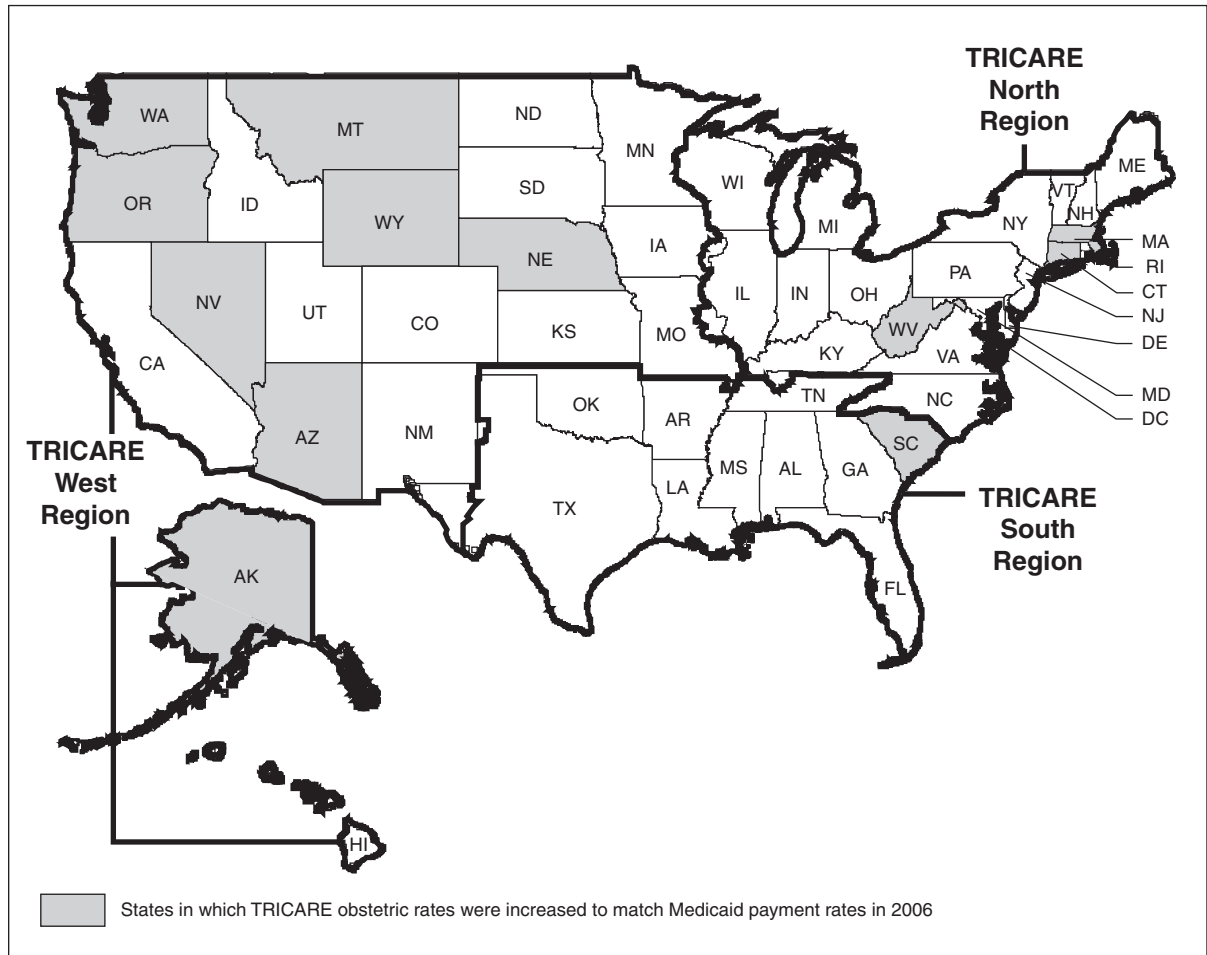
³¹State Medicaid payments for obstetric care varied widely in 2006. In its comparison of TRICARE payment rates and state Medicaid payment rates, TMA found that state Medicaid payments for the set of obstetric services related to an uncomplicated vaginal delivery (or the closest equivalent set of services under the state's payment system) ranged from \$616 in Ohio to \$2,859 in Connecticut.

³²In 2006, the 6 billing codes used to identify states for the Medicaid-related payment increase together accounted for about 90 percent of TRICARE's total payments for obstetric care, while the 14 billing codes together accounted for over 97 percent of payments for obstetric care.

³³In implementing this change across the 12 states, TMA made a total of 118 distinct payment increases by adjusting its payment rates for any of the 14 billing codes that were paid below the Medicaid payment rate in the state. The average payment increase in 2006 was \$142, with a median payment increase of about \$69. TMA estimated that program costs would increase by about \$2 million annually as a result of this change.

³⁴Annually, TMA compares TRICARE payment rates and Medicaid state payment rates for obstetrics. According to TMA, 11 of the 12 states that received the increase to the Medicaid payment rate in 2006 (Arizona, Connecticut, Massachusetts, Montana, Nebraska, Nevada, Oregon, South Carolina, Washington, West Virginia, and Wyoming) also received matching rates in 2007. Alaska did not receive a Medicaid matching rate increase for 2007 as its payment rates were raised above the Medicaid rate in February 2007 by a TRICARE demonstration project.

Figure 2: States Receiving TRICARE Payment Rate Increases for Obstetric Care Services to Match State Medicaid Rates, 2006



Source: GAO analysis of DOD data.

- *Under the locality-based waiver authority, TRICARE increased payment rates for perinatology services in Alaska.* On November 21, 2005, TMA approved a locality waiver request to raise payment rates for perinatologists in Alaska in response to obstetric specialist supply problems.³⁵ TMA raised TRICARE payment rates to 140 percent of the obstetric payment rates set in the TRICARE physician fee schedule in response to physician concerns that the TRICARE payment rate was too low. TMA officials noted that there were only three perinatologists in the state at that time; these providers had agreed to continue participating when the payment rate was raised to 140 percent. On February 1, 2007, under a 3-year demonstration program, TMA began paying all physician services in Alaska at 135 percent of the rates set in the TRICARE physician fee schedule, including nonspecialty obstetric care

³⁵Perinatologists are obstetric specialists who provide care for women in high-risk pregnancies. They generally receive the same global obstetric payment level as obstetricians and other physicians who focus on patients who are not high risk.

services.³⁶ As a result, the gap in payment for services provided by perinatologists and other physicians providing obstetric care in Alaska narrowed substantially.³⁷

- *Under the locality-based waiver authority for network providers, TRICARE increased payment rates for physicians providing obstetric care in the Ellsworth Air Force Base PSA, South Dakota.* On May 16, 2006, TMA approved a locality waiver request to increase payment rates for obstetric services provided by a group practice of 12 obstetricians in the Ellsworth Air Force Base PSA, South Dakota.³⁸ Stating that TRICARE’s payment rates for obstetric care were too low, the group practice had decided to leave the TRICARE network. In its review of the waiver request, TMA found that obstetric care was not offered at the local MTF. Furthermore, there were no other civilian obstetricians practicing in the area to accept the TRICARE beneficiaries that were receiving care from the group practice. TMA concluded that its payment rates should be increased due to severely limited access to network-based obstetric care in the PSA. TMA set its obstetric payment rates at 115 percent of the established payment rate and the group of physicians agreed to remain in the civilian provider network. In the event that other obstetricians located in the area were willing to join the TRICARE network, TMA officials indicated that they would consider whether the increased payment rate was still necessary to ensure beneficiary access to care from network physicians.

In 2005 and 2006, Managed Care Support Contractors Met Their Targets for Network Civilian Obstetricians in Most TRICARE Localities

In 2005 and 2006, managed care support contractors met most of their targets for the number of obstetricians in TRICARE’s civilian provider networks. Of the 175 PSAs subject to TRICARE’s standards for network adequacy, 135 PSAs (77 percent) met targets for network civilian obstetricians during all reported periods during 2005 and 2006. Relatively few localities frequently fell short of the contractor-set targets, with “frequently” defined by us as missing targets during four or more reported periods during 2005 and 2006. Across the three contractors’ regions, 24 PSAs (14 percent) frequently fell short of targets for obstetricians. Nineteen of these 24 PSAs were still short of their targets as of late calendar year 2006, the last reporting period for which we obtained data. Another 16 PSAs (9 percent) fell short of targets during one to three reporting periods in 2005 and 2006.

³⁶See 71 Fed. Reg. 67112-13 (Nov. 20, 2006).

³⁷TMA officials indicated that the payment rate increase for Alaska was necessary due to an overall scarcity of providers, their reluctance to accept TRICARE payment rates, transportation issues, and other factors. Through the demonstration project, TMA expects to obtain information about how increased payment rates affect provider participation in TRICARE, beneficiary access to care, and the cost of health care services.

³⁸The waiver also included payment for gynecology, which focuses on reproductive health care services for women.

The 24 PSAs where contractors frequently fell short of targets for civilian obstetricians include a mixture of urban and rural counties. Sixteen of the 24 PSAs are made up of predominately urban counties while 8 PSAs are predominately rural counties.³⁹ Some of the locations may have been affected by overall shortages of practicing civilian obstetricians. In 2004, nationwide, there were 12.5 practicing obstetricians and gynecologists per 100,000 population.⁴⁰ In that year, 15 of the 24 PSAs were below this national average, whereas 8 of the 24 PSAs exceeded the national average.⁴¹

The North region had the greatest number of localities—17 PSAs—that frequently fell short of targets for civilian obstetricians. (See fig. 3.) The South region had 5 PSAs and the West, 2 PSAs, which frequently did not meet targets for civilian obstetricians during the review period.

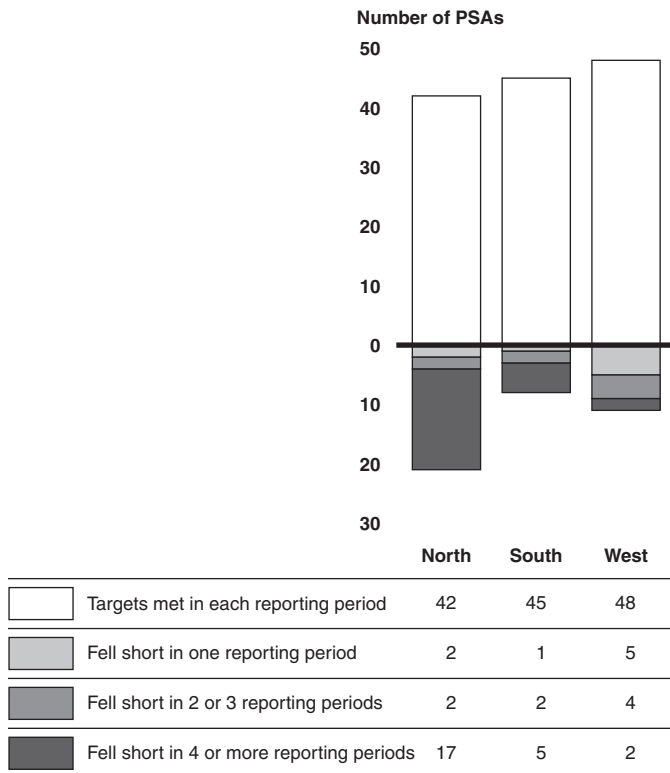
Our finding that more than three-fourths of PSAs met their physician supply targets for all reported periods is an indicator that access was not likely a problem for most TRICARE beneficiaries seeking obstetric care. However, we could not be conclusive about access from the contractors' data alone because of other factors that can influence access. For example, in PSAs where targets were consistently met, access could have been a problem if managed care support contractors overestimated the percentage of TRICARE patients that network civilian obstetricians were willing to treat. Alternatively, in PSAs that frequently fell short of established targets, network civilian obstetricians may have been willing to take on more TRICARE patients than had been estimated by the managed care support contractors.

³⁹The 24 PSAs with recurring shortfalls of civilian network obstetricians include a total of 1,580 counties, of which 1,022 counties (65 percent) are urban and 558 (35 percent) are rural.

⁴⁰These figures are based on 2005 data from the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services.

⁴¹Two of the PSAs are located within the same county and thus the 24 PSAs collapse into 23 PSAs when reporting on county-level statistics.

Figure 3: Number of PSAs That Met or Fell Short of Targets for Civilian Obstetricians by TRICARE Region, 2005 and 2006



Source: GAO analysis of TRICARE managed care contractor data.

Note: Data for the North region are quarterly from March 2005 through November 2006. Data from the West region are quarterly from January 2005 through September 2006, and data from the South region are monthly for January, April, July, and October 2005 and 2006. Managed care contractors use different models to set targets for the number of physicians in the civilian provider network.

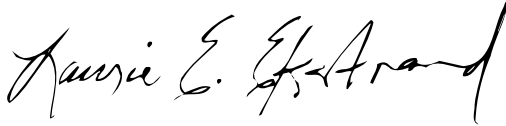
In separate discussions with national associations representing obstetricians and military family members, association officials indicated that, in 2006, their members did not relate substantial concerns about the adequacy of TRICARE’s payment rates or access to civilian obstetricians. The representatives of managed care support contractors also told us they had received a minimal number of concerns from beneficiaries and network civilian obstetricians about obstetric care matters.

Agency Comments

We provided a draft of this report to DOD for comment. DOD’s comments are reprinted in enclosure II. In its comments, DOD stated that it agreed with our findings and provided technical comments. We incorporated DOD’s technical comments as appropriate.

We are sending copies of this report to the Secretary of Defense and other interested parties. In addition, this report will be available at no charge on GAO’s web site at <http://www.gao.gov>. We will also make copies available to others upon request. If

you or your staff have any questions about this report, please contact me at (202) 512-7114 or ekstrandl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Phyllis Thorburn, Assistant Director; Alexander Dworkowitz; Hannah Fein; Jenny Grover; and Darryl Joyce made key contributions to this report.

A handwritten signature in black ink that reads "Laurie E. Ekstrand". The signature is written in a cursive style with a large initial 'L' and 'E'.

Laurie E. Ekstrand
Director, Health Care

Enclosures – 2

List of Committees

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

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

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

The Honorable John P. Murtha
Chairman
The Honorable C.W. Bill Young
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

The Change in TRICARE Payments for Obstetric Care as Compared to Inflation

Table 1 shows the change in TRICARE’s payment rates for six common obstetric billing codes that include payment for childbirth, relative to the change in inflation, from 1997 to 2006.

Table 1: Percentage Change in TRICARE Payment Rates for Six Obstetric Care Billing Codes Compared to the 2.7 Percent Average Annual Change in Medical Inflation, 1997 through 2006

Services billed under six obstetric codes	Average annual change (percentage)
Set of obstetric services related to an uncomplicated vaginal delivery	0.3
Vaginal delivery only	0.0
Vaginal delivery and postpartum care	0.0
Set of obstetric services related to an uncomplicated cesarean section	0.3
Cesarean delivery only	0.0
Cesarean delivery and postpartum care	0.0

Source: GAO analysis of TRICARE payment data.

Note: Together, the six billing codes accounted for about 90 percent of TRICARE’s total payments for obstetric care in 2006. The rate of inflation is measured by the Medicare Economic Index (MEI). The MEI is a measure of inflation relative to physicians’ practice costs and general wage levels. The MEI includes a set of inputs used in furnishing services such as a physician’s own time, nonphysician employees’ compensation, rent, and medical equipment. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies. TRICARE payment rates for four of the six obstetric care billing codes were above Medicare payment rates in 2006: vaginal delivery only; vaginal delivery, including postpartum care; cesarean delivery only; and cesarean delivery, including postpartum care.

Comments from the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

JUL 18 2007

Ms. Laurie Ekstrand
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Ekstrand:

This is the Department of Defense (DoD) response to the Government Accountability Office's (GAO) draft report, GAO-07-941R, "TRICARE: Changes to Access Policies and Payment Rates for Services Provided by Civilian Obstetricians," dated July 2, 2007 (GAO Code 290602).

Thank you for the opportunity to review and provide comments on the Draft Report. We have reviewed the report for technical accuracy and agree with the findings. I have attached several technical comments in reference to effective dates for TRICARE changes for payment rates and services. In addition, I concur with the Draft Report's conclusions. DoD is pleased the GAO found that the TRICARE managed care support contractors met most of the targets for the number of physicians in the provider network for 2005 and 2006 and that is an indicator that access was not likely a problem for most TRICARE beneficiaries seeking obstetric care.

My points of contact are Ms. Reta Michak (Functional) at (303) 676-3440 and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-3492.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Ward Casscells".

S. Ward Casscells, MD

Enclosure:
As stated

(290602)

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