

GAO

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Services, U.S. Senate and House of
Representatives

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DEFENSE HEALTH CARE

TRICARE Claims Processing Has Improved but Inefficiencies Remain





Highlights of [GAO-04-69](#), a report to the Committees on Armed Services, U.S. Senate and House of Representatives

Why GAO Did This Study

Testifying before Congress in 2002, military beneficiary groups and civilian managed care support contractors described problems with the processing of TRICARE claims for civilian-provided care. These problems included slow payments and procedures that made claims processing inefficient.

The Bob Stump National Defense Authorization Act of 2003 required GAO to review improvements to TRICARE claims processing and continuing impediments to claims processing efficiency. Specifically, GAO describes (1) efforts to improve claims processing and changes in processing timeliness and (2) Department of Defense (DOD) procedures and data that continue to affect claims processing efficiency.

To identify improvements to claims processing and impediments to processing efficiency, GAO analyzed 1999 and 2002 claims data for changes in processing timeliness. GAO also interviewed and analyzed claims processing documentation from DOD officials, managed care support contractors, and claims processors.

What GAO Recommends

To improve the efficiency of TRICARE claims processing, GAO recommends that DOD evaluate how it issues program changes and identify ways to improve the consolidation and scheduling of such changes. DOD concurred with the recommendation.

www.gao.gov/cgi-bin/getrpt?GAO-04-69.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Majorie E. Kanof at (202) 512-7101.

DEFENSE HEALTH CARE

TRICARE Claims Processing Has Improved but Inefficiencies Remain

What GAO Found

In an effort to improve TRICARE claims processing, DOD and its managed care support (MCS) contractors have made changes that are designed to make it more efficient. First, they have jointly identified—and then eliminated or changed—certain DOD requirements they deemed inefficient and nonessential to accurate claims processing. For example, contractors are no longer required to hold claims with incomplete information and request the missing information from the provider or beneficiary. Instead, contractors may now return some claims with missing information. In another change, DOD eliminated preauthorization requirements for certain procedures and gave the MCS contractors more latitude for determining when preauthorizations are appropriate. To encourage providers to submit their claims electronically, DOD gave MCS contractors the authority to decide whether to adjudicate electronically submitted claims sooner than those submitted on paper. Further, MCS contractors have worked with their claims processors to implement new technologies for data input, claims routing, customer service, and claims submission. Finally, MCS contractors and their claims processors have improved the timeliness with which they process claims. In fiscal year 2002, claims processors processed over 97 percent of claims in 30 days or less—an improvement over fiscal year 1999, when 91 percent of claims were processed in 30 days or less.

Although DOD and its MCS contractors have made changes to improve claims processing, some DOD procedures and inaccuracies in its data continue to create inefficiencies in TRICARE claims processing. Some DOD procedures may create inefficiencies by inadvertently increasing the demand for customer service, which claims processors are required to provide. Additionally, inaccuracies in DOD eligibility data—data that are needed to process TRICARE claims—can contribute to claims processing delays or rework if, for example, claims must be reprocessed when errors are identified. Finally, some DOD procedures lead to rework for claims processors, either in the form of reprocessing claims or reprogramming processing software. For example, when DOD makes program changes to TRICARE to alter or create a health benefit, it does not adhere to any schedule. In 2002, DOD made 123 program changes on 19 different dates throughout the year. Given the fact that implementing these changes often involves reprogramming and testing processing software, this approach can create rework for claims processors when DOD issues similar or related changes on separate occasions.

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Abbreviations

CDCF	central deductible catastrophic cap file
CMS	Centers for Medicare & Medicaid Services
DEERS	Defense Enrollment Eligibility Reporting System
DMDC	Defense Manpower Data Center
DOD	Department of Defense
DRG	diagnosis-related group
EMC	electronic media claims
HCSR	health care service record
HIPAA	Health Insurance Portability and Accountability Act of 1996
MCS	managed care support
MTF	military treatment facility
OCR	optical character recognition
PGBA	Palmetto Government Benefits Administrators
TED	TRICARE encounter data
TFL	TRICARE for Life
TMA	TRICARE Management Activity
TMAC	TRICARE maximum allowable charges
WPS	Wisconsin Physician Services

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United States General Accounting Office
Washington, DC 20548

October 15, 2003

The Honorable John Warner
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Duncan L. Hunter
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

In 2003, more than 8.7 million active duty personnel, their dependents, and retirees are eligible to receive health care through TRICARE, the military's \$26.4 billion-per-year health care system. Medical care under TRICARE is provided by Department of Defense (DOD) personnel in military treatment facilities (MTF) or through civilian providers in civilian facilities. Civilian-provided care requires that providers or beneficiaries submit claims to DOD managed care support (MCS) contractors who, on behalf of TRICARE, are responsible for adjudicating and paying the claims according to established policies and procedures. The MCS contractors have each hired subcontractors, referred to as claims processors, to perform these functions. During fiscal year 2002, DOD's MCS contractors were responsible for processing approximately 42 million TRICARE claims worth approximately \$4.6 billion dollars.¹

Since its inception in 1995, TRICARE has garnered criticism over its claims processing performance. During 2002, for example, testimony before the House Armed Services Committee, Subcommittee on Military Personnel,

¹These numbers do not include claims from TRICARE for Life (TFL), a separate program from TRICARE. TFL is a program for Medicare-eligible beneficiaries enrolled in Medicare Part B, which covers charges from licensed practitioners, as well as clinical laboratory and diagnostic services, surgical supplies and durable medical equipment, and ambulance services. TFL pays expenses remaining after Medicare has paid its share of claims.

discussed problems with the timeliness of claims payments.² This testimony also identified DOD policies and procedures for claims processing that confuse beneficiaries and providers and create disincentives for electronic claims submission, which is more efficient than paper claims submission.

In response to concerns over claims processing, the Bob Stump National Defense Authorization Act of 2003³ directed us to report on improvements to TRICARE claims processing and continuing impediments to claims processing efficiency. Specifically, as agreed with the committees of jurisdiction, this report describes (1) DOD, MCS contractor, and claims processor efforts to improve TRICARE claims processing and changes in processing timeliness and (2) DOD procedures and data that continue to affect claims processing efficiency.

To identify improvements in TRICARE claims processing, we compared the timeliness with which DOD processed its claims between fiscal years 1999 and 2002. To make this comparison, we obtained and analyzed data from health care service records (HCSR), which are the final records of TRICARE claims. To identify efforts to improve TRICARE claims processing, we interviewed and obtained documentation from officials and representatives from the TRICARE Management Activity (TMA), the DOD agency responsible for managing TRICARE; DOD's MCS contractors; and claims processors. To obtain information on TRICARE requirements that affect claims processing efficiency, we interviewed the same officials and representatives, along with beneficiary and provider representatives. We reviewed DOD's request for proposals for the new health care contracts that DOD awarded in August 2003, and we interviewed DOD and MCS contractor officials to determine how the new contracts might affect claims processing efficiency.⁴ We also reviewed our prior work on TRICARE and Medicare claims processing. Our review did not include claims processed under DOD's TFL program for Medicare-eligible beneficiaries because TFL is a separate program that follows different

²*Hearings on the National Defense Authorization Act for Fiscal Year 2003—H.R. 4546 and Oversight of Previously Authorized Programs Before the Subcomm. on Military Personnel of the House Comm. on Armed Services, 107th Cong. 297-318 and 318-334 (2002)* (statements of MCS contractors and beneficiary representatives, respectively).

³Pub. L. No. 107-314, § 711(c), 116 Stat. 2458, 2588 (2002).

⁴DOD issued a request for proposals in August 2002 because the current health care contracts will be expiring.

program rules and uses different claims processing procedures. We conducted our work from June 2002 through October 2003 in accordance with generally accepted government auditing standards. For more on our scope and methodology, see appendix I.

Results in Brief

In an effort to improve TRICARE claims processing, DOD and its MCS contractors have made changes that are designed to make it more efficient. First, they have jointly identified—and then eliminated or changed—certain DOD requirements they deemed inefficient and nonessential to accurate claims processing. For example, contractors are no longer required to hold claims with incomplete information and request the missing information from the provider or beneficiary. Instead, contractors may now return claims with missing information, as long as the necessary information cannot be supplied from in-house sources. In another change, DOD eliminated preauthorization requirements for certain procedures and gave the MCS contractors more latitude for determining when preauthorizations are appropriate. In an effort to encourage providers to submit their claims electronically, DOD gave MCS contractors the authority to decide whether to adjudicate electronically submitted claims sooner than those submitted on paper. Further, MCS contractors have worked with their claims processors to implement new technologies for data input, claims routing, customer service, and claims submission. Finally, MCS contractors and their claims processors have improved the timeliness with which they process claims. In fiscal year 2002, claims processors processed over 97 percent of claims in 30 days or less—an improvement over fiscal year 1999, when 91 percent of claims were processed in 30 days or less.

Although DOD and its MCS contractors have made changes to improve claims processing and MCS contractors have exceeded DOD's standard for processing timeliness, some DOD procedures and inaccuracies in its data continue to create inefficiencies in TRICARE claims processing. Some DOD procedures lead to rework for claims processors, either in the form of reprocessing claims or reprogramming processing software. For example, when DOD makes program changes to TRICARE to alter or create a health benefit, it does not adhere to any schedule. In 2002, DOD made 123 program changes on 19 different dates throughout the year. Given the fact that implementing these changes often involves reprogramming and testing processing software, this approach can create rework for claims processors when DOD issues similar or related changes on separate occasions. Some DOD procedures may create inefficiencies by inadvertently increasing the demand for customer service, which claims

processors are required to provide. For example, the method used for calculating TRICARE's liability when beneficiaries have other health insurance can lead to claim outcomes that are not understood by providers and beneficiaries. When providers and beneficiaries question such outcomes, claims processors must explain the benefit calculation. Finally, inaccuracies in DOD eligibility data—data that are needed to process TRICARE claims—can contribute to claims processing delays or rework if, for example, claims must be reprocessed when errors are identified.

We are recommending that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to evaluate DOD's process for issuing program changes and to identify ways to improve the consolidation and scheduling of such changes. In commenting on a draft of this report, DOD concurred with the report's findings and recommendation.

Background

Under TRICARE, MTFs provide the majority of health care for beneficiaries. However, civilian providers supplement this care, and claims must be submitted by providers or beneficiaries to MCS contractors' claims processors for this civilian-provided care. There are three options under which TRICARE beneficiaries may obtain civilian-provided care:

- TRICARE Prime, a program in which beneficiaries enroll and receive care in a managed network similar to a health maintenance organization;
- TRICARE Extra, a program in which beneficiaries receive care from a network of preferred providers; and
- TRICARE Standard, a fee-for-service benefit that requires no network use.

The Office of the Assistant Secretary of Defense for Health Affairs establishes TRICARE policies and procedures and has overall responsibility for the program. TMA, under Health Affairs, is responsible for awarding and administering contracts to MCS contractors that manage the delivery of care to beneficiaries in 11 regions. While the MCS contractors are ultimately responsible for claims processing activities, all of them have subcontracted with one of two claims processors that process the claims and handle beneficiary and provider inquiries associated with them. (Table 1 contains a list of regions, their MCS contractors, and their claims processors.)

Table 1: Regions, Managed Care Support Contractors, and Claims Processors

Region	MCS contractor	Claims processor
Northeast	Sierra Military Health Services	Palmetto Government Benefits Administrators
Mid-Atlantic and Heartland	Humana Military Healthcare Services	Palmetto Government Benefits Administrators
Southeast and Gulfsouth	Humana Military Healthcare Services	Palmetto Government Benefits Administrators
Southwest	Health Net Federal Services	Wisconsin Physicians Service
Central	TriWest Healthcare Alliance, Inc.	Palmetto Government Benefits Administrators
Southern California, Golden Gate, and Hawaii-Pacific	Health Net Federal Services	Palmetto Government Benefits Administrators
Northwest	Health Net Federal Services	Wisconsin Physicians Service

Source: DOD

In August 2003, DOD awarded new civilian health care contracts, known as TNEC that will reorganize the 11 regions into 3—North, South, and West—with a single contract for each region.⁵ Implementation of these new contracts is expected to begin in June 2004. See appendix II for maps depicting the current and future TRICARE regions.

Claims processing begins with the receipt of claims—either paper or electronic—and any supporting documentation that is submitted by providers and beneficiaries.⁶ Information from paper claims must be scanned or manually entered into the processing system used by the claims processor. Data from electronic claims automatically enter the system after the system verifies that each entry or field on the form contains appropriate data. Compared to paper claims, electronically submitted claims can be processed more efficiently because they do not

⁵DOD has awarded TNEC contracts to Health Net Federal Services for the TRICARE North region, to Humana Military Healthcare Services for the TRICARE South region, and to TriWest Healthcare Alliance Corp. for the TRICARE West region. Palmetto Government Benefits Administrators will process claims for the North and South regions, and Wisconsin Physicians Service will process claims for the West region.

⁶According to TRICARE claims processors, providers submit about 99 percent of the claims, with beneficiaries submitting the rest.

require handling in the mailroom, document preparation, imaging, data entry, and storage of the original document. Furthermore, claims processors told us that because each field in an electronic claim must be completed before it is accepted into the processing system, electronic claims generally are more complete and have fewer errors from imaging and data entry than paper claims. As a result, they are more likely to be processed without manual intervention.

Once claims data enter the system, they are subject to automatic edits designed to ensure their accuracy and to determine how the claim will be adjudicated. For instance, one edit cross-checks the Defense Enrollment Eligibility Reporting System (DEERS) to verify beneficiaries' eligibility.⁷ At any time during this automated process, a claim can require manual intervention by claims processing employees to correct errors, supply missing data, or verify that the provided care was properly authorized, medically necessary, and appropriate. After adjudication, the claim is either paid or denied and the beneficiary and provider are notified of the outcome. The final record of the claim is sent to DOD in the form of a HCSR. HCSRs do not affect the amount of beneficiary or provider reimbursement, nor do they delay claims processing timeliness. (Appendix III contains a more detailed description of the claims processing flow. See app. IV for a more detailed description of the HCSR.)

DOD requires its MCS contractors to meet certain standards for claims processing timeliness. Specifically, DOD requires them to process 95 percent of retained claims within 30 calendar days of receipt, 100 percent of retained claims within 60 days, and 100 percent of all excluded claims within 120 days, unless DOD specifically directs a MCS contractor to

⁷DEERS is a DOD database maintained by the Defense Manpower Data Center (DMDC), a DOD contractor. DEERS contains service-related eligibility and demographic data used to determine eligibility for military benefits, including health care, commissary, and exchange privileges for all service members, retirees, and their family members. As individuals enter the military, the services add information to DEERS. The services are responsible for updating information as service members' military status changes. Individual service personnel are responsible for enrolling their dependents in DEERS at local military installations and for notifying DEERS when an eligible dependent's status changes.

continue holding for processing a claim or group of claims.⁸ DOD verifies whether MCS contractors are meeting timeliness standards by monitoring its database of HCSRs.

DOD, like other entities that offer health plans and are providers of health services, is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to use uniform standards for data code sets and electronic transactions, including claims filing.⁹ HIPAA was enacted to combat waste, fraud, and abuse; to improve the portability of health insurance coverage; and to simplify the administration of health care.¹⁰ Uniform standards for electronic filing will allow providers to use the same software to submit claims to all insurance plans, including TRICARE. However, providers retain the option of submitting claims on paper if they so choose.¹¹ The compliance date for this requirement is October 15, 2003.¹²

⁸Before processing, DOD classifies submitted claims as either retained, excluded, or returned. Retained claims are those held in the MCS contractor's possession, which contain sufficient information to allow processing to completion, and all claims for which missing information may be developed from in-house sources. Excluded claims are claims held at the discretion of the contractor for external development of information necessary to process the claim to completion, claims requiring development for possible third-party liability, or claims requiring intervention by another MCS contractor or DOD. Returned claims are claims with missing, incomplete, or discrepant information that cannot be resolved using all in-house methods; are not held by the contractor as excluded claims; and are subsequently returned to the sender.

⁹Pub. L. No. 104-191, sec. 262, § 1175(a), 110 Stat. 1936, 2027 (codified at 42 U.S.C. § 1320d-2(a) (2000)).

¹⁰H.R. Rep. No. 104-496, pt. 1, at 174 (1996).

¹¹65 *Fed. Reg.* 50,312, 50,314 (Aug. 17, 2000).

¹²Administrative Simplification Compliance Act, Pub. L. No. 107-105, § 2 (a)(1), 115 Stat. 1004 (2001).

DOD, MCS Contractors, and Claims Processors Have Made Changes to Improve Claims Processing Efficiency, and Timeliness Has Improved

DOD and its MCS contractors have made a number of changes to TRICARE claims processing since the beginning of 1999 that are designed to improve its efficiency. They have jointly identified certain procedural and adjudication requirements as nonessential to claims processing. These requirements have been eliminated or changed in an effort to reduce the need for manual intervention during processing and to encourage the electronic submission of claims. Furthermore, MCS contractors have worked with their claims processors to implement best industry practices designed to improve claims processing efficiency. These practices include the use of new technologies for data input, claims routing, customer service, and claims submission. Finally, MCS contractors, working with their claims processors, have improved the timeliness with which they adjudicate and pay claims.

DOD and the MCS Contractors Have Made Changes Designed to Improve Claims Processing Efficiency

In July 1999, DOD and the MCS contractors instituted a joint initiative to improve claims processing efficiency that eliminated an existing requirement that claims processors hold claims submitted with incomplete information and obtain, if possible, the information needed to process the claim. Before July 1999, claims processors had been required to retain all claims with missing information, request this information from providers and beneficiaries if the information was not available from in-house sources—such as the DEERS database—and ultimately deny the claim if the information was not received within 35 days. The claims processors reported that managing these claims and matching them with additional information when it was received increased their workload. Also, according to claims processors, the information was frequently received after the 35-day period elapsed. The claims processors would then have already denied the claim, and it would have to be resubmitted. With the elimination of the requirement, MCS contractors return claims with missing information, as long as the necessary information cannot be supplied from in-house sources. For example, a claim missing a required signature would be returned to the submitter. In contrast, a claim missing a beneficiary's date of birth would not be returned because this information could be found in the DEERS database.

DOD and the MCS contractors also jointly identified certain requirements that they determined were unlikely to alter payment or care decisions and that, if eliminated, would make claims processing more efficient. One joint DOD and MCS contractor initiative decreased the number of

DOD-required preauthorizations and gave the MCS contractors more latitude to determine when preauthorizations are necessary.¹³ DOD eliminated preauthorization requirements for 21 procedures, including cataract removal, hernia repair, caesarian section, and tonsillectomy. Although preauthorizations are used to ensure the medical necessity of and appropriate access to health care before the care is provided, they also can delay claims processing because they often require manual intervention by claims processing staff to ensure the care was properly ordered. By giving MCS contractors the authority to eliminate preauthorization requirements that were not essential to accurate claims adjudication, certain categories of claims could be processed and reimbursed with less manual intervention.

Further, a joint initiative intended to create an incentive for providers to submit claims electronically resulted in DOD giving MCS contractors the authority to decide whether to adjudicate electronically submitted claims at a faster rate than those submitted on paper.¹⁴ Electronically submitted claims can be processed more efficiently than paper claims. However, prior to this initiative, MCS contractors paid claims as they were received and adjudicated with no distinction between paper or electronic submission. In January 2000, DOD gave MCS contractors the authority to decide to pay electronically submitted claims as soon as they were processed and to delay payment of paper-submitted claims, as long as the contractors met the basic overall standards for claims processing timeliness. In fiscal year 2003, two MCS contractors responsible for 5 of the 11 TRICARE regions decided to delay payment on some types of provider-submitted paper claims.¹⁵ However, MCS contractors told us it was too soon to determine whether this change has resulted in providers submitting more claims electronically.

¹³Preauthorizations are a standard of managed health care that require a physician or other medical provider to certify, before a procedure is performed, that the procedure being considered is medically necessary and the proposed location for delivery of care is appropriate. If required preauthorizations for care are not obtained, the associated services rendered may not be reimbursed or reimbursements may be reduced when claims are processed.

¹⁴The Centers for Medicare & Medicaid Services (CMS) has encouraged providers to submit claims electronically by requiring its claims processing contractors to delay payment of Medicare claims submitted on paper.

¹⁵The remaining two MCS contractors told us they decided to reimburse paper claims and electronic claims in the order in which they were processed.

DOD also adopted another initiative intended to increase the number of electronically submitted claims. As of July 1, 2003, it changed the requirements for provider identification on claims forms, making it easier for providers to submit their claims electronically.¹⁶ The change allows providers to submit claims using their Medicare identification number or another alternate provider identifier. Before this change, the provider identification number required for TRICARE claims was not compatible with the software used by many providers to submit claims. As a result, many providers had to modify their claim systems and retrain staff if they wanted to submit TRICARE claims electronically. Because TRICARE is generally a small portion of their business, providers had little incentive to make these changes.¹⁷

In addition to their collaborative efforts with DOD, claims processors, since the beginning of 1999, have implemented best industry practices, including new technologies designed to increase the efficiency of claims processing. These technologies include

- using optical character recognition (OCR) technology, which enables the efficient, cost-effective, and high-quality capturing of claims data without any manual data entry;
- providing claims processing staff with the capability to immediately resolve and adjust claim errors when responding to provider and beneficiary inquiries, instead of requiring them to hold corrections for resolution at a later date; and
- employing electronic routing systems to send simpler claims to less experienced processors and more complex ones to those who have been trained to adjudicate them.¹⁸

¹⁶HIPAA required that the Secretary of Health and Human Services adopt standard unique provider identifier numbers. Pub. L. No. 104-191, sec. 262, § 1173(b)(1), 110 Stat. 1936, 2025. The regulations to implement this provision were not expected until October 2003 at the earliest, according to CMS officials responsible for these regulations. Providers will be required to comply with the regulation beginning 2 years after its effective date, which will be included in the regulation when it is published.

¹⁷For example, one claims processor estimated that TRICARE is frequently about 3 percent of a provider's business.

¹⁸For example, if a multifaceted surgery claim needed clinical review, the electronic routing system would send the claim segments needing review to a nurse with appropriate surgery expertise instead of the claim being initially reviewed by an individual without the required expertise.

Claims processors have also adopted best industry practices by providing customer service via the Internet and by providing the capability for Internet claim submission. To do this, both claims processors have created Web sites that providers and beneficiaries can use to inquire about the status of submitted claims and to obtain patient and benefit information. In addition, one claims processor gives physicians the option of submitting claims via the Internet. In general, claims submitted via the Internet can be immediately processed without human intervention. According to this claims processor, the current number of Internet claim submissions is small¹⁹ but is likely to grow because of the ease of submission and the speed at which these claims are processed. MCS contractors told us that they have plans for additional Web-based enhancements that will further simplify TRICARE claims processing and provide additional services for both providers and beneficiaries, such as allowing institutions to submit claims via the Internet and providing additional self-help features.

MCS Contractors' Claims Processors Have Improved Claims Processing Timeliness

In fiscal year 2002, MCS contractors' claims processors processed over 97 percent of claims in 30 days or less—exceeding DOD's standard that 95 percent of retained claims be processed within 30 calendar days.²⁰ This is an improvement over fiscal year 1999, when they processed 91 percent of all claims within 30 days.²¹ (See table 2.) During this time period, the number of claims processed increased 43 percent, from 29.2 million in fiscal year 1999 to 41.7 million in fiscal year 2002.²²

¹⁹In June 2003, 2 percent of this processor's claims were submitted via the Internet.

²⁰We also found that in fiscal year 2002, 82 percent of all claims were processed in 15 days or less, while in fiscal year 1999, 76 percent were processed in 15 days or less.

²¹A portion of this improvement may be due to the DOD and MCS contractor initiative that started late in fiscal year 1999 and permitted MCS contractors to return claims submitted with insufficient or missing information. About 2 percent of claims were returned in fiscal year 2002. However, according to claims processors, many of these claims would have been returned even before this initiative.

²²In addition, claims processors processed 41.7 million TFL claims in fiscal year 2002.

Table 2: Percentage of TRICARE Claims Processed in 30 Days or Less in Fiscal Years 1999 and 2002

	1999		2002	
	Percent	Number (in thousands)	Percent	Number (in thousands)
All claims ^a	91.4	28,413	97.2	38,965
Method of claim submission				
Electronic	97.7	11,968	99.0	19,533
Paper	86.8	16,445	95.4	19,432
Type of provider^b				
Professional	88.5	18,770	96.0	24,923
Pharmacy	97.9	9,327	99.6	13,660
Institutional	69.7	316	86.5	382
Dollar amount paid by DOD				
Less than \$100	92.5	24,832	97.5	32,469
\$100 to \$999	84.9	3,205	96.2	5,991
\$1,000 or more	72.3	376	89.1	505

Source: DOD.

Note: GAO analysis of DOD claims data.

^aThese calculations include only claims for health care provided inside the United States. They do not include Senior Pharmacy claims and Medicare claims. In addition, they do not include claims if the final record of a claim was modified due to reprocessing.

^bProfessional claims represent care rendered by physicians and other health care providers, such as physical therapists. Pharmacy claims are claims for prescription drugs. Most institutional claims represent care provided by hospitals.

Even though MCS contractors' processing timeliness increased in all categories of claims from fiscal year 1999 to fiscal year 2002, timeliness in each category varied. For instance, pharmacy claims, which in fiscal year 2002 constituted about 35 percent of all claims, were almost always processed within 30 days because they were submitted electronically in nearly all cases. On the other hand, in fiscal year 2002, 86.5 percent of institutional claims and 89.1 percent of claims with government liability of \$1,000 or more were processed within 30 days or less. Institutional and high-dollar claims are usually more complicated and often require medical review, adding to processing time. However, MCS contractors still met DOD's standard for overall processing timeliness because institutional claims comprised only about 1 percent of overall claims, and claims with liability over \$1,000 comprised only 1.3 percent of contractors' claims.

Therefore, these claims had little effect on MCS contractors' ability to meet DOD's standard.

DOD's Procedures and Inaccurate Data Continue to Create Some Inefficiencies in Claims Processing

Although DOD and MSC contractors have made changes to make claims processing more efficient, some of DOD's procedures, as well as inaccuracies in its data, continue to create inefficiencies in TRICARE claims processing. In some cases, DOD's procedures lead to rework for claims processors, either in the form of reprocessing claims or reprogramming processing software. Other DOD procedures, such as the method for calculating TRICARE's liability when beneficiaries have other health insurance, lead to claim outcomes that are not understood by providers and beneficiaries. This confusion may increase claims processors' workload when there is additional demand for them to provide customer service. Finally, inaccuracies in DOD eligibility data contribute to claims processing delays and rework, which create inefficiencies in TRICARE claims processing.

DOD's Procedures for Making Program Changes to TRICARE Lead to Rework and Increased Demand for Customer Service

DOD's procedures for making program changes to TRICARE create inefficiencies in claims processing. Program changes include the introduction of new exclusions or inclusions in coverage, the creation of new benefit packages for special populations, revisions to billing procedures, changes in reporting requirements, or other administrative changes. DOD does not adhere to a set schedule for making health benefit or other program changes. In 2002, DOD made 123 program changes on 19 different dates throughout the year.²³ For example, in May 2002, DOD made 41 changes on 4 different days. DOD officials told us they had limited control over scheduling some program changes because approximately one-third of changes result from new laws or regulations.

Implementing program changes often involves reprogramming and testing processing software, and not adhering to a schedule for issuing changes can create extra work for claims processors. When unscheduled changes give claims processors little or no time to anticipate, implement, and test the changes, claims processors said they are more likely to make errors in their programming. These programming errors must be corrected and create additional work when incorrectly processed claims must be reprocessed.

²³In 1999, DOD made 310 program changes, in 2000 it made 194, and in 2001 it made 172.

In addition, when DOD has issued similar or related changes on separate occasions, claims processors have needed to reprogram their software on multiple occasions for a single benefit area. While DOD has made some attempts to issue changes at the same time, three of the four MCS contractors said these attempts to consolidate changes have, in some cases, delayed the implementation of some changes. They said that such delays result either in beneficiaries not receiving the benefits of a change as soon as possible or in claims processing rework if adjudicated claims are retroactively affected and must be reprocessed.

Unscheduled changes also make it difficult for providers and beneficiaries to account for or learn about recent changes. When these changes result in claims outcomes that providers and beneficiaries do not understand, claims processors experience demands for customer service to explain the outcomes, even if the claims in question have been properly adjudicated. For example, according to a claims processor, providers often require customer service when program changes have added to or deleted codes that they use to bill for procedures. When this happens, providers become confused when the amounts on recently adjudicated claims differ from the amounts they previously were reimbursed for identical services.

MCS contractors are required to educate providers and beneficiaries about policies and procedures that have an impact on claims processing—such as new benefits or changes in billing requirements.²⁴ However, because TRICARE is often a relatively small portion of most providers' business, providers have little incentive to participate in educational seminars or to read the many bulletins and updates to stay current on the frequent program changes. Therefore, MCS contractors told us that they also maintain relationships with provider associations and provide one-on-one education through phone conversations or on-site visits to individual providers. Most educational efforts are directed at providers because beneficiaries submit few claims. However, MCS contractors publish periodic newsletters for beneficiaries and provide beneficiary briefings.

²⁴MCS contractors disseminate information on program changes through Web sites, monthly or quarterly newsletters, and periodic bulletins.

DOD's Procedures for the Coordination of the TRICARE Benefit with Other Insurers May Increase Demand for Customer Service

According to DOD officials, MCS contractors, and claims processors, DOD's procedures for calculating TRICARE liability when beneficiaries have other health insurance is the claims processing area that causes the most confusion for providers and beneficiaries.²⁵ Officials told us that providers and beneficiaries frequently misunderstand the outcomes of claims involving other health insurance. Officials told us that TRICARE providers and beneficiaries are often confused because in many cases TRICARE does not provide any payment when a beneficiary has other health insurance.²⁶ In these cases, there is no TRICARE cost share because the other health insurance reimbursement is equal to or greater than the reimbursement that TRICARE allows. When providers and beneficiaries question such decisions, claims processors must explain TRICARE's benefit calculation. This increases the demand for customer service, which creates inefficiencies in TRICARE claims processing. One MCS contractor told us that about 10 percent of its priority inquiries during September and October 2002 were related to questions about other health insurance.²⁷

Although DOD officials, MCS contractors, and claims processors all told us that the procedures for calculating TRICARE liability when beneficiaries have other health insurance result in inefficiencies in claims processing, the extent of this problem has not been determined. MCS contractors and claims processors could provide very little data demonstrating the impact of these procedures on the efficiency of claims processing. Furthermore, DOD officials told us that when the new contracts for civilian-provided care are implemented, the procedures for calculating TRICARE liability when beneficiaries have other health insurance will be simplified.

²⁵One claims processor told us that 25 percent of the TRICARE claims it processed involved other health insurance. The other processor could not provide these data for TRICARE claims.

²⁶10 U.S.C. § 1079(j)(1) (2000).

²⁷Priority inquiries are those received from members of Congress, the Office of the Assistant Secretary of Defense (Health Affairs), TMA officials, Surgeons General, flag officers, state officials, and others.

DOD's Procedure for Determining Responsibility for Processing Beneficiaries' Claims Contributes to Rework

DOD's procedure for determining which contractor is responsible for beneficiaries' claims creates inefficiencies in TRICARE claims processing. Confusion over this responsibility can lead to MCS contractors receiving—and in some cases beginning to process—claims over which they have no jurisdiction. These improperly submitted claims must eventually be reprocessed by another MCS contractor. Under TRICARE rules, an MCS contractor is responsible for processing all the claims of beneficiaries who live or are enrolled in its region regardless of the region of the country where care was received. As a result, when beneficiaries receive care in regions where they do not live, some providers incorrectly submit claims to the MCS contractor responsible for the region.²⁸ When providers submit claims to the incorrect MCS contractor, the claims processor must then notify the provider and forward these claims to the MCS contractor with proper jurisdiction. According to claims processors, out-of-jurisdiction submission is the main reason for returned claims.²⁹ In fiscal year 2002, officials from one claims processor told us they returned nearly 1 million of the claims they received, and officials from the other claims processor said they returned over 400,000 received claims.³⁰ Under the terms of TNEX, jurisdictional problems are likely to be reduced when the 11 current regions will be replaced by 3 larger ones.

Inaccuracy of DOD Data Used to Verify Eligibility Creates Processing Delays and Rework

Inaccuracies in DOD's DEERS data create delays in the processing of claims. Processors are required to use the DEERS database to verify the eligibility of TRICARE beneficiaries, but when these data are inaccurate, the related claims cannot always be processed or they may be processed incorrectly. There are two main reasons why DEERS eligibility data are incorrect. First, TRICARE beneficiaries, who are responsible for keeping their personnel data current, do not always report changes—such as marriage, divorce, or the birth of a child—that may affect their dependents' eligibility status. Second, when the military status of TRICARE beneficiaries changes, the services may not report these changes to update the database on time—even though these changes in status can affect TRICARE eligibility. As a result, DEERS may not always indicate whether beneficiaries have moved from inactive reserve to active

²⁸In contrast, the jurisdiction for processing Medicare fee-for-service physician claims is determined by the location where the service is provided.

²⁹Claims processors told us their statistics on returned claims include those claims forwarded to another MCS contractor as well as those returned to the submitter.

³⁰The 400,000 claims include TFL claims submitted to the wrong contractor.

status or if they have changed the TRICARE option through which they are receiving their health care. Moreover, when beneficiaries retire or change their branch of service, these changes may not be correctly reflected in DEERS on time.

According to DOD officials, MCS contractors are currently only allowed to access and change information related to TRICARE enrollments that are less than 289 days old.³¹ All other changes needed to update the database are handled by DMDC, the contractor who maintains DEERS for DOD. Without timely and accurate eligibility data, MCS contractors must delay processing some claims whose outcomes are contingent on changes to DEERS until DMDC makes the necessary corrections. According to a DOD contractor, as of June 2003, about 1,000 military sponsors and their dependents had claims that could not be immediately processed because of problems stemming from DEERS.

In other cases, claims are processed with inaccurate data from DEERS, leading to claim outcomes that are incorrect. For example, when reservists are mobilized to active duty, their DEERS file must reflect this or their dependents will appear to be ineligible for services and denied care. Further, if DEERS does not indicate the correct enrollment status for a dependent, his or her claim might be denied or if it is paid, may result in copayment charges that might not have been required. Claims with incorrect outcomes decrease claims processing efficiency because they must be reprocessed when errors are identified and often require additional customer service. According to MCS contractors and claims processors, inaccuracies in DOD's DEERS are responsible for increased demands for customer service and claims processing rework. However, MCS contractors told us they have no specific data that demonstrate increased demands for customer service or record how much rework is related to problems in DEERS.

With the implementation of TNEC contracts, DOD will be upgrading the existing DEERS system to New DEERS. According to a DOD official, New DEERS will be easier to program than the existing DEERS and will help ensure that some beneficiary changes—such as address and jurisdictional changes—are immediately reflected in the system. However, problems

³¹According to DOD officials, this period was temporarily extended to 289 days when a July 2001 change in the system created many enrollment errors. However, DOD specifications only allow contractors to change enrollment data that are less than 60 days old.

related to beneficiaries' failure to notify the system of changes may continue. In addition, with the implementation of TNEX, MCS contractors will not be allowed to access and change enrollment information that is more than 60—rather than 289—days old.

Conclusions

Since fiscal year 1999, the timeliness of TRICARE claims processing has improved, and it currently exceeds DOD's timeliness standards. During this time, DOD and its MCS contractors have also made a number of changes, both procedural and technological, to TRICARE claims processing that are intended to improve its efficiency. However, some DOD procedures result in inefficiencies in TRICARE claims processing. Specifically, DOD's procedures for introducing program changes continue to create additional work and increased levels of provider and beneficiary inquiries, even though DOD has taken some steps to improve the process for scheduling program changes. DOD clearly faces a number of considerations when determining how to schedule program changes and cannot always control when legislative changes must be implemented. However, because MSC contractors have raised significant concerns about the scheduling process, it appears that further consolidation of program changes and improvements in scheduling may be warranted.

Other inefficiencies may result from procedures for calculating the TRICARE liability when beneficiaries have other health insurance, from confusion over DOD's procedure for determining which contractor is responsible for beneficiaries' claims, and from inaccuracies in DOD data used to verify TRICARE eligibility. Inefficiencies resulting from these procedures and inaccurate data may be reduced once the new contracts for civilian-provided health care are implemented. However, at this time it is not possible to determine the extent to which these inefficiencies may be affected by the implementation of the new contracts.

Recommendation for Executive Action

To improve the efficiency of TRICARE claims processing, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to evaluate DOD's process for issuing program changes and to identify ways to improve the consolidation and scheduling of such changes.

Agency Comments

DOD provided written comments on a draft of this report. (See app. V.) DOD concurred with the report's findings and recommendation.

In its written comments, DOD noted that one of the constraints in consolidating changes to TRICARE contracts is the variation in effective revisions and other program enhancements, sometimes arising from statutory effective dates for new provisions. However, DOD said it would work to improve consolidations and scheduling of changes as it transitions to the new TRICARE contracts over the next 18 months.

We are sending copies of this report to the Secretary of Defense, appropriate congressional committees, and other interested parties. Copies will also be made available to others upon request. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>. If you or your staff have questions about this report, please contact me at (202) 512-7101. Other contacts and staff acknowledgments are listed in appendix VI.



Marjorie E. Kanof
Director, Health Care—Clinical
and Military Health Care Issues

Appendix I: Scope and Methodology

To identify improvements in claims processing timeliness, we compared the timeliness with which the Department of Defense (DOD) processed its claims between fiscal years 1999 and 2002. To do this we asked DOD to prepare two spreadsheets using the database of health care service records (HCSR). The first spreadsheet provided information on claims processing time and included only initial¹ claim submissions that had been processed to completion for each year, stratified by type of claim (professional, pharmacy, and institutional), processing time (less than or equal to 15 days, 16-30 days, 31-60 days, 61-120 days, and greater than 120 days), submission method (electronic or paper), and the dollar amount paid by DOD (less than or equal to \$0, greater than \$0 and less than \$100, \$100 to \$999, \$1,000 to \$4,999, \$5,000 to \$9,999, \$10,000 to \$99,999, and \$100,000 and more). The second spreadsheet included all claims processed to completion for each year, stratified by type of claim (professional, pharmacy, and institutional), submission method (electronic or paper), the dollar amount paid by DOD (less than or equal to \$0 and greater than \$0), the presence or absence of other health insurance, and denied claims. Both of these spreadsheets excluded claims for health care provided outside the United States as well as Senior Pharmacy claims, TRICARE for Life (TFL) claims, and Medicare claims from Base Realignment and Closure sites. These types of claims were excluded because they follow different program rules and use different claims processing procedures. We evaluated the reliability of the HCSR database by obtaining information about DOD's efforts to ensure its reliability and by assessing the consistency of the resulting data by comparing it with internal DOD reports that were produced using another database. Through this evaluation we determined that the data were sufficiently reliable to provide information on the timeliness of claims processing. However, we did not independently review the computer programs DOD used to prepare these spreadsheets.

To identify DOD efforts to improve TRICARE claims processing, we interviewed and obtained documentation from officials at (1) the TRICARE Management Activity (TMA) in Aurora, Colo., (2) the four managed care support (MSC) contractors—Sierra Military Health Services, Inc. in Baltimore, Md.; Humana Military Healthcare Services in Louisville,

¹Claims that were subsequently adjusted after their addition to the HCSR database were excluded from this spreadsheet because the processing time, which included adjustments, was not wholly under the control of the claims processor. If these claims were included, the processing time would have been artificially lengthened since submitters could take weeks before providing the information that made the adjustment necessary.

Ky.; TriWest Healthcare Alliance in Phoenix, Ariz.; and Health Net Federal Services in Rancho Cordova, Calif., and (3) the two claims processing subcontractors, Palmetto Government Benefits Administrators (PGBA) in Surfside Beach, S.C., and Wisconsin Physician Services (WPS) in Madison, Wis.

To describe how DOD procedures and data affect claims processing efficiency, we interviewed and obtained documentation from officials at TMA, the four MSC contractors, and claims processing subcontractors. We reviewed TRICARE's process for creating a final record of a processed claim, looking for inefficiencies in the process of creating HCSRs and comparing the process with one that will be used to create data records for TNEX. We obtained beneficiaries' views on claims efficiencies by interviewing and obtaining documentation from officials from the Military Coalition, an organization representing the members of the uniformed services. We also reviewed our prior work on TRICARE and Medicare claims processing. In addition, we obtained data from DOD's Change Order Tracking System to identify the number of program changes DOD made in 1999, 2000, 2001, and 2002. We evaluated the reliability of the 1999 and 2000 database by comparing it with lists of change orders obtained from the MCS contractors, who were charged with implementing those change orders. This comparison indicated that the data were sufficiently reliable for us to use and, therefore, we did not do a similar comparison for data from 2001 and 2002.

To identify areas where DOD procedures and data might have affected claims processing efficiency, we identified the major differences between processing TRICARE claims and processing commercial or Medicare claims. We confirmed this information in meetings with officials from the Centers for Medicare & Medicaid Services (CMS) and with two of its claims processing subcontractors—PGBA and WPS—who also process commercial healthcare claims. We also obtained comparison information on claims processing from officials from the American Medical Association and the Health Insurance Association of America.

Finally, we obtained information from DOD on its next generation of TRICARE contracts, TNEX, to identify how claims processing may change in the future. We also interviewed and obtained documentation from DOD and CMS experts on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to determine how it may affect claims processing efficiency.

Our review did not include claims processed under DOD's TFL program because TFL is a supplemental insurance program that pays second to Medicare and follows some different claims processing procedures. We performed our work from June 2002 through October 2003 in accordance with generally accepted government accounting standards.

Appendix II: Comparison of Current and Future TRICARE Regions

The shaded areas in figure 1 represent the 11 current TRICARE geographic regions. The shaded areas in figure 2 represent the 3 planned TRICARE geographic regions under the TNEX contracts that were awarded in August 2003.

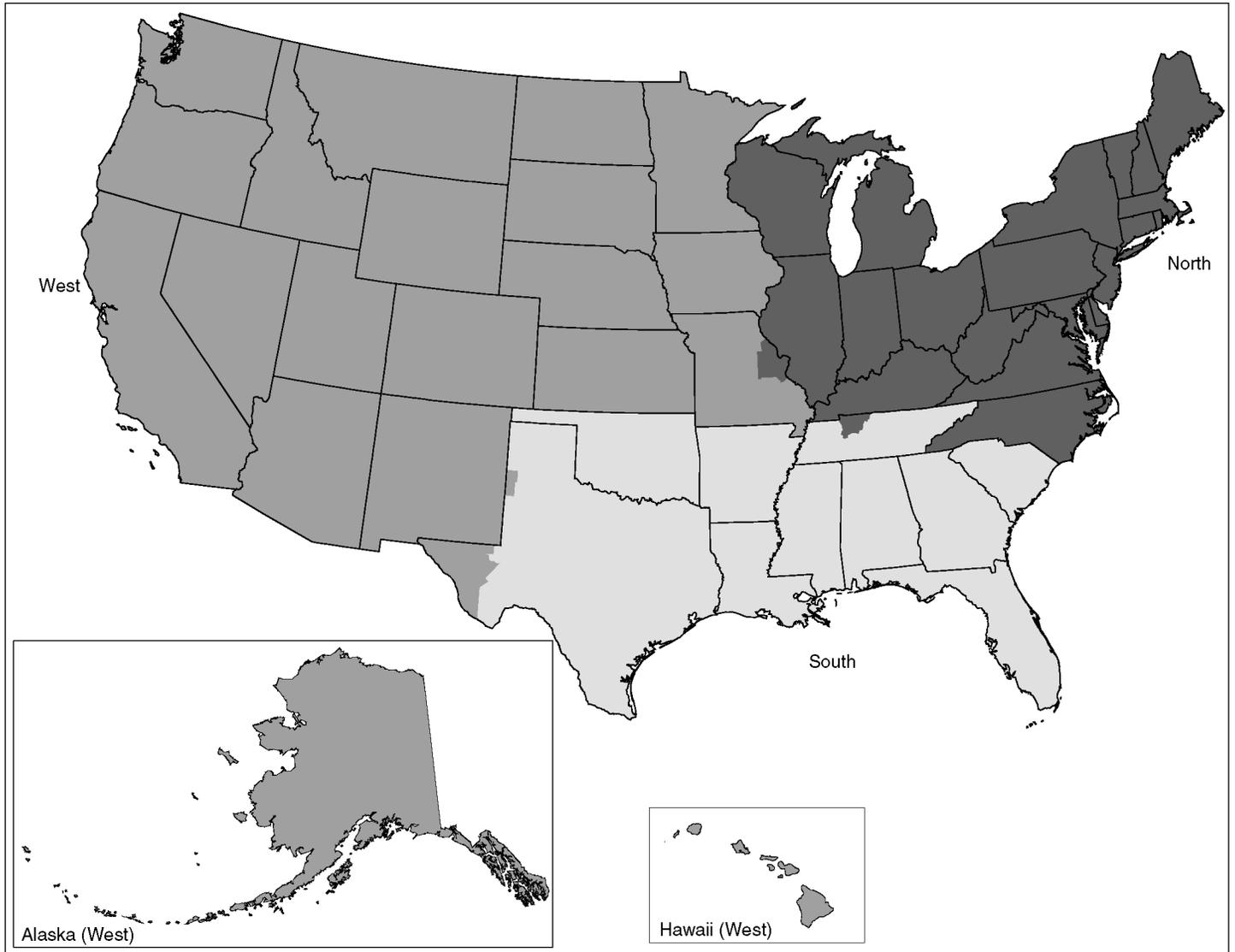
Figure 1: Current TRICARE Regions



Source: DOD.

Appendix II: Comparison of Current and Future TRICARE Regions

Figure 2: Future TRICARE Regions After TNEC Implementation



Source: DOD.

Appendix III: TRICARE Claims Flow

TRICARE claims processing begins when claims processors receive claims in one of three ways—on paper, electronically, or via the Internet.¹ Paper claims are sent to a unique post office box for each TRICARE contract. Optical character recognition (OCR) technology is used to enter paper claims directly into the processing system whenever possible. If this is not possible, claims are manually entered into the system through interactive data entry. The claims processing system precredits electronic media claims (EMC) and Internet-submitted claims before accepting them into the system to ensure that the required fields contain appropriate data. For instance, system edits ensure that the fields identifying who is submitting the claim are complete.

Once claims enter the processing system, paper and electronic claims are processed similarly. The processing system either automatically finalizes claims² or identifies that they require manual intervention, deferring finalization. Some manual intervention results from incorrect or missing claims data, in which case claims processors obtain the needed information from MCS contractor-maintained files or request additional information from providers or beneficiaries before claims processing is resumed. Other manual reviews, resulting from claim edits that stop the process, ensure care was medically necessary and properly authorized.

As claims flow through the processing system, computer edits are applied to each claim to ensure the precision and reliability of claim data and to determine how the claim will be adjudicated. Among these edits are

- validity and consistency edits that confirm the data are accurate and uniform;³
- provider edits that ensure only credentialed providers are reimbursed for care and that identify the specific location services were rendered, in order to apply the correct payment, including any discounts agreed to by contracted providers;

¹Providers generally use forms that they use to submit Medicare claims—HCFA-1500 and UB-92. Beneficiaries submit claims on DD 2642 forms. To obtain reimbursement for civilian care outside the United States, providers and beneficiaries use DD form 2520.

²When a claim is finalized, the adjudication process is complete—a decision has been made about whether DOD has a liability on the claim and the amount that will be paid.

³Validity edits check for the presence of an expected value in the data field, such as a number in an age field. Consistency edits check for the accuracy of an expected data value relative to another, known data value, such as relating 'female' to 'hysterectomy'.

- Defense Enrollment Eligibility Reporting System (DEERS) edits that verify beneficiaries' eligibility for TRICARE and whether they are enrolled in Prime;
- historical edits that confirm services rendered to a beneficiary are in accordance with past utilization of care—such as examining any dramatic changes in a beneficiary's use of health care services;
- edits that determine the benefits that TRICARE will pay and that validate physician preauthorizations and referrals when they are required;
- ClaimCheck edits that help prevent overpayment by analyzing relationships between medical procedure codes;
- duplicate logic reviews that ensure claims are not paid twice by inspecting dates of service, provider numbers, types of service, and procedure codes; edits that access pricing files to determine the amount TRICARE can pay for provided services;⁴ and
- edits that access the central deductible catastrophic cap file (CDCF) to determine the payment after deductibles are applied.⁵

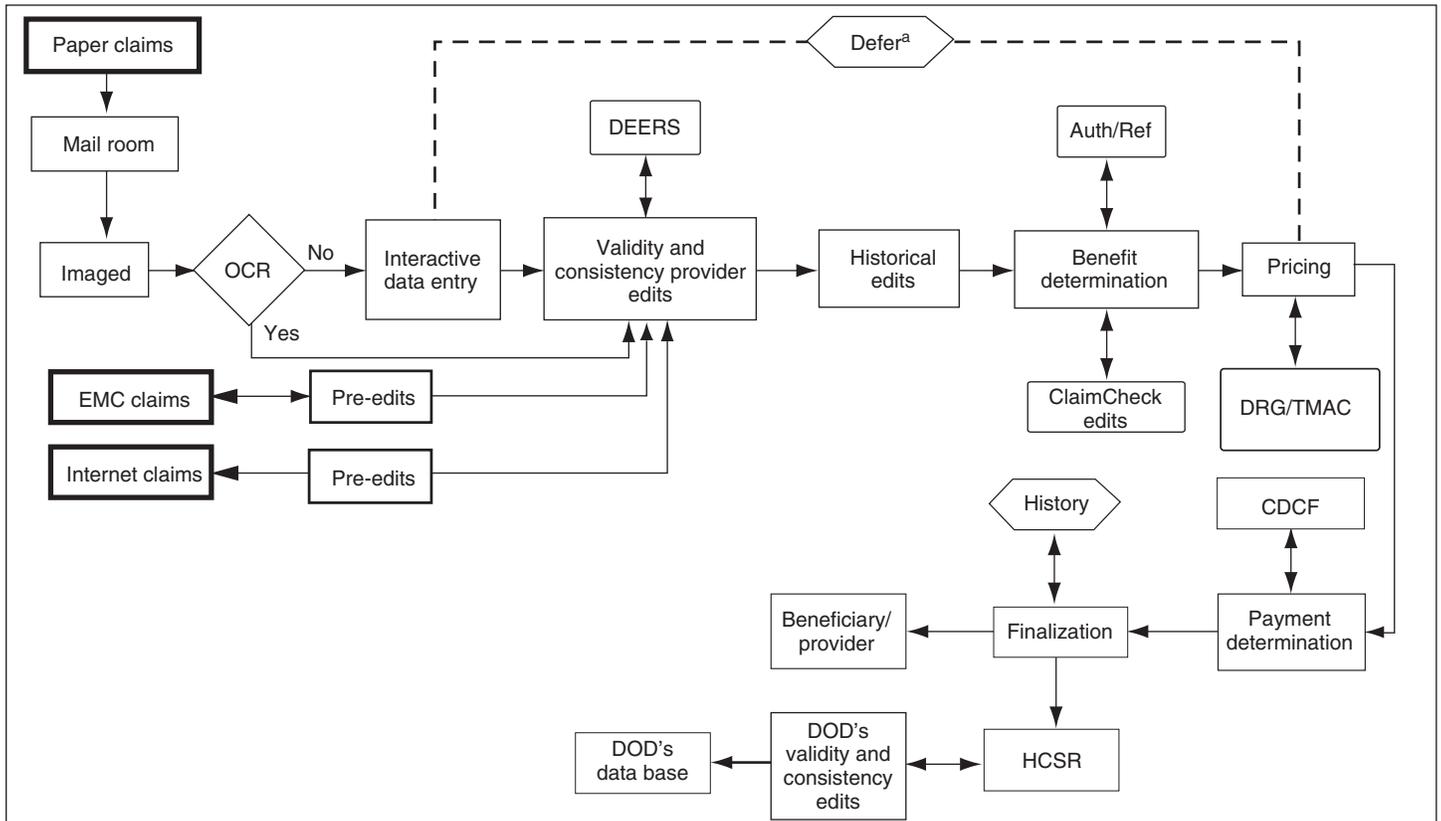
Once claims are finalized, the system mails payments and explanations of benefits to providers and beneficiaries and updates provider file information and beneficiaries' claim histories.

After claims processing is complete, claims processors send Health Care Service Records (HCSR) electronically to the Department of Defense (DOD), where HCSRs are subjected to an additional set of validity and consistency edits. DOD maintains and archives HCSRs, which are the final documentation of each claim's adjudication. DOD uses HCSRs for monitoring contractor performance, financial oversight, audit accountability, and fraud and abuse detection. See appendix IV for additional information on HCSRs. See figure 3 for an overview of EMC, Internet-submitted, and paper claim processing flow.

⁴The claims system accesses diagnosis-related group (DRG) and TRICARE maximum allowable charge (TMAC) files to determine the maximum amount that DOD can pay for the specific services that have been provided.

⁵The CDCF also maintains information on the amount to be applied to beneficiaries' catastrophic cap coverage for each fiscal year.

Figure 3: TRICARE Claims Flow



Source: GAO.

Note: The following is a list of the abbreviations used in this figure.

- Auth/Ref: preauthorizations and referrals
- CDCF: central deductible catastrophic cap file
- DEERS: Defense Enrollment Eligibility Reporting System
- DOD: Department of Defense
- DRG: diagnosis-related group
- EMC: electronic media claims
- HCSR: health care service record
- OCR: optical character recognition
- TMAC: TRICARE maximum allowable charges

^aAt any point between Interactive Data Entry and Pricing, processing can be deferred and the claim can loop back to obtain additional information, usually requiring manual intervention.

Appendix IV: Health Care Service Records

The Department of Defense (DOD) requires claims processors to create an electronic record of each claim called a Health Care Service Record (HCSR). DOD uses HCSRs to ensure compliance with TRICARE requirements and provide standardized information on medical services provided to TRICARE beneficiaries. Claims processors create HCSRs either during claims processing or after claim adjudication, depending on the system they have developed. Claims processors then submit the HCSRs to DOD. Before HCSRs are accepted into DOD's database, they are subject to many edits designed to ensure that the data are correct and in a standard format. HCSRs do not affect the amount of beneficiary or provider reimbursement, nor does creating them delay claims processing.

When a HCSR fails an edit, claims processors must resolve the problem before the data can be added to the HCSR database.¹ Most HCSRs are correctly rejected because they do not conform to DOD's specifications, such as when a required data element is not present. However, according to claims processors and DOD officials, in a very small percentage of cases HCSRs are rejected because inaccuracies in DOD's editing programs incorrectly reject them. For example, HCSRs were erroneously rejected when DOD changed the codes used by claims processors to identify services and procedures but did not modify its own edits to reflect these changes. This error was subsequently corrected when claims processors identified the problem.

HCSRs are useful to DOD. By requiring that claims processors produce data in a format amenable to its edits, DOD attempts to ensure that MCS contractors are following TRICARE requirements. In addition, DOD uses the HCSR database for other purposes, including financial oversight and fraud and abuse detection. HCSR data are also used in fraud investigations conducted by other departments and agencies, including the Department of Justice, Federal Bureau of Investigation, and Defense Criminal Investigative Service.

Under the terms of the TNEX contracts, DOD will require claims processors to submit TRICARE encounter data (TED) records instead of

¹About 4 percent of submitted HCSRs—including TRICARE for Life and Basic TRICARE claims—initially fail HCSR edits.

HCSRs.² DOD, MCS contractors, and claims processors agree that TEDs is a simpler format for claims records. DOD estimates that the number of records submitted may be reduced by about 1 million annually under TNEX.

²The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 required use of the TRICARE encounter data information system rather than the health care service record for maintaining information on covered beneficiaries. Pub. L. No. 106-398, § 727(1), 114 Stat. 1654, 1654A-188 (2000).

Appendix V: Comments from the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

OCT 9 2003

Ms. Marjorie E. Kanof
Director, Health Care-Clinical and Military Health Care Issues
U.S. General Accounting Office
Washington, DC 20548

Dear Ms. Kanof,

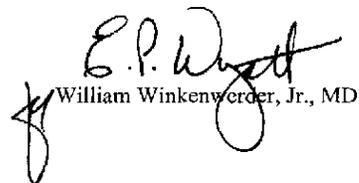
This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "DEFENSE HEALTH CARE: TRICARE Claims Processing Has Improved but Inefficiencies Remain," dated September 12, 2003 (GAO Code 290191, GAO-04-69).

Thank you for the opportunity to review and comment on the draft report. Overall, I concur with the findings of the audit. As you noted in the draft report, substantial efforts to improve TRICARE claims processing have been undertaken, and claims processing timeliness has improved dramatically.

The GAO recommended that Assistant Secretary of Defense for Health Affairs evaluate the process for issuing program changes and to identify ways to improve the consolidation and scheduling of changes. We concur with this recommendation, and will work to implement it as we transition to the new TRICARE contracts over the next 18 months. We note that one of the constraints on consolidation of changes to TRICARE contracts is the variation in effective dates for benefit revisions and other program enhancements, sometimes arising from the statutory effective dates for new provisions.

Please feel free to address any questions to my project officers on this matter, Mr. Thomas Osoba/ TRICARE Management Activity Operations at (303) 676-3492 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-3492.

Sincerely,


William Winkenwerder, Jr., MD

GAO DRAFT REPORT DATED SEPTEMBER 12, 2003
GAO-04-69 (GAO CODE 290191)

"DEFENSE HEALTH CARE: TRICARE Claims Processing Has
Improved but Inefficiencies Remain"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION

RECOMMENDATION 1: The General Accounting Office (GAO) recommended that, the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to evaluate their process for issuing program changes and to identify ways to improve the consolidation and scheduling of changes. (p.26/GAO Draft Report)

DoD RESPONSE: We concur with this recommendation, and will work to implement it as we transition to the new TRICARE contracts over the next 18 months. We note that one of the constraints on consolidation of changes to TRICARE contracts is the variation in effective dates for benefit revisions and other program enhancements, sometimes arising from the statutory effective dates for new provisions.

Appendix VI: GAO Contacts and Staff Acknowledgments

GAO Contacts

Kristi Peterson, (202) 512-7951
Lois Shoemaker, (404) 679-1806

Acknowledgments

In addition to those named above, key contributors to this report were Cynthia Forbes, Krister Friday, and John Oh.

Related GAO Products

Defense Health Care: Oversight of the TRICARE Civilian Provider Network Should Be Improved. [GAO-03-928](#). Washington, D.C.: July 31, 2003.

Defense Health Care: Oversight of the Adequacy of TRICARE's Civilian Provider Network Has Weaknesses. [GAO-03-592T](#). Washington, D.C.: March 27, 2003.

Defense Health Care: Most Reservists Have Civilian Health Coverage but More Assistance Is Needed When TRICARE Is Used. [GAO-02-829](#). Washington, D.C.: September 6, 2002.

Medicare: Recent CMS Reforms Address Carrier Scrutiny of Physicians' Claims for Payment. [GAO-02-693](#). Washington, D.C.: May 28, 2002.

Defense Health Care: Across-the-Board Physician Rate Increases Would be Costly and Unnecessary. [GAO-01-620](#). Washington, D.C.: May 24, 2001.

Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly. [GAO-01-513](#). Washington, D.C.: April 30, 2001.

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Defense Health Care: Claims Processing Improvements Are Under Way but Further Enhancements Are Needed. [GAO/HEHS-99-128](#). Washington, D.C.: August 23, 1999.

Defense Health Care: DOD Needs to Improve Its Monitoring of Claims Processing Activities. [GAO/T-HEHS-99-78](#). Washington, D.C.: March 10, 1999.

Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians. [GAO/HEHS-98-80](#). Washington, D.C.: February 26, 1998.

Defense Health Care: Actions Under Way to Address Many TRICARE Contract Change Order Problems. [GAO/HEHS-97-141](#). Washington, D.C.: July 14, 1997.

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