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THE TRICARE MANAGED CARE SUPPORT CONTRACTS--AN ANALYSIS OF THE BID PRICE ADJUSTMENT AND RESOURCE SHARING MECHANISMS.

by

Robert R. Cox

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Principal Advisor: Sandra M. Desbrow

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DOD health care costs are escalating rapidly. Managed care is one way to control costs effectively while maintaining, or increasing, quality and accessibility of care. The TRICARE Program has transformed CHAMPUS from being a fee-for-service system to a managed care organization. DOD understands that to run a smaller more efficient health care system effectively, it must continue to pursue managed care. TRICARE must continually improve on health care delivery methods. This starts by implementing an effective, well-constructed contract.

This thesis examines the unique features of the Tri-Service Coordinated Care (TRICARE), Managed Care Support (MCS) contracts. Specifically, it answers the question--What are the unique characteristics of the military's TRICARE MCS contracts, and are they functioning sufficiently to achieve the objectives of the TRICARE Program? In answering this question, the bid price adjustment (BPA) and risk sharing mechanisms are analyzed. The TRICARE Program is compared to past Military health care programs and the considerations which led to the inclusion of the bid price adjustment (BPA) and risk sharing mechanisms are examined. Finally, a working-level perspective of the problems with these unique mechanisms is presented, and recommendations are made to improve the next generation of TRICARE MCS contracts.

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Robert R. Cox
Lieutenant, SC, United States Navy
B.S., United States Naval Academy, 1988

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Author: Robert R. Cox

Approved by: Sandra M. Desbrow
Sandra M. Desbrow, Principal Advisor

Mark Stone
Mark Stone, Associate Advisor

Reuben T. Harris
Reuben T. Harris, Chairman
Department of Systems Management

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TABLE OF CONTENTS

I. INTRODUCTION 1

A. BACKGROUND 1

B. RESEARCH QUESTIONS 4

C. LITERATURE REVIEW AND METHODOLOGY 5

D. SCOPE AND LIMITATIONS OF THE THESIS 6

II. THE TRICARE PROGRAM 7

A. HISTORY OF MILITARY MEDICINE 7

1. Trend Towards Managed Care 10

2. Fee-For-Service and Managed Care Trade-Offs 11

a. Cost 12

b. Quality 13

c. Access 14

B. CAPITATION: PRIVATE SECTOR VS. DOD 15

C. TRICARE OVERVIEW 17

1. Goals and Missions 17

2. Contract Type 18

3. Lead Agent Roles 19

4. The Triple Option Program 20

D. CONCLUSION 21

III. UNIQUE ASPECTS OF TRICARE MCS CONTRACT 23

A. BID PRICE ADJUSTMENT (BPA) - BACKGROUND INFORMATION 23

B. BID PRICE AND BPA FORMULAS 25

1. MTF Utilization Index 27

a. Inpatient Utilization Factor 28

b. Outpatient Utilization Factor 29

c. MTF Utilization Information Data Flow 31

2. CHAMPUS Eligibility Factor 31

3. CHAMPUS Price Inflation Reimbursement Index (CPIRI) 32

4. Risk Sharing 33

5. Loss Sharing Corridor 34

6. Gain Sharing Corridor 35

C. RESOURCE SHARING 36

1. Internal Resource Sharing 37

2. External Resource Sharing 38

D. RESOURCE SHARING, BID PRICE, AND BPA INTERACTIONS . 39

E. CONCLUSION 41

IV. DATA PRESENTATION AND ANALYSIS 43

A. PHONE INTERVIEWS 44

B. SURVEY QUESTIONNAIRE 44

1. Survey Questions 1.a. and 1.b 46

2. Survey Questions 2.a. and 2.b. 49

3. Survey Questions 3.a., 3.b., and 3.c. 51

4. Survey Questions 4.a. and 4.b. 53

5. Survey Question 5. 55

6. Survey Questions 6.a. and 6.b. 56

V. CONCLUSIONS AND RECOMMENDATIONS 61

A. CONCLUSIONS 61

B. RECOMMENDATIONS 67

C. SUMMARY 71

D. AREAS FOR FURTHER RESEARCH 73

APPENDIX 75

LIST OF ACRONYMS 77

LIST OF REFERENCES 81

INITIAL DISTRIBUTION LIST 85

I. INTRODUCTION

Today's military health care organizations are under extreme pressure to reduce cost, while maintaining high quality medical care. The mission of the Military Health Services System (MHSS) is 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 [Department of Defense] DOD health care [Health Affairs-1995, p. 1]." This is no easy task in an era in which the discretionary portion of the Federal budget, specifically the military budget, is shrinking.

The focus of this study is to analyze the unique features of the Tri-Service Coordinated Care (TRICARE) Managed Care Support (MCS) contracts. These contracts are a fixed-price type with a provision for a bid price adjustment (BPA) and a risk sharing mechanism. They cover active duty members, their family members, and military retirees. Active duty members, however, are only covered by the contracts to a limited degree because they are required to use military treatment facilities (MTFs) when available. Specifically, this thesis examines the health care considerations which led to the inclusion of the bid price adjustment (BPA) and risk sharing mechanisms found in all of the TRICARE MCS contracts.

A. BACKGROUND

During the last decade there has been mounting concern about the increasing growth rate of health care expenditures in the United States and in the Department of

Defense (DOD)[Braendel, pg 7]. This point is illustrated by the National Health Care Review Panel, headed by Hillary Clinton in 1992 and 1993, as well as test programs established by DOD. Between 1985 and 1995, budget expenditures for Medicare and Medicaid have increased at an average annual rate of ten percent and 15 percent, respectively [CBO 1996, p. 70]. Projections for the next decade indicate similar increases. Military health care spending has been growing at rates comparable to the Federal programs. Between 1986 and 1994, military health care expenditures increased at an average annual rate of 9.34 percent [Doyle, Slide 21]. To put this into perspective, the Congressional Budget Office (CBO) projects that the economy will grow at an average rate of 2.1 percent per year and inflation will be around three percent per year between 1997 and 2006 [CBO 1996, p.71]. The growth of health care and other mandatory portions of the Federal budget coupled with the tightening of discretionary portions of the budget show that if the current trend of growth continues, health care will continue to consume a greater portion of the Federal budget, as well as the Defense budget. In fact, from the early 1960s to 1992 health care costs have grown from six percent to 14 percent of the gross domestic product (GDP) [Gatrell, pg 2]. Consequently, there is increasing concern about how to curb this growth rate. Furthermore, there has been tremendous pressure from Congress to reorganize the Federal and Military Health Care systems since the mid 1980's [Marmor, pg 21-30].

The Office of the Assistant Secretary of Defense for Health Affairs [OASD (HA)] states that the purpose of the TRICARE MCS contracts is to achieve the following goals:

1. Improving beneficiary access to care;
2. Assuring the security of a high quality, consistent health care benefit for all MHSS beneficiaries, at low cost;
3. Preserving choice for all non-active duty participants; and
4. Containing overall DOD health care costs. [Health Affairs-1996, pg 5]

Under TRICARE, the United States is divided into 12 health care regions (See Appendix), with seven MCS contracts covering the regions. This is a decentralized system in which each region has a lead agent, the Military Treatment Facility (MTF) with the highest ranking military commander within each region. Part of DOD's effort to reorganize the military's health care system has been to implement the seven TRICARE MCS contracts and push some of the decision making authority down to the lead agents [GAO-HEHS 94-145, pg 2-6].

Due to the size and complexity of the MCS contracts, they are being phased in over several years. To date, five of the seven contracts have been signed, with four performing health care delivery. Currently, the seventh contract is scheduled to start health care delivery in late 1997. After the seven original TRICARE MCS contracts are implemented, a second round, referred to as "the next generation of contracts," will begin. Preparation for and drafting of the next generation of contracts is underway at OASD (HA) and the TRICARE Support Office (TSO), with input for changes coming from many of the experienced regions, and ongoing studies discussed in Section C of this Chapter.

Even though the MCS contracts are being phased in over several years, contracts of this magnitude (over $12 billion for seven MCS contracts), providing every aspect of health care for an ever changing number of active duty personnel, family members, and retirees, are naturally very complicated legal documents. To help deal with the uncertainty inherent in such a gargantuan undertaking, the Government has incorporated several complex provisions. Due to the unique nature of the provisions, which have been created specially for the MCS contracts, Government administrative contracting officers (ACOs) are administering contract provisions with which they have had no previous experience. These provisions include, but are not limited to, the BPA, risk sharing, and the concept of resource sharing. As will be demonstrated later, it is nearly impossible to talk about one of these provisions without including the others. The application of these provisions has not been simple and has caused atypical problems for lead agents and contract administrative personnel.

B. RESEARCH QUESTIONS

This thesis analyzes the primary question: What are the unique characteristics of the military's TRICARE MCS contracts, and are they functioning sufficiently to achieve the objectives of the TRICARE Program? To answer this primary research question, five subsidiary questions are addressed:

(1) What is the objective of the TRICARE program, and how does the TRICARE program differ from past military health care programs?

(2) What challenges have ACOs, lead agents, and Contracting Officer's Technical Representatives (COTRs) encountered while administering the unique aspects of the TRICARE MCS contracts?

(3) What are the Government's [experienced regional staffs, ASD (HA), and COTRs] analyses, suggestions, and critiques?

(4) What other contractual mechanisms might be used, or how might current mechanisms be tailored, to facilitate contract administration?

(5) How may this analysis help improve future TRICARE MCS contracts?

C. LITERATURE REVIEW AND METHODOLOGY

This research effort investigates the unique provisions of TRICARE MCS contracts and the incentives provided by these provisions. There are several ongoing studies within DOD investigating the optimal structure of the next generation of contracts. These include studies by OASD (HA), GAO, as well as independent contractors such as Kennell and Associates. These studies are, without exception, procurement sensitive and unavailable for review [Meyer, 1996]. Furthermore, they include only limited input from lead agents and ACOs with actual hands-on experience in administering the contracts. Therefore, this thesis focuses on problems encountered by administrative personnel by gathering inputs and suggestions from each region, consolidating these inputs and suggestions, and making recommendations for improving future TRICARE MCS contracts.

Data have been gathered primarily through telephone interviews and electronic mail surveys to key individuals in the lead agent offices of Regions III, IV, VI, VIII, IX, X, and XI. Furthermore, working papers from OASD (HA) and experienced regions, as well as relevant literature have been reviewed for background information and evaluation purposes.

D. SCOPE AND LIMITATIONS OF THE THESIS

The focus of the analysis is to examine the unique provisions used in TRICARE MCS contracts. Specifically, the objectives of the current provisions, how they are working to date, and how the next generation of MCS contracts might be better constructed will be analyzed.

The current TRICARE MCS contracts have only been in place since September of 1994, and health care delivery began in March of 1995. Thus, the only data analyzed are for the period 1995 to 1996. This small amount of data can, however, be used to draw germane conclusions. Details from ongoing studies will not be available for review until late 1997, and therefore cannot be utilized for this thesis.

II. THE TRICARE PROGRAM

This chapter provides a brief history of military medicine, describing its path from the inception of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in 1956, to today's environment and the administration of the TRICARE MCS contracts. This chapter also gives an overview of the TRICARE system, including a description of its goals and mission, the lead agent's role, and the beneficiary's options within TRICARE.

A. HISTORY OF MILITARY MEDICINE

Medical care for families of active duty members of the Armed Forces can be traced to the inception of the Armed Forces themself. "In 1884, Congress directed that 'medical officers of the Army and contract surgeons shall whenever possible attend the families of the officers and soldiers free of charge' [GAO-HEHS 94-145, p.3]." The concept of providing families free care evolved over the next century through numerous conflicts. In September of 1966, Public Law 89-614 created the system currently known as CHAMPUS. CHAMPUS was designed to enhance the MTF's capability to provide medical care to active duty family members as well as retirees.

Since 1966, CHAMPUS has supplemented the MTFs to comprise the MHSS. CHAMPUS has operated as a fee-for-service type insurance program (defined below). However, "this system lacked sufficient incentives and tools to control expenditures and

provide beneficiaries accessible care on an equitable basis [GAO-HEHS94-145, p. 3]." This statement, in itself, provides a basis for two of TRICARE's four goals.

A ballooning Federal budget deficit and frequent CHAMPUS cost overruns throughout the early and mid 1980s, prompted the exploration of alternative methods of cutting health care costs, while still providing quality service [Braendel, pg 6-11]. This exploration led to several DOD demonstration projects, which were authorized by Congress [Braendel, pg 50]. These projects began in October 1987 with partnership agreements between DOD and civilian health care providers in several areas of the country.

In 1988, the next reform project began in California and Hawaii. This was called the CHAMPUS reform initiative (CRI). It offered CHAMPUS beneficiaries a triple option benefit program which is still maintained in the TRICARE program. CRI's triple option program included:

1. Standard CHAMPUS choice--a traditional indemnity insurance plan
2. Preferred Provider Organization (PPO) choice
3. Health Maintenance Organization (HMO) choice

These options are explained more thoroughly in the "TRICARE Overview" section below. The PPO and HMO option made CRI the first program to introduce managed care aspects, frequently found in civilian health care plans, into the DOD health care system. Managed Care is defined as follows:

> All activities performed by payer, insurer or health care provider organizations to assure delivery of appropriate and quality health care to beneficiaries. These activities include, but are not restricted to; quality assurance, utilization management, peer review, provider selection, patient cost sharing, capitation and other provider incentive plans. Organizations involved in managed care may use one, all or any combination of these activities to improve the quality and cost effectiveness of health care delivery. [Braendel, pg 18-19]

Soon after the initiation of CRI, the Catchment Area Management (CAM) initiative was launched. CAM was "similar to CRI except that the focus is on the local catchment area, rather than across several states [Braendel, pg 51]." A catchment area is the area within a 40-mile radius of an MTF. Under CAM, provider networks are organized within a catchment area, by the MTF commander, rather than by the contractor. MTF commanders are given the responsibility for funds for direct care provided in his MTF, as well as for CHAMPUS funds to send beneficiaries to civilian physicians.

Another CRI project was introduced in Washington and Oregon (now Region XI), in September 1992. With this second initiative, the lead agent concept was developed. The lead agent concept was designed to decentralize decision making in the execution of MCS contracts [Meyer, 1996]. This concept, as well as lead agent missions and roles, is further explained in the "TRICARE Overview" section below.

After five years of demonstration projects, DOD announced the implementation of TRICARE on 22 September 1993. The first TRICARE MCS contract was awarded for Region XI on 8 September 1994, and health care delivery began in March 1995. The TRICARE program continues to include managed care features in the MCS contracts, using the lessons learned from the many demonstration projects [Meyer, 1996]. The

TRICARE contracts still use the triple option program from CRI, catchment area management from the CAM initiative, and lead agent concept developed in the second CRI.

1. Trend Towards Managed Care

Since the mid-1980s, military health care has trended away from fee-for-service toward managed care. This is primarily to cut costs. The civilian health care sector has seen a similar trend since the late 1970s. To understand the Military's trend more completely, it is important to understand how the current payment system is structured for military health care as compared with the previous system. Until the mid 1980s, if a military doctor referred a patient to the civilian community under CHAMPUS, the cost of that referral would be borne by the Office of the Secretary of Defense (OSD). Therefore, the individual Service's medical community did not feel the economic impact of its referral decisions. This created a strong incentive to send patients to the civilian community, placing a severe financial burden on OSD. Large cost overruns became the norm, rather than the exception. OSD merely requested additional funds from Congress year after year [Braendel, p. 10]. In 1988, Congress responded by shifting this cost burden to the individual Service's medical community. MTF commanders and others now clearly saw the economic hardships that civilian referrals created. This payment structure secured the movement toward the cost cutting of managed care systems and was a catalyst for the TRICARE program.

2. Fee-For-Service and Managed Care Trade-Offs

Although there are many areas of concern to be addressed in the area of health care delivery, this thesis focuses on three: cost, quality, and access. Managed care has the benefit of lower costs, but there is sometimes a trade-off between lower cost and quality of service provided by a health care plan or beneficiary choice of/access to a health care provider. To understand these trade-offs, several terms need to be defined:

> Fee for Service - A system of reimbursement in which a medical provider charges a patient (or third-party payer) a specific price for a specific service.
>
> Indemnity insurance - A traditional health insurance plan in which the patient submits the medical bill to the insurance company for a specified level of reimbursement which may be equal to or less than the fee charged.
>
> Preferred Provider Organization (PPO) - Under this system, providers, usually organized by networks or panels, offer medical care for a set fee. Various benefits, such as lower co-insurance and better coverage, create incentives for patients to see "preferred" doctors. Restrictions on care givers are, by contrast, the disincentives.
>
> Health Maintenance Organizations (HMO) - A prepaid medical care plan in which the organization receives a certain amount (usually monthly), and patients seek treatment from its affiliated medical staff. The goal is to provide affordable health care through forms of MANAGED CARE--in which a PRIMARY-CARE provider is supposed to act as gatekeeper to specialists and expensive medical tests. Often subscribers pay a small amount at each visit. Patients in HMOs have variable limits on their choice of doctors.
>
> Cost Sharing - A provision of a health care plan that requires individuals to cover some part of their medical expenses. It may help to hold down costs by deterring individuals from seeking unnecessary care, or it may discourage necessary care. In universal insurance plans, cost sharing is a form of taxation on being sick and using services. Typical forms include deductibles, co-payment, and co-insurance. [Marmor, pg 255-269]

a. Cost

The annual rate of cost growth for health care typically decreases when moving from a fee-for-service environment, or indemnity type insurance plan, to an HMO type organization [Doyle, slide 23]. A preferred provider organization falls somewhere in the middle on the cost continuum of managed care [Kongstvedt, pg 35]. However, as cost decreases, freedom to choose between doctors also decreases [Doyle, slide 23]. To understand this it may be helpful to consider the incentives created by each of the systems. In a fee-for-service/indemnity environment, the patient will be reimbursed for most of the fee paid to the provider, so there is little monetary incentive for the patient to decrease doctor visits unless an insurance maximum is reached. Furthermore, the provider charges a fee for every service rendered. That fee may be set for a specific service and may be constrained by the competitive market, but the bottom line is that the more service the provider gives, the more money will flow into his/her pocket [Eastaugh, pg 106]. A simple example is a doctor that charges $25 for treating colds. It costs the doctor $15 in expenses to provide the service. If the doctor treats one patient he makes $10 profit, two patients $20, etc. Therefore, the incentive is to provide more service. Whether considering a company's, the military's, or the Federal Government's health care system, if the incentive is to provide more service, total health care costs will increase. Fee-for-service systems have incentivized overprovision of inappropriate or unnecessary care. [Eastaugh, pg 106]

Conversely, in an HMO environment, the provider (the HMO) is given a fixed fee per enrolled member for a pre-determined period of time. The HMO receives

this fee whether services are rendered to enrollees or not. Thus, the incentive for the HMO is to provide less care and in the long run it provides an incentive to provide preventive care (e.g., promoting smoking cessation classes, AIDS awareness classes). However, less service could also result in lower quality service, and/or care that is inaccessible, so this must be closely monitored. [Eastaugh, pg 105-106]

b. Quality

As the trend towards managed care in health care, specifically military health care, escalates, so do concerns about the quality of care. Managed care systems could be tempted to put cost considerations above that of quality of care [Marmor, pg 156]. Quality can have different definitions to different people. Therefore, it may be difficult to identify the characteristics of quality care, much less differentiate between degrees of quality.

When examining quality, the different systems' incentives again become a central issue. In a fee-for-service environment, a provider is incentivized to provide more care, perhaps more than might be necessary for a given situation [Eastaugh, pg 106]. Therefore, quantity vice quality of care, was the primary concern under such systems.

As stated above, HMOs and managed care systems may have an incentive to provide less care [Eastaugh, pg 106]. Therefore, the question becomes: Does less care mean lower quality care? Some people contend that systems whose incentives are to provide less service, also have incentive to not perform all necessary clinical care [Nudd, pg. 43-44]. Furthermore, "the most common objection that physicians will actually voice

about managed care is that it reduces the quality of care [Kongstvedt, pg 429]." However, some studies have discovered that HMOs are adequately monitoring quality, and that no evidence of a difference in quality of care given by an HMO than that given in a traditional fee-for-service/indemnity system exists [Eastaugh, pg. 132]. Thus, DOD has attempted to devise a system that achieves strict cost objectives while maintaining quality service [Health Affairs-1996, pg 1-2].

c. Access

The third critical component of health care is access to care, preferably easy access while controlling costs and maintaining quality. "For purchaser and members alike, access is an absolutely critical area [Kongstvedt, pg 410]." Access is defined as "the timely use of personal health services to achieve the best possible outcomes [Kongstvedt, pg 409]. For simplicity, this thesis lumps beneficiary choice of care providers as a subsidiary of access. Access is driven by the structure of the health care plan.

In a fee-for-service environment, providers are reimbursed for each service that is performed. The fee-for-service option encourages giving more care, and virtually eliminates any risk to the care giver of losing money. Therefore, more providers are willing to accept insurance on a fee-for-service basis. In this sense, care is more accessible in a fee-for-service environment. Another aspect of fee-for-service is choice. Typically indemnity insurance plans give beneficiaries free choice of which providers to use [Aaron, pg 188]. Therefore, as long as the provider accepts the insurance plan, then the beneficiary is free to be seen by the doctor of his choice.

Conversely, in an HMO, providers are given a set fee per enrollee per time period. If the provider spends more on that patient than the predetermined fee during a specific time period, it results in a direct loss of profit. This is a risk that some providers are not willing to take. To mitigate this risk, HMOs limit beneficiaries as to their choice of providers, or charge an extra fee if the beneficiary uses a provider outside of the HMO. [Aaron, pg 8]

PPOs provide the same payment structure for the providers as do the HMOs. Therefore, they provide the same incentives and risks for care givers to enter into the health care market. However, unlike HMOs, PPOs do not mitigate their risk by limiting the beneficiary's choice of provider. PPOs allow that choice, but increase co-payments, or premiums, if the beneficiary chooses a provider that is different from the list of "preferred" providers.

B. CAPITATION: PRIVATE SECTOR VS. DOD

Capitation is defined as "a payment mechanism in which health care providers are paid a fixed amount of money each month per enrolled member to cover services over a period of time. The provider agrees to this fixed, predetermined fee, regardless of how many times the member uses the service. The rate can be fixed for all members, or it can be adjusted for factors such as the age and sex of the members, based on actuarial projections of medical utilization." [Halvorson, 1993]

HMOs utilize the capitation budgeting concept. Based on the success of HMOs, DOD is increasingly looking towards using a capitated budgeting system to contain health

care costs. Capitation budgeting is designed to provide health care providers financial incentives to contain costs [Nudd, Pg. 9]. However, because the provider is paid a predetermined fixed fee, regardless of how many times a patient utilizes his services, the provider shoulders all of the risk with regard to exceeding the capitated rate.

Capitation provides different incentives in DOD than in the private sector. In the private sector profit is a driving force. To receive more profit in a capitated environment, private sector managed care organizations (HMOs) have an incentive to minimize costs by reducing demand for medical care. However, MTF commanders have little incentive to make profits. This is because "any funds remaining in the MTFs Annual Planning Figure (APF) are rolled back to the respective Service." [Chavez, pg. 54]

Another reason that capitation provides different incentives in the private sector and DOD is the way that the per capita rate is determined. Market forces drive the capitated rate in the private sector. Therefore, HMOs must provide a per capita rate lower than that of its competitors in order to compete in the health care market. Any reduction in costs below the per capita rate results in increased profits for the HMO, but these profits do not affect its future capitated rates. [Chavez, pg 55]

Conversely, capitated rates in DOD are determined by using historical cost data. Therefore, if an MTF provides care for costs under the capitated rate, it could affect the rate that it receives the following year. Therefore, improving efficiency and reducing costs could make the MTF's job more difficult in future years by lowering their capitated rate. [Chavez, pg. 55]

C. TRICARE OVERVIEW

This section discusses the goals and missions of the TRICARE program. Then, it examines the methods implemented by the MHSS in the TRICARE program to achieve these goals. These methods include: contract type, lead agent's role, and beneficiary's triple option mechanism. Finally, this section describes some of the current problems that TRICARE is facing which must be considered in developing the next generation of contracts.

1. Goals and Missions

According to OSD (HA) the TRICARE Program is based on goals consistent with providing the three main aspects of health care: cost, quality, and access. The goals are [Health Affairs-1995, p.1]:

1. Improving beneficiary access to care;
2. Assuring the security of a high quality, consistent health care benefits for all MHSS beneficiaries, at low cost;
3. Preserving choice for all non-active duty participants; and
4. Containing overall DOD health care costs.

There are several mechanisms, centered on achieving these goals, which guide the implementation of the TRICARE program. Three are discussed in this section, contract type, lead agent roles, and the triple option benefit program.

2. Contract Type

There are several aspects of health care delivery that are difficult to quantify on a prospective basis. For example, due to the transient nature of military personnel and because of several rounds of the Base Realignment and Closure Commission, the beneficiary population within a region is difficult to predict. Therefore, health care providers who bid on any of the TRICARE MCS contracts incur a certain amount of risk. This risk increases when variables such as prices, beneficiary population (with a fluctuating military population due to frequent rotation, BRAC, and contingency operations) and health care services utilization are projected for a multi-year contract more than a year in advance of the start of health care services. Risk is also multiplied when the length of the contract spans over several years. TRICARE MCS contracts contain all of the above risk factors and, therefore, very difficult to prospectively price. [Region XI MCS contract, 1994]

Based on the goals of the TRICARE program, the MHSS states that it is necessary to contain the costs of military health care. It is difficult to contain costs when using a cost-reimbursement type contract for health care delivery. Therefore, "it is the intent of the Government to 'fix' the price of [TRICARE] contract[s] for all cost elements where it is reasonably possible for an offeror to evaluate and estimate the costs and risks associated with the delivery of managed health care services to the MHSS [Region XI MCS contract, p. 150]." The Government also realizes the risks to the offeror and has implemented a new type of contract that is a fixed price "at risk" arrangement. The at risk feature allows the Government and the provider to share gains and losses through risk sharing corridors.

The percentage of gains or losses that each side bears depends on the level of gains or losses. At a predetermined level, the Government bears full responsibility for all losses. "This methodology utilizes a Bid Price Formula, which projects health care services prices based on preliminary data, and a Bid Price Adjustment Formula, which adjusts the projected price based on actual levels of CHAMPUS population, CHAMPUS reimbursement policy and MTF utilization [Region XI MCS contract, pg. 150]." The Government provides the preliminary estimates to the successful bidder based on data collected for a 12-month period immediately prior to the start of health care services, the Data Collection Period (DCP). This method is explained in detail in Chapter III.

3. Lead Agent Roles

As a result of the CRI in 1988 and 1993, the Government gained valuable experience in the execution of MCS contracts. In 1993, DOD divided the nation into 12 health care regions. Each region is led by the highest ranking commander of an MTF within that region, known as the Lead Agent. DOD has taken the position that since health care is delivered locally, it **must** be managed locally [Health Affairs-1995, pg. 2]. Therefore, lead agents take on an especially important role.

Lead agents were developed to integrate issues and policies, which are sometimes conflicting between regions and services, and to establish the most effective method to deliver health care to a region [Lamar, pg 12]. Prior to 1994, there was no central control authority within each region who coordinated health care delivery, ensuring that MTFs operated in the most efficient and effective manner. Therefore, decisions were made at a

level where decision makers did not necessarily understand issues which were unique to a particular region. This led MTF commanders to make decisions that sub-optimized at the hospital level, and which may or may not have made sense from a regional perspective. Now that lead agents coordinate care and monitor performance for an entire region, sub-optimizing at the hospital level can damage regional performance. Therefore, MTF commanders are incentivized to develop working relationships within their region to gain shared knowledge and enhance regional performance.[Engelhart, 1996]

4. The Triple Option Program

A major feature of the TRICARE Program, designed to achieve its overarching goals, is the triple option benefit. CHAMPUS eligible beneficiaries are offered three options: 1. Enroll in an HMO-type program referred to as TRICARE Prime (hereafter referred to as Prime); 2. Use a PPO called TRICARE Extra (hereafter referred to as Extra); or 3. Use civilian health care providers, on a fee-for-service, non-restricted basis, known as TRICARE Standard (hereafter referred to as Standard). Using the triple option program, TRICARE can achieve the cost benefits of managed care while maintaining the choice provided in fee-for-service programs for those who demand such access.

Prime enrollees predominantly use "network" providers. However, they retain the freedom to utilize non-network providers for cost sharing (or co-insurance) payments that are substantially higher than Standard rates. A Prime beneficiary's co-insurance payments are somewhat lower than those who use the preferred provider network under Extra, making low cost the primary attraction of the Prime option, both from the beneficiary and

MHSS perspective. Prime is the most aggressive option toward achieving the goal of containing overall health costs. It is the least aggressive option toward achieving the goal of preserving beneficiary choice and access to care.

Beneficiaries that use Extra, predominantly use physicians that are in a preferred provider network. The benefits of Extra are that it uses a network of providers which is larger than that used in the Prime option. Furthermore, Extra does not require enrollment by the beneficiary. Like TRICARE Prime, on a case-by-case basis, beneficiaries can use physicians that are not in the network, but they must then pay higher co-insurance rates than Standard. Because it is not totally "managed" care like Prime, TRICARE Extra is not as effective at containing cost. However, the Extra option provides beneficiaries with more choice for a smaller increase in co-insurance rates when network providers are not utilized.

TRICARE Standard is identical to its predecessor, standard CHAMPUS. Standard is run as a traditional fee-for-service program. Co-insurance rates are substantially higher using this program than in the Prime or Extra options when network providers are utilized. Standard is the least aggressive program at containing cost and the most aggressive program at preserving beneficiary choice.

D. CONCLUSION

This chapter provided a brief history of military medicine, describing the "Road to TRICARE." This "Road" explained the different systems under which civilian health care

agencies and insurance companies operate, and the systems that DOD is utilizing to implement the TRICARE program.

After two years of administering the TRICARE MCS contracts, the Government has developed many lessons learned. The MHSS and the TRICARE MCS contracts strive to maintain a balance between containing health care costs and preserving beneficiary (and overall) choice, while maintaining quality care. However, the different systems provide different incentives to both health care providers and beneficiaries. Furthermore, because of the budget system and other political influences, the military has added pressures that civilian organizations need not consider when implementing a health care system. This chapter explained some of the methods that DOD has used to mitigate these pressures in their TRICARE program. The contractual provisions which are unique to the TRICARE MCS contracts are examined in the next chapter.

III. UNIQUE ASPECTS OF TRICARE MCS CONTRACT

This chapter identifies and explains the contracting provisions and mechanisms that are unique to the TRICARE MCS contracts. Specifically, it addresses two areas: the Bid Price Adjustment (BPA) and resource sharing provisions. Although these provisions are addressed separately in the TRICARE contracts, their objectives are intertwined. For example, a change in the amount of resource sharing in which the MCS contractor engages will have an effect on the final bid price through the BPA. Most of the information contained in this chapter is the author's interpretation of Section G of the MCS contracts. Because there are slight differences in regional contracts, Region XI is used as the model for this analysis.

A. BID PRICE ADJUSTMENT (BPA) - BACKGROUND INFORMATION

The BPA is a contract mechanism that was created specifically for TRICARE MCS contracts [Smith, 1996]. The goal of the BPA is to ensure that the bid price for the MCS contracts is fair to both the Government and the MCS contractor [Smith, 1996]. The BPA is simple in concept, but complicated in operation. Its purpose is to adjust the proposed bid price for factors that are outside of the contractor's control [MDA906-94-C-0003]. Initially, the Government provides the contractor with estimates of the number of eligible health care beneficiaries, the cost per eligible beneficiary, MTF utilization rates (i.e., how many beneficiaries will use MTFs vs civilian care for each type of service

offered), and the effect planned programs will have on costs (e.g., adding smoking cessation classes). These data are collected by the Government during the Data Collection Period (DCP), which consists of the 12-month period proceeding the start date of health care delivery. The contractor develops a bid price based on these estimates and eight trend factors, including:

1. Per unit price inflation;
2. Cost sharing (e.g., as patient's co-payment changes, how will this affect the bid price);
3. Provider discounts (e.g., based on network developments, what discounts can be achieved);
4. Claims management;
5. Utilization of CHAMPUS facilities per eligible beneficiary (i.e. estimation of how many times each beneficiary will utilize civilian CHAMPUS facilities);
6. Resource Sharing;
7. Intensity (e.g., based on case mix or seriousness of illness, as explained in MTF Utilization subsection below); and
8. Utilization Management.

Currently, the practice is to adjust the bid price once a year, however, the RFP for the MCS contract for Regions I, II, and V applies quarterly BPAs. The bid price is adjusted to account for changes between the DCP estimates and actual experience for the following variables:

1. CHAMPUS eligible population;
2. CHAMPUS costs during the DCP;
3. MTF utilization rate measured by actual inpatient Non-availability Statements (NASs) issued and number of outpatient MTF visits; and
4. Actual inflation rates and changes in CHAMPUS reimbursement policy (CPIRI). [Condra, 1996]

Thus, the contractor's bid is a starting price which is adjusted up or down to account for changes that are beyond its control. Simply stated, the Government will pay the contractor more than its bid price if the region's CHAMPUS eligible population is higher than predicted in the DCP. If the population is less than forecasted, the contractor's bid price is lowered, and the contractor receives less money. By comparing actual experience to the data collected in the DCP, each factor is analyzed and adjusted using the same methodology utilized above for population.

An adjustment may also be made to inpatient prices, based on case mix between MTFs and CHAMPUS facilities relative to the DCP. This is to prevent MTFs from changing their case mix and treating less serious illnesses in-house, while sending more serious illnesses to civilian providers. This would lower the MTF's costs and raise the contractor's costs, because it generally costs more money to treat more serious illnesses. However, if there was not a case mix adjustment, the contractor would not be compensated by the BPA because the number of patients treated by each may not have changed relative to the DCP.

B. BID PRICE AND BPA FORMULAS

A contractor derives the bid price he proposes for a TRICARE MCS contract from a very specific formula. The original price is based upon Government estimates and is adjusted annually, or quarterly, to account changes in actual experience from the prior base period's (either the DCP or an adjusted option period) estimates. It is also adjusted

for changes in the inflation rates and CHAMPUS reimbursement policies (CPIRI index). Finally, once the actual cost is calculated for each option period, the risk sharing corridors, are applied.

The bid price formula is shown in the table below.

$C = O \times E \times [(M_p \times P \times Q) + (M_e \times R \times S) + (M_s \times T \times U)]$; where
C = projected cost for each cost category
O = MTF utilization index
E = number of CHAMPUS eligibles
M_p, M_e, M_s = base period cost per eligible for Prime, Extra, and Standard, respectively
P, R, T = proportion of eligibles for Prime, Extra, and Standard, respectively
Q, S, U = total trend index for Prime, Extra, and Standard, respectively

Bid Price Formula

The cost, C, is calculated for Active Duty Dependents (ADD) and Non-Active Duty Dependents (NADD) based on seven care categories:

1. Inpatient medical costs/surgical costs
2. Inpatient obstetrics/gynecology costs
3. Inpatient psychiatric costs
4. Outpatient nonpsychiatric Emergency Room (ER) and office visit costs
5. Outpatient psychiatric ER and office visit costs
6. Outpatient radiological and laboratory costs
7. Other outpatient costs (i.e. prescription drugs, ambulatory surgery, and other outpatient procedures

The bid price is adjusted for each of the seven health care categories using the following formula:

AC = BC x (O_a/O_p) x (E_a/E_p) x (C_a/C_p); where
AC = adjusted cost for the option period being adjusted
BC = cost in the base period
O_a, O_p = "O" factor (MTF utilization), actual and projected
E_a, E_p = eligible population, actual and projected
C_a, C_p = CPIRI index, actual and projected

Bid Price Adjustment Formula

The following subsections will describe the various portions of the BPA formula and outline the process by which adjustments are calculated.

1. MTF Utilization Index

The MTF utilization index, O, is commonly referred to as the "O" factor throughout the medical community. There are two basic assumptions made which create the need for the "O" factor adjustment. These assumptions are that the contractor's costs will increase if: 1) there is a decrease in the number of outpatient visits to MTFs within a region, or 2) there is an increase in the number of NASs issued for inpatient visits. However, if MTF utilization decreases, utilization of the contractor's facilities will not necessarily increase on a one for one basis because all persons who are unable to obtain care from a MTF do not always see a civilian care provider. This may be because of cost

sharing requirements for CHAMPUS or they may have other insurance options than CHAMPUS [Montgomery, pg. 4-6]. The "O" factor is broken down into inpatient and outpatient categories and measured by changes in the number of NASs issued per eligible beneficiary for the inpatient category and the number of outpatient visits for the outpatient category. Moreover, the "O" factor is calculated separately for ADDs and NADDs.

a. Inpatient Utilization Factor

The inpatient "O" factor is calculated based on the change in NASs issued per eligible beneficiary during an option period as compared to the base period. The inpatient "O" factor is computed using the following formula:

O = [(N_o/N_b) x N%] + nonN%; where
N_o = number of NASs per eligible issued in the option period
N_b = number of NASs per eligible issued in the base period
N%= Proportion of CHAMPUS costs requiring an NAS
nonN% = Proportion of CHAMPUS costs not requiring an NAS

Inpatient MTF Utilization Factor Adjustment Formula

If the number of NASs issued increases, the "O" factor will be greater than one and the bid price will be adjusted upward. Conversely, if the number of NASs decrease, the "O" factor will be less than one and the bid price will decrease. The increase or decrease in price is based on average cost per NAS issued during the DCP and applied to the change in the number of NASs issued during the period being adjusted. For example,

when the bid price is applied, each NAS issued for ambulatory surgery costs the Government approximately $4,300. This is based on historical cost data collected in the DCP. The ultimate adjusted bid price will be changed, according to the formula set out above, based on the number of NASs issued, not NASs used. A cancelled NAS is tallied in the monthly NAS count unless another one is reissued during the same month in which the original NAS was issued. If a cancelled NAS is not reissued in the same month, a reissue in the following month will also be included in the total NAS count.

A case mix adjustment may be applied to the inpatient "O" factor so that MTFs cannot "game the system" and send more serious inpatient cases to CHAMPUS providers, thus reducing MTF costs while maintaining consistent numbers of issued NASs. Several categories of care are assigned Relative Weighted Products (RWPs). The case mix adjustment applies indices which are calculated based upon the average number of RWPs per admission to CHAMPUS as compared to RWPs per admission to MTFs. One important point to realize is that the case mix adjustment is only applied if the case mix indices for CHAMPUS and the MTFs move in opposite directions and the magnitude of change for both case mix indices is at least two percent, relative to the DCP.

b. Outpatient Utilization Factor

The outpatient "O" factor relies upon the change in the number of CHAMPUS outpatient visits (OPVs) per eligible CHAMPUS beneficiary based upon the following formula:

O = $[C_b + (M_b - M_o) / VTF] / C_b$; where
C_b = CHAMPUS OPVs per eligible in the base period
M_b = MTF OPVs per eligible in the base period
M_o = MTF OPVs per eligible in the option period being adjusted
VTF = Volume Tradeoff factor

Outpatient MTF Utilization Factor Adjustment

The bottom line is that if the number of MTF OPVs decrease, the "O" factor will be greater than one and the contract price will increase as a result of the BPA and vice versa. All of the above factors are easily measured, except the VTF.

The VTF is calculated to reflect the fact that changes in MTF outpatient visits by non-active duty beneficiaries do not produce equal and opposite changes in CHAMPUS utilization. Through analysis the Government has determined that for every 1.8 fewer MTF OPVs there is one additional CHAMPUS OPV among all ADDs . For NADDs the ratio is 2.2:1. The contractor is free to use the Government's estimates for VTFs or calculate its own for each contract option period, averaged across each of the seven health care categories. [Montgomery, pg 5-8]

c. MTF Utilization Information Data Flow

MTF utilization data are collected by all MTFs within a region. Each MTF enters these utilization data into a service-specific, central data base. There are currently three central data bases used in the collection of utilization data. OASD (HA) utilizes an actuarial support contractor, Kennell and Associates, to collect and manipulate utilization data, and forecast trends for future contract option periods [Condra, 1996]. Once Kennell and Associates completes this task, data are passed to OASD (HA), which in turn sends the data to regional lead agents for validation. The information is validated and returned to OASD (HA), which compiles this, and other adjustment factor information, to make annual adjustments to the bid price. After all adjustment factor information is collected and compiled, OASD (HA) sends the adjustment calculations to the PCO at the TRICARE Support Office (TSO). Finally, the PCO issues a modification to the MCS contractor, which changes the contracts original bid price [Norris, 1996].

2. CHAMPUS Eligibility Factor

The second factor in the bid price formula, and subsequently the BPA, considers the number of CHAMPUS eligible beneficiaries within each region for which the contractor will be "at risk" to provide care. CHAMPUS eligibles are broken down into two categories: ADDs and NADDs. Within these categories, the Government provides the contractor with estimates of the number of CHAMPUS eligibles broken down into "eligible months" for the contractor to formulate its bid price. These data are collected

throughout the DCP and do not include Prime beneficiaries with an MTF as their Primary Care Manager (PCM), PCMs being the manager who authorizes medical services for an individual. PCMs are often referred to as "gatekeepers" in a civilian health care network. Changes in eligible months are what the BPA utilizes to determine the dollar value change to the contract for the CHAMPUS eligibility factor.

The data to be used for the CHAMPUS eligible beneficiary adjustment will be determined by the actual average number of eligibles as listed in the quarterly Defense Enrollment Eligibility Reporting System (DEERS) report. The DEERS database is updated continually as patients are admitted to MTFs [Vector Research, Inc., pg 2-2]. The actual average number of eligibles is multiplied by 12 to compute eligible months for the BPA. The number of eligibles for each region is used by Kennel and Associates, and passed to OASD (HA) to make annual BPAs [Norris, 1996]. Bid prices are adjusted retrospectively based on changes from the base period to the option period being adjusted.

3. CHAMPUS Price Inflation Reimbursement Index (CPIRI)

Price inflation and changes in CHAMPUS reimbursement policies can dramatically effect the unit price for health care in each of the seven care categories. These changes can substantially increase the risk placed on the contractors and/or the Government in a fixed price arena. It is especially difficult to predict these changes when each TRICARE MCS contract spans a period of five years. The CPIRI adjustment was designed to mitigate this risk.

The CPIRI is based on 12 components (or update factors). Each of these components is assigned a weight that is fixed throughout the contract. The sum of all the weights total 100 percent. The indices are measured from the midpoint of the DCP to the midpoint of the option period being adjusted. Therefore, each index is set at 1.0 at the midpoint of the DCP. If there is a projected 2.7 percent increase in the cost of medical care due to inflation and changes in CHAMPUS reimbursement policies between the midpoint of the DCP to the midpoint of the first option period, the projected CPIRI for option period one will be set at 1.027. At the end of option period one, the Government will compare the actual values of the CPIRI against the projected values. If the percentage value of the difference between actual and projected values of the CPIRI falls outside of a preset range, the contractor's bid for health care costs will be adjusted by the entire difference. For example, in the RFP for regions VII and VIII, the percentage difference in actual and projected CPIRI had to exceed two percent for option period one, three percent in option periods two and three, and four percent in option periods four and five, for the CPIRI adjustment to be made to health care costs.

4. Risk Sharing

Finally, after the actual cost of health care is calculated through the bid price adjustment formula, contract risk sharing is applied. TRICARE MCS contracts are fixed-price "at risk" contracts. This means that the Government and the contractor share the

risk in both overruns and underruns of the contracts as losses and gains are placed into risk sharing corridors as described below.

The contractor's bid price for TRICARE MCS contracts is the sum of four components: administrative costs, administrative profit, health care costs and health care profit. Administrative costs, administrative profit, and health care profit are fixed with the contractor's best and final offer (BAFO). However, due to the difficulty in projecting health care costs, they may be adjusted periodically by the BPA as explained above in Section B. The following subsections will explain how losses and gains are placed in corridors and apportioned between the Government and the contractor.

5. Loss Sharing Corridor

The mechanics of a fixed-price, at-risk contract are similar to those found in a fixed-price incentive-firm (FPIF) contract. However, in an incentive-firm contract, the point of total assumption (PTA) is the point where the contractor bears the burden, dollar for dollar, of all further cost overruns. In an at-risk arrangement, the point of total Government responsibility (POTGR) is the point where the responsibility for further cost overruns rests solely on the Government. This point occurs when the contractor has absorbed losses equal to or greater than the cumulative profits he gained from previously completed option periods plus a predetermined amount of equity which the contractor has put at risk. Shared gains realized from previous option periods are included in this figure. The amount of equity held at risk is unique to each MCS contract.

The loss sharing corridor in the MCS contracts has three tiers. The loss corridor, and first tier, begins when actual health services costs exceed the adjusted proposed health care services price (APHCSP). The APHCSP is calculated by the BPA formula described in Section B above. Until the actual costs reach 101 percent of the APHCSP, the contractor is responsible for all accumulated losses. When actual costs are between 101 percent and the POTGR, the Government bears responsibility for 80 percent of the losses incurred. Lastly, when actual costs are greater than the POTGR, the Government bears responsibility for 100 percent of further losses.

6. Gain Sharing Corridor

Underruns, or gains, are shared in a similar fashion as losses. The gain sharing corridor is also tiered. It starts with the adjusted proposed health care services cost (APHCSC). It should be noted that the APHCSC includes only the health care services cost component and not any of the three fixed cost components. Gains between zero and 20 percent of the APHCSC fall into the first tier of the gain sharing corridor. Eighty percent of the first tier gains are retained by the Government and 20 percent are retained by the contractor. The Government retains 90 percent of the gains greater than 20 percent of the APHCSC while the contractor retains only ten percent of these gains. It is important to note that any gains realized by the contractor are at risk for recovery by the Government if future option periods fall past the POTGR in a loss sharing corridor. Gains

can also be used to pay the Government for past losses in option periods where the POTGR was exceeded.

The figures below illustrate the basic structure of risk sharing corridors [Contract MDA906-94-C-0003, pg. 165]:

Loss Sharing Corridor	Actual Cost vs. APHCSP	Govt / Contractor Share
1	100 to ≤ 101%	0% / 100%
2	>101% to POTGR	80% / 20%
3	>POTGR	100% / 0%

Figure 1: Loss Sharing Corridor

Gain Sharing Corridor	Actual Cost vs. APHCSC	Govt / Contractor Share
1	≥80% to <100%	80% / 20%
2	<80%	90% / 10%

Figure 2: Gain Sharing Corridor

C. RESOURCE SHARING

Resource sharing is another contracting mechanism that is unique to the TRICARE MCS contracts. It is a mechanism that seeks to optimize the use of available medical resources within a region. "In the context of resource sharing, this translates into determining the types and amounts of resources which should be shared between a

Military treatment facility (MTF) and a managed care support contractor in order to ensure the lowest overall health care costs for the [G]overnment [Montgomery, pg 1]." Although this sharing of resources seeks to lower the overall cost to the Government, it is the Government's intention to have the contractor share in these savings through resource sharing agreements (RSAs). Under the TRICARE contracts, RSAs can be internal or external agreements.

1. Internal Resource Sharing

Under internal resource sharing agreements, civilian physicians provide care in an MTF. In this scenario, the MCS contractor avoids paying the institutional costs under CHAMPUS, but still incurs costs for professional services. The savings incurred by the avoidance of institutional costs should be shared between the government (e.g., the MTF) and the MCS contractor.

Savings from internal resource sharing can be realized by the Government in one of three ways:

1. Resource sharing savings investments can be included in the contractor's BAFO. In this case, his BAFO would include a cost per eligible trend factor for resource sharing savings. For example, if a contractor's physician uses the MTF, the contractor avoids the cost of claims processing. This lowers the initial bid price.

2. If partial workload credit is negotiated in the RSA, the Government will realize savings through the BPA when calculating the "O" factor. Note that if partial workload credit is not negotiated in the RSA, the Government will not achieve these savings because the contractor will receive NAS equivalent credit for his resource sharing effort and the MTF will not get credit for the increased MTF workload.

3. The Government will also realize any residual savings obtained by the contractor through the application of the BPA. The Government's share of the savings depends on which risk sharing corridor applies. [Vector Research, Inc., pg 4]

2. External Resource Sharing

MTF physicians provide care in the contractor's medical facility under external resource sharing agreements. In this way the MCS contractor still pays the institutional costs under CHAMPUS, but avoids paying the cost for professional services [Vector Research Inc., pg 19]. This cost avoidance also results in savings that should be shared between the Government and the MCS contractor.

Savings from external resource sharing can be realized by the Government in the same ways as internal resource sharing, except the Government does not realize savings from the contractor's BAFO. BAFOs do not contain external resource sharing because

they are separately negotiated arrangements between the MTF and the contractor. [Vector Research Inc., attachment 1] Therefore, savings can only be realized through the "O" factor adjustment, and through risk sharing adjustments.

D. RESOURCE SHARING, BID PRICE, AND BPA INTERACTIONS

Resource sharing can effect the bid price in a maximum of three ways: through the BAFO, "O" factor, and risk sharing. The first way, through the BAFO, uses resource sharing to change the contractor's original bid price. This is accomplished by using a resource sharing trend factor. This factor is usually less than one and reflects the contractor's best estimates as to the impact of resource sharing on CHAMPUS costs [Vector Research Inc., pg 5]. For example, if a contractor feels he could achieve 10 percent savings through resource sharing, he would apply a trend factor of .90. This factor is develop by using a savings-to-cost ratio. For example, if a contractor estimates an average savings-to-cost ratio of 2.50 and plans to spend $20,000 in resource sharing expenditures, this amount translates to a gross cost avoidance of $50,000 ($20,000 x 2.5 = $50,000) and a net contract reduction of $30,000 ($50,000 - $20,000) [Vector Research Inc., pg 6]. The $30,000 net savings are reflected in the development of the trend factor and a lower initial bid price.

The second way for resource sharing to effect the bid price is through the "O" factor in the BPA formula. When internal resource sharing occurs, MTF utilization increases, either through a decreased number of NASs per eligible for inpatient care or an

increased number of MTF outpatient visits. Either way, this would result in a lower bid price when the "O" factor is applied during the BPA process. When calculating this effect, the Government must be careful to ensure that the savings have not already been accounted for in a lower initial bid price. This would, in effect, double the savings that the Government should appropriately receive [Engelhart, 1996]. Therefore, it is appropriate to include the impact of resource sharing in the "O" factor adjustment only after the contractor has reached the level of spending he applied when calculating the trend factor ($20,000 for the example above). [Vector Research Inc., pg 9]

Internal resource sharing utilizes the expertise of civilian physicians in a MTF. The service that the civilian physician provides is a service that would, without resource sharing, result in the issuance of a NAS. This is because the MTF would not normally have the capability to perform that service and it would be necessary to issue a NAS to refer a patient to a civilian provider. To account for the decreased number of NASs issued as a result of internal resource sharing, NAS equivalents are issued when a CHAMPUS physician provides inpatient care in an MTF. Also, internal resource sharing increases the number of outpatient visits to an MTF that would normally be performed in a civilian facility. This number of extra visits is subtracted from the MTF's outpatient visit count before the "O" factor adjustment is calculated [Vector Research Inc., Pg 9]. Both of these adjustments cease when the full effect of the resource sharing trend factor has been achieved.

The final way in which resource sharing may effect the bid price is through risk sharing. This puts both the Government and the contractor partially at risk for the success or failure of a resource sharing agreement. If the agreement is a success and the contractor avoids more costs through resource sharing than projected in his original bid price, then the Government will receive 80 or 90 percent of that excess cost avoidance, depending on which gain sharing corridor is applicable. Conversely, if the contractor is unable to achieve the savings projected in his original bid price, then the Government may share in those losses. The government could be responsible for 0, 80 or 100 percent of the losses depending on the applicable loss sharing corridor (Refer to Figure 1 on page 36 of this Chapter).

E. CONCLUSION

This chapter identifies and explains the unique aspects of the TRICARE MCS contracts including: contract type, risk sharing, BPA, and resource sharing. These aspects are separate, yet intertwined. As with many complicated systems, problems often surface. Some question why the system is so complicated, and others feel it does not address enough issues. Chapter IV discusses some of the issues and problems that Government personnel face when administering the TRICARE MCS contracts. It also discusses and analyzes responses to a survey questions regarding the unique contract aspects.

IV. DATA PRESENTATION AND ANALYSIS

This chapter discusses and analyzes data collected through a series of interviews and survey responses of lead agent representatives from each TRICARE region and representatives from three other MTFs. These individuals were selected because of their experience and their attendance at the TRICARE Financial Management Executive Education Program (TFMEEP) seminar, held in Monterey, California from 13-17 October 1996. Data were collected a variety of ways. First, extensive phone interviews were conducted with working level individuals from several regional lead agent offices, other large MTFs, and OASD (HA). Distinguishable, recurring categories of concern surfaced through these interviews. These concerns helped develop a survey, which was distributed to the attendees of the TFMEEP seminar. The survey was also sent to several contracting officer's technical representatives (COTRs) to get a perspective from the MTF level. The intent of the survey was to obtain a working level viewpoint of the problems associated with the BPA process and resource sharing aspects of the MCS contracts. These ideas were then consolidated to make meaningful recommendations for the structure of future TRICARE MCS contracts.

A. PHONE INTERVIEWS

During phone interviews, four areas of concern were consistently raised concerning the BPA process and resource sharing. They are:

1. The complexity of the BPA process;
2. The methods by which the Government holds a contractor "at risk" for the costs associated with health care delivery (e.g., fairness in the risk sharing structure, in patient distribution);
3. The inability of the BPA process to account for structural changes within DOD (e.g., downsizing, Base Realignment and Closure Commission [BRAC]); and
4. The inefficiency of resource sharing and resource support agreements.

B. SURVEY QUESTIONNAIRE

Based upon the concerns voiced in telephone interviews, as well as recommendations from consulting agencies (Kennell and Associates and Vector Research Corporation), the following survey questions were developed:

1. a. What problems have you encountered (or do you expect to encounter) in administering the BPA mechanism?
   b. Are any of these contractual problems?

2. a. What problems have you encountered (or do you expect to encounter) in administering Resource Sharing Agreements?
   b. Are any of these contractual problems?

3. a. How do you hold a contractor "at risk" for health care costs when MTFs control the level of care provided to CHAMPUS eligibles?
   b. If you feel the contractor is not at risk, how does the Government provide the contractor incentives to hold down costs?
   c. Does the Bid Price Adjustment accomplish the above?

4. a. Assuming the goal of the BPA is to make fair and equitable adjustments to the contracts, how could the Government make the BPA simpler yet capture the circumstances needed to keep the contractor from charging a premium for risk?
   b. Does the BPA, as currently written, capture enough of these circumstances, or does it capture too many? Why?

5. Is the risk sharing structure set up in the BPA manuals fair and equitable? Why or why not?

6. a. What contractual changes can be made to facilitate administration of the BPA process?

   b. What type of provisions can be added to or deleted from the contract to achieve a fair and equitable price and minimize the risk premium that the Government ultimately pays?

A total of 22 surveys were sent via electronic mail, of which five were returned. Eleven more surveys were conducted through telephone interviews. The survey was sent to one or more lead agent representatives from every TRICARE Region, three contracting officer's technical representatives (COTRs), one individual from the Center for Health care

Education and Studies, and three people from major MTFs that are not designated as lead agents, but who attended the TFMEEP conference.

Additionally, the survey targeted GS-13, or higher, Government employees and O-3, or higher, military grade officers to ensure that experienced personnel, in both acquisition and health care delivery, were represented. Furthermore, respondents were informed that the survey was attempting to gather information to make recommendations to change future TRICARE MCS contracts.

1. Survey Questions 1.a. and 1.b

1.a. What problems have you encountered (or do you expect to encounter) in administering the bid price adjustment?

1.b. Are any of these problems contractual?

(a) Discussion.

Question 1.a was asked to ascertain what problems with the BPA working level individuals felt most effected contract administration. All 16 of the surveys received had answers to this question and three common responses were received. First, a majority of the respondents felt that there was inadequate information flow between Government entities for the BPA process to function smoothly. Second, the BPA process is too

complex. Lastly, the MTFs do not have adequate incentives to cooperate with the MCS contractors because the savings from a reduction in the contract bid price do not flow to the MTF level. It should be noted that, although several problems were mentioned, most of the respondents expressed that the BPA is working as the Government intended, but that the BPA process could be improved.

All seven responses received for question 1.b. were unanimous--the complexity of the BPA process is a contractual problem. All seven responded that the number of factors in the contract should be reduced, or the TRICARE contracts should be fully capitated.

(b) Analysis of Response Data.

From the 16 surveys received, 50 percent of the respondents felt that the biggest problem with the BPA process was that the information flow between Government agencies, including OASD (HA), the procuring contracting officer (PCO), the ACOs, lead agent staffs, and MTFs was inadequate. The information includes adjustment factor numbers used by the PCO, in conjunction with OASD (HA), to make adjustment to the bid price. Region XI, felt that because its region was the first to implement a TRICARE contract, the information flow process had not been established at the time, but felt that the problem had been subsequently corrected for other TRICARE regions. Yet, seven

other regions expressed that there is still a problem with receiving timely information to prevent or correct problems.

The second most common response to question 1.a. was that the BPA process was too complex. Specifically, respondents felt there are too many factors involved in making the adjustments. Several suggestions were made to remedy this problem. Four (50 percent) of the eight surveys that stated complexity was a problem, suggested reducing the adjustment factors to only those that involve force movement. Force movement includes items such as rapid, mass deployment of forces and base closure resulting from BRAC. Three (38 percent) others suggested that full capitation (as explained in Chapter II) of the contracts was the only way to solve the complexity issue. It is important to note that in follow-up interviews, most of the respondents who stated that the BPA process was too complicated, prefaced their responses by stating that the BPA process was working as the Government intended and that it accomplished the goal of making fair and equitable adjustments to the bid price. Their suggestions would only simplify the process.

Four (25 percent) of the respondents stated that the MTFs do not have adequate incentives to cooperate with the MCS contractors because the savings from a reduction in the contract bid price do not flow back to the MTF level. Furthermore, MTFs feel that losses incurred from an increased bid price are not distributed fairly among the MTFs or along Service lines.

2. Survey Questions 2.a. and 2.b.

2.a. What problems have you encountered (or do you expect to encounter) in administering Resource Sharing Agreements?

2.b. Are any of these problems contractual?

(a) Discussion.

Question 2.a. was asked to ascertain what problems with resource sharing working level individuals felt most affected contract administration. A majority of the regions surveyed felt that the resource sharing aspect of the TRICARE contracts was working well. Only five (31 percent) of the 16 surveys suggested any problems related to the resource sharing aspect of the contracts. However, three problems were mentioned on more then one survey and merit discussion.

No response specifically targeted any problems as contractual. However, several stated that the complexity of the BPA process and the BPA's relationship to resource sharing made resource sharing inherently difficult to analyze and understand.

(b) Analysis of Response Data.

Five (31 percent) out of the 16 individuals surveyed responded to questions 1.a. and 1.b.. The two most common problems discussed relate directly to the BPA.

They are: 1.) MTFs have very little success in understanding how resource sharing agreements will affect the BPA; and 2.) MTFs do not have adequate incentives to cooperate with the MCS contractors because the savings realized from resource sharing agreements do not flow back to the MTF level. The third problem, mentioned on only two surveys, suggested that the Government does a less than adequate job at financial analysis and, therefore, can not properly analyze resource sharing opportunities.

Of the five surveys with a response to this question, 100 percent strongly believed that the MTFs have very little success in understanding how resource sharing agreements affect the BPA process. Three (60 percent) of the five that answered this question felt that this was due to the complexity of the BPA process not to the MTFs' capability. However, two respondents felt that the MTFs, in general, do lack the capability to conduct thorough financial analysis and, therefore, can not properly analyze resource sharing opportunities. These two respondents stated further that this lack of capability is why MTFs can not relate resource sharing to the BPA process.

The same four individuals who stated that incentives were a problem in question 1.a., reiterated this statement in question 2.a. All four felt that resource sharing saved the Government money, but that MTFs do not get enough credit in this process. Additionally, all four felt that 100 percent of the saving accrued from resource sharing agreements should be distributed between the MTFs, based upon each facility's

contribution to savings. This would still save the Government money on an overall basis, and it would incentivize MTFs to participate fully in the process.

3. Survey Questions 3.a., 3.b., and 3.c.

3.a. *How do you hold a contractor "at risk" for health care costs when MTFs control the level of care provided to CHAMPUS eligibles?*

3.b. If you feel the contractor is not at risk, how does the Government provide the contractor incentives to hold down costs?

3.c. *Does the Bid Price Adjustment accomplish the above?*

(a) Discussion.

Question 3.a. was asked because, during telephone interviews, several individuals raised concerns about how the Government holds the contractor at risk for health care costs. Specifically, there were increased concerns when MTFs control the level of care that they provide to CHAMPUS eligibles.

The purpose of question 3.b. was to obtain suggestions on how to hold the contractor at risk for health care costs effectively so that the Government is not held accountable for wasteful or unnecessary contractor spending. Most of the telephone

interviews revealed that Government personnel feel that the contractor is not at risk and should be more accountable for health care costs.

Question 3.c. was asked to obtain a sense of how well the BPA process is working as far as holding the contractor at risk for health care costs. A total of seven people responded to this question: two negative, five positive.

(b) Analysis of Response Data.

Most of the respondents answered questions 3.a. and 3.b. together. A total of 11 responses was received to these questions. The majority (64 percent) of these responses felt that the contractors were not at risk in the current contracts, and that the Government should move more toward capitation. Some respondents mitigated this statement with a suggestion that the Government should separate the contracts and capitate most aspects but leave an option to adjust the bid price for Force movements.

When analyzing the seven answers received to question 3.c., the data seemed to contradict the statements received for questions 3.a. and 3.b.. Five respondents answered that the BPA did accomplish the task of holding the contractor at risk. Only two (29 percent) said it did not. However, four went on to say that it only partially accomplished the task, and that the contracts should move towards full capitation.

4. Survey Questions 4.a. and 4.b.

4.a. *Assuming the goal of the BPA is to make fair and equitable adjustments to the contracts, how does the Government make the BPA simpler yet capture the circumstances needed to keep the contractor from charging a premium for risk?*

4.b. *Does the BPA Process, as currently written, capture enough of these circumstances, or does it capture too many? Why?*

(a) Discussion.

Both question 4.a. and 4.b. were asked so that the author could address subsidiary research question Number 5 from Chapter I. This question was developed with the assistance of Mr. Bart Smith of Kennell and Associates, a Government support contractor that helped OASD (HA) construct the bid price and BPA formulas in the current TRICARE contracts. From his experience, Mr. Smith stated that Government personnel want "the best of all worlds" [Smith, 1996]. They want simple contracts, where the contractor retains most, if not all, of the risk at the lowest possible price. Consequently, this question was developed to get a working level perspective on how the Government can attain the "best of all worlds" from the TRICARE MCS contracts. Two common answers to question 4.a. were found in the 15 responses. No answers were

received for question 4.b., necessitating follow-up interviews, which obtained this information.

(b) Analysis of response data.

The most frequent response received for question 4.a. was to move towards capitation. Ten of the 15 responses (67 percent) included capitation. However, of these ten responses, five did not feel full capitation was the correct way to hold down the risk premium that the Government would pay under such a system. Three of these five felt that the TRICARE contracts should be separated by primary care manager (PCM), and capitated accordingly. The contractor would be capitated for the population for which he was the PCM, and the Government would be capitated for the population for which it was the PCM. Two of the five respondents felt full capitation was not correct, stating that there needs to be a provision to adjust the contractor's bid price for force movements, but the adjustments could be made much simpler than the current BPA process.

The five other responses to question 4.a. stated that the BPA process could work correctly, as currently written, if there were an adequate data system to track information. Furthermore, this data system must be able to pass information between Government entities and the contractor.

When asked question 4.b., ten of 16 respondents felt that the BPA, as currently written, contained more than enough circumstances and made the process complex. Several respondents went on to state that the complexity of the current system probably cost the Government and the contractor more in administrative costs than capitation would add in risk premium.

5. Survey Question 5.

5. Is the risk sharing structure set up in the BPA manuals fair and equitable? Why or Why not?

(a) Discussion.

This question intended to discover if the risk sharing corridors in the contracts favored the contractor or the Government. The author felt that suggestions might flow easily from the data if the risk sharing structure showed obvious bias toward either the contractor or the Government. Twelve out of the 16 surveys received responded to this question.

(b) Analysis of response data.

Of the 12 responses received, five stated that the risk sharing structure was fair, and seven stated that it was biased either toward the Government or the contractor. Of the seven that said it was unfair, four felt it favored the contractor, and three felt it favored the Government. Furthermore, on the written surveys received, there was little, or no, explanation of why the respondents felt that the risk sharing structure was biased.

The author feels that these data are inconclusive, so follow-up interviews were conducted to aquire more information. During these interviews, it became clear that most (73 percent) of those who responded, felt that loss sharing corridors favored the contractor, and gain sharing corridors favored the Government. These respondents felt that the contractor should bear a greater burden of the losses, as well as keep a greater percentage of the gains as profit. They felt this would create more of an incentive for the contractor to hold down costs. Three individuals (27 percent) who responded, again stated that the risk sharing structure was fair and should not be changed.

6. Survey Questions 6.a. and 6.b.

6.a. What contractual changes can be made to facilitate administration of the BPA Process?

6.b. What type of provisions can be added to, or deleted from, the contract to achieve a fair and equitable price and minimize the risk premium that the Government ultimately pays?

(a) Discussion.

These questions were asked so that the author could obtain a different perspective on subsidiary research question Number 5 from Chapter I. Questions 6.a. and 6.b. attempted to gather specific recommendations from experienced, working level individuals as to how they would change future TRICARE MCS contracts. However, none of the surveys were returned with recommendations for contractual changes. Therefore, follow-up interviews were conducted. These phone interviews addressed more specific areas, such as size of the contracts, number of adjustment factors, capitation, and frequency of BPAs. Suggestions were given in these specific areas as well as other areas.

(b) Analysis of response data.

Eleven telephone surveys and four follow-up interviews were conducted. Of the 15 total interviews, nine stated that the Government would benefit from having more, smaller contracts. The most common suggestion was to have one contract per region. The main reasons given were that smaller contracts would be more manageable,

easier to administer, and the adjustment information would be easier to compile and distribute. Region X, which shares one contract with Regions IX and XII, revealed that it could take over a month to get an administrative letter to the contractor, because of the coordination difficulties with having more than one region on a single contract. Another reason given to support smaller contracts is that it would enhance competition because smaller MCS contractors would have the capability to bid, and possibly win these contracts. As it stands now, only massive health care network organizations have the necessary resources to bid successfully on contracts of such magnitude. Five of the nine who suggested smaller contracts, also addressed a down-side to smaller contracts. This is that coordination of consistent health care benefits to all beneficiaries would become difficult with several smaller contracts. A suggestion to remedy this problem was to write performance specifications vice detailed "how to" specifications and let the lead agents monitor performance. Why should we outline a specific process for contractors with extensive experience in health care delivery? Two individuals stated that another potential problem resulting from smaller contracts is that the contractors will lose economies of scale which are now being realized.

One respondent suggested that the Government would benefit by having fewer, larger contracts. No supporting statements were provided as to why he made this suggestion. Five respondents stated that the contracts are the right size, but that the

Government needs more time to learn how to operate in the managed care arena. Two of these five respondents stated that the Government should consolidate the regions that now share contracts to mitigate the coordination problem.

When asked about adjustment factors, no one felt that there needed to be more adjustment factors. Seven respondents felt that there should be fewer adjustment factors. Six out of these seven felt that the Government should move towards full capitation. Several ACOs stated that contractors incur significantly lower risk than would be incurred in a typical fixed price contract because of the adjustment factors.

Eight of the eleven respondents felt it would be beneficial to conduct BPAs more frequently. Some reasons given were that there would be less financial impact, fewer surprises, and fewer discrepancies between the adjustment factor numbers of the contractor, lead agent, and OASD (HA). The three other respondents felt that it might be beneficial to do adjustments more often, but were skeptical about the Government's capability to accomplish this, given the complexity and time required to make such adjustments.

V. CONCLUSIONS AND RECOMMENDATIONS

This chapter makes statements of conclusion to the primary and subsidiary thesis research questions. It also provides recommendations as to how the next generation of TRICARE contracts should be structured and present benefits and limitations of that structure. Finally, this chapter identifies areas for further research.

The researcher bases these conclusions and recommendations on the literature review, initial interviews, survey results, and follow up interviews.

A. CONCLUSIONS

1. Primary Research Question. What are the unique characteristics of the TRICARE MCS Contracts, and are they functioning sufficiently to achieve the objectives of the TRICARE Program?

The unique characteristics of the TRICARE MCS contracts identified include the Bid Price Adjustment and resource sharing processes. The BPA and resource sharing mechanisms are functioning sufficiently to achieve the overall objectives of the TRICARE Program of providing consistent, quality, an affordable health care to active duty military members, their families and retirees. This does not mean the processes function without difficulty or problems. Now that the Government has experience in the managed care

arena and historical data is being compiled, some of the characteristics of both the BPA and resource sharing processes can be changed so that contract administration can function better and health care can be delivered more smoothly.

2. *Subsidiary Question #1. What is the objective of the TRICARE program, and how does the TRICARE program* differ from past military health care programs?

As identified in Chapter II, OSD (HA) states that the objectives of the TRICARE Program are:

a. Improving beneficiary access to care;

b. Assuring the security of a high quality, consistent health care benefits for all MHSS beneficiaries, at low cost;

c. Preserving choice for all non-active duty participants; and

d. Containing overall DOD health care costs.

TRICARE contracts are drafted to achieve these goals.

The TRICARE Program differs from past military health care programs in several ways. DOD is trying to capitalize on the strengths of civilian health care plans and tailor those plans to fit the unique environment of the military. Traditionally, military health care plans for dependents and retirees who could not be accommodated in an MTF operated on a fee-for-service basis. That is, if CHAMPUS eligible beneficiaries sought care from a

civilian provider, the Government would pay that provider a specific price for a specific service. However, there was no incentive for providers to limit the amount of care that they were providing military customers because the more care that was provided, the more money the provider received. Furthermore, there was no incentive for the military beneficiary to seek less care because the care was provided at little or no cost to them.

Several CHAMPUS Reform Initiatives sought to implement managed care aspects of health care into the Military health care system. These initiatives created items such as the triple option program, Catchment Area Management (CAM), and the lead agent concept. TRICARE combined all of these items when it was launched on 8 September 1994.

3. Subsidiary Question #2. What challenges have ACOs, lead agents, and Contracting Officer's Technical Representatives encountered while administering the unique aspects of the TRICARE MCS contracts?

The problems identified concerning the BPA and resource sharing were many. Concerning the BPA, the primary problem identified was that there was inadequate information flow between Government entities for the BPA process to function smoothly. One gentleman compared this problem to keeping a checkbook. A person might be very meticulous about writing down the amount for each check he writes, but the bank in

which the account is held could have different amounts recorded for those same checks. The second problem identified is that the BPA process is too complex. Specifically, there are too many adjustments encompassed in the BPA process. The information flow problem further complicates the BPA process. The final problem reported was that the MTFs do not have adequate incentives to cooperate with the MCS contractors because the savings from a reduction in the contract bid price do not flow to the MTF level. It is important to note that, although several problems were mentioned, most of the data gathered supported the conclusion that the BPA process is working as the Government intended, and the system is not "broken." However, there are improvements that can be made.

Two of the problems identified with resource sharing relate directly to the BPA: MTFs have very little success in understanding how resource sharing agreements will affect the BPA; and MTFs do not have adequate incentives to cooperate with the MCS contractors because the savings realized from resource sharing agreements do not flow back to the MTF level. The third problem with resource sharing is that the Government does an inadequate job of financial analysis and, therefore, can not properly analyze resource sharing opportunities. Again, as with the BPA process, it should be noted that most of the research suggests that resource sharing is working as the Government intended, but improvements can be made.

4. Subsidiary Question #3. What are the Government's [experienced regional staffs, OASD (HA), and COTRs] analysis, suggestions, and critiques?

There were a numerous opinions voiced and suggestions made as to what changes were needed in the BPA process and resource sharing provision of the TRICARE MCS contracts. However, answers became more vague when specific questions were addressed concerning how the necessary changes could be implemented. Despite the vagueness of the replies, several recurring themes were observed, from which suggestions and solutions could be drawn.

There is a problem with the information flow between lead agents, MTFs, OASD (HA), and the contractor. Information from OASD (HA) is not distributed in a timely manner to lead agents and MTFs, which makes them reactive, vice proactive, in responding to changes indicated by the data. Furthermore, the data are often times provided in a form that results in difficulty in validation by the lead agents and MTFs. A major suggestion from Government personnel was to consolidate the several, Service-specific data bases that are currently utilized into one. This would allow lead agents, who represent all of the Services within a region, to coordinate more effectively with the MTFs.

Another problem Government personnel identified is the complexity of both resource sharing and the BPA process. There were several suggestions to remedy this

problem. One way is to simply eliminate several of the adjustment factors involve in the BPA. This would increase the risk incurred by the contractor, and the Government would likely pay for this in the contractor' s original bid price. However, a tremendous administrative burden would be lifted from the lead agents, and more resources could be directed to other areas of concern. Another way to address this problem is to eliminate adjustment factors altogether and capitate the contracts. This would further increase the contractor's risk. As discussed in Chapter II, there are several advantages and disadvantages to capitation as used in HMOs. The same apply to capitation of the TRICARE contracts.

Some suggested that resource sharing agreements should be separated from the BPA process. This aspect will be implemented in the TRICARE MCS contract for Region I, II, and V. This contract is now in the RFP evaluation phase of the procurement process.

There were also several suggestions to make the risk sharing corridor a more fair and equitable method to adjust the contract price. Most respondents recommended that the contractor should bear a greater burden for the losses and retain a greater portion of the gains. There were also a further suggestion to eliminate the tiered structure of the risk sharing corridors because it creates "backward" incentives. As now written, the contracts reduce the contractor's share of gains from 20 to ten percent, if those gains exceed 20

percent of the APHCSC. Most Government respondents felt that the contractor share of the gains should increase if the it strived to achieve greater savings. The POTGR creates the same kind of "backward" incentive because the contractor can act inefficiently and irresponsibly after this point is reached.

5. Subsidiary Question #4. What other contractual mechanisms might be used, or how might current mechanisms be tailored, to facilitate contract administration?

6. Subsidiary Question #5. How may this analysis help improve future TRICARE MCS contracts?

Subsidiary questions #5 and #6 will be addressed in the recommendations section below.

B. RECOMMENDATIONS

1. Recommendation #1. Incorporate a standard data system to collect BPA data for all Services. The researcher agrees with suggestion made to consolidate the Service specific data bases into one. This data base must be available, with BPA data, on a real-time basis to MTFs, lead agents, OASD (HA), and the contractor. This will not only allow the lead agents and MTFs to become proactive to correct discrepancies, but it will also tremendously accellerate the process of validating the data once OASD (HA)

released final BPA numbers for each option period. Providing this information to the contractor affords it the opportunity to question any data prior to releasing the final BPA for each option period. Furthermore, it gives the contractor the feeling that the Government is being forthright and honest in its dealings. In the current system, the contractor may refute figures in the final BPA but not have any input until the process is complete. Although information should be provided to the contractor, it should be provided on a "read only" basis, to ensure there can be no alteration of the figures.

2. Recommendation #2. Move significantly towards full capitation. Several lead agents suggested fully capitating the TRICARE MCS contractors. This would be inappropriate at the present time because it would place the contractor too much at risk with the unpredictable nature of the Military's population. Under a fully capitated system, a large, extended-period contingency operation could put severe financial strain on, or potentially bankrupt, a contractor. With a sudden decrease in population, the contractor would not be able to realize economies of scale that it predicted upon submission of its original bid price. Full capitation is not recommended for these reasons, unless an adjustment factor for force movements and population is included. All other adjustment factors should be eliminated because they are unnecessary, or they burden the process of contract administration. The contractor should be held at risk for these factors because

elimination of some will have a negligible effect and others, while they may increase the contractor's bid price, represent risk that is inherent in fixed-price contracts.

3. Recommendation #3. Educate Military personnel and require a minimum specified education level for MCS contractors. One problem identified for resource sharing is that Government personnel do not have the ability to do effective financial analysis in resource sharing opportunities. Resource sharing agreements are negotiated on the MTF level, yet lead agent staffs are receiving most of the education opportunities. Business education opportunities must be provided to MTF commanders, administrators, and physicians, so that they can make informed, efficient, and effective decisions.

4. Recommendation #4. Alter the risk sharing structure in two ways:

a. Keep it simple with one share ratio for overruns and one share ratio for underruns.

b. Make the share ratio for both gains and losses shallower (65/35 for gains and 75/25 for losses).

The researcher agrees with the assertion made by lead agent personnel that the risk sharing corridors may create contractor incentives that are inconsistent with Government desires. Therefore, it is recommended that the tiered aspect of loss and gain

sharing corridors be eliminated. This includes eliminating the POTGR and the portion of total contractor responsibility in the loss sharing corridor, as well as the 90/10 share ratio in the gain sharing corridor. This change will not only eliminate the "backward" incentive, it will also create a simpler system, making business analysis easier to perform.

During telephone interviews it was revealed that Government personnel felt gains favored the Government and losses favored the contractor. What was not actually stated but was sensed by the researcher during interviews, was the feeling that this slant toward one, or the other, party directly affected attitudes and performance negatively. The gain sharing structure, as currently designed, does not create a strong incentive for the contractor to achieve substantial savings. Furthermore, it creates an attitude, by the contractor, that the Government is not fair and honest in its dealings. This negatively affects the atmosphere during any necessary negotiations or meetings. At worst it could influence the customer service provided to TRICARE beneficiaries. Likewise the loss sharing category does not create a strong enough incentive for the contractor to save money. Furthermore, it produces an attitude, by the Government, that the contractor is lazy and non-caring.

Making the gain sharing ratio shallower allows the contractor to keep a greater portion of the savings, and creates an incentive to achieve greater savings. Furthermore, it relays to the contractor that Government is willing to work with it to

achieve the goal of lowering overall health care costs. Making the loss sharing ratio shallower will hold the contractor more accountable for losses incurred and create an incentive to spend efficiently. Moreover, it could change the Government's attitude by making it realize that the Contractor is striving to save because it has a significant stake in the losses.

5. Recommendation #5. Utilize performance specifications.

As one respondent to the survey stated "Why should we tell the contractor how to do things, when we can tell them what we want and simply monitor results [Engelhart, 1996]?" The current TRICARE contracts contain detailed specifications that direct to the contractor precise procedures for providing care, customer service, and other aspects. This limits the contractor's innovation. Furthermore, it slows and restricts the implementation process of many new, money-saving processes by requiring new proposals to be submitted if the new process does not conform to the Government prescribed process. Time and money is wasted in this manner.

C. SUMMARY

Prior to CHAMPUS in 1956, MTFs provided health care to active duty military members, their families, and retirees. It was an exception, rather than the rule, for

dependents or retirees to seek medical care in the civilian health care sector. Today, seeking civilian care is the standard for dependents and retirees. This trend has been caused by the closure of many MTFs due to military downsizing and the corresponding use of civilian care facilities.

Accordingly, DOD health care costs are escalating rapidly. Managed care is one way to control costs effectively while maintaining, or increasing, quality and accessibility of care. The TRICARE program has moved CHAMPUS from being a fee-for-service system to a managed care organization.

The Department of Defense understands that to run a smaller more efficient health care system effectively, it must continue to pursue managed care. TRICARE must continually improve on health care delivery methods. This starts by implementing an effective, well-constructed contract.

The bid price adjustment mechanism was designed so that inherent risk in the TRICARE contracts could be shared fairly between the contractor and the Government. The resource sharing feature was designed so that the contractor and the Government could utilize available resources effectively to lower the overall price to the Government. These mechanisms are unique to TRICARE MCS contracts, and they are fulfilling their intended purposes, albeit not to everyone's satisfaction. However, as more historical financial data are available, upon which contractors can base their proposed bid prices,

these mechanisms will no longer be necessary as now structured. Instead, the Government should move to a system of capitated care and include an adjustment factor for major force-level population fluctuations within a region. This would put the contractors in the same position of risk found in their non-DOD managed care contracts.

D. AREAS FOR FURTHER RESEARCH

The following are possible areas where further research could be accomplished in the area of TRICARE contracting:

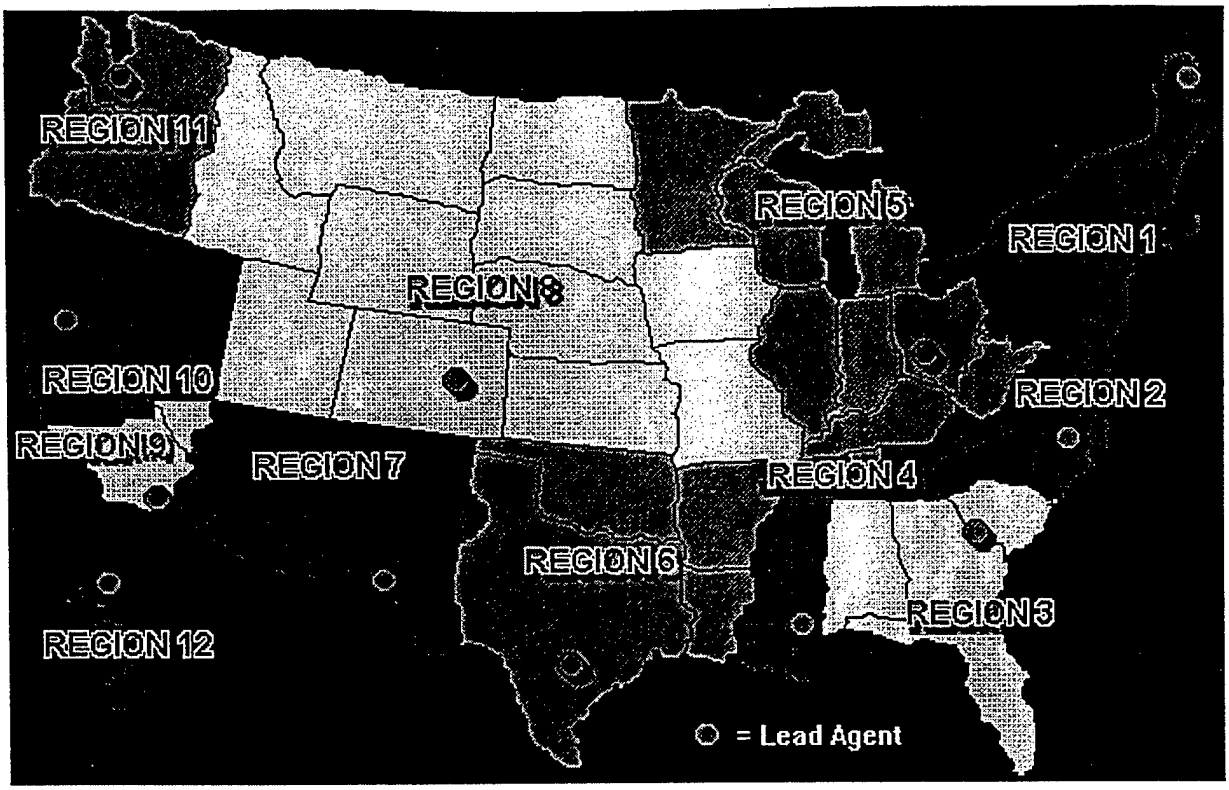
1. Analyze the changes that are taking place in the RFP for Regions I, II, and V. Determine what financial impact these changes will have on MTFs and overall DOD health care costs.

2. Develop performance work statements for the next generation of TRICARE MCS contracts.

3. Develop further economic and other incentives that DOD could provide to motivate health care providers to reduce cost and maintain quality.

4. Conduct a study which focuses on quality issues. Determine whether changes proposed in the RFP for Regions I, II, and V will affect quality.

APPENDIX


REGION 11
REGION 5
REGION 1
REGION 8
REGION 10
REGION 2
REGION 9
REGION 7
REGION 4
REGION 6
REGION 3
REGION 12
= Lead Agent

LIST OF ACRONYMS

ACO	ADMINISTRATIVE CONTRACTING OFFICER
ADD	ACTIVE DUTY FAMILY MEMBER (FORMERLY DEPENDENTS)
APF	ANNUAL PLANNING FIGURE
APHCSC	ADJUSTED PROPOSED HEALTH CARE SERVICES COST
APHCSP	ADJUSTED PROPOSED HEALTH CARE SERVICES PRICE
BAFO	BEST AND FINAL OFFER
BPA	BID PRICE ADJUSTMENT
BRAC	BASE REALIGNMENT AND CLOSURE
CAM	CATCHMENT AREA MANAGEMENT
CBO	CONGRESSIONAL BUDGET OFFICE
CHAMPUS	CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
COTR	CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE

CPIRI	CHAMPUS PRICE INFLATION REIMBURSEMENT INDEX
CRI	CHAMPUS REFORM INITIATIVE
DCP	DATA COLLECTION PERIOD
DEERS	DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM
DOD	DEPARTMENT OF DEFENSE
GAO	GENERAL ACCOUNTING OFFICE
GDP	GROSS DOMESTIC PRODUCT
HMO	HEALTH MAINTENANCE ORGANIZATION
MCS	MANAGED CARE SUPPORT
MHSS	MILITARY HEALTH SERVICES SYSTEM
MTF	MILITARY TREATMENT FACILITY
NADD	NON ACTIVE DUTY FAMILY MEMBER (FORMERLY DEPENDENT)
NAS	NON-AVAILABILITY STATEMENT
OASD (HA)	OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS
OPV	OUTPATIENT VISITS

OSD	OFFICE OF THE SECRETARY OF DEFENSE
PCM	PRIMARY CARE MANAGER
PCO	PROCURING CONTRACTING OFFICER
POTGR	POINT OF TOTAL GOVERNMENT RESPONSIBILITY
PPO	PREFERRED PROVIDER ORGANIZATION
RFP	REQUEST FOR PROPOSAL
RSA	RESOURCE SHARING AGREEMENT
RWP	RELATIVE WEIGHTED PRODUCT
TFMEEP	TRICARE FINANCIAL MANAGEMENT EXECUTIVE EDUCATION PROGRAM
TRICARE	TRI-SERVICES COORDINATED CARE
TSO	TRICARE SUPPORT OFFICE
VTF	VOLUME TRADE-OFF FACTOR

LIST OF REFERENCES

Aaron, Henry J., The Problem That Won't Go Away, Reformin U.S. Health Care Financing, The Brookings Institution, 1996.

Braendel, Douglas A., Research Paper: A Managed Care Model for the Military Departments, Individual study for the Army War College, 15 May 1990.

Chavez, Anthony S., Capitation Based Resource Allocation: Does It Provide the Necessary Financial Incentives for the MTF to Achieve Technical and Allocative Efficiency?, Masters Thesis, Naval Postgraduate School, December 1995.

Condra, Gary, Lieutenant Colonel, U.S. Army, Region XI lead agent office, personal interview, 20 November 1996.

Congressional Budget Office (CBO) of the United States, Report to the Senate and House of Representatives Committees on the Budget, May 1996.

Doyle, Richard, Presentation to the TRICARE Financial Management Executive Education Program, 21 October 1996.

Eastaugh, Steven R., Health Economics - Efficiency, Quality, Equity, Auburn House, 1992.

Engelhart, Robert J., Personal Interview, 10 October 1996.

Halvorson, George C., Strong Medicine, New York, Random House, 1993.

Kongstvedt, Peter R., The Managed Health Care Handbook, 3rd ed., Aspen Publishers, Inc., 1996.

Lamar, Steven, DOD Health Care Reform: TRICARE, Basic Program Overview, 1994.

Marmor, Theodore R., Understanding Health Care Reform, Yale University Press, 1994.

Montgomery, John E., Captain, MSC, USN, Optimizing Resource Sharing Opportunities Under Managed Care Support Contracts, December 1994

Myer, Dennis, Chief of Operations, Region XI Lead Agent, Personal Interview, 27 August 1996.

Norris, Sharon, Office of the Assistant Secretary of Defense (Health Affairs), Personal Interview, 2 December 1996.

Nudd, Lorraine E., An Analysis of the Financial Incentives Provided By a Capitation-Based Resource Allocation System Within the Military Medical Department, December 1993.

Office of Civilian Health and Medical Program of the Uniformed Services, The History of CHAMPUS and Its Evolving Role in TRICARE, 12 July 1996.

Smith, Bart, Kennell and Associates, Personal Interview, 29 October 1996.

TRICARE Contract Number MDA906-94-C-0003, Region XI, 8 September 1994.

TRICARE Request for Proposal Number MDA906-95-R-0005, Region I, II, and V, 2 October 1995.

United States Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), MHSS Strategic Planning, 29 July 1996.

United States Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Policy Guidelines, 9 May 1995.

United States Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), Updated TRICARE Policy Guidelines, 29 January 1996.

United States Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), Overview of the TRICARE Program, 1 November 1995.

United States General Accounting Office (GAO), Report Number HEHS-96-100, Defense Health Care - TRICARE Progressing, but Some Cost and Performance Issues Remain, 7 March 1996.

United States General Accounting Office, Report Number HEHS-95-142, Defense Health Care - Despite TRICARE Procurement Improvements, Problems Remain, 3 August 1995.

United States General Accounting Office, Report Number HEHS 94-145, Statement of Mr. David P. Baine, Director, Federal Health Care Delivery Issues, Health, Education and Human Services Division to the House of Representatives Armed Services Committee, 19 April 1994.

Vector Research Corporation, User Handbook for the Bid Price Adjustment (BPA) Central Data Update Tool, Version 1.0, 30 May 1996.

Vector Research Corporation, Resource Sharing Financial Analysis Worksheets Users Guide, 9 August 1996.

Woodley, Leon, Colonel, USA, The Military Health Care System: On the Road to Privatization, Individual Study Project for the U.S. Army War College, 15 April 1996.

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