United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Military Personnel,
Committee on Armed Services, House of Representatives

For Release on Delivery
Expected at 1:00 p.m.
Wednesday, March 10, 1999

DEFENSE HEALTH CARE

DOD Needs to Improve Its Monitoring of Claims Processing Activities

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-78

Defense Health Care: DOD Needs to Improve Its Monitoring of Claims Processing Activities

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss issues and problems we have identified relating to our ongoing assessment of health care claims processing for the Department of Defense's (DOD) TRICARE program. TRICARE is a nationwide managed health care program and represents a redesign of DOD's $15.6 billion per year health care system.[1] DOD has contracted with private sector health care companies, who are referred to as managed care support contractors, to administer the program on a regional basis. Contractors' responsibilities include developing networks of civilian providers, arranging care for beneficiaries, providing customer service, and processing claims. During 1998, contractors processed about 28 million health care claims, including those submitted under DOD's former fee-for-service program.

Last year, we reported on providers' concerns about TRICARE reimbursement rates and slow and cumbersome claims payment.[2] Contractors acknowledged that during the start-up phase of health care delivery they experienced some problems processing claims in a timely manner, primarily because claims volume was higher than expected. However, even when contractors became more timely, providers continued to complain about slow payment and expressed confusion about claims adjudication. In response to this Subcommittee's concerns about these complaints, we are evaluating the performance of DOD's contractors in processing TRICARE claims.

My statement today will highlight our preliminary findings on claims processing timeliness and accuracy as well as the effectiveness of a commercially available software program to edit TRICARE claims. The information we present is based on an ongoing evaluation of the claims processing performance of TRICARE regions that were in operation for at least 1 year as of July 1998. (See appendix I.) During the course of our work, we met with officials of DOD and its contractors and toured their claims processing facilities. We also spoke with representatives of physicians' groups and with officials of the company responsible for developing and distributing the claims editing software that DOD uses. In

[1]DOD previously provided health care under the Civilian Health and Medical Program of the Uniformed Services, a fee-for-service program

[2]Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians (GAO/HEHS-98-80, Feb. 26, 1998).

addition, we obtained and analyzed nearly 20 million completed claims to determine whether they were processed in a timely manner. We reviewed DOD's efforts to assess accuracy but did not independently audit claims for accuracy. We expect to issue a report in the near future.

In summary, our work to date for the 1-year period included in our review has shown that TRICARE's contractors in 8 of the 11 regions processed 86 percent (or 16 million) of the claims on time overall, exceeding DOD's timeliness standard of processing 75 percent of claims within 21 days. However, only 66 percent of hospital or institutional claims were processed on time, while 97 percent of pharmacy claims were processed on time, and 81 percent of professional claims were processed on time. The nearly 3 million claims that did not meet the timeliness standards were mostly from physicians and other providers. Moreover, DOD does not know whether contractors are paying claims accurately because fewer than half of the claims are subject to the audit, and the methodology used to calculate payment error is statistically unsound. According to contractors, the principal reasons for claims processing problems are the complexity of the TRICARE program and frequent program changes, requiring modifications to claims processing software and procedures. Specifically, at the time of our review, DOD had instructed contractors to implement about 650 changes, or about 130 changes on average for each contract.

DOD's claims editing software, designed to ensure that providers are accurately reimbursed for services, affected 3.5 percent of claims and saved more than $53 million in fiscal year 1998. We found, however, that inappropriate denials were sometimes made because DOD's software did not always comply with industry standards. This resulted from DOD's poor communication and slowness to make program changes that affected editing outcomes. In addition, providers were frustrated because they mistakenly believed that they had no recourse for claims denied by the editing software. If not resolved, these kinds of problems as well as the volume of claims processed late, despite meeting the timeliness standard overall, could cause problems in attracting the number of civilian providers necessary to ensure that beneficiaries have adequate access to health care.

Background

DOD's primary medical mission is to maintain the health of 1.6 million active duty service personnel and to provide health care for them during military operations. DOD additionally offers health care to 6.6 million nonactive duty beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. Most health care is

provided in military-operated hospitals and clinics worldwide and is supplemented by care provided by civilian providers under TRICARE. TRICARE is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization, a preferred provider organization, and a fee-for-service benefit. The health maintenance organization option, called TRICARE Prime, is the only option for which beneficiaries must enroll. TRICARE Extra is the preferred provider organization option, and TRICARE Standard is the fee-for-service option.

TRICARE is geographically organized into 11 health care regions that are administered by five contractors. Among the contractors' many responsibilities are claims processing, for which all have subcontracted with one of two companies. DOD requires contractors to meet specific timeliness and accuracy standards when processing claims. The tasks required to process claims include claims receipt, data entry, claims adjudication, and claims payment or denial. Contractors must process 75 percent of claims within 21 days to meet DOD's timeliness standard. This standard applies to all claims, even those that need additional information to be processed. By way of comparison, Medicare requires that 95 percent of complete electronic claims be paid in 14 days and that 95 percent of complete paper claims be paid in 30 days. DOD also requires contractors to maintain a 98-percent payment accuracy rate. Medicare has a goal of 90-percent accuracy for the next 5 years. The timeliness and accuracy standards of private plans vary.

DOD verifies timeliness standards but relies upon external audits for accuracy verification. DOD uses information from its electronic health care service record (HCSR) database to verify timeliness. Contractors prepare and submit to DOD a HCSR for every claim processed to completion. To verify whether contractors' accuracy standards are being met, DOD monitors a sample of processed claims through a quarterly external audit with two components—payment accuracy and data input accuracy.

DOD requires contractors to use ClaimCheck, a commercial off-the-shelf software program that performs a prepayment review of claims and helps prevent overpayments by analyzing the appropriateness of billing on professional claims. The basic ClaimCheck software package contains approximately five million edits. However, companies that purchase ClaimCheck may customize the edits to reflect their plans' benefit structure. DOD purchased ClaimCheck software in March 1994 and had it

customized for TRICARE. DOD refers to its customized version as TRICARE ClaimCheck.

Concerns Exist About Claims Processing Timeliness

Our analysis to date has shown that TRICARE's contractors met DOD's timeliness standards by paying more than 16 million claims within 21 days.[3] Even so, nearly three million claims were paid late. We found differences in timeliness by category, which includes pharmacy, hospital or institutional, and professional claims. For example, contractors did not meet the standard for hospital or institutional claims. Nonetheless, they were still able to meet DOD's standard overall, primarily because pharmacy claims were paid faster. DOD has proposed several initiatives to improve claims processing timeliness, including the adoption of some Medicare standards.

Timeliness Standards Were Met Overall, but Some Impediments Exist

As table 1 shows, the three contractors responsible for 8 of the 11 TRICARE regions met DOD's contractual timeliness standards of processing 75 percent of claims within 21 days. In fact, between July 1997 and June 1998, these contractors exceeded the standard by processing 86 percent of claims on time. However, nearly three million claims did not meet the timeliness standard, and of these claims, more than 80 percent were from physicians and other professional providers. Furthermore, only 66 percent of claims from hospitals and other institutions were processed within 21 days. Hospital claims take longer to process for many reasons such as their higher cost, numerous line items, and the need for review by a medical professional. In contrast, 97 percent of pharmacy claims met the standard. Pharmacy claims were processed more quickly because they are usually simple claims and 90 percent are submitted electronically, which is faster.

[3]Includes claims from Foundation Health Federal Services, Inc.; Humana Military Healthcare Services, Inc.; and TriWest Healthcare Alliance, Inc.; but not from Anthem Alliance for Health, Inc., or Sierra Military Health Services.

Table 1: Processing Time for Claims Processed Between July 1, 1997, and June 30, 1998

	Claims processed				
	0–21 days		More than 21 days		
Category of claims	Number	Percent	Number	Percent	All claims
Pharmacy	6,506,867	97	215,252	3	6,722,119
Hospital or institutional	473,964	66	243,382	34	717,346
Professional	9,480,983	81	2,265,093	19	11,746,076
All claims	16,461,814	86	2,723,727	14	19,185,541

Planned Efforts to Improve Timeliness

Through discussions with contractors, DOD has identified changes that could improve claims processing timeliness as well as other aspects of the program. One of these proposed changes will eliminate unnecessarily prescriptive requirements for assessing the medical necessity of care that has been provided and will allow contractors to select and use a nationally accepted criterion for assessing necessity. The current adjudication process is slowed because contractors must review and follow extensive criteria to determine whether payment should be allowed. A second change will adopt Medicare's timeliness standards, which differentiate between paper and electronic claims and require contractors to pay interest on late claims. Medicare requires that 95 percent of complete electronic claims be paid in 14 days and that 95 percent of complete paper claims be paid in 30 days. Another change will adopt Medicare's practice of returning incomplete claims. By adopting Medicare's standards and practices, DOD will be mirroring a program that is more familiar to providers. These initiatives should help improve the completeness of claims initially received as well as provide incentives for contractors to process claims in a timely way. In addition, they should increase the submission of electronic claims, which are paid faster and are cheaper to process.

Another impending change that should increase electronic claims submissions is the administrative simplification requirement of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). The act requires the industrywide adoption of uniform standards for electronic transactions, including filing claims. The timetable to adopt standards has slipped because of the large number of comments received in response to

the proposed regulations implementing the act and industry preoccupation with identifying and resolving year 2000 computer issues. However, this effort should be under way in middle to late 1999.

Claims Processing Accuracy Is Unknown; Program Complexity Affects Processing Accuracy

DOD does not know whether contractors are meeting contractual requirements for claims processing payment accuracy because its primary assessment tool uses a statistically unsound methodology. Furthermore, several factors, including TRICARE's complex program structure and continual program changes, add to the difficulty of accurately processing claims.

Audit Methodology Does Not Adequately Measure Payment Accuracy

DOD uses external audits to assess the contractors' compliance with payment accuracy standards by sampling processed claims and calculating the percentage of dollars paid in error. However, the method for these audits is statistically unsound because it does not accurately represent the amount of overpayment and underpayment for two reasons. First, the sample excludes all claims under $100; consequently, only about 40 percent of processed claims are subject to the audit for payment accuracy. Second, the magnitude of inaccurate payment is calculated in such a way that the computed error rate is not representative of all claims subject to audit in a given period. Therefore, the calculated error rate is not an accurate indicator of the overall payment processing accuracy. We applied appropriate statistical methods to the same data DOD used in its quarterly audit reports and recomputed error rates. Rates were generally higher, in one instance increasing from 5.5 percent to 10.5 percent.

In addition, DOD's method for calculating payment accuracy does not give a complete picture of payment accuracy. For example, another useful measure would be to calculate the number of claims processed accurately as a percentage of the total number of claims processed. When accuracy is calculated using this method, error rates for some of the contract periods we examined were as high as 25 percent.

TRICARE's Complexity and Frequent Changes Add to the Difficulty of Accurately Processing Claims

Contractors told us that, of the many programs they administer—including Medicare and other private plans—TRICARE is the most complicated and unique, contributing to claims processing difficulties. The following features contribute to TRICARE's complexity.

- Each of TRICARE's three options has a different array of benefits, copayments, and deductibles. Claims require different adjudication procedures, depending on which option is involved, and, even within each option, different claims processing rules apply.
- For the Prime and Extra options, provider reimbursement information is difficult to keep accurate because payment agreements are complicated and individual providers may belong to multiple practices with different agreements.
- Claims submitted under the Standard option are also confusing to process because providers under this option can either accept TRICARE payment in full or charge up to an additional 15 percent on a claim-by-claim basis.
- TRICARE is always the final payer when other health insurance is involved. Thus, contractors must understand the requirements of many other programs' benefit structures and obtain reimbursement information before a claim can be processed to completion.
- For each claim, contractors must connect with and rely on selected DOD databases to determine eligibility, deductibles, and enrollment. Contractors stated that this requirement complicates claims processing and increases the opportunity for errors. In contrast, most insurers maintain these data internally.

Further compounding claims processing complexity are TRICARE's frequent program changes, which usually require contract modifications. At the time of our review, DOD had instructed the contractors we reviewed to implement about 650 contract modifications—an average of about 130 per contract since the beginning of the program. According to the contractors, their ability to process claims accurately is impeded because some changes require system reprogramming and testing as well as staff retraining. In the future, DOD hopes to resolve some of these problems by consolidating changes and providing longer notification periods.

Providers and beneficiaries also contribute to problems with claims processing accuracy because they sometimes submit claims with inaccurate information. Subsequently, when the errors are identified, the claim must be resubmitted and reprocessed. The contractors told us that because TRICARE is usually a small percentage of most providers' practices, they have little incentive to educate themselves on the complex and frequently changing requirements.

DOD Management Problems Impede the Effectiveness of ClaimCheck

DOD's commercial claims editing software, ClaimCheck, is designed to ensure that providers are accurately reimbursed for the services they provide. During fiscal year 1998, ClaimCheck saved more than $53 million and affected 3.5 percent of claims. ClaimCheck is a key player in the claims editing software industry, with more than 200 customers nationwide, including more than 60 percent of Blue Cross Blue Shield carriers and the Department of Veterans' Affairs. In October 1998, the Health Care Financing Administration started using ClaimCheck to prevent overpayments in the Medicare program. However, despite its general acceptance in the insurance industry, providers have expressed concerns about the accuracy of some ClaimCheck decisions because some information is not shared with them. Some of these concerns seem appropriate because of DOD delays in initiating policy changes that affect the software.

For example, providers expressed concerns about ClaimCheck because its edits are not published and available to them. Therefore, they cannot be assured that it follows the American Medical Association's (AMA) medical procedure coding guidance, the industry standard. According to DOD officials, TRICARE claims will be paid appropriately if providers follow AMA's guidelines because ClaimCheck's edits are based upon industry standards. However, we identified a few instances in which DOD's version of ClaimCheck did not comply with industry standards because DOD was slow to implement policy changes that affected the software's outcomes. The denial of surgical pathology payments to dermatologists provides an excellent example.[4] In April 1996—early into the implementation of ClaimCheck—DOD officials realized that the software did not recognize physicians by specialty. As a result, it was not able to identify dermatologists who, unlike other physicians, should be paid for surgical pathology procedures. While this is a limitation of ClaimCheck, it could have been readily resolved through a modification of the contractors' claims processing systems. However, DOD waited almost 2 years before providing contractors with the contract modification directing them to make this change. One contractor stated that it lost dermatologists from its network solely because DOD did not react quickly to this needed modification.

[4]Surgical pathology is the microscopic examination of sampled tissue.

In another instance, providers were upset because they mistakenly believed that they could not obtain explanations for edits that affected their claims. In order to maintain its competitive edge over other vendors, ClaimCheck's programming is not shared with the public or even its purchasers. But the distributors of ClaimCheck stated that their product is not a mysterious "black box" because they provide narrative explanations to purchasers on how every edit works. DOD officials acknowledged that they were aware of contractors' misconception that the edits are proprietary and cannot be shared and added that providers can request and receive information on specific edits.

Finally, providers' frustrations are compounded by poor communication by DOD and its contractors regarding their available recourse over ClaimCheck determinations. DOD told contractors that ClaimCheck determinations could not be appealed but did not sufficiently communicate to them that an allowable charge review process could be used for reviewing ClaimCheck determinations. As a result, contractors improperly informed providers and beneficiaries that they had no recourse when ClaimCheck denied or modified a claim. After beneficiaries and providers complained that DOD and its contractors did not make a review process available to them, the Congress mandated that DOD establish an appeals process for ClaimCheck denials in the Defense Authorization Act for Fiscal Year 1999 (P.L. 105-261).

Conclusions

In conclusion, we found that DOD's contractors have met DOD's standard by paying at least 75 percent of claims on time. Even so, providers are concerned because millions of claims are not being paid in a timely way. Moreover, the overall timeliness of contractors' performance masks weaker performance in processing certain specific claims, including those submitted by hospitals. It appears that the majority of claims processing issues currently being faced by the TRICARE system are rooted in weaknesses in DOD's approach to monitoring and communicating with its contractors. Furthermore, DOD's methodology for its payment accuracy audits is statistically unsound and does not provide an accurate measurement of payment errors. Although the extent of error is unknown, contractors told us that TRICARE's inherent complexity also impedes claims processing accuracy. In addition, we found that inappropriate denials were sometimes made because of DOD's poor communication and slowness to make program changes that affect ClaimCheck outcomes. Providers were further frustrated because they mistakenly believed that they had no recourse for ClaimCheck denials.

Claims processing problems are causing providers to become disillusioned with the TRICARE program. Although DOD and contractors are taking steps to address these problems, if they are not resolved, DOD could face increasing problems attracting the number of civilian providers necessary to ensure that beneficiaries have adequate access to health care. Later this year, we will be issuing a report with recommendations, which, if implemented, should help address DOD's claims processing problems.

Mr. Chairman, this concludes my prepared statement. I will be glad to respond to any questions you or other Subcommittee members may have. We look forward to continuing to work with the Subcommittee as it exercises its oversight of the TRICARE program.

	TRICARE contractor	TRICARE subcontractor
Regions included in our review		
Northwest	Foundation Health Federal Services, Inc.	Wisconsin Physicians Service
Southwest	Foundation Health Federal Services, Inc.	Wisconsin Physicians Service
Southern California, Golden Gate, and Hawaii-Pacific	Foundation Health Federal Services, Inc.	Palmetto Government Benefits Administrators
Central	TriWest Healthcare Alliance, Inc.	Palmetto Government Benefits Administrators
Southeast and Gulf South	Humana Military Healthcare Services	Palmetto Government Benefits Administrators
Regions not included in our review[a]		
Northeast	Sierra Military Health Services	Palmetto Government Benefits Administrators
Mid-Atlantic and Heartland	Anthem Alliance for Health, Inc.	Palmetto Government Benefits Administrators

[a]We did not include these regions because they did not have at least 1 year of claims processing experience as of July 1998.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary, VISA and MasterCard credit cards are accepted, also.

Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Official Business
Penalty for Private Use $300

Address Correction Requested

Bulk Rate
Postage & Fees Paid
GAO
Permit No. GI00