[Categorical Listing] [Numerical Listing]

This policy is clarified by HA Policy 97-046

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

JAN 29 1996

MEMORANDUM FOR: ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)

SUBJECT: Updated TRICARE Policy Guidelines

This memorandum transmits the January 1996, revision to the TRICARE policy guidance, dated February 18, 1994, for the TRICARE Lead Agents and Military Treatment Facility (MTF) commanders. These guidelines should be used in the development of their TRICARE plans and programs.

This document will continue to be refined to reflect our experiences and "lessons learned" as we progress in the implementation of TRICARE. Updates to the guidelines will be dated to reflect their currency and will appear on the Health Affairs home page on the World Wide Web.

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HA POLICY 96-025

POLICY GUIDELINES FOR

IMPLEMENTING MANAGED CARE REFORMS

IN THE

MILITARY HEALTH SERVICES SYSTEM

January 1996

OVERVIEW

The mission of the Military Health Services System (MHSS) is to be ready to provide top quality health services, whenever needed, in support of military operations and to members of the Armed Forces, their families, and others entitled to DoD health care. As the world's pre-eminent military health services system, we are accountable to the American people for support of national security and the health of military personnel, retirees, and their families.

Together, we are committed to:

- Readiness for joint operations in a dynamic global environment,
- Provision of top quality cost effective health benefits,
- Development of military and civilian leaders who excel in a changing world, and
- Innovation and the application of new technology

These policy guidelines describe the principles and design of the DoD TRICARE Program. They describe its key features, including strategies for the delivery, organization and financing of care, and improved accountability. This policy guidance incorporates by reference, the DoD Medical Readiness Objectives 2001, and replaces the Department's previous TRICARE Policy Guidelines dated February 18, 1994.

TRICARE PROGRAM GOALS AND GUIDING PRINCIPLES

The TRICARE Program is based on the following goals:

- Provide medical services and support to the Armed Forces prior to and during military operations;

- Improve beneficiary access to care;
- Assure a high quality, consistent and efficient health care benefit for all Military Health Services System MHSS beneficiaries; at a reasonable cost;
- Provide more choices for all non-active duty participants;
- Contain overall DoD health care costs; and
- Obtain maximum enrollment into the TRICARE Prime option of eligible beneficiaries, including active duty members.

PRINCIPLES

The principles that guide the design and implementation of the TRICARE program are as follows:

- **Provide medical services and support to members of the Armed Forces to keep them physically prepared for deployment.** We will do our part to insure a combat-ready force. In addition, we will enable the Department to retain a healthy force capable of meeting its broad-ranging mission requirements.
- **Implement Managed Care.** TRICARE is the military managed care program. It will ensure accountability for health care spending and provide beneficiaries access to high quality care. For other than active duty beneficiaries, the program will provide more freedom to choose among alternative sources of health care.
- **Designate regional health service areas and Lead Agents.** The TRICARE program restructures the geographic Military Health Services System into Health Services Regions, each administered by a Lead Agent, who is designated by the TRICARE Executive Committee. The Lead Agent functions as the focal point for health services and collaborates with the other Military Treatment Facility (MTF) commanders within the region to develop an integrated plan for the delivery of health care for their beneficiaries. These regions were established to ensure an adequate beneficiary population base to support cost-effective volumes of care under TRICARE Support contracts, and regional access to tertiary care provided primarily by military medical centers.
- **Central oversight with local accountability and execution.** Health care is delivered locally; therefore, it must be managed locally. Consequently, MTF commanders will have the tools, flexibility, and authority to make appropriate decisions about the delivery of care. Lead Agents and MTF commanders will be accountable for the health care costs, quality and access in their delivery areas for all beneficiaries, in both the civilian networks and the direct care system. The system's performance will be monitored by the Military Departments and the Office of the Assistant Secretary of Defense for Health Affairs.
- **TRICARE Managed Care Support (MCS) Contracts.** A fixed price, at-risk contract, combining

civilian managed care networks with fiscal and administrative support, will support each Lead Agent, and complement the majority of services provided in the MTFs. The Department will perform economic analyses required by statute, before implementing any regional, at-risk, managed care support program based on the combined cost of health care in the direct care system and CHAMPUS.

- **Ensure several choices for other than active duty beneficiaries in their selection of health care options.** There are three choices offered under the program: 1) TRICARE Prime (Health Maintenance Organization option); 2) TRICARE Extra (Preferred Provider Organization option; and 3) TRICARE Standard (same as Standard CHAMPUS). TRICARE Prime includes additional preventive and primary care services. The TRICARE Prime enrollment option provides its customers with the advantages of managed health care, such as assignment to a primary care manager and assistance in making specialty appointments and claims filing. Although this option is voluntary for all CHAMPUS eligibles, all active duty will be enrolled in the program. Both TRICARE Prime and TRICARE Extra should minimize out-of-pocket costs.

- **Provide a uniform health care benefit to eligible beneficiaries.** The Uniform HMO Benefit, which prescribes cost sharing for CHAMPUS beneficiaries who choose to enroll in TRICARE Prime, was announced by DoD on December 15, 1994. Establishment of the Uniform HMO Benefit, was mandated by section 731 of the National Defense Authorization Act for Fiscal Year 1994. It requires the establishment of a Uniform Benefit option, which shall "to the maximum extent practicable" be included "in all future managed health care initiatives undertaken by DoD. This option is to provide "reduced out-of-pocket costs and a benefit structure that is as uniform as possible throughout the United States."

- **Improve access to health care for all DoD beneficiaries**. Each regional military health care plan, comprised of military and civilian provider networks, must have attributes of size, composition, mix of providers and geographical distribution that together will adequately address the healthcare needs of all DoD beneficiaries with emphasis on those who choose to enroll.

- **Make the most efficient use of MHSS resources.** MTFs are the heart of the military health care delivery system, providing about seventy-five percent of all care, system-wide. Primary care managers and health care finders, new cornerstones in the military health care system, will direct enrolled patients to the MTF, or when care is not available there, to civilian providers under contract to the Department in a managed care support contract. This will optimize the use of military health system direct care resources and minimize out-of-pocket costs for beneficiaries. MTFs and TRICARE Managed Care Support contractors will implement standardized, strong utilization management programs to reduce unnecessary care and ensure access to the appropriate level of care.

- **Achieve a uniform standard of quality.** The DoD is striving for uniform standards of quality, which will apply equally to health care in the direct care system and any care purchased from civilian providers under managed care support contracts.

- **Provide Specialized Treatment Services (STS).** Those clinical services involving high technology and high cost procedures, will be available to DoD beneficiaries at designated facilities, both within and among Health Services Regions. The STS program will operate in accordance with ASD(HA) Policy Memorandum, October 18, 1995, and 32 CFR 199.4(a)(10).

- **Achieve effective use of information systems.** One key to the success of the TRICARE Program is the effective use of information systems; both the integration of present systems and the rapid fielding of new integrated, open systems. Without timely information on access, utilization, and cost, the maximum benefits of TRICARE cannot be realized. Communication of policy and other information among all of the Regions, the Services, and Health Affairs will be greatly enhanced by the use of the World Wide Web.

- **Enrollment in TRICARE Prime.** Active duty members are enrolled into the Prime option. Other CHAMPUS-eligible beneficiaries may voluntarily enroll in this option. Assignment of a Primary Care Manager is part of the enrollment process. Enrollment allows the system to match beneficiary demand for health services with the appropriate level of medical support. Priority for enrollment is in the following order: active duty, family members, and all other eligible beneficiaries. Central to TRICARE is the enrollment of Active Duty family members. Lead Agents must focus efforts to market TRICARE Prime as the health care option of choice to Active Duty family members, and to maximize their participation in the Prime program.

PART I

MEDICAL READINESS

Each Lead Agent is expected to work with the Services' MTFs in the region to coordinate requirements for each Service's medical units and personnel. The Lead Agents should review their contract regarding contractor and Lead Agent responsibility pertaining to personnel backfill issues.

PART II

LEAD AGENT RESPONSIBILITIES

This listing is designed to clarify LAs roles without being prescriptive thus fostering variation in execution based on the needs of each region. It purposely lacks detailed guidance to allow for maximum local flexibility. It specifically does not identify the LA as the exclusive stakeholder of regional planning responsibilities nor imply any command and control over the military medical treatment facilities (MTF) commanders in the region. LAs are expected to communicate and work collaboratively with regional MTF commanders, Service Headquarters and the Office of the Assistant Secretary of Defense (Health Affairs) (HA) to support the multiple missions of the Military Health Services System (MHSS). The innovation and dedication of the LAs has been exemplary. LAs are encouraged to continue to share their experiences and successes among themselves and with the MHSS leadership so that, utilizing the tenets of Total Quality Leadership, we can enhance TRICARE and the entire MHSS.

Lead Agents should be familiar with the MHSS and Service-specific Strategic Plans to ensure that their activities directly support these coordinated plans. Although there is no mandate for each region to have its own Strategic Plan, strategic planning activities stimulate the identification of regional customers, determination of internal and external threats and opportunities, and collaborative planning and coordination that supports integrated health care delivery. These activities have proven extremely beneficial and have promoted an increased sense of team building and personal ownership.

Authority to make decisions regarding direct care funds, facility maintenance and personnel actions within the MTF is retained by the parent Service. All funds collected through the Third Party Collection Program are retained by the MTF that provided the care.

The National Capital Region will functionally carry out the Lead Agent responsibility through a Tri-Service Board with annual rotation of the chairperson. The TRICARE Managed Care Support (MCS) contract responsibility will be carried out by staff assigned to the TRICARE office located at Walter Reed Army Medical Center.

A. Readiness

- Support contingency operations and mobilization requirements, including backfill, while maintaining peacetime operations through the MCS contract, resource sharing, reserve units or other resource support arrangements
- Support ongoing medical readiness training in region
- Participate in planning and execution of CONUS casualty reception

B. Develop, Execute and Annually Update a Regional Health Services Plan (RHSP)

- Manage regional referral patterns and coordinate Non-Availability Statements
- Coordinate rightsizing and skill mix making recommendations to Services and HA
- Participate in decisions related to MTF patient mix and availability of clinical services
- Implement comprehensive regional Utilization Management (UM) and Quality
- Management (QM) programs
- Resolve coordination issues with overlapping catchment areas
- Coordinate plans for health promotion and preventive services

- Review the level and cost of resource sharing among MTFs and the MCS contractor throughout the region

C. Regional Business Management

- Monitor direct care regional expenses/costs
- Analyze, monitor and report standardized health metrics across region
- Monitor regional budget targets; monitor CHAMPUS budget targets
- Coordinate Quality Management systems with higher HQs
- Maintain regional enrollment data
- Evaluate technology using business case management principles
- Measure and benchmark ambulatory and inpatient care with case management, UM, outcomes management and clinical path development
- Assist Services and HA in developing universal definitions and standards for PCMs, specialty services, and ancillary support
- Serve as an agent for change in re-engineering health care delivery
- Collect, analyze, and distribute "Lessons Learned" within (and among) the region(s)
- Work with MTF commanders to establish priorities for directing beneficiaries to the direct care system
- Coordinate the development of annual capitalization, maintenance, repair and renovation plans for all MTFs

D. Contract Management

- Lead in the development, execution and evaluation of the regional MCS contract
- Propose innovative contract improvements with MTF commanders and obtain Service buy-in to MCS contract
- Create MTF incentives to optimize the use of MTFs through resource sharing

- Reduce managed care overhead at MTFs and LA offices using appropriate contract and non-contract mechanisms

- Partner with OCHAMPUS

- Recommend/make modifications to the MCS contract based upon the RHSP and unique regional needs

- Work with the MCS Contractor (a) develop and maintain an integrated network of civilian providers to complement direct care system capabilities, and (b) coordinate health care delivery among military and civilian health care providers in the region

- Ensure the network meets beneficiary needs within DoD access standards

- Be fully involved in the development, procurement, transition and operation of the MCS contract through an Administrative Contracting Officer Representative (ACOR) and a regional TRICARE Support program manager

E. Marketing

- Serve as the focal point of all marketing activities within their regions, including communications products and research

- Ensure MTF Commanders are fully involved in local marketing. As the center of all education and information activities for their catchment area, the MTF is crucial in reaching beneficiaries, media and the general community

- Brief local installation commanders and senior Line leaders about all aspects of TRICARE and the provisions of this plan, enlisting their support for the program

- Ensure all MTF staff members are educated and routinely updated about TRICARE Implementation. MTF staff members are the best educators for the beneficiary population and should offer a comprehensive series of presentations about TRICARE to all beneficiary groups, especially to base personnel by unit

- Ensure distribution of DoD produced materials for use in the internal and external public affairs activities

- Coordinate contractor marketing activities with the TRICARE Marketing Office (TMO)

- Maintain a proactive TRICARE working group with all MTF and installation Public Affairs offices in the Region

- Oversee pre- and post-contractor award marketing programs including a cooperative strategy for proactive, customer-oriented, educational, informational, promotional and research activities designed to

support the implementation and continuing success of TRICARE

F. Integration Issues

- Achieve MHSS solution vice redundant regional efforts
- Facilitate ongoing, timely communication with MTFs and encourage feedback
- Recognize command prerogatives
- Keep military chain of command, Service SGs and HA informed of ongoing issues
- Coordinate relations with other agencies, ensuring they are informed of regional progress of MHSS initiatives
- Support for joint R&D efforts
- Conduct ongoing evaluations of resource utilization, clinical services and access. Coordinate corrective actions through the direct care or civilian support systems
- Develop overall policy with MTFs on Non-Availability Statement issuance and management of Specialized Treatment Services May choose to transfer part of these functions to the MCS contractor
- Designate and maintain the regional Specialized Treatment Services (STS) program for certain resource intensive clinical services within the region IAW applicable provisions of the CHAMPUS regulation and the STS Program (OASD(HA) Policy Memo, October 18, 1995.)
- Recommend National STSs to HA

G. Information Management Support Systems

- Define and document needed information management support
- Work with MTFs, other LAs, Executive Agents, Services and HA to assure region-wide deployment planning/execution/integration/coordination across multiple information system projects
- Participate in and oversee automated information systems projects and programs
- Establish regional information exchange requirements among MCS contractors, MTFs and LAs
- Coordinate the development of a region-wide information systems modernization plan for all MTFs within the Health Services Region

To carry out these responsibilities, the Lead Agent will work cooperatively with each of the regional MTFs to achieve the most effective use of the direct care system. The extent of inter-Service cooperation and the administrative skills Lead Agents can offer in the development and execution of the RHSP are critical determinants of the success of TRICARE. Achievement of DoD performance standards will be monitored jointly by HA and the Military Departments. In-depth knowledge of regional capacity for direct care services will enable the Lead Agent to develop policies for referrals, STS establishment and Non-Availability Statement issuance.

Lead Agents should develop a regional management structure resourced by the Services out of their existing budgets. Health Affairs will make every effort to support the regional health services planning needs identified by the Services. The composition of the regional office will be determined by the Lead Agent in coordination with other MTFs in the region and will include Tri-Service staffing.

When instituting changes necessitated by the transition to regionally-based health service plans, Lead Agents will seek concurrence by the Military Departments and MTF commanders. In the event of a disagreement, resolution will be sought first at the regional level by the MTF commanders and the Lead Agent. Lead Agents will elevate unresolved disputes within ten working days to their parent Service Surgeon General for coordination and resolution with the affected Military Departments. (In the case of the National Capital Region, disputes will be forwarded through the parent Service of the chairperson.) Unresolved disputes at the Surgeon General level will be forwarded for final disposition within ten days to HA through the Assistant Service Secretaries for Manpower, Readiness and Reserve Affairs. The final decision regarding the issue under dispute will be provided within ten working days by the Assistant Secretary of Defense (Health Affairs).

HA has promulgated the scope of services, including cost shares, for a Uniform Military Health Care Benefit which will be incorporated into all DoD managed care programs, including Uniformed Services Treatment Facilities (final rule published in Federal Register on October 5, 1995). Because of the scope, magnitude and complexity of the MHSS, the extensive nature of TRICARE reforms and the need to minimize any unforeseen effects on readiness or beneficiary care, TRICARE will be phased-in over the four-year period that began October 1, 1993. Before awarding any MCS contract to complement health services provided by the direct care system, HA must perform economic and other analyses required by law (P.L. 102-396) to certify that the costs of the contract do not exceed current costs of standard CHAMPUS. Such certification will consider the impact on the cost of health care in the direct care system attributable to the MCS contract.

REGIONAL HEALTH SERVICES PLANS

Lead Agents, in coordination with the MTF commanders within the region, will develop the regional health services plan. Each Lead Agent will provide an annual update of its Regional Health Services Plan to the Assistant Secretary of Defense for Health Affairs. This plan will be submitted formally through the proper Service chain-of-command.

Planning will cover a broad range of the program aspects of managed care. These planning elements must each be addressed to assure effective integration with regional health care operations and regional TRICARE Support contracts. In keeping with the principle of decentralized execution, the Office of the Assistant Secretary of Defense for Health Affairs will prescribe general topics to be addressed in the plan. Each plan should include a regional map and organizational chart. Health Affairs will review the regional health services plans and provide

comments to the Lead Agent through their respective Service.

REGIONAL HEALTH SERVICES PLAN OUTLINE

Planning elements to be addressed:

I. Health Services Region Managed Care Goals

A. Region Map

B. Organizational Chart

II. Medical Readiness

III. Resource Management

A. Direct Care, CHAMPUS, and Military Personnel Funds

B. Investment Strategy for CHAMPUS

C. Capitation Methodology

D. Third Party Collection Program

IV. Network Development

A. Primary Care Network

B. Specialty Network

C. Referral Policies

V. Enrollment

VI. Utilization Management and Quality Monitoring

VII. Clinical Preventive Services/Health Promotion

VIII. Information Systems

IX. Evaluation Plan

X. Specialized Treatment Services

XI. Graduate Medical Education

XII. Federal Civilian Employees with Occupational Illness/Injuries

REGIONAL LEAD AGENTS AND SUPPORTED POPULATIONS
MEDICAL TREATMENT FACILITIES
(Does not include USTFs)

LEAD AGENT (Health Service Region)	POPULATION	ARMY	NAVY	AIR FORCE	TOTAL
National Capital[1] (1)	1,072,309	4	4	5	13
Portsmouth (2)	881,438	3	3	2	8
Eisenhower (3)	1,040,429	4	4	5	13

Keesler (4)	587,734	3	2	5	10
Wright-Patterson (5)	646,698	2	1	3	6
Wilford Hall (6)	959,710	4	1	9	14
William Beaumont (7)	400,868	2	0	6	8

Fitzsimons/ (8)	712,299	5	0	9	14
Ft. Carson					
San Diego (9)	690,866	1	3	3	7
David Grant (10)	360,468	1	2	4	7
Madigan (11)	358,024	1	2	1	4

Tripler (12)	153,349	1	0	0	1
TOTAL	7,864,192	31	23	53	105

(DMIS FY94 data)

A) TRICARE Europe is in the process of developing its regional health services plan based on TRICARE policy.

B) TRICARE Pacific, to include Alaska, is developing a Federal Health Care Partnership plan.

[1]The National Capital Region will functionally carry out this policy through a Tri-Service board with annual rotation of the chair person. The contract responsibility for the board will be carried out by Walter Reed Army Medical Center.

PART III

RESOURCE MANAGEMENT

One of the guiding principles of the TRICARE Program is to optimize the use of MHSS resources. Resource allocation and financing mechanisms have been designed to encourage improved efficiency and effectiveness. The MHSS resources are allocated based on a capitation-based methodology that allocates operation and maintenance dollars for direct care, CHAMPUS and military personnel resources. These funds are allocated from the central Defense Health Program that was established to improve overall management of the military health services program.

Capitation

The concept of capitation is recognized nationally as an important strategy for containing the cost of health care. Under the MHSS capitation system, the commander of each MTF assumes responsibility for providing health

services to a defined population for a fixed amount per beneficiary. Regardless of the amount of health services used, there is no financial incentive under a capitation methodology to inappropriately increase the number of services or to provide more costly care than is clinically appropriate. Because a capitated allocation system makes the MTF commander responsible for providing all health services, there are built-in incentives for care to be provided in the most cost-effective setting -- the use of preventive services, the efficient delivery of each episode of care, and the careful monitoring of the volume of provided services. Capitation discourages inappropriate hospital admissions, excessive lengths of stay, and unnecessary services. And, because the MHSS will set the capitation amount prospectively, the health care provider cannot influence the funding received for beneficiaries' care within the period of the allocation. Quality assurance and utilization management programs will monitor appropriate utilization of medically necessary services to ensure that budgetary controls do not erode the provision of needed care.

Basic Resource Allocation Plan

Resource allocations are based upon a two-step process that reflects each Service's individual requirements yet is consistent with the overall Defense Health Program resource allocation framework. Health Affairs allocates CHAMPUS and direct care operation and maintenance dollars and military personnel resources to the three Services using a financially-based modified capitation methodology. The Military Departments allocate resources to each of their MTFs based on a modified capitation methodology, designed by the Services to meet their unique requirements as approved by Health Affairs. The Military Departments will identify all CHAMPUS resources for the Lead Agent's management oversight at each of the twelve regions. The method for further allocating the CHAMPUS resources will be dependent on the Service affiliation of the regional Lead Agent and the existence of a fixed price, at-risk managed care support contract. Calculation of the allocation of CHAMPUS resources to MTFs in regions with such contracts will be done by Health Affairs and provided to the Military Departments.

Operation and Maintenance, Direct Care and Military Personnel Resources

Under the regionalization concept, the direct care and military personnel resources will continue to flow through the Military Departments to the MTFs without change. The MTF commander will continue to control allocated operation and maintenance direct care and military personnel resources. The non-interchangability of military personnel and operation and maintenance resources during the budget development and execution phases of the Planning, Programming, and Budgeting System creates a problem that will need new, more flexible budgeting and long range planning. Including military manpower in the resource equation will drive a more integrated planning approach at the Service and the MTF level.

It is expected that commanders and their staffs will make manpower decisions early enough to affect military assignments and balance their overall staffing levels. In the short term, excess military resources can be directed on a temporary basis to provide needed health care services at other MTFs in lieu of contracts or CHAMPUS. Service-specific command and control of the MTFs and legal liability for over-obligation of operation and maintenance direct care resources will also continue without change.

CHAMPUS Resources

All CHAMPUS resources will be allocated by Health Affairs to the Military Departments based on the capitation methodology. Until managed care support contracts are established for all regions, the Military Departments will

calculate both catchment area and non-catchment area costs for their beneficiaries in each of the regions.

In regions that do not have a managed care support contract in place, the operation and maintenance CHAMPUS funds will be included in the initial budget allocation of the Military Departments. The Military Departments will hold their Services' share of the CHAMPUS budget at the Service headquarters level. The Military Departments will identify the beneficiaries' share of the CHAMPUS requirement for each region, and will report the amount held for each region to the Lead Agent's parent Service. Or in the case of the National Capital Region, to ensure continuity of CHAMPUS fiscal operations and planning, the Military Departments will identify their beneficiaries' share of the CHAMPUS requirement and will report the amount held for the National Capital Region to Walter Reed Army Medical Center. Each of the Lead Agents will receive information and fiscal guidance through their parent Service's chain-of-command that identifies their total CHAMPUS budget with Service-specific and catchment area-specific subtotals. (For example, the Air Force has Lead Agent responsibility in the Wright-Patterson Region. At the Surgeons General level, the Army and Navy will notify the Air Force of the total funds they are holding for their Service's beneficiaries in the Wright-Patterson Region. The Air Force will then be responsible for providing the necessary financial information and fiscal guidance to the Lead Agent, who is the Commander, USAF Medical Center Wright-Patterson).

Lead Agents will assume administrative responsibility for coordinating the management of the CHAMPUS program within their specified area of responsibility. Based on the regional health services plan, developed by the Lead Agent and coordinated with each of the Services represented in the region, the Lead Agent will recommend to the Services that CHAMPUS resources be released to the appropriate MTF for direct care projects designed to reduce overall costs. The expenditure of CHAMPUS resources by the Military Departments will be monitored by catchment area and region.

In regions with TRICARE managed care support contracts, the MTFs' CHAMPUS allocations will be retained by the parent Services and pooled among the Services to fund the Lead Agent's execution of the support contract. Health Affairs will calculate both catchment area and out-of-catchment area CHAMPUS allocations and provide them to the Military Departments. Under this methodology, each Service remains jointly accountable for the TRICARE managed care support contract.

CHAMPUS Budget Savings/Overruns

If an MTF commander generates identifiable CHAMPUS savings the parent Service of the MTF will retain the savings. The commander, with guidance from the designated Lead Agent, will develop cooperative management initiatives to invest funds to increase overall efficiency. In some cases, these initiatives may involve bringing CHAMPUS work in-house. The management initiatives will be reflected in the jointly developed regional health services plan and approved by the affected Military Departments. As an incentive for the local commanders, the Lead Agent, with the approval of the MTFs parent Service, will project in advance the estimated overall CHAMPUS net savings--the local military medical treatment facility/parent Service will then be authorized to retain 100 percent of the actual earned savings. If the CHAMPUS claims of the MTF, exceed or overrun the authorized budget, then the MTF, or parent Service, must make up the difference. TRICARE managed care support contract bid price adjustments will be funded by the MTF or parent Service.

Transfer Payments

Under capitation methodology, the MTF commander assumes responsibility for providing health services to a defined population, with a fixed amount of resources per beneficiary. However, in military medicine, the user population of an MTF does not necessarily come from a defined catchment area. Military beneficiaries are not all enrolled as in a civilian managed care scenario and are able to go to any MTF for treatment. In turn, these facilities can refer patients to other military hospitals for care. Historically, MTF funding and workload has included patients from non-catchment areas and other MTF catchment areas (referrals). Therefore, they have been given resources in their capitated allocation for that workload. Because the cost of care for these beneficiaries is included in the medical capitated allocation, MTF commanders continue to receive funds to care for these beneficiaries and should continue to provide them appropriate care.

The regional Lead Agent will be responsible for managing the referral patterns for low cost, high volume outpatient and ancillary referrals. The Transfer Payment Policy was issued by the ASD(Health Affairs) on May 22, 1995. Based on historical data from the Retrospective Case Mix Analysis System (RCMAS) and adjusted for shifts in population and mission changes, e.g., changes in services rendered, Military Departments will establish funded baseline quantities for referrals into an MTF (inpatient care payable, i.e., referred to an MTF from another MTF or from non-catchment areas) and referrals from an MTF (inpatient care receivable, i.e., referred by a MTF to another MTF) for each MTF within the United States.

MTF commanders should encourage more aggressive management of referrals to tertiary care providers and should ensure that only appropriate cases are referred to other MTFs. If the MTF is below the inpatient care receivable amount, they can effectively use that amount to re-capture current CHAMPUS workload. There may be unused capacity in many MTFs which can be effectively employed to re-capture current CHAMPUS workload if the MTF budget is supplemented, through transfer payment, for the equipment, personnel and/or supplies needed to perform the added medical services. The MTF does not pay for care given at any other MTF until the baseline is reached.

The transfer payment policy will also apply to MTFs under managed care support contracts. Once a non-availability statement (NAS) is issued, the managed care support contractor should be afforded the opportunity to purchase the care from either the network or another MTF. If the contractor chooses to purchase the care from another MTF, no additional funds should be required to be paid to the MTF.

Shared Resource Information

This resource allocation framework is targeted toward the managed care environment that features direct care services augmented by at-risk contractor support. To achieve the goals embodied by the TRICARE Program, particular emphasis must be placed on coordination of resources and responsibilities during the transition of CHAMPUS contractor support from the historical fee-for-service system to one in which the contractor is at-risk. Prior to the establishment of TRICARE managed care support contracts, the regional CHAMPUS resources will be coordinated and monitored by the Lead Agent to achieve savings through the development of negotiated discounts, provider networks, and utilization management options under established CHAMPUS regulations, DoD Instructions, and existing CHAMPUS Fiscal Intermediary and Utilization Management contracts. To successfully implement the TRICARE Program, the Lead Agents and MTF commanders must know the full cost of the assets employed to deliver health care services. The Military Departments will develop and publicize their capitation methodology for allocating all applicable operating resources to each catchment area to include: military personnel, operation and maintenance direct care, and operation and maintenance CHAMPUS. Sharing

of resource management information among MTF commanders, Lead Agents, Military Departments and Health Affairs staff is required to preclude inappropriate intra- and inter-regional resource shifting. Timely access on a "need to know" basis to available plans and resource information--financial, workload, manpower and beneficiary population--must be assured at all organizational levels. To this end, CHAMPUS claims data posting was expedited by reducing the allowed beneficiary claims filing period from 24 to 12 months, thereby bringing this period into greater alignment with civilian healthcare plans.

Resource Management Plans

A detailed resource management plan that includes the areas of resource allocation and execution will be developed locally and provided by each MTF commander - first to the next level of command and control and then to the designated Lead Agent for review. With the Lead Agent's approval, the resource management plan will become an integral part of the overall Regional Health Services Plan. Significant changes instituted by Lead Agents will be coordinated with affected commanders. Disagreements over regional resources are to be first addressed at the regional level by the MTF commanders and the Lead Agent. If concurrence is not reached at the regional level, then the MTF commander will elevate the open issue for resolution through the appeals process specified earlier in this policy guidance.

Lead Agents will be responsible for and have the authority to oversee CHAMPUS dollars for their regions following the award of the TRICARE Support contract. Each of the hospitals within the regions will be funded directly for direct care and military personnel dollars; however, CHAMPUS funds will be managed on a regional basis. Although the capitated budget of the MTF includes its CHAMPUS target, these targets are rolled up to the regional level for Lead Agent oversight. Thus, a balance will have to be achieved between direct care and CHAMPUS operations. The effective management of referrals between direct care and CHAMPUS providers coupled with strong utilization management efforts within both systems will be essential to the financial success of regional health care operations.

Resource Management Plans developed by the Lead Agents (the MTF commanders will become key components of regional health services plans) will include, as a component of these plans, regional coordinating requirements relative to the maintenance, renovation, and replacement of facilities. The plan will further address the requirements of the draft Joint Regulation on Review Procedures for High Cost Medical Equipment (AR 40-65/NAVMEDCOM INST 6700.4/AFI 41-206) relative to the purchase and maintenance of high-cost medical equipment. Third Party Collection Program procedures should also be addressed in the resource management plan.

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Last update: 1/11/1999