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Report to Congressional Committees

DOD HEALTH CARE

Improvements Needed for Tracking Coordination of Specialty Care Referrals for TRICARE Prime Beneficiaries

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Improvements Needed for Tracking Coordination of Specialty Care Referrals for TRICARE Prime Beneficiaries

Why GAO Did This Study

Specialty care referrals are a key component of care coordination for TRICARE Prime beneficiaries. Each Prime beneficiary is assigned to a primary care manager either at an MTF or within the civilian provider network. Primary care managers are responsible for overseeing all aspects of their patients' care, which includes making referrals for specialty care when needed.

The National Defense Authorization Act for Fiscal Year 2017 included a provision for GAO to examine care coordination within and between the direct and purchased care systems. Among other objectives, this report examines the extent to which the referral management process facilitates the coordination of primary and specialty care for TRICARE Prime beneficiaries. GAO examined relevant policies; analyzed current referral data from five MTFs it visited, selected for variety in military service, geographic location, and numbers of referrals; and interviewed officials with DHA and the military services. GAO also discussed the implementation of MHS Genesis with officials at DOD and the four MTFs where it has been implemented.

What GAO Recommends

GAO recommends that the Secretary of Defense ensure that (1) MTF referral staff are trained to process and accurately document information in MHS Genesis about specially care referrals and (2) MHS Genesis is configured to produce reports with reliable data on the referral process. DOD concurred with both of these recommendations.

What GAO Found

The Department of Defense's (DOD) Defense Health Agency (DHA) has limited information about the extent to which the referral management process facilitates the coordination of primary and specialty care for beneficiaries enrolled in TRICARE Prime—a managed care option—because information about their specialty care referrals is not always complete or accurate. The coordination of care for these beneficiaries is important because they may move between military treatment facilities (MTF) and civilian providers to obtain needed care. DHA requires specialty care providers to share documentation about the care they provided for referring primary care managers to review. This and other information is to be documented in the Referral Management Suite (RMS), the information technology system used by MTF officials to track and process referrals. However, GAO found that the five MTFs it visited had incomplete and unreliable data in RMS due to lack of training and insufficient staff. For example, GAO found that some MTFs were not tracking referral results in RMS due, in part, to lack of training. Officials with each of the military services told GAO that they are aware of RMS reliability issues and have been working to address them through system updates, training, and hiring staff.

DHA has begun to replace RMS and other existing information technology systems with Military Health System (MHS) Genesis, a new electronic health record system. The implementation of MHS Genesis began in 2017 at four MTFs, which have experienced difficulties with system implementation, including with referral management.

- GAO found that the four MTFs using MHS Genesis were not adequately trained on how to use its referral management component prior to the system's deployment. This limited the MTFs' ability to process and track referrals, and led to concerns about the reliability of the system's referral data. While MHS Genesis training on referral management has been redesigned for the next round of MTFs slated for implementation in summer 2019, officials said that it remains unclear whether this training will provide the guidance needed for MTF officials to accurately process and capture information on specialty care referrals. Without adequate training, DHA cannot ensure that the referral data in MHS Genesis accurately reflects the referral experiences of its Prime beneficiaries, potentially impacting the timeliness and quality of care they receive.

- DHA and military service officials who are responsible for developing standardized referral management guidance for the department—the Referral Management Working Group—said that they have not been able to obtain reports about referrals for the four MTFs that use MHS Genesis. The system would need to be configured to produce the types of referral reports needed, according to these officials, who told GAO they have been working with the DHA officials responsible for system implementation to develop such reports. Without reliable reports on referrals, DHA will continue to lack the information it needs about the coordination of care for its TRICARE Prime beneficiaries, impeding its ability to manage referrals, as well as ensuring these beneficiaries receive needed care.

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June 12, 2019

The Honorable James M. Inhofe
Chairman
The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Adam Smith
Chairman
The Honorable Mac Thornberry
Ranking Member
Committee on Armed Services
House of Representatives

In fiscal year 2018, the Department of Defense (DOD) offered health care services to more than 9 million eligible beneficiaries in the United States and abroad through TRICARE, its regionally structured health care program.[1] Under TRICARE, the department contracts with private sector companies—referred to as managed care support contractors (contractors)—to develop and maintain civilian provider networks and provide other services, such as specialty care referrals and claims processing.[2] Eligible beneficiaries can obtain primary and specialty health care services through the department's direct care system of military hospitals and clinics, referred to as military treatment facilities (MTF), or through its purchased care system of civilian providers.

Beneficiaries enrolled in TRICARE Prime, DOD's managed care option, must generally obtain referrals for their specialty care.[3] Referral

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[1]Eligible beneficiaries include active duty personnel and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and retirees and their dependents and survivors. Active duty personnel include Reserve component members on active duty for at least 30 days.

[2]DOD has two TRICARE regions (East and West), and each region has its own contractor.

[3]Beginning on Jan. 1, 2018, TRICARE's non-Medicare-eligible beneficiary population could be enrolled in one of two basic health plan options—TRICARE Prime (a managed care option) or TRICARE Select (a self-managed, preferred provider option). This population includes all beneficiaries who do not meet the requirements for obtaining health care coverage under Medicare, which is generally available to people age 65 or older, younger people with disabilities, and people with end-stage renal disease.

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management is a key component of care coordination for these beneficiaries because they may move between the direct and purchased care systems to obtain the care they need. TRICARE Prime beneficiaries are assigned to a primary care manager either at an MTF or within the civilian provider network. Primary care managers are responsible for overseeing all aspects of their patients' care, which includes making referrals for specialty care. To ensure the continuity of care for these beneficiaries, specialty care providers are required to share documentation about the care they provided during patients' visits for the referring primary care managers to review.[4] As of March 2019, 5.1 million beneficiaries—over half of the eligible population—were enrolled in TRICARE Prime.

DOD's Defense Health Agency (DHA) administers the TRICARE program, which includes overseeing the contracts and setting policy for both the direct and purchased care systems, among other responsibilities. DHA is currently in the process of making changes to its information technology systems and to its organizational responsibilities—both of which will impact referral management. Since 2008, MTFs have primarily used an information technology system, called the Referral Management Suite (RMS), to process and track their specialty care referrals, according to DHA officials. In 2017, DHA began implementing Military Health System (MHS) Genesis, a new system that is designed to standardize electronic health records throughout DOD, and which will replace existing systems, including RMS. The implementation of MHS Genesis began at four MTFs, each of which has reportedly experienced difficulties with the system.[5]

Additionally, the National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017), as amended, transferred administrative and management responsibility for MTFs from the military services' (Army, Navy, and Air Force) medical commands to DHA, including responsibility for referral

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[4]The process for submitting documentation of beneficiaries' care differs in the direct and purchased care systems. For example, MTF specialty care providers submit beneficiary information through the MTF's referral management center, which is responsible for processing and tracking all referrals.

[5]DHA plans to continue implementation at four additional sites on the West Coast by the end of calendar year 2019. The implementation of MHS Genesis is scheduled to be complete for all MTFs by the end of 2024.

management.[6] On Oct. 1, 2018, DHA initiated an incremental process for assuming these responsibilities and plans to complete this process by Oct. 1, 2021.[7]

The NDAA 2017 included a provision for GAO to examine several issues related to DOD's delivery of health care, such as the coordination of care within and between the direct and purchased care systems.[8] In this report, we examine to what extent

1. the referral management process facilitates the coordination of primary and specialty care between the direct and purchased care systems for TRICARE Prime beneficiaries; and

2. DHA monitors TRICARE Prime specialty care referrals for the direct and purchased care systems.

To determine the extent to which the referral management process facilitates the coordination of care between the direct and purchased care systems for TRICARE Prime beneficiaries, we conducted site visits to a non-generalizable sample of five MTFs and reviewed and analyzed available RMS data on their specialty care referrals. The five MTFs included three MTFs representing each of the military services and an enhanced multi-service market area with two MTFs—Raymond W. Bliss Army Health Center (Fort Huachuca, Arizona), Naval Medical Center-San Diego (San Diego, California), 78th Medical Group (Robins Air Force Base, Georgia), and Brooke Army Medical Center and 59th Medical Wing Wilford Hall Ambulatory Surgical Center (Joint Base, San Antonio, Texas).[9] These MTFs were selected based on geographic diversity and a range in the numbers of specialty care referrals from the direct to the

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[6]Within the direct care system, most MTFs are under the direction and control of their respective military service medical commands, including the Army Medical Command, the Navy Bureau of Medicine and Surgery, and the Air Force Major Commands. The Department of the Navy delivers health care to the Marine Corps. Pub. L. No. 114-328, § 702(a)(1), 130 Stat. 2000, 2193 (2016), codified, as amended, at 10 U.S.C. § 1073c.

[7]The John S. McCain National Defense Authorization Act for Fiscal Year 2019 (NDAA 2019) extended the date for the transfer of the administration of the MTFs to the DHA to September 30, 2021. Pub. L. No. 115-232, § 711 (a)(1). 132 Stat. 1636, (2018).

[8]Pub. L. No. 114-328, § 751, 130 Stat. 2000, 2244-2245 (2016).

[9]Enhanced multi-service markets are multiple MTFs within the same geographic location that are organized under a single market manager and a unified business performance plan. Enhanced multi-service markets include San Antonio, Texas and the National Capitol Area, among others.

purchased care system. For these five MTFs, we analyzed RMS data on the extent to which documentation of beneficiaries' visits were submitted by the civilian specialty care providers for the MTF primary care managers from February 2017 to February 2018.[10] We also analyzed the available RMS data, for the MTFs we visited, from the MTF specialty care providers for the civilian network primary care managers.[11] Additionally, we reviewed RMS data, for the MTFs we visited, on MTF's closure of specialty care referrals made from the direct to the purchased care system from December 2017 through July 2018.[12] We reviewed relevant documentation about RMS and interviewed knowledgeable officials about the accuracy and completeness of the system's data, which is discussed further in the report. We also reviewed DHA's July 2018 guidance for standardizing appointments and specialty care referrals, and relevant sections of the TRICARE Operations Manual.[13] We interviewed DHA and military service officials who participate in the Referral Management Working Group, which produces the department's referral management guidance, about how they use specialty care referral data in RMS to track the coordination of primary and specialty care.[14] We also reviewed documentation and interviewed relevant DHA and Referral Management Working Group officials about the department's transition to the new

[10]Per DHA guidance, MTFs must close a referral with or without documentation of the beneficiary's visit to the civilian provider network within 180 days of the referral's issuance. Therefore, we requested data for a complete year (February 2017-February 2018) because the end date was around 180 days prior to the July 2018 date of our data request.

[11]Civilian specialty care providers can be within or outside of the contractor's provider network and primary care managers are always within the contractor's provider network. As a result, we use the terms "civilian network primary care manager" and "civilian specialty care provider" throughout this report. A network provider is an individual or institutional provider that has a contract with the TRICARE contractor to provide care to TRICARE eligible beneficiaries.

[12]At the time of our review, DOD's guidance only addressed the closure of referrals from the direct to the purchased care system. Therefore, we did not examine data on the closure of other referrals, such as those made between providers in the direct care system. Further, in requesting a report with data on closure of referrals in August 2018, DHA officials told us that they had changed the report's methodology, and prior to December 2017, some data on this report would not be reliable.

[13]Defense Health Agency, *Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs)*. Interim Procedures Memorandum 18-001 (Washington, D.C.: July 2018).

[14]While specialty care referrals can be made between civilian providers in the purchased care system, DHA and the military services do not play a role in coordinating this care.

electronic health record system, MHS Genesis, to determine how this new system may impact the referral management process. Furthermore, we interviewed officials at the four MTFs where MHS Genesis has been implemented, and we compared how the MTFs' staff were trained to process referrals in MHS Genesis to federal standards for internal control related to developing competent individuals.[15] Finally, we interviewed an official that represents military beneficiaries about their concerns regarding the referral process.[16]

To determine the extent to which DHA monitors TRICARE Prime specialty care referrals for the direct and purchased care systems, we reviewed the methodology DHA developed for assessing MTFs' performance with referrals generated in the direct care system, as well as the two subsequent quarterly performance reports using this methodology (April 2018 and August 2018).[17] We also reviewed DHA's July 2018 guidance for standardizing appointments and specialty care referrals that describes the monitoring responsibilities of DHA leadership, and we interviewed DHA officials about the data they use to monitor referrals. For purchased care referrals, we reviewed relevant sections of the managed care support contracts to identify contractors' referral management requirements, as well as their required monthly reports on referrals for the East Region (January through July 2018) and the West Region (May 2018 through July 2018).[18] We reviewed relevant documentation and interviewed DHA's TRICARE Health Plan officials, who conduct contractor oversight, about contractors' referral management requirements, and DHA's oversight structure and activities. We also

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[15]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[16]The Military Coalition is a group comprised of 32 organizations representing more than 5.5 million members of the uniformed services, including active duty, reservists, retirees, veterans, and their survivors and families.

[17]DHA developed the methodology in response to legislative requirements to standardize its medical appointment process. At the time of our study, the quarterly performance reports issued in April and August 2018 were the only two reports DHA had issued using that methodology.

[18]The shortened time frame for the West region was due to referral issues that began at the start of health care delivery in January 2018. These issues resulted in a waiver of certain requirements to help ensure timely access to specialty care through April 2018.

interviewed relevant contractor officials for both TRICARE regions about DHA's oversight of contract requirements for specialty care referrals.

We conducted this performance audit from April 2018 to June 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Referral Management Working Group

DHA and the military services work together on issues related to specialty care referrals through the Referral Management Working Group, which was established in September 2013.[19] According to its charter, the working group provides a forum for evaluating the referral process and making department-wide recommendations to

- optimize referral management through improved coordination within the direct care system and between the direct and purchased care systems;

- develop policies, business rules, training and other guidance on the management of referrals;

- establish new initiatives, technology, system changes, and electronic workflows related to the management of referrals; and

- establish department-wide performance measures, including data sources, definitions and reports related to the management of referrals.

Referral Management Guidance and Requirements

As part of DHA's efforts to standardize the medical appointment process, including referral management, the Referral Management Working Group developed standardized guidance for the direct care system in 2017 that all of the military services are required to follow. Updated in July 2018, this guidance supersedes existing military-service-specific referral management policies. It outlines how the MTFs 1) process referrals within

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[19]The working group includes members from each of the military services (Army, Navy, and Air Force) and DHA.

the direct care system, 2) how they send referrals to the purchased care system, and 3) how they process referrals received from the purchased care system. The guidance also addresses how these processes are to be documented in both RMS and MHS Genesis.

Each MTF has a referral management center that is responsible for processing specialty care referrals for its facility. DHA's guidance outlines how the MTFs' referral management centers are to facilitate the sharing of documentation about TRICARE Prime beneficiaries' care

- **from MTF specialty care providers:** When a referral management center accepts a specialty care referral from a civilian network primary care manager, the center is required to submit documentation of the beneficiary's visit—called "referral results"—from the MTF specialty care provider back to the civilian network primary care manager, and to track this submission in RMS or MHS Genesis.

- **to MTF primary care managers:** When an MTF primary care manager sends a referral to a civilian specialty care provider, the referral management center must follow up on required documentation the civilian specialty care provider is to submit about the beneficiary's visit, called a clear and legible report (CLR).[20] The receipt of the report is documented in RMS or MHS Genesis.[21]

Historically, the contractors were responsible for following up on civilian specialty care providers' submission of CLRs to the MTFs' referral management centers. However, ultimately in 2013, the responsibility for this function was transferred to the MTFs' referral management centers. In order to follow up on a CLR, MTF officials must follow several steps, including checking the contractors' claims database to determine if the referral was used and contacting the specialty care provider multiple times to request the CLR. MTFs were given additional funding to address this new responsibility, and many continue to hire staff to carry out this function, according to Referral Management Working Group officials. Under the most current TRICARE contracts, DHA is requiring the

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[20]CLRs are specialty care consultation and referral reports, histories and physicals, progress notes, notes on episodes of care, other beneficiary information (such as laboratory reports), and discharge summaries for beneficiaries referred by MTFs to civilian specialty care providers.

[21]The CLRs are to be uploaded into DOD's Health Artifact and Image Management Solutions system, which is DOD's general repository for loading medical documentation, including consultation, laboratory, and radiology results.

contractors to have a process in place to address civilian specialty care providers that do not submit CLRs as required.

Separately, the TRICARE Operations Manual outlines referral requirements that both MTFs and the contractors must follow. The requirements are similar to those in DHA's July 2018 guidance, but include additional information for the contractors. For example, the manual includes specific requirements contractors must follow to ensure that specialty care referrals from a civilian network primary care manager are first offered to the local MTF to determine whether that MTF has the capability and capacity to provide the care. This process is called the "right of first refusal."[22]

Process for Specialty Care Referrals Made by Civilian Network Primary Care Managers

The process for referrals made by civilian network primary care managers varies depending on whether the referring MTFs have the capability and capacity to provide the specialty care:

- If a civilian network primary care manager generates a referral for specialty care, the contractor is required to contact the local MTF for the "right of first refusal." If the MTF does not have the capability and capacity to provide the care, the TRICARE Prime beneficiary obtains his or her care from a civilian specialty care provider who must submit a record of the beneficiary's visit to the referring primary care manager. Each contractor specifies its own requirements for civilian specialty care providers to submit this information to civilian network primary care managers.

- If a civilian network primary care manager generates a referral for specialty care that the MTF does have the capability and capacity to provide, the TRICARE Prime beneficiary may obtain his or her specialty care at the MTF.[23] After the beneficiary obtains care from the MTF specialty care provider, the MTF's referral management center is required to submit the referral results to the referring civilian network primary care manager. (See fig. 1.)

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[22]According to the TRICARE Operations Manual, capability is the scope of services the provider is both capable of performing and willing to perform, and capacity is the amount of time or number of services a provider is able to perform. MTFs' provide information on capability and capacity in documentation provided to the contractor.

[23]The contractor consults current lists of MTF specialty care capabilities maintained by the MTF referral management center in order to facilitate the "right of first refusal" process.

Figure 1: Process for Making a Specialty Care Referral for a TRICARE Prime Beneficiary from the Purchased to the Direct Care System
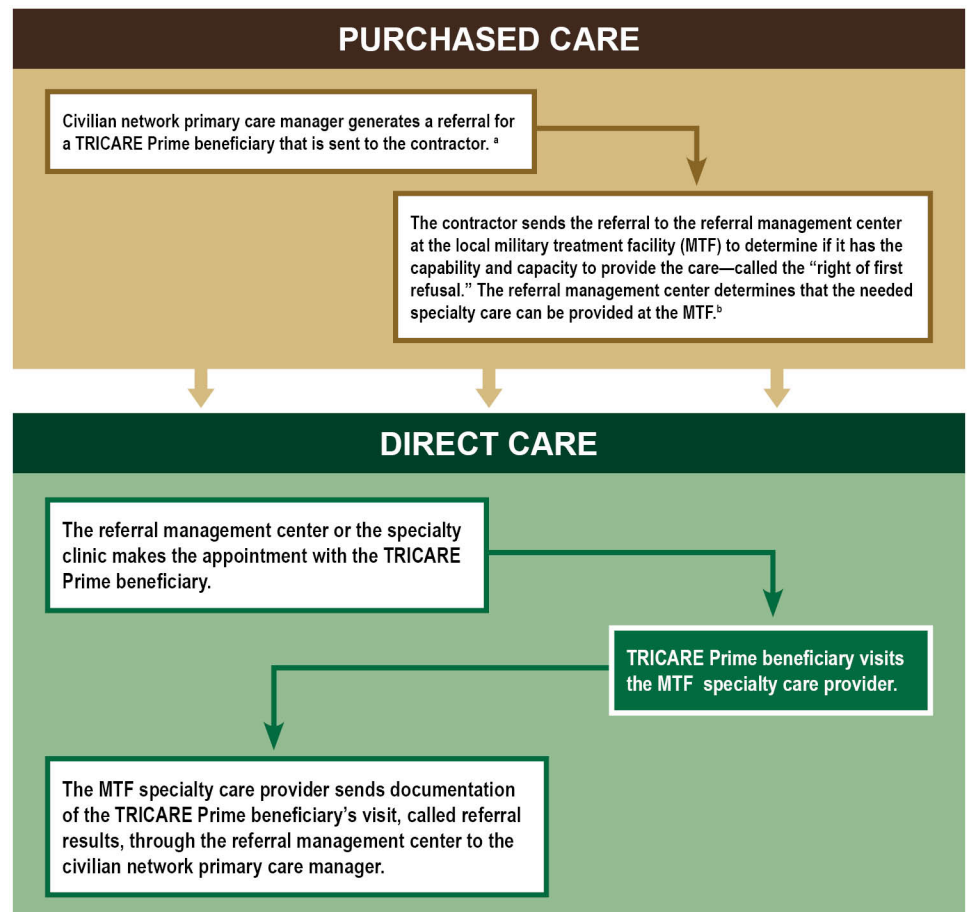
Source: GAO analysis of Department of Defense documents. | GAO-19-488

Note: Direct care is the care received at military hospitals and clinics, referred to as MTFs, and purchased care is care received through a system of civilian provider networks. The Department of Defense (DOD) contracts with private sector companies—contractors— to develop and maintain civilian provider networks and provide other services, such as processing specialty care referrals. This figure represents the general process followed when a civilian network primary care manager makes a specialty care referral to the direct care system. However, these steps may change depending on several factors, such as whether the beneficiary lives near a military installation.

[a]Beneficiaries enrolled in TRICARE Prime, a managed care option, are assigned to a primary care manager either at an MTF or within the civilian provider network. Primary care managers are responsible for overseeing all aspects of their beneficiaries' care, which includes making referrals for specialty care when needed. Civilian primary care managers are within the contractor's provider network.

[b]Each MTF has a referral management center that is responsible for processing specialty care referrals for its facility. TRICARE defines capability as the scope of services the provider is both capable of performing and willing to perform, and capacity as the amount of time or number of services a provider is able to perform. As part of determining capacity, the referral management

center must ensure that the specialty care appointment can be provided within TRICARE Prime's access-to-care standard of 28 days or less.

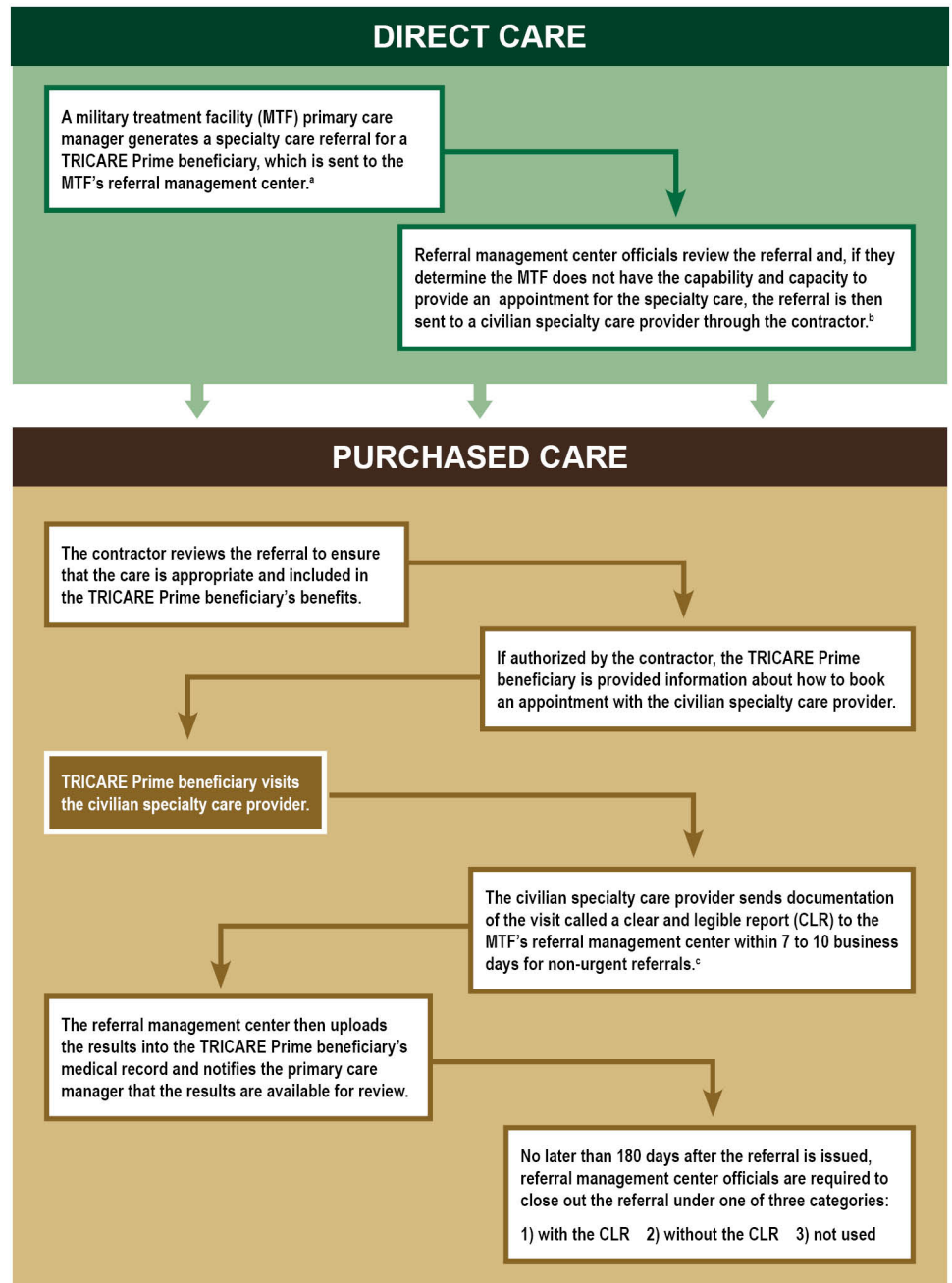## Process for Specialty Care Referrals Made by MTF Primary Care Managers

Similarly, the process for referrals made by MTF primary care managers depends on whether the local MTF has the capability and capacity to provide the care:

- If a primary care manager at the MTF generates a referral for specialty care that the MTF has the capability and capacity to provide, the TRICARE Prime beneficiary obtains his or her care from the MTF specialty care provider. MTF specialty care providers are not required to submit documentation of the beneficiary's visit to the referring primary care manager because they share the same electronic health record system.

- If a primary care manager at the MTF generates a referral for specialty care that the MTF does not have the capability and capacity to provide, the TRICARE Prime beneficiary may obtain his or her care from a civilian specialty care provider, who must submit a CLR to the MTF for the primary care manager to review. Each contractor specifies the time frame in which the CLR must be provided.[24] The required time frame is the same for both TRICARE regions—2 days for urgent care referrals, and 7 to 10 days for all other referrals. (See fig. 2)

[24]Each contractor develops a provider handbook to outline the roles and responsibilities of civilian providers both within and outside of its network.

Figure 2: Process for Making a Specialty Care Referral for a TRICARE Prime Beneficiary from the Direct to the Purchased Care System

DIRECT CARE

A military treatment facility (MTF) primary care manager generates a specialty care referral for a TRICARE Prime beneficiary, which is sent to the MTF's referral management center.[a]

Referral management center officials review the referral and, if they determine the MTF does not have the capability and capacity to provide an appointment for the specialty care, the referral is then sent to a civilian specialty care provider through the contractor.[b]

PURCHASED CARE

The contractor reviews the referral to ensure that the care is appropriate and included in the TRICARE Prime beneficiary's benefits.

If authorized by the contractor, the TRICARE Prime beneficiary is provided information about how to book an appointment with the civilian specialty care provider.

TRICARE Prime beneficiary visits the civilian specialty care provider.

The civilian specialty care provider sends documentation of the visit called a clear and legible report (CLR) to the MTF's referral management center within 7 to 10 business days for non-urgent referrals.[c]

The referral management center then uploads the results into the TRICARE Prime beneficiary's medical record and notifies the primary care manager that the results are available for review.

No later than 180 days after the referral is issued, referral management center officials are required to close out the referral under one of three categories:

1) with the CLR   2) without the CLR   3) not used

Source: GAO analysis of Department of Defense documents. | GAO-19-488

Note: Direct care is the care received at military hospitals and clinics, referred to as MTFs, and purchased care is care received through a system of civilian provider networks. The Department of Defense (DOD) contracts with private sector companies—contractors— to develop and maintain civilian provider networks and provide other services, such as processing specialty care referrals. This figure represents the general process followed when an MTF primary care manager makes a specialty care referral to the purchased care system.

[a]Beneficiaries enrolled in TRICARE Prime, a managed care option, are assigned to a primary care manager either at an MTF or within the civilian provider network. Primary care managers are responsible for overseeing all aspects of their beneficiaries' care, which includes making referrals for specialty care when needed. Each MTF has a referral management center that is responsible for processing specialty care referrals for its facility.

[b]The TRICARE program defines capability as the scope of services the provider is both capable of performing and willing to perform, and capacity as the amount of time or number of services a provider is able to perform. As part of determining capacity, the referral management center must ensure that the specialty care appointment can be provided within TRICARE Prime's access to care standards of 28 days or less.

[c]CLRs are specialty care consultation and referral reports, histories and physicals, progress notes, notes on episodes of care, other beneficiary information (such as laboratory reports), and discharge summaries for beneficiaries referred by MTFs to civilian specialty care providers.

MTFs' Requirements for Closing Referrals

MTFs' referral management centers are required to enter referral disposition information into RMS (or MHS Genesis, once implemented) to indicate whether the referral was used. According to DHA's guidance, referral management centers are responsible for closing referrals from their facilities to civilian specialty care providers within 180 days of the referrals' issuance. In contrast, MTFs currently are not explicitly required to close referrals made by their primary care manager to their specialty care providers or referrals generated by the "right of first refusal" process. However, DHA plans to include additional requirements for closing these referrals in its updated guidance, according to officials.[25]

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[25]Officials from the Referral Management Working Group told us that they are currently developing an update to this guidance that should be completed by July 2019. Additionally, DOD is in the process of making changes to streamline its TRICARE Prime referral process in response to recent legislation. For example, the NDAA 2017 requires DOD to allow non-active duty TRICARE Prime beneficiaries to use urgent care facilities without the need for a specialty care preauthorization. In addition, the NDAA 2019 requires DOD to streamline the referral process for TRICARE Prime beneficiaries in calendar year 2019.

DHA Has Limited Information about the Extent to Which the Referral Process Facilitates the Coordination of Care between the Direct and Purchased Care Systems for TRICARE Prime Beneficiaries

Referral Data Was Incomplete and Unreliable for the MTFs Reviewed, and the Reports Examined Did Not Accurately Reflect the Referral Process

DHA has limited information about the extent to which the referral process facilitates the coordination of care for TRICARE Prime beneficiaries between the direct and purchased care system based on issues we identified with the completeness and reliability of the data and reports we reviewed from RMS. Specifically, we found that the five MTFs we visited had incomplete and unreliable data in RMS about receipt of CLRs, the submission of specialty care referral results, and the closure of specialty care referrals. In addition, we found that the RMS reports used by the Referral Management Working Group were not reliable for assessing certain aspects of the referral process due, in part, to unreliable data in RMS as well as a flawed methodology. The Referral Management Working Group, which includes officials from DHA and the military services' medical commands, acknowledged the limitations of this referral data in RMS. Officials with the military services' medical commands told us that they have been meeting routinely with their MTFs' referral management centers to help address issues with the reliability of RMS data.

CLRs: We found that the CLR data in RMS for the five MTFs we visited were incomplete. As a result, the referral management center officials at these MTFs could not accurately determine if they received CLRs for all referrals they sent to civilian specialty care providers as required by DHA's guidance. For example, the RMS data we reviewed indicated that these MTFs received between 20 to 77 percent of the CLRs they

expected. [26] Officials from one MTF told us that their CLR data in RMS was incomplete because the MTF did not have enough staff to follow up on CLRs that had not been received, which they described as a time-intensive process. These officials told us that they recently hired contract staff to begin the process of following up on CLRs for specialty care referrals. In addition, the RMS data for another MTF indicated that they had received less than half of their CLRs (45 percent), but officials from this MTF told us they thought they had received almost all of their CLRs and could not explain the difference.

Specialty care referral results: We found that the submission of specialty care referral results was generally not being tracked in RMS, as required by DHA's guidance for the three MTFs we visited that accept these referrals.[27] As a result, information in RMS about the submission of referral results is incomplete, limiting MTFs' ability to determine whether MTFs have been submitting all specialty care referral results as required. Officials from the three MTFs told us that although they submitted their referral results, they generally had not been using RMS to track the submission of this information. Instead, officials with two of the MTFs told us that they used the contractors' database to track referral results because RMS has had ongoing issues with receiving required data from its administrative system, which is used for scheduling appointments, among other things.[28] However, officials from the two MTFs told us that these issues have been resolved as of January 2019, and since that time they had begun using RMS to track referral results. Further, officials with the remaining MTF told us that they previously tracked this information in a spreadsheet, but they recently learned how to track it in RMS. According to a Referral Management Working Group official, RMS is capable of tracking the submission of specialty care referral results, but MTF officials may not understand how to use this capability.

Closure of specialty care referrals: We found that RMS data on the closure of specialty care referrals (from MTF primary care managers to civilian specialty care providers) for the five MTFs we visited was

[26]Our analysis of CLRs received did not include referrals that had not been used.

[27]Two of the five MTFs we visited are small facilities and do not accept purchased-to-direct care referrals because they do not have the capability.

[28]The Composite Health Care System allows clinicians to electronically perform patient appointment processes and scheduling, order laboratory tests, authorize radiology procedures, and prescribe medications.

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unreliable due to inconsistencies we identified between the RMS data we reviewed and MTF officials' statements about the closed referrals for their facility. As a result, these MTFs may have difficulty determining whether their referrals had been used and whether they closed these referrals within 180 days as required by DHA guidance. For example, one MTF had closed around 75 percent of its referrals in RMS as "not used." However, officials at this MTF told us that many of these referrals were likely used, but were closed as "not used" because staff needed to close referrals in RMS quickly and did not have time to determine the referrals' status. Officials we spoke with at another MTF told us they did not understand the full capabilities of RMS and had not been using this data to determine whether or not they had closed their specialty care referrals. A third MTF told us they closed all of its referrals within the required time frame of 180 days; however, we found that only about half of its referrals were documented as closed in RMS. Officials at this MTF could not explain this discrepancy.[29]

RMS reports: In 2017, the Referral Management Working Group began monitoring MTFs' RMS data as part of its effort to develop DHA's initial standardized guidance for appointments and referral management. Officials with the Referral Management Working Group told us that two reports from RMS—the CLR Percent Received Report and the Referral Performance Report—have been used to assess the receipt of CLRs and closure of specialty care referrals.[30] For the MTFs we visited, we found the CLR Percent Received Report to be unreliable in determining whether CLRs were received due to both the report's flawed methodology and MTFs' input of inaccurate information into RMS.[31] Officials with the working group acknowledged the limitations of this report and told us that they supplement this information with another RMS report, the Referral Performance Report, which they use to review the closure of specialty care referrals. However, when we reviewed the CLR and specialty care referral closure data in the Referral Performance Report, we also

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[29]In April 2019, an official from this MTF told us that the MTF has fixed this discrepancy in RMS, although officials still could not explain why it occurred.

[30]DHA officials who maintain information technology systems develop the methodology for these reports in consultation with the Referral Management Working Group, according to working group officials.

[31]The methodology for the CLR Percent Received report removes referrals from the denominator when the referrals have been closed as either "not used" or "without a CLR." Therefore, the results on the number CLRs received may be artificially inflated because the number of referrals without a CLR are removed from the overall calculation.

identified inaccuracies with these data.[32] For example, we found that several MTFs had closed more direct-to-purchased care referrals than they had issued. Officials with the Referral Management Working Group explained that some MTFs are inaccurately inputting data into RMS. As a result, there are inaccuracies in the Referral Performance Reports, such as referrals that are double counted. Officials said that these MTFs will need to be trained on how to accurately input data into RMS.

Officials with each of the military services' medical commands who participate in the Referral Management Working Group told us that they began taking steps to address their concerns about the reliability of RMS data in an effort to implement the standardized appointment and referral guidance at their MTFs. They have worked with DHA on two updates to RMS—one in March 2018 and one in January 2019—in an effort to address some of these data concerns.[33] In addition, they have been reviewing and discussing data with their MTFs' referral management center officials, sometimes through their regional officials, on a monthly or quarterly basis to discuss available RMS data, including data on CLRs and closures of referrals, among other things. Further, the military service medical commands are working to help their MTFs obtain more staff to pursue outstanding CLRs. In addition, the medical commands are focused on teaching their MTFs' referral management center staff to correctly input referrals and avoid inadvertent double counting.

Inadequate Training on Processing Referrals in MHS Genesis Has Contributed to Data Reliability Concerns for Four Pilot MTFs; Updates to the System Are Planned

DHA's initial implementation of MHS Genesis—which will replace RMS and other systems—did not include adequate training for referral management, resulting in concerns about data reliability. Specifically, referral management center officials with the four MTFs using MHS Genesis told us that although training was provided on the use of the system, this training did not adequately address the use of the system's referral management component prior to its deployment. These officials told us they generally trained themselves and most developed their own training materials on the system, which requires a different referral processing workflow than RMS. This lack of training limited MTFs' ability to use MHS Genesis to evaluate their performance and led to MTF

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[32]The Referral Performance Reports have more than 40 data elements. We reviewed the six elements in the report that related to the closure of direct-to-purchased care referrals and obtaining CLRs.

[33]These updates included improved transmission of data from the Composite Health Care System and updates to beneficiary categories.

officials' concerns about the reliability of the system's referral data. For example, officials at two of the MTFs told us that their staff had not been provided training on how to aggregate data on the receipt of CLRs even though MHS Genesis is capable of generating this report. As a result, their staff manually tracked the receipt of individual CLRs, not only increasing the risk of errors, but also making it more difficult to assess their facilities' overall performance. An MTF official at one of these facilities told us that the CLR report from MHS Genesis was likely unreliable because staff had not received formal training on how to accurately use the system to input and process referral data. Federal standards for internal control highlight the importance of training to develop staff competencies appropriate for key roles.[34] Without adequate training, DHA cannot ensure that the data and reports derived from MHS Genesis accurately reflect the referral experiences of its TRICARE Prime beneficiaries, or whether any remediation is needed with regard to the process.

MTF officials also told us that it took longer to process referrals in MHS Genesis, and as a result, some MTFs had to add staff to their referral management centers or extend the centers' hours to process referrals within required time frames. The Referral Management Working Group told us that they are working with DHA officials to upgrade the referral management component of the MHS Genesis system to help improve the referral process. A DHA official responsible for system implementation stated that standardized training will be developed and provided to MTF staff to correspond with the upgrade, which the official anticipates will be implemented in summer 2020. In the interim, this official told us that they have redesigned the MHS Genesis training on referral management, which DHA plans to use for the MTFs included in the next wave of MHS Genesis implementation in summer 2019. However, Referral Management Working Group officials are unclear whether the redesigned training will address the concerns expressed by the MTFs currently using the system.

Furthermore, Referral Management Working Group officials told us that they have not been able to obtain reports about referrals for MTFs that use MHS Genesis. Working group officials explained that MHS Genesis may be capable of producing the types of referral reports they need, but the system would need to be configured by DHA to do so. These officials

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[34]GAO-14-704G.

told us that they have been working with the DHA officials who are overseeing system implementation to identify the data and methodology needed to develop reports on specialty care referrals, including information on CLRs, referral results, and specialty care referral closures. Working group officials said that they were aware that MHS Genesis already produces a report on CLRs received, but they were concerned about using it because they had been cautioned by MTF officials that the report contained inaccurate data. As an initial step, these officials told us that they requested the methodology for this report in order to determine its accuracy; however, as of March 2019, they had not received this information. Federal standards for internal control state that management should use quality information to achieve its objectives. Quality information is obtained through relevant data from reliable sources in a timely manner based on the identified information requirements.[35] Without reliable reports on specialty care referrals, the Referral Management Working Group may have difficulties not only determining TRICARE Prime beneficiaries' use of referrals, but also fulfilling its goals of optimizing and standardizing the referral management process.

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[35]GAO-14-704G.

DHA's Monitoring of TRICARE Prime Specialty Care Referrals in the Direct Care System Is Expected to Evolve and in the Purchased Care System Is Focused on Contractors' Reports

DHA's Monitoring of TRICARE Prime Specialty Care Referrals for the Direct Care System Is Limited, but Expected to Evolve as DHA Assumes Administrative Responsibilities for MTFs

DHA, through its Clinical Business Operations branch, monitors TRICARE Prime specialty care referrals for the direct care system. Specifically, DHA uses one of the 15 metrics it established based on its requirement to standardize appointments across MTFs—the average number of days elapsed from referral to appointment booked.[36] This metric is derived from the MHS Dashboard, which contains MTF health care performance measures based on data from DHA's current electronic health record system.[37] DHA plans to monitor a second metric related to referrals—average days from referral to appointment decision or send to a civilian specialty care provider—when they obtain additional staff.

DHA's current approach for monitoring direct care system referrals is expected to evolve as it assumes administrative responsibilities for the remaining MTFs, but DHA has not yet determined its new organizational structure or its corresponding staffing needs. DHA's July 2018 standardized appointment and referral management guidance assigned oversight responsibilities for referrals to Regional Commands, which would be a new organizational structure within DHA. However, according

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[36]Other measures include the percent of demand for care that was unmet within a given month and the percentage of appointments that were leaked to the network, which occurs when the MTF has the capability to provide specialty care, such as orthopedics but sends the referral to a civilian specialty care provider.

[37]Data posted to the MHS Dashboard is extracted from the MHS Data Repository. The MHS Dashboard does not contain data for the four MTFs at which MHS Genesis has been deployed.

to a DHA official, the Regional Command structure is no longer being considered, and DHA is now pursuing a different organizational structure that is in the process of being approved. As a result, DHA has not determined the staffing it would need, including the staff needed to monitor specialty care referrals for TRICARE Prime beneficiaries. In addition, DHA has not yet determined the monitoring activities that would be conducted by its staff versus the military services, according to DHA officials.

DHA Uses Required Monthly Reports from Its Contractors to Oversee Referrals in Its Purchased Care System

Within DHA's TRICARE Health Plan Division, referral management officials monitor contractors' performance on purchased care referrals by reviewing data in three required referral management reports the contractors submit on a monthly basis. These reports include:

1. the "preauthorization/authorization and referral timeliness/accuracy" report that provides information on the total number of referrals that met timeliness and accuracy requirements in the previous month;

2. the "right of first refusal" report that indicates the number of referrals accepted and declined by each MTF via this process in the previous month; and

3. the "directed referrals" report that provides information on care provided by network and non-network specialty care providers in a geographic area where a specific specialty may not be available from a network specialty care provider.

When any of the reports demonstrate that a contractor is not meeting its requirements, DHA officials said that they may ask the contractor to implement a corrective action plan. For example, at the January 2018 start of health care delivery to TRICARE beneficiaries in the West region, DHA officials found that the contractor's performance on referral processing timeliness failed to meet contract requirements and was inadequate to meet the overall demand for specialty care referrals. According to DHA officials, the contractor was managing about 8,000 referrals a day, and within a few weeks, the contractor had a queue of 70,000 referrals that needed to be processed. DHA officials instituted a corrective action requiring the contractor to submit daily referral processing status reports in addition to their monthly reports. They also instituted a waiver that allowed TRICARE Prime beneficiaries to see a civilian specialty care provider without an authorized referral from the contractor. The waiver was removed in April 2018 based on information in the contractor's daily reports, which indicated that the contractor had

eliminated the backlog and was meeting referral processing timeliness requirements.

As DHA's organizational structure evolves, it plans to modify its organizational responsibilities for monitoring contractors' performance. DHA's TRICARE Health Plan Division has been using a regional structure—the TRICARE Regional Offices (East and West)—to conduct oversight of contractors' performance in meeting certain contract requirements, including those for referrals. However, in 2018, DHA began the process of collapsing oversight responsibilities across the regions.[38] As a result, certain regional officials now oversee their specific area of responsibility, such as specialty care referrals, for the entire U.S. and do not focus solely on their individual region.

Conclusions

The referral management process is a key component of care coordination for TRICARE Prime beneficiaries who may move between the direct and purchased care systems to obtain needed specialty care. However, our review of selected MTFs' referral data revealed that DHA does not know the extent to which care is being coordinated for this population because MTFs' referral management centers do not always document accurate and complete referral information in RMS due to a lack of staff and the need for additional training. Furthermore, some of the RMS reports used by the Referral Management Working Group are based on data that are not reliable and a methodology that does not accurately reflect key information. Consequently, military service officials with the Referral Management Working Group have been working with DHA and their MTFs to improve the reliability of RMS data through system updates, training, and hiring staff.

It will also be important for DHA to ensure that the types of problems experienced with RMS do not recur with MHS Genesis. However, the four MTFs using MHS Genesis have already experienced difficulties with processing and tracking referral information due, at least in part, to the lack of adequate training. While MHS Genesis training on referral management has been redesigned for the next round of MTFs slated for

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[38]DHA's TRICARE Health Plan office is organized into several components, each of which is responsible for distinct areas of contractor oversight for a distinct region (East and West). As part of its reorganization in 2018, DHA began moving away from a regional division of responsibility for its staff. While some components have implemented this change, as of March 2019, not all components have done so.

implementation in summer 2019, it remains unclear whether this training will provide the guidance needed for MTF officials to accurately process and capture information on specialty care referrals. Without adequate training on processing referrals in MHS Genesis, DHA increases its risk that the data and reports derived from the system may not accurately reflect the referral experiences of its TRICARE Prime beneficiaries.

As DHA assumes administrative responsibilities for all MTFs, developing reports for MHS Genesis that accurately reflect TRICARE Prime beneficiaries' referral experiences will become even more paramount. Without this, the Referral Management Working Group will continue to be hampered in its ability to update DHA's referral management guidance that is intended to standardize the referral management process across all MTFs. Further, DHA will continue to lack accurate information it needs to determine whether the referral management process is facilitating the delivery of timely and quality care to its TRICARE Prime beneficiary population through effective care coordination.

Recommendation for Executive Action

- The Secretary of Defense should direct DHA to ensure that MTFs' referral management center staff are trained to process and accurately document information in MHS Genesis about specialty care referrals, including the receipt of CLRs, the submission of referral results, and the closure of referrals. (Recommendation 1)

- The Secretary of Defense should direct DHA to ensure that MHS Genesis is configured to produce reports that accurately reflect the use and outcomes of specialty care referrals. (Recommendation 2)

Agency Comments

DOD provided written comments on a draft of this report, which are reprinted in appendix I. DOD also provided technical comments, which we incorporated as appropriate. In its written comments, DOD concurred with both of our recommendations and noted that DHA has worked with the MHS Genesis program office to improve training and reporting. DOD stated that DHA will assess the effectiveness of the improved training when MHS Genesis is rolled out to the next wave of MTFs starting in fiscal year 2020 and will make additional training and reporting improvements as subsequent waves of MTFs are transitioned to MHS Genesis through fiscal year 2024.

We are sending copies of this report to the Acting Secretary of Defense and appropriate congressional committees. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix II.

Debra A. Draper
Director, Health Care

Appendix I: Comments from the Department of Defense

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

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WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAY 2 3 2019

Ms. Debra Draper
Director, Health Care
U. S. Government Accountability Office
441 G St., NW
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-19-488, "DOD HEALTH CARE: Improvements Needed for Tracking Coordination of Specialty Care Referrals for TRICARE Prime Beneficiaries" dated April 29, 2019 (GAO Code 102752).

Thank you for the opportunity to provide management comments (attached) on the draft report recommendations. We appreciate the in-depth review and findings related to the processes for monitoring the care coordination of specialty care referrals. The DoD concurs with both of the GAO recommendations focused on ensuring military Medical Treatment Facility referral staff are trained to process and accurately document specialty care information in Military Health System (MHS) GENESIS and that MHS GENESIS is configured to produce reports with reliable data on the referral process. The Defense Health Agency has worked with the MHS GENESIS program office to improve training and reporting and will assess the effectiveness of the improved training in the Wave 1 MHS GENESIS roll-out starting in Fiscal Year (FY) 2020 and will make additional training and reporting improvements in subsequent waves through FY 2024.

We sincerely thank the GAO team members for developing this report and for the steadfast commitment to protecting the health and wellness of our Service members, civilian workforce, and beneficiaries.

Sincerely,

Tom McCaffery
Principal Deputy Assistant Secretary of
Defense (Health Affairs)

Attachment:
As stated

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to those named above, key contributors to this report were: Bonnie Anderson, Assistant Director; Danielle Bernstein, Analyst-in-charge; Jennie Apter; Jacquelyn Hamilton; Jennel Lockley; and Vikki Porter.