

Testimony of

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On behalf of Mid-Atlantic Women's Care
Norfolk, VA

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of the House Armed Services Committee

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Defense Health Program Overview

Mr. Chairman and Members of the Subcommittee, my name is Holly Puritz and I am an obstetrician-gynecologist practicing in Tidewater, Virginia. I am honored to be here to discuss my practice's experience with TRICARE and our difficult decision to discontinue our participation with the program.

My practice, Mid-Atlantic Women's Care, was created in 1997 by the merger of eleven independent ob-gyn practices. Our group now has 72 physicians operating in 28 medical practice sites and four imaging centers, which offer mammography, breast ultrasound and bone densitometry. We serve a geographic area from the Outer Banks of North Carolina, to Williamsburg, Virginia, to as far west as Franklin, Virginia. Our region has several military bases and is home to thousands of servicemen and women and their families.

As a practice, our vision is to be the premier provider of a full spectrum of high quality, cost-effective obstetrical and gynecological services in Southeastern Virginia. To do this, we foster a team-based approach that incorporates technology, quality, and caring into women's healthcare to create long-term, trusting patient relationships.

In 2004, TRICARE was approximately 5-10% of our overall patient base. In some offices within our practice, this percentage was nearly 20%. Effective March 1, 2005, our practice stopped participating in TRICARE. We agreed to continue seeing pregnant patients through their delivery to ensure continuity of care. We decided to end our participation in TRICARE for several reasons, including quality of care concerns, administrative hassles far worse than any other third party payor, and low reimbursement.

Quality of Care Concerns

We want to provide the best care to our patients and we felt that TRICARE did not allow our doctors to practice at our usual standard of care. For example, private insurers and Medicaid recognize that a morphology ultrasound of an OB patient at 20 weeks gestation is appropriate and clinically useful to determine fetal size and positioning and to look for any potential fetal and placental abnormalities. Beginning this year, however, our new vendor, Health Net, informed us that our prior contractor misinterpreted TRICARE policy and now an ultrasound is covered only if there is a TRICARE-authorized medical indication. Since failure to provide a 20-week ultrasound, in our opinion, is a breach in standard of care, we absorbed that extra cost on behalf of our patients.

In some high-risk pregnancies, it is necessary to refer patients to a maternal-fetal medicine specialist, who is equipped to handle these complicated conditions and will provide valuable consultation for the primary obstetrician. A good working relationship between consultants and primary physicians is imperative for good patient care. Eastern Virginia Medical School—where we customarily refer our high-risk patients with private or Medicaid/Medicare insurance—does not participate with TRICARE.

Our only option in the region is to refer women to the Portsmouth Naval Hospital, where we frequently have trouble getting timely consultative appointments for ultrasound, diabetic evaluations or other high-risk conditions. We get minimum feedback from those referrals and care is not as seamless as it is with our maternal-fetal medicine referrals for other patients. We have had high-risk pregnant women wait up to four weeks for a diabetic consult. One of my partners spent five hours of her own time trying to get her pregnant diabetic patient seen at the Navy Hospital when her sugars were dangerously high. She finally sent the patient, chart in hand, to Labor and Delivery so that someone at the Hospital would take ownership for this woman's care. These barriers to care are not acceptable and make it impossible for us to provide good quality of care.

Administrative Problems

TRICARE was unnecessarily labor intensive for our administrative staff. Collecting payments from TRICARE had become increasingly difficult and more costly, while collecting from commercial payors had become significantly more efficient and less expensive.

In TRICARE, claims are not processed consistently and cannot be corrected online, and it is not uncommon for 6 months to elapse before a claim is settled. In contrast, Medicare processes claims automatically, usually in 14 days or less. Medicaid provides a single authorization number as soon as the patient is seen, which enables the business office to process all claims easily.

Adding to the TRICARE difficulties, the contract with each vendor is for a limited term. The incumbent vendor is often underbid at the end of the term and our practice is then faced with a transition and the problems associated with the new vendor's learning curve.

Administration was made more difficult under Health Net because they do not have provider representatives in the area, as the previous contractor did. In the past, these provider representatives were local people who took ownership of problems, who were easy to contact, who had a name, phone number and fax number and with whom the business office could establish a good working relationship. The provider representatives also would hold quarterly workshops where information was updated, questions answered and new employees oriented. This was extremely helpful.

Our practice has also experienced large fluctuations in the volume of business from TRICARE. This inconsistent referral volume from the military treatment facility makes it very difficult to manage long-term costs and commitments, such as leases and employment contracts with physicians.

Low Reimbursement

It is a common complaint from physicians, particularly those who accept patients in government-financed programs, but low reimbursement was certainly a factor in our decision to stop participating in TRICARE.

We have invested over \$500,000 in electronic medical record systems and have faced rising office costs due to nurse and staff salaries and medical liability insurance. Our medical liability costs have skyrocketed in the last several years, increasing by over 200% two years ago and 30% last year. The region's rising medical liability rates have driven our colleagues out of business. As a result, there are many privately insured women in search of ob-gyn care and we could easily fill our practice without accepting patients from any government payer.

TRICARE's reimbursement is woefully inadequate and is significantly below the actual cost of providing care. It is roughly two-thirds of what we are paid by other insurance carriers in Hampton Roads. For example, TRICARE pays \$1,537.10 for nine months of obstetrical care and delivery, compared to a commercial payment of \$2,281.39. Even paying 100% of the Medicare rate was insufficient because of the other problems involved in TRICARE—difficulties obtaining authorizations for referrals, the inability to be reimbursed outside the global rate for ultrasound, denials of appropriate claims and the lack of TRICARE staff assistance in resolving issues.

We've always believed that we have a public duty to serve women in Medicaid, Medicare and TRICARE. We work hard to develop lasting relationships with our patients. When we informed patients of our decision to drop TRICARE, it was difficult to accept their angry phone calls and letters. We heard from a woman whose two daughters were delivered by one of our partners; two decades later, mother and both daughters were still under our care. We know that at least one of them, like many of our TRICARE patients, will be seeking a new physician due to our decision. We worry about the ability of our former patients to find a new source of care in our region.

From an emotional standpoint, it was a difficult decision to stop accepting TRICARE. However, from a business and quality of care perspective, the decision was clear: we could no longer practice high-quality medicine within the current TRICARE system.

Mr. Chairman, as physicians operating under TRICARE, we felt the program was forcing us to provide care at a level that is below that of other carriers. Our military and their dependents deserve the same standard of medical care as the rest of the population and we at Mid-Atlantic Women's Care are not prepared to accept anything less for them.