Audit Report

OVERLAPPING INPATIENT TREATMENT EXPENDITURES FOR DOD BENEFICIARIES ENROLLED IN MEDICARE HEALTH MAINTENANCE ORGANIZATION PLANS

Report Number 99-152 May 13, 1999

Office of the Inspector General
Department of Defense

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Acronyms

CHCS	Composite Health Care System
DMIS	Defense Medical Information System
DRG	Diagnosis Related Group
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
McCOY	Managed Care Option Information
MTF	Military Treatment Facility

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202

May 13, 1999

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Audit Report on Overlapping Inpatient Treatment Expenditures for DoD Beneficiaries Enrolled in Medicare Health Maintenance Organization Plans (Report No. 99-152)

We are providing this audit report for information and use. We conducted the audit in response to a request by your office. We considered management comments on a draft of this report in preparing the final report.

Comments on the draft of this report conformed to the requirements of DoD Directive 7650.3 and left no unresolved issues. Therefore, no additional comments are required.

We appreciate the courtesies extended to the audit staff. Questions on the audit should be directed to Mr. Michael A. Joseph (mjoseph@dodig.osd.mil) or Mr. Timothy J. Tonkovic (ttonkovic@dodig.osd.mil) at (757) 766-2703. See Appendix C for the report distribution. The audit team members are listed inside the back cover.

David K. Steensma

David K. Steensma
Deputy Assistant Inspector General
for Auditing

Office of the Inspector General, DoD

Report No. 99-152 May 13, 1999
(Project No. 8LF-5027)

Overlapping Inpatient Treatment Expenditures for DoD Beneficiaries Enrolled in Medicare Health Maintenance Organization Plans

Executive Summary

Introduction. The audit was requested by the Assistant Secretary of Defense (Health Affairs). The Assistant Secretary was concerned that the Federal Government was paying twice for inpatient treatment provided by military treatment facilities to beneficiaries enrolled in Medicare health maintenance organization plans.

Military retirees and dependents are eligible for medical treatment at military treatment facilities on a space available basis. Most military beneficiaries, age 65 and older, are also entitled to Medicare, a national insurance program. Military beneficiaries may select a health maintenance organization plan as their Medicare provider. In FY 1997, there were 47,326 inpatient admissions for beneficiaries age 65 and older at 95 military treatment facilities located in Guam, Puerto Rico, and the United States. The 47,326 admissions represented about 24 percent of the DoD inpatient workload effort in FY 1997 at the 95 military treatment facilities.

Objectives. The overall audit objective was to determine DoD military treatment facility expenses for inpatient treatment of beneficiaries enrolled in Medicare health maintenance organization plans. We also explored alternatives to eliminate overlapping Federal Government expenditures for beneficiaries with dual eligibility.

Results. Military treatment facilities provided inpatient treatment to eligible beneficiaries who were enrolled in Medicare health maintenance organization plans. As a result, DoD expended about $45.2 million for inpatient treatment in FY 1997 for dual-eligible beneficiaries on whose behalf the Health Care Financing Administration made per capita payments for covered medical treatment, including the expense of inpatient treatment. By eliminating the overlapping expenses, the Government could put approximately $271 million to better use over 6 years (see Finding section for details). Further, as a result of the limitations discussed in Appendix A, the estimated expenses for treatment for eligible beneficiaries in military treatment facilities may be understated.

Current laws permit DoD beneficiaries to enroll in Medicare health maintenance organization plans while maintaining their eligibility to use military treatment facilities. Although dual eligibility is not improper, the Government may be paying twice for

inpatient treatment opportunities that are available only to a unique beneficiary group. In that regard, we believe that corrective action is warranted and will coordinate our audit results with the Inspector General, Department of Health and Human Services.

Summary of Recommendations. We recommend that the Assistant Secretary of Defense (Health Affairs) develop a strategy to reduce or eliminate overlapping expenditures for DoD beneficiaries, age 65 and older, who are enrolled in health maintenance organization plans and provided access to military treatment facilities. The strategy should be coordinated with personnel from DoD, the Department of Health and Human Services, and the Office of Management and Budget. If the overlapping expenditure issue cannot be resolved without the enactment of legislation, then we recommend the preparation and coordination of a legislative proposal.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the recommendations to develop a strategy to reduce or eliminate the overlapping expenditures and agreed to aggressively pursue a means to eliminate the overlapping expenditures. The Assistant Secretary also agreed to consider the desirability of a legislative proposal to address the overlapping payment issue. The Assistant Secretary also stated that resolution of the overlapping expenditure issue would not produce savings, but could result in the availability of additional health care services for DoD beneficiaries. See the Finding section for a summary of management comments and the Management Comments section of the report for the complete text of the comments.

Audit Response. Management comments are responsive to the recommendations. We agree that resolution of this issue should not result in a reduction of the Defense Health Program Appropriation, but could result in additional health care services being made available to DoD beneficiaries.

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Background

Request for Audit. In March 1998, the Assistant Secretary of Defense (Health Affairs) requested that the Inspector General, DoD, determine the DoD expenses for inpatient treatment provided to beneficiaries enrolled in Medicare health maintenance organization (HMO) plans.

Medicare. Medicare is a national health insurance program for individuals 65 years of age and older and is administered by the Health Care Financing Administration (HCFA), a Federal agency of the Department of Health and Human Services. Medicare pays for primary health care for retirees and is divided into the following three parts.

- Part A helps pay for inpatient hospital treatment, skilled nursing facilities, and hospice care, as needed. Generally, a beneficiary can enroll in Part A without paying a premium if the individual worked for at least 10 years in Medicare-covered employment.

- Part B helps pay for inpatient and outpatient physician services, outpatient hospital treatment, and various other medical services. Part B is optional, and in 1999 requires a monthly premium of $45.50 from participants. The Part B premium was $43.80 in 1997 and 1998.

- Public Law 105-33, "The Balanced Budget Act of 1997," established Medicare+Choice that enables Medicare beneficiaries to obtain medical treatment through a variety of risk-based plans that are designated as Part C of Medicare. Part C includes HMOs (formerly under Part A and Part B), religious and fraternal benefit plans, and other coordinated care plans that meet Medicare+Choice standards. To enroll in Part C plans, the beneficiaries must be entitled to Part A and participate in Part B.

Because this report discusses issues related to Medicare beneficiaries, the phrase *HMO plan* used throughout the report refers to HMO plans receiving payments from HCFA. Medicare benefits are generally provided through a fee-for-service system or through a managed care program such as a Medicare HMO plan.

Fee-for-Service System. Under a fee-for-service system, Medicare pays the provider allowable amounts for specific individual episodes of treatment and the patient is responsible for paying the balance.

HMO Plans. HMO plans contract with HCFA to provide all covered medical treatment for a monthly fee (per capita payment) for each enrollee. The 1997 monthly fee was about $440. During 1997, beneficiaries were allowed to enroll or disenroll on a monthly basis. Some HMO plans may also require payment of a premium from the beneficiary. The HMO plans provide health care through a network of physicians and hospitals in a service area. HMO plans provide comprehensive benefits and participants are not required to pay the Medicare deductibles and coinsurance. In some cases, Medicare beneficiaries have the option of paying for additional benefits. The two types of

HMO plans are risk and cost. HMO risk plans limit an enrollee's nonemergency treatment to network providers who are financially at risk for all treatment. Members generally must receive all covered treatment through the plan or from health treatment professionals referred by the plan. In most cases, HMO risk plans will not reimburse for treatment when a member obtains nonemergency treatment outside the plan without prior approval.

HMO cost plans also have provider networks. However, the participant may choose to be treated outside the plan, in which case Medicare will pay a portion of the expense for treatment and the beneficiary will be responsible for paying the balance. In 1997, less than 4 percent of HMO plan enrollees were in cost plans. In our sample of 2,975 inpatient admissions, only 3 admissions were enrolled in an HMO cost plan. Because HMO cost plans allow the beneficiary to go outside the plan, we included only the HMO risk plans in our analysis. See Appendix A for a discussion of our audit scope and statistical sampling methodology.

Beneficiary Choice. Many military retirees and dependents, 65 and older, are eligible to receive medical treatment from DoD and Medicare providers. Dual-eligible military retirees and dependents can receive medical and dental treatment at military treatment facilities (MTFs) on a space available, no fee basis. They are also entitled to Medicare, Part A as a result of their military service or civilian employment. Many also participate in Part B and some elect Part C, HMO plans for their medical treatment. As a result, military eligible beneficiaries can opt for health care benefits from DoD or Medicare programs depending on availability, expense, personal convenience, and the perception as to where they receive the best medical treatment. In FY 1997, 47,326 beneficiaries age 65 and older were admitted at 95 MTFs located in Guam, Puerto Rico, and the United States. The 47,326 admissions represented about 24 percent of the DoD inpatient workload for FY 1997 at the 95 MTFs.

Objectives

The objective was to determine the DoD MTF expenses for inpatient treatment of beneficiaries enrolled in Medicare HMO plans. We also explored alternatives to eliminate overlapping Federal Government expenditures for beneficiaries with dual eligibility. See Appendix A for a discussion of the audit scope and methodology.

DoD Inpatient Treatment for Beneficiaries Enrolled in Medicare Health Maintenance Organization Plans

Military treatment facilities provided inpatient treatment to eligible beneficiaries who were enrolled in HMO plans. At the same time that beneficiaries received inpatient treatment in MTFs, HCFA made per capita payments to HMO plans for covered medical benefits, including the expense of inpatient treatment. DoD and HCFA made the overlapping expenditures because:

- Federal law and policy allowed for the dual eligibility of beneficiaries age 65 and older in MTFs and HMO plans and
- the authority of HMO plans to reimburse DoD for inpatient treatment provided at MTFs to dual-eligible beneficiaries was not settled.

As a result, DoD expended about $45.2 million for inpatient treatment in FY 1997 for dual-eligible beneficiaries on whose behalf HCFA made payments to HMO plans. By eliminating the overlapping expenditures, the Federal Government could put approximately $271 million to better use over 6 years.

Background

HMO plans receive a per capita payment from HCFA for enrolled beneficiaries. The per capita payment is a fixed amount designed to cover all medical treatments a beneficiary needs while enrolled in an HMO plan. Overlapping expenditures exist when DoD incurs expenses for providing inpatient treatment to dual-eligible beneficiaries while HCFA is paying an enrollment fee to an HMO plan for the same beneficiary.

Medical Treatment for Dual-Eligible Beneficiaries

In FY 1997, there were approximately 4,900 inpatient admissions in which DoD provided treatment to beneficiaries who were enrolled in HMO plans when the treatment was received. According to FY 1997 inpatient admission information obtained from DoD, 47,326 Medicare eligible beneficiaries and dependents were admitted at 95 MTFs for treatment in Guam, Puerto Rico, and the United States. All of the inpatient admissions were assigned a diagnosis related group (DRG)* that was covered by Medicare. We sampled 2,975 inpatient admissions, and verified whether or not the individuals were enrolled in an HMO risk plan. We considered an individual to have dual eligibility if the individual was an inpatient at an MTF while concurrently enrolled in an HMO plan. We did not consider an individual to have dual eligibility if the individual was enrolled in an

* DRGs are classifications of diagnoses in which patients demonstrate similar resource consumption and length-of-stay patterns.

HMO plan in FY 1997, but was not enrolled in the plan during the month inpatient treatment was received at a DoD MTF. The dual eligibility resulted in overlapping expenditures by the Federal Government. See Appendix B for a summary of inpatient admissions by MTF.

Federal Law Allows Dual Eligibility

Dual eligibility was the primary cause of the Federal Government's overlapping expenses for inpatient treatment of DoD and Medicare eligible beneficiaries. Military retirees and dependents are eligible for medical treatment in MTFs based on a sponsor's military service and entitlement to a retirement annuity. MTFs provide medical treatment on a space available basis at no expense to the beneficiaries. Title 10, United States Code, Section 1074 (10 U.S.C. 1074), "Medical and Dental Care for Members and Certain Former Members," states that a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay may, upon request, be given medical and dental treatment in any facility of any uniformed service, subject to the availability of space and facilities and the capabilities of the medical staff. 10 U.S.C. 1076, "Medical and Dental Care for Dependents: General Rule," states that a dependent of a member, or former member entitled to retired or retainer pay, may, upon request, be given medical and dental treatment in facilities of the uniformed services. Medical treatment for dependents is subject to the availability of space and facilities and the capabilities of the medical and dental staff.

In 1965, Congress established the Medicare program as Title XVIII of the Social Security Act. Medicare was established in response to the specific medical treatment needs of the elderly, and in 1973, the severely disabled and persons with kidney disease. Citizens or permanent residents of the United States are eligible for Medicare if they worked for at least 10 years in Medicare-covered employment and are age 65 or older. Whether or not an eligible beneficiary is covered by Medicare is not considered in determining the availability of medical treatment services in an MTF.

There is no authority for DoD to deny medical treatment to eligible beneficiaries when the beneficiaries are enrolled in HMO plans receiving per capita payments from HCFA. As discussed above, 10 U.S.C. 1074(b) and 1076(b) provide that military retirees and their dependents may be afforded treatment in MTFs as space and medical capabilities permit.

Authority for Medicare HMO Plans to Reimburse DoD for Inpatient Treatment

Overlapping expenditures also occurred because it was unclear whether HMO plans had the statutory authority to reimburse DoD for inpatient treatment provided by the MTFs. The Social Security Act, Title XVIII, Section 1814 (42 U.S.C. 1395f(c)), states that no payment may be made to any provider of services, except a provider that is determined to be providing services to the public generally as a community institution or agency. Section 1814 also states that no such payment may be made to any provider of services when the

provider is obligated by law to render services at public expense. HCFA has taken the position that under that provision, it cannot pay DoD for medical treatment provided to HMO plan enrollees.

The Code of Federal Regulations, Title 32, part 220, "Collection From Third Party Payers of Reasonable Hospital Costs," implements provisions of 10 U.S.C. 1095 and establishes the statutory obligation of third party payers to reimburse DoD the reasonable expense for medical treatment provided to eligible beneficiaries. 10 U.S.C. 1095 states that except as provided in subsection (j), collection may not be made from plans that are administered under Title XVIII of the Social Security Act. Section 1095(j) provides that the Secretary of Defense may enter in an agreement with any HMO, health care prepayment plan or other similar plan providing for collection for treatment services provided to covered beneficiaries who are also enrollees in such plans.

While it is unclear if current law precludes DoD from obtaining reimbursement from HMO risk plans for Medicare benefits, current law allows HMO plan enrollees to receive additional and supplemental health care services in MTFs from or through arrangements made by the HMO plan.

On May 1, 1997, the Acting Chief Counsel of the Department of Health and Human Services stated that it may be legally permissible for an MTF to contract with an HMO risk plan and offer enrollees the opportunity to receive health care services in the MTF as additional or supplemental benefits. The Acting Chief Counsel noted that the HMO risk plan would have to be willing to enter into such a contract and would have to assign appropriate value to the cost of such a benefit. The Acting Chief Counsel also noted that plans may not offer health care services in MTFs unless those services are offered to all Medicare enrollees of the plan, whether eligible for DoD treatment or not. Aside from the additional or supplemental benefits, HCFA also permits HMO plans to offer flexible benefit packages to various employer groups. See Appendix A for a description of additional and supplemental benefits, and flexible benefit packages.

The DoD Office of General Counsel has pointed out that published Medicare policy permits HMO plans to offer extra benefits to members of particular employer groups including former military personnel. In a June 9, 1997, memorandum to HCFA, the Associate Deputy General Counsel (Health Affairs) presented a discussion of flexible benefit packages. The Associate Deputy General Counsel determined that an HMO plan can offer additional or supplemental benefits to DoD eligible enrollees in the form of referrals to DoD for needed health care services, reimbursable by the HMO plan, and not be required to offer the same to non-DoD eligible HMO plan enrollees. The Associate Deputy General Counsel also cited 10 U.S.C. 1095 (j) that allows agreements between DoD and HMO plans to permit MTFs to make collections as part of an effort to coordinate the two entitlements of dual-eligible beneficiaries.

While we recognize that DoD beneficiaries are considered an employer group, there is disagreement about the level of medical treatment and the amount of reimbursement that can be negotiated between HMO plans and MTFs.

Congress has, in some instances, given DoD the authority to obtain reimbursement for Medicare benefits provided to Medicare-eligible military retirees or dependents in an MTF.

Medicare Subvention Demonstration Project. Recent legislation demonstrates that Congress recognizes the viability of having DoD MTFs serve as HMO providers in certain locations. In August 1997, Congress added Section 1896 to the Social Security Act (42 U.S.C. 1395 ggg) to provide statutory authority for the Medicare subvention demonstration project for military retirees. It authorizes the Secretary of Health and Human Services and the Secretary of Defense to establish a demonstration project at six sites. The subvention demonstration project includes two components. The first component, TRICARE Senior Prime, allows MTFs to function as Medicare+Choice (Part C) HMO plans and provide a full range of comprehensive health care services to enrolled DoD retirees. The demonstration project authorizes Medicare to pay DoD an amount equal to 95 percent of what Medicare pays HMO plans for medical treatment to Medicare eligible military retirees or dependents. The second component, Medicare Partners, permits military retirees enrolled in a limited number of Medicare+Choice plans to receive certain specialty and inpatient Medicare services through MTFs. The demonstration project allows Medicare+Choice plans to contract with MTFs for specialty and inpatient care.

Potential Solutions to Overlapping Expenditures

We considered two possible solutions to the overlapping expenditure issue: discontinuing treatment of dual eligible patients in the MTFs, and allowing HMO plans to reimburse DoD for the cost of medical treatment provided by MTFs to HMO plan enrollees. Either solution would likely require change to existing laws and regulations, and either solution carries significant policy and political implications.

Discontinuing Treatment in DoD MTFs. If a beneficiary loses access to a MTF by enrolling in an HMO plan, then enrollment in HMO plans could be discouraged. We recognize that denying MTF access is a potential solution to the overlapping expenditure problem discussed in the report. However, such action is also contrary to the quality of life initiatives in DoD to increase medical treatment options for DoD beneficiaries age 65 and older, as evidenced by the recent approval of the TRICARE Senior Prime demonstration project. Under the TRICARE Senior Prime demonstration project, TRICARE essentially becomes an HMO plan. Absent some specific authority, we do not view enrollment in an HMO plan as a basis for administratively denying one the availability of MTF treatment. If such an option were pursued, we believe that the better course would be to seek a legislative provision similar to that which denies Medicare eligible retirees access to DoD contracted health care services.

HMO Plan Reimbursement. Reimbursement to DoD from HMO plans for medical treatment services could have the effect of eliminating or minimizing overlapping expenditures. If appropriate statutes were changed, MTFs could enter into reimbursable agreements with HMO plans, depending on the ability of MTFs to be cost competitive with HMO plan network providers for the same services. This solution may require changes to the Social Security Act to

specifically allow payment to DoD from HMO plans. If such authority were provided, issues such as the need for the HMO plan to precertify DoD treatment of beneficiaries would need to be resolved for the solution to be practical.

Conclusion

Information from the Department of Health and Human Services indicates that the number of Medicare contracts with managed care organizations increased from 193 in FY 1993 to 410 in FY 1997. During the same time period, there was steady growth in the number of Medicare beneficiaries enrolled in managed care plans. In September 1997, approximately 5.7 million (14.7 percent) of the total Medicare eligible population were enrolled in a managed care plan. The 5.7 million enrollees equate to about a 93-percent increase in HMO plan enrollment since FY 1994.

We recognize that military beneficiaries, age 65 and older, use HMO plans and MTFs as medical treatment options and that this practice complies with current legislation. However, the dual availability of medical treatment services from HMO plans and MTFs resulted in about $45 million in overlapping Federal Government expenditures for FY 1997. Elimination of the overlapping expenditures would enable the Federal Government to put approximately $271 million to better use over 6 years. If enrollment in HMO plans continues to increase, overlapping Federal Government expenditures could become higher. We note that the $271 million does not include overlapping expenditures for outpatient treatment and does not account for the impact of inflation on future expenditures.

We do not believe there is a simple solution to this issue, nor do we believe that DoD or HCFA can unilaterally resolve the overlapping expenditure issue. We also recognize the implications to the quality of life for beneficiaries with dual eligibility.

Recommendations, Management Comments, and Audit Response

We recommend that the Assistant Secretary of Defense (Health Affairs):

1. Develop a strategy to reduce or eliminate overlapping expenditures for providing medical treatment benefits to beneficiaries, age 65 and older, who are enrolled in health maintenance organization plans and provided access to military treatment facilities. The strategy should consider all expenses for medical treatment. In developing the strategy, the Assistant Secretary should coordinate and consult with personnel from DoD, the Department of Health and Human Services, the Health Care Financing Administration, and the Office of Management and Budget.

2. Develop a legislative proposal if it is determined that the overlapping expenditures should be resolved with the enactment of new legislation. A legislative proposal would seek to reduce or eliminate overlapping

expenditures for providing medical treatment to beneficiaries, age 65 and older, who are concurrently enrolled in health maintenance organization plans and allowed access to DoD military treatment facilities.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the recommendations and agreed that her office would aggressively pursue a means to eliminate the overlapping expenditures by the earliest possible date. The Assistant Secretary stated that her office will consult with the Department of Health and Human Services and the Office of Management and Budget on this issue. The Assistant Secretary agreed to consider a legislative proposal if a proposal would reduce or eliminate the overlapping expenditures. The Assistant Secretary also agreed that the estimate of $271 million in overlapping expenditures was understated because it did not factor in ambulatory care and other services provided to Medicare eligible retirees. The Assistant Secretary stated that resolution of the overlapping expenditure issue would not produce "savings" for the Defense Health Program, but could result in additional health care services for DoD beneficiaries.

Audit Response. Management comments are responsive to the recommendations. We recognize that resolution of the overlapping expenditure issue should not result in a reduction of the Defense Health Program Appropriation, but could result in additional health care services being made available to DoD beneficiaries.

Appendix A. Audit Process

Scope

Work Performed. We obtained inpatient data for 47,326 DoD retiree and dependent inpatient admissions in 95 MTFs located in Guam, Puerto Rico, and the United States. We used the data from FY 1997 to determine the expense to treat inpatients, age 65 and older, who were enrolled in HMO plans. We also performed a judgmental sample of individual inpatient records to validate the accuracy of the Defense Medical Information System (DMIS) data that were used in our statistical sample of 2,975 inpatient admissions.

We obtained data from DMIS that captures inpatient information through a standard inpatient data record linked to a military sponsor's social security number. We selected a statistical sample of 2,975 records to determine whether a patient was enrolled in an HMO plan at the time of MTF admission. We worked with auditors from the Inspector General, Department of Health and Human Services to identify patients who were enrolled in an HMO risk plan at the same time they received treatment in an MTF. We did not consider HMO cost plans in our projection because there were only 3 inpatient admissions out of 2,975 admissions in which the inpatient was enrolled in an HMO cost plan.

Dependent inpatients who received medical treatment in an MTF were identified in the HCFA database under the military sponsor's HMO plan history. Auditors from the Inspector General, Department of Health and Human Services provided us a copy of the HMO plan enrollment history for each of the sampled inpatients. We compared the data obtained from DMIS with the HMO plan enrollment histories to identify patients who were enrolled in an HMO plan when admitted to an MTF as an inpatient.

Limitations to Audit Scope. The DMIS database identifies patient records using a military sponsor's social security number. We were unable to identify dependent patients who were enrolled in HMO plans independent of their military sponsor. Also, we did not determine the costs of preoperative and postoperative visits that resulted from inpatient treatment at MTFs. The civilian sector generally considers associated preoperative and postoperative visits as part of inpatient treatment costs. In some cases, there may have been extensive preoperative and postoperative visits that were related to a single inpatient treatment. However, the DoD health care system does not recognize preoperative and postoperative costs as part of the cost of inpatient care. Additionally, we did not identify outpatient medical treatment provided to dual-eligible beneficiaries by MTFs.

We also did not evaluate the per capita reimbursement rates established for HMO plans that operate in areas with large numbers of age 65 and older military beneficiaries. If rates were adjusted to account for the level of inpatient treatment provided by MTFs, a portion of the cost of treatment provided in the MTFs might not represent an overlapping expenditure. Although auditors from the Inspector General, Department of Health and Human Services, did not believe the HMO rates were adjusted based on the dual-eligibles use of the

MTFs, they stated that if such an adjustment occurred, it would be insignificant. Finally, we did not determine the number of inpatient treatments that HMO plans provided to age 65 and older military beneficiaries who were eligible for medical treatment in MTFs. Therefore, we do not know how much medical treatment dual-eligible beneficiaries received from HMO plans during FY 1997. As a result of the limitations, the estimated expenses for treatment for dual-eligible beneficiaries in MTFs may be understated.

For each DRG, Assistant Secretary of Defense (Health Affairs) personnel provided us standard DoD expense rates for each in-patient admission in our sample. We did not verify the accuracy of the DoD expense rate information for the sampled DRGs because those expenses represented the DoD third-party billing rates and were not calculated separately for this audit.

Additional and Supplemental Benefits. The Code of Federal Regulations, Title 42, part 417, "Health Maintenance Organizations, Competitive Organization Plans, and Health Care Prepayment Plans," implements three additional benefit categories for HMO plans: additional, mandatory supplemental, and optional supplemental. HMO plans are obligated to provide "additional benefits" to all enrollees either as a reduction in the HMO premium rate or in charges for services provided to Medicare enrollees, or as additional benefits that are beyond the required Part A and Part B coverage. In some cases, an HMO may require all its enrollees, regardless of health status, to accept and pay for "mandatory supplemental" benefits that are health care services in addition to those covered by Medicare. "Optional supplemental" benefits are medical services that the enrollee may elect in exchange for an additional premium charge.

Flexible Benefit Packages. HCFA permits HMO plans to offer "flexible benefits packages" that consist of lower premiums and extra benefits to enrollees. Flexible benefit packages are different from additional or supplemental benefits and are offered only to Medicare beneficiaries enrolled as members of an employer group. Retired military employees, who are Medicare eligible, constitute an employer group. However, the cost of the extra benefits and premiums are negotiated directly between the HMO plan and the employer or union.

DoD-wide Corporate Level Goals. In response to the Government Performance and Results Act, DoD has established 6 DoD-wide corporate level performance objectives and 14 goals for meeting these objectives. This report pertains to achievement of the following objective and goal.

- **Objective:** Fundamentally reengineer the Department and achieve a 21st century infrastructure. **Goal:** Reduce costs while maintaining required military capabilities across all DoD mission areas. **(DoD-6)**

DoD Functional Area Reform Goal. Most major DoD functional areas have also established performance improvement reform objectives and goals. This report pertains to achievement of the following functional area objective and goal.

- **Health Care Functional Area. Objective:** Become a benchmark health system. **Goal:** Work aggressively to ensure appropriate resources are available to deliver the military health entitlement/benefit. **(MHS-4.3)**

High Risk Area. The General Accounting Office has identified several high-risk areas in the DoD. This report provides coverage of the Defense Infrastructure high-risk area.

Audit Type, Dates, and Standards. This economy and efficiency audit was performed from June through November 1998 in accordance with auditing standards issued by the Comptroller General of the United States as implemented by the Inspector General, DoD. We did not review the management control program because the overlapping expenditure issue is related to policy rather than a management control weakness.

Methodology

Use of Computer-Processed Data. We relied on information from DMIS and the DoD Composite Health Care System (CHCS). The DMIS is an on-line automated information system that supports the collection, integration, validation, analysis, and reporting of data related to the military health care system. The DMIS provides access to all available information from the reporting MTFs at an aggregate level.

The CHCS is an automated information system that provides patient data management capabilities for MTFs. Some of the specific areas included in CHCS are health care administration; patient registration, admission, disposition, and transfer; and inpatient activity documentation.

Reliability of Computer-Processed Data. We limited our test of the reliability of computer-processed data to 106 medical records at three MTFs. We relied extensively on computer-processed data from the DMIS and CHCS systems. To test the reliability of the computer-processed data, we validated information obtained from DMIS to medical records at Brooke Army Medical Center, Fort Sam Houston, Texas; the National Naval Medical Center, Bethesda, Maryland; and Wilford Hall Air Force Medical Center, Lackland Air Force Base, Texas. At those locations we reviewed 30 of the 106 patient medical records included in our sample to determine the accuracy of the information from DMIS. The data we obtained included the sponsor's social security number, the patient gender and date of birth, dates of admission and discharge, and the DRG. We also performed a reverse check by reviewing 76 of the 106 inpatient medical records to verify whether information from inpatient medical records at the MTF had been entered into CHCS and submitted to DMIS. From the information reviewed in the 106 records, we concluded that the computer-processed data from DMIS were reliable as used in meeting the audit objective. Our limited test is not intended to imply any conclusion as to the overall accuracy of the CHCS or DMIS.

We also relied on HMO plan enrollment information provided by the Managed Care Option Information (McCOY) computer system at HCFA. The McCOY system contains a comprehensive history of beneficiary enrollment information

in HMO plans. We relied on the accuracy of the McCOY system to identify beneficiaries enrolled in HMO plans. We did not test the accuracy of the database because the system is external to DoD.

Use of Technical Assistance. Personnel from our Quantitative Methods Division developed a statistical sampling plan to estimate the number and dollar impact of inpatient treatment at MTFs for military beneficiaries enrolled in an HMO plan when treatment was received. The sample results provided data to evaluate the number of beneficiaries, percent of admissions, and expenses associated with treating HMO plan enrollees.

Universe Represented. The audit covered dual-eligible beneficiaries who were inpatients at an MTF during FY 1997. The universe comprised 47,326 admissions, of which 16,442 were admissions at TRICARE Senior Prime demonstration sites and 30,884 admissions were at nondemonstration sites.

Sampling Design. Two stratified samples were designed to separate TRICARE Senior Prime demonstration sites from nondemonstration sites. Each sample was stratified by a composite measure that incorporated the relative expense of the medical treatment for each DRG and the relative percent of HMO population penetration in an MTF catchment area. A catchment area is about a 40-mile radius from the MTF. The sample for demonstration sites included 1,581 admissions for Medicare eligible inpatients and the sample for nondemonstration sites contained 1,394 admissions for Medicare eligible inpatients.

Confidence Interval Table. The following table shows statistical projections of the sample data.

Expense of MTF Medical Treatment Provided To Dual-Eligible Beneficiaries

	Lower Bound	Point Estimate	Upper Bound
MTF inpatients enrolled in Medicare HMO plans	4,339	4,903	5,466
Percent of total admissions	9.2	10.4	11.6
Dollar impact (millions)	$41.64	$45.19	$48.74

Confidence Interval Statement. With 90-percent confidence, the probability of inpatient treatment at MTFs by Medicare eligible beneficiaries enrolled in an HMO plan is between 9.2 percent and 11.6 percent, with 10.4 percent as the best estimate. The dollar impact of covering these Medicare eligible beneficiaries is between $41.64 million and $48.74 million, with $45.19 million as the best estimate.

Contacts During the Audit. We visited or contacted individuals and organizations within DoD and the Department of Health and Human Services and a DoD contractor. Further details are available on request.

Summary of Prior Coverage. There were no audits in the last 5 years that were directly related to the audit objective.

Appendix B. Inpatient Admissions for Patients Age 65 and Older by Military Treatment Facility

During FY 1997, there were 47,326 inpatient admissions for individuals age 65 and older at 95 MTFs in Medicare regions. An inpatient admission occurs when an individual is admitted to an MTF for treatment, usually requiring one or more nights stay. In some cases, the same beneficiary may have had more than one admission during FY 1997. In our statistical sample of 2,975 admissions that we reviewed at HCFA, 464 admissions were for patients enrolled in HMO plans at the same time inpatient treatment was provided in an MTF.

Military Treatment Facility Name or Location	Inpatient Admissions for Patients 65 and Over: Total Number	Total in Sample	Sample Enrolled in HMO
Army			
Walter Reed AMC[1]	4,014	143	7
Brooke AMC	3,669	343	98
Madigan AMC	3,009	217	48
Beaumont AMC	2,184	11	0
Tripler AMC	1,662	249	2
Eisenhower AMC	1,321	11	0
DeWitt ACH[2]	722	8	1
Womack AMC	714	7	0
Martin ACH	538	5	0
Evans ACH	433	33	6
Darnall ACH	419	18	1
Fort Leonard Wood ACH	286	1	0
Reynolds ACH	286	22	0
Moncrief ACH	211	2	0
Irwin ACH	185	1	0
Winn ACH	176	1	0
Blanchfield ACH	149	3	0
Keller ACH	140	2	0
Bayne-Jones ACH	121	1	0
Ireland ACH	111	1	0
McDonald ACH	73	0	0
Lyster ACH	66	0	0
Fort Bliss ACH	63	4	0
Kimbrough ACH	42	0	0
Fox ACH	35	0	0

[1]Army Medical Center.

[2]Army Community Hospital.

Military Treatment Facility Name or Location	Inpatient Admissions for Patients 65 and Over		
	Total Number	Total in Sample	Sample Enrolled in HMO
Bassett ACH	34	0	0
Patterson ACH	20	0	0
Munson ACH	18	2	0
Weed ACH	11	0	0
Navy			
NH[3] San Diego	2,794	452	95
NNMC[4] Bethesda	2,259	107	4
NH Portsmouth	1,922	15	0
NH Pensacola	640	3	0
NH Bremerton	374	28	2
NH Camp Pendleton	350	54	4
NH Jacksonville	311	21	2
NH Charleston	293	2	0
NH Guam	285	4	0
NH Camp Lejeune	227	2	0
NH Newport	185	13	0
NH Roosevelt Roads	143	0	0
NH Beaufort	133	0	0
NH Great Lakes	116	2	0
NH Groton	104	5	0
NH 29 Palms	58	0	0
NH Cherry Point	43	0	0
NH Corpus Christi	39	1	0
NH Oak Harbor	35	1	0
NH Lemoore	24	0	0
NH Millington	16	0	0
NH Patuxent River	7	0	0
Air Force			
Wilford Hall AFMC[5]	4,463	368	89
Grant AFMC	2,701	349	73
Wright-Patterson AFMC	1,656	81	2
Malcom Grow AFMC	1,488	25	2
Keesler AFMC	1,184	94	0

[3]Naval Hospital.

[4]National Naval Medical Center.

[5]Air Force Medical Center.

Military Treatment Facility Name or Location	Inpatient Admissions for Patients 65 and Over		
	Total Number	Total in Sample	Sample Enrolled in HMO
Eglin AFB[6]	551	0	0
Nellis AFB	551	73	11
Scott AFB	547	24	1
Air Force Academy	314	28	2
MacDill AFB	286	17	1
Elmendorf AFB	268	1	0
Sheppard AFB	261	22	0
McClellan AFB	244	23	5
Langley AFB	231	1	0
Luke AFB	167	13	3
Vandenberg AFB	136	15	2
Offutt AFB	135	4	0
Shaw AFB	135	0	0
Davis Monthan AFB	120	14	1
Kirtland AFB	118	18	2
Maxwell AFB	108	1	0
Ellsworth AFB	77	0	0
Mountain Home AFB	65	1	0
Minot AFB	51	1	0
Tinker AFB	49	0	0
Tyndall AFB	47	0	0
Hill AFB	39	1	0
Holloman AFB	34	0	0
McGuire AFB	33	0	0
Dover AFB	29	2	0
Seymour Johnson AFB	27	0	0
Robins AFB	20	0	0
Cannon AFB	19	0	0
Francis E. Warren AFB	14	0	0
Edwards AFB	13	1	0
Altus AFB	12	0	0
Grand Forks AFB	12	1	0
Patrick AFB	12	2	0
Dyess AFB	11	0	0
Barksdale AFB	10	0	0
Beale AFB	9	0	0

[6]Air Force Base.

Military Treatment Facility Name or Location	Inpatient Admissions for Patients 65 and Over		
	Total Number	Total in Sample	Sample Enrolled in HMO
Whiteman AFB	5	0	0
Little Rock AFB	2	0	0
Moody AFB	2	0	0
Total	**47,326**	**2,975**	**464**

Appendix C. Report Distribution

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House Subcommittee on Government Management, Information, and Technology, Committee on Government Reform
House Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

APR 19 1999

MEMORANDUM FOR INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Audit Report on Overlapping Inpatient Treatment Expenditures for DoD Beneficiaries Enrolled in Medicare Health Maintenance Organization Plans (Project No. 8LF-5027)

We have reviewed the audit report (Project No. 8LF-5027) and concur with the findings of the report (see attachment) as presented in the section headed "Conclusion." As you may be aware, this issue was identified by the Department of Defense (Office of General Counsel) who brought it to the attention of the Assistant Secretary of Defense (Health Affairs). The then Acting Assistant Secretary of Defense (Health Affairs) requested the DoDIG conduct a review to determine the magnitude of the issue. The end result is the referenced audit report.

My points of contact are LCDR Ehresmann, Ph.D., MSC, USN, OASD(HA) at (703) 681-1724; email: Elaine.Ehresmann@ha.osd.mil and Mr. Gunther J. Zimmerman (TRICARE Management Activity) at (703) 681-7889, e-mail: Gunther.Zimmerman@tma.osd.mil.

Dr. Sue Bailey

Attachment:
As stated

Comments on
Draft of a Proposed Report
Overlapping Inpatient Treatment Expenditures for DoD
Beneficiaries Enrolled in Medicare
Health Maintenance Organization Plans
DoD IG Project No. 8LF-5027

OASD(HA) concurs with the findings of the report, as presented in the section headed "Conclusion." We agree that the estimate of $271 million in overlapping expenditures is understated because it does not factor in ambulatory care and other services provided by military facilities to Medical HMO enrollees, nor does it account for the impact of inflation on future expenditures. We do not at present have an estimate that takes these additional factors into account, but believe the total amount is quite significant. We also note that a resolution of this issue would not produce "savings" for the Defense Health Program, but could result in additional health care services being made available to DoD beneficiaries, particularly those who are Medicare eligible.

The draft report makes two recommendations

Recommendation #1: Develop a strategy to reduce or eliminate overlapping expenditures for providing medical treatment benefits to beneficiaries, age 65 and older, who are enrolled in health maintenance organization plans and provided access to military treatment facilities. The strategy should consider all expenses for medical treatment. In developing the strategy, the Assistant Secretary should coordinate and consult with personnel from DoD, the Department of Health and Human Services, the Health Care Financing Administration, and the Office of Management and Budget.

Response: Concur. We agree this is a significant problem and will aggressively pursue a means to eliminate these overlapping expenditures. We will do so in consultation with DHHS and OMB. Our goal is to develop a clear strategy to reduce or eliminate overlapping expenditures by the earliest possible date.

Recommendation #2. Develop a legislative proposal if it is determined that the overlapping expenditures should be resolved with the enactment of new legislation. A legislative proposal would seek to reduce or eliminate overlapping expenditures for providing medical treatment to beneficiaries, age 65 and older, who are concurrently enrolled in health maintenance organization plans and allowed access to DoD military treatment facilities.

Response: Concur. We will consider the desirability of a legislative proposal to address this important issue.

Audit Team Members

The Readiness and Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, DoD, prepared this report.

Shelton R. Young
Raymond D. Kidd
Michael A. Joseph
Henry D. Barton
Timothy J. Tonkovic
Douglas L. Jones
Robert J. Hanlon
Brian M. Taylor
Mary J. Gibson
James R. Knight
Carolyn A. Swift