Report No. D-2008-045 February 7, 2008

Inspector General
United States
Department of Defense

Controls Over the TRICARE Overseas Healthcare Program

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Acronyms

ACH	Automated Clearinghouse
ISOS	International SoS
PCDIS	Purchased Care Detail Information System
PGBA	Palmetto Government Benefits Association
PPP	Purchasing Power Parity
QMD	Quantitative Methods Division
SOFA	Status of Forces Agreement
TGRO	TRICARE Global Remote Overseas
TMA	TRICARE Management Activity
WPS	Wisconsin Physician Services

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February 7, 2008

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Report on Controls Over the TRICARE Overseas Healthcare Program (Report No. D-2008-045)

We are providing this report for review and comment. We considered your comments on a draft of this report when preparing the final report.

DoD Directive 7650.3 requires that all recommendations be resolved promptly. The comments of the Assistant Secretary of Defense (Health Affairs) were partially responsive. We request additional comments from the Assistant Secretary of Defense (Health Affairs) on the material management control weaknesses, potential monetary benefits, and Recommendations A.1.b., A.1.d., A.7., B.3., and B.5. by March 7, 2008.

If possible, please send management comments in electronic format (Adobe Acrobat file only) to Audyorktown@dodig.mil. Copies of the management comments must contain the actual signature of the authorizing official. We cannot accept the / Signed / symbol in place of the actual signature. If you arrange to send classified comments electronically, they must be sent over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Questions should be directed to Mr. Michael A. Joseph at (757) 872-4815, extension 223, or Mr. Scott J. Grady at (757) 872-4759. See Appendix G for the report distribution. The team members are listed inside the back cover.

Robert F. Prinzbach II
Acting Assistant Inspector General
Readiness and Operations Support

Department of Defense Office of Inspector General

Report No. D-2008-045 **February 7, 2008**
(Project No. D2005-D000LF-0267.000)

Controls Over the TRICARE Overseas Healthcare Program

Executive Summary

Who Should Read This Report and Why? Policymakers and senior managers involved in the management of medical claims should read this report to gain an understanding of the potential for improper payments for health care provided to overseas DoD beneficiaries.

Background. This is the second of two reports addressing controls at TRICARE Management Activity over payments made for health care services rendered overseas. This report covers the accuracy of TRICARE overseas claims payments and the adequacy of and need for additional price caps for overseas health care. TRICARE Management Activity is a DoD field activity responsible for managing the TRICARE program, including contracting for claims-processing services to support the military health system. The Overseas Program supports approximately 479,000 beneficiaries overseas. Total health care costs for the Overseas Program were $187.3 million in FY 2005 and $210.9 million in FY 2006, while administrative contract costs for the Overseas Program were $21.3 million in FY 2005 and $25.3 million in FY 2006.

Results. We performed this audit to evaluate controls over the TRICARE payments made for health care services provided overseas to TRICARE beneficiaries. Generally, TRICARE Management Activity pays overseas health care claims as billed. Government contractors responsible for processing TRICARE overseas health care claims made inaccurate payments (duplicate payments and overpayments) to host-nation providers and to TRICARE beneficiaries. Based on a statistical sample, we estimate TRICARE Management Activity made $14.6 million in duplicate payments and overpayments during FY 2004 and FY 2005 for health care rendered to TRICARE beneficiaries. We project that TRICARE Management Activity could put about $29.7 million of Defense Health Program funds to better use during the execution of the FYs 2008 through 2013 Future Years Defense Plan by strengthening internal controls, establishing sound contract surveillance plans, and improving recoupment procedures (finding A).

TRICARE Management Activity plans to revise existing Philippines price caps and to implement price caps in Panama. We believe TRICARE Management Activity could further control health care costs by:

- establishing price caps for professional services and hospital inpatient claims in countries with high dollar volumes of claims and in countries that experience significant increases in health care costs;

- ensuring that all TRICARE claims, including TRICARE Global Remote Overseas claims, filed in a given country are subject to the same price caps; and

- implementing price caps in Guam and the U.S. Virgin Islands that are based on those used by the Centers for Medicare & Medicaid Services.

Proceeding with the price cap initiatives in the Philippines and Panama and expanding similar price caps in other countries could result in TMA annually putting at least $16 million in Defense Health Program funds to better use, totaling $96 million during the execution of FYs 2008 through 2013 Future Years Defense Plan (finding B). See Appendix E for the Summary of Potential Monetary Benefits. See the Findings section of the report for the detailed recommendations.

Management Comments and Audit Response. The Assistant Secretary of Defense (Health Affairs) agreed with most of the recommendations to strengthen internal controls over duplicate payments and overpayments. The Assistant Secretary fully agreed with establishing sound contract surveillance plans and improving recoupment procedures.

Additionally, the Assistant Secretary fully agreed with implementing price caps for professional and institutional payments in the Philippines and Panama, and implementing those caps for all claims, including TRICARE Global Remote Overseas claims. The Assistant Secretary agreed with implementing price caps in other countries; however, the actions planned did not fully satisfy the intent of the recommendation. Moreover, the Assistant Secretary did not fully agree with implementing price caps in Guam and the U.S. Virgin Islands based on those used by the Centers for Medicare & Medicaid Services. The Assistant Secretary did not comment on the material management control weaknesses or potential monetary benefits.

We believe all the recommendations in the report remain valid, and we request the Assistant Secretary to provide additional comments on the final report by March 7, 2008. Based on additional information provided by management, we changed the monetary benefits associated with duplicate health care payments and reduced the total potential monetary benefits in finding A from $43.8 million to $29.7 million. For more details on the reduction in potential monetary benefits, see the Management Comments on the Finding and Audit Response section in finding A. See Appendix F for a listing of all recommendations on which we considered management comments responsive and those requiring additional comments. We also request additional comments on the material management control weaknesses and the potential monetary benefits cited in the report. See the Findings sections of the report for details of management comments on each recommendation and the audit response. See the Management Comments section of the report for the complete text of management comments.

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Background

This is the second of two reports addressing controls at TRICARE Management Activity (TMA) over payments made for health care services rendered in overseas locations. This report covers the accuracy of TRICARE claims payments and the adequacy of and need for additional price caps for overseas health care. This audit was suspended on October 19, 2005, and resumed on April 17, 2006, while the audit team provided assistance to the U.S. Attorney's Office, Western District of Wisconsin, on the investigation of TRICARE fraud in the Philippines.

Military Health System. The Office of the Assistant Secretary of Defense (Health Affairs) exercises authority, direction, and control over DoD health facilities, funding, personnel, programs, and other medical resources. TMA is a DoD field activity responsible for managing the TRICARE program under the authority and direction of the Assistant Secretary of Defense (Health Affairs). TMA is responsible for contracting for claims-processing services necessary to support TRICARE and the military health system.

TRICARE Overseas Program. The TRICARE Overseas Program (Overseas Program) is the DoD managed health care program for care outside the continental United States. The Overseas Program supports approximately 479,000 beneficiaries overseas. Six contracts support the Overseas Program with contractors processing more than 1 million Overseas Program claims per year. Total health care costs for the Overseas Program were $187.3 million in FY 2005 and $210.9 million in FY 2006, while administrative contract costs for the Overseas Program were $21.3 million in FY 2005 and $25.3 million in FY 2006. See Appendix D for costs broken out by contract.

Objectives

Our overall audit objective was to evaluate administrative controls over the Overseas Program. Specifically, we assessed the accuracy of claims payments, the adequacy of existing price caps in the Overseas Program, and the need for additional price caps. We also reviewed internal controls related to the overall objective. See Appendix A for a discussion of the scope and methodology and prior coverage related to the objectives. See Appendix B for a discussion of the use of electronic funds transfer in the Overseas Program. See Appendix C for legislation and TRICARE policies related to the Overseas Program.

Review of Internal Controls

DoD Instruction 5010.40, "Manager's Internal Control (MIC) Program Procedures," January 4, 2006, requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the adequacy of the controls.

Scope of the Review of Internal Controls. We reviewed the internal control procedures for the Overseas Program. We specifically reviewed the accuracy of the claims payments, adequacy of price caps, and risk of fraudulent and abusive activity within the Overseas Program.

Adequacy of Internal Controls. We identified material internal control weaknesses in the Overseas Program, as defined by DoD Instruction 5010.40. TMA controls were inadequate to ensure the accuracy of claims payments or that TRICARE is not excessively billed for services rendered. Recommendations A.1. through A.7., if implemented, will reduce the likelihood of erroneous claims payments. Recommendation B.1., if implemented, will reduce excessive billing. We estimate that implementing the recommendations in this report will result in potential monetary benefits of $125.7 million during execution of the FYs 2008 through 2013 Future Years Defense Plan (see Appendix E for the Summary of Potential Monetary Benefits).

Prior Audit Report. We also identified a material internal control weakness for TMA in our first audit report on the Overseas Program. Report Number D-2006-051, "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance," February 10, 2006, found TMA controls did not adequately ensure that third-party billing agencies were properly submitting TRICARE overseas claims. In addition, TMA had not established procedures for detecting unlawful waivers of cost shares and deductibles. TMA did not agree that weaknesses identified in the prior report were material. We deferred resolution of the identified internal control weakness until issuance of this report. The combination of control weaknesses identified in this report and the first report further supports the materiality of the conditions identified. We request that the Assistant Secretary of Defense (Health Affairs) comment on the material internal control weaknesses in this final report.

A. Accuracy of Claims Payments

Government contractors responsible for processing TRICARE overseas health care claims made inaccurate payments (duplicate payments and overpayments) to host-nation providers and to TRICARE beneficiaries. The inaccurate payments occurred because claims processors lacked necessary internal controls and because TMA did not develop adequate and timely contract surveillance plans. Further, TMA needed to improve procedures used to recoup duplicate and overpayments. As a result, we estimate TMA made inaccurate payments totaling $14.6 million for overseas health care claims during FY 2004 and FY 2005. We project TMA could put $29.7 million of Defense Health Program funds to better use during the execution of the FYs 2008 through 2013 Future Years Defense Plan by strengthening internal controls, establishing sound contract surveillance plans, and improving recoupment procedures.

Contractors Processing Overseas TRICARE Claims

In August of 2004, traditional foreign-claims processing became part of the TRICARE Managed Care Support Contract, South Region. Traditional foreign claims are claims for health care provided to TRICARE beneficiaries who reside overseas in nonremote locations except for active-duty Service members and family and Medicare-eligible individuals living in Puerto Rico. Humana Military Health Services, the prime contractor for the TRICARE South Region, subcontracted its foreign-claims-processing responsibility to Wisconsin Physician Services (WPS). WPS is commonly referred to as *the* foreign-claims-processing contractor because it processes most overseas claims, approximately 687,000 out of more than 1 million claims processed per year. In addition to traditional foreign claims processed under the TRICARE South Region contract, an overseas claim may be processed under five other contracts. The type and location of the beneficiary determine jurisdiction over a specific claim. Appendix D details the claim jurisdictions and the contractors responsible for processing claims.

Accuracy of Claims Payments

Government contractors responsible for processing TRICARE overseas health care claims made inaccurate payments (duplicate payments and overpayments) to host-nation providers and to TRICARE beneficiaries. We identified and interviewed participating providers in the three TRICARE overseas regions and found claims-processing payment errors in all three. To determine the magnitude of inaccurate claims payments, we selected a statistical sample of overseas health care claims. Our statistical sample consisted of 347 episodes of overseas care (526 claims) from 39 countries with claims processed under each of the six Overseas Program processing contracts. We obtained and reviewed the provider bills submitted for each paid claim and evaluated the payment made to the provider or beneficiary for accuracy. Our statistical sample identified 24 duplicate payments and 26 overpayments. From the statistical sample results,

we estimate TMA made $14.6 million in duplicate payments and overpayments during FY 2004 and FY 2005 for health care rendered to TRICARE beneficiaries. See Appendix A for details of the statistical sample universe and methodology.

Although 72 percent of the statistically sampled claims were processed under the TRICARE South Region subcontract, we identified errors in processing under five of the six existing contracts for foreign claims processing. The errors included payment for claims with third-party liability, duplicate claims, administrative charges, and mathematical errors. We also identified payment errors resulting from contractors not applying required cost containment measures, and we identified a potential conflict of interest.

Duplicates. On the basis of the 24 duplicate payments identified in the statistical sample, we estimate TRICARE overseas-claims-processing contractors made duplicate payments totaling $7.5 million in FY 2004 and FY 2005. According to the foreign-claims-processing contractor, in FY 2005 and FY 2006, it was unsuccessful in recouping about 38 percent of the duplicate payments made. Using that recoupment rate, we project that TMA could put $1.4 million[1] of Defense Health Program funds to better use each year and $8.5 million during the execution of the FYs 2008 through 2013 Future Years Defense Plan by strengthening controls over duplicate payments. In addition to selecting our statistical sample, we chose providers to interview in Panama and Germany. Eleven of thirty-five providers and third-party billing agencies we interviewed stated they received more than 160 duplicate payments for health care services provided to TRICARE beneficiaries. After informing TMA of the possible duplicate payments, and months after our return from our visit to Panama, one of the hospitals complained of continued duplicate payments and forwarded three examples to our attention. We followed up on the largest example and found the claim was assigned four different claim numbers, processed eight times over a span of 3 years, and resulted in a duplicate payment of more than $34,000 to the provider. In April 2007 we met with representatives of the claims processor, who agreed the processing of this claim resulted in a duplicate payment totaling about $34,000 and initiated action to recoup the payment. In May 2007, TRICARE received reimbursement from the provider for the full amount.

Overpayments. On the basis of the 26 overpayments identified in the statistical sample, we estimate TRICARE overseas-claims-processing contractors made inaccurate payments totaling $7.1 million in FY 2004 and FY 2005. In addition to the inaccuracies identified through our statistical sample, a review of claims during Phase One of the audit identified overpayments by one of the overseas-claims-processing contractors that had not been previously reported. During Phase One, we provided assistance to the Defense Criminal Investigative Service, reviewing approximately 600 claims submitted by the Health Visions Corporation. We identified substantial overpayments made by one of the

[1] We divided duplicate payments of $7,496,907 (rounded to $7.5 million in the body of the report) in FY 2004 and FY 2005 by 2 years and arrived at $3,748,453.50 per year. We applied the unsuccessful recoupment percentage of 38 percent to $3,748,453.50 and arrived at $1,424,412.33 (rounded to $1.4 million in the body of the report). To obtain the 6 -year figure, we multiplied the amount by six and arrived at $8,546,473.98 (rounded to $8.5 million in the body of the report).

claims-processing contractors to Health Visions (whose former chief executive officer pleaded guilty to committing fraud against TRICARE).

Of the claims reviewed during Phase One, we identified six for which the contractor paid $197,704 even though the billed amount totaled only $36,883, resulting in overpayments totaling $160,822, or 436 percent, as shown in Table 1.

Table 1. Phase One Overpayments Identified

Claim Number	Year of Service	Amount of Claim Filed by Billing Agency	Amount Paid by TRICARE	Overpayment
2003343PH03623	2003	$ 13,933.62	$ 133,933.62	$ 120,000.00
2004056PH04142	2003	4,145.88	6,218.82	2,072.94
2004057PH01758	2003	6,323.68	12,647.36	6,323.68
2004131PH03409	2003	5,554.21	23,534.30	17,980.09
2003161PH02579	2002	5,790.51	9,402.09	3,611.58
2002277PH02593	2002	1,134.71	11,968.16	10,833.45
Total		**$ 36,882.61**	**$ 197,704.35**	**$ 160,821.74**

Internal Controls, Contract Oversight, and Recoupment Procedures

The inaccurate payments occurred because claims processors lacked necessary internal controls and because TMA did not develop adequate and timely contract surveillance plans. Further, TMA needed to improve procedures used to recoup duplicate and overpayments. Our statistical sample of 347 episodes of care (526 claims) contained 24 duplicate payments and 26 overpayments. According to the foreign-claims-processing contractor, it has experienced limited success in recouping inaccurate payments made to beneficiaries and providers: its rate was 62 percent for FYs 2005 through 2006. Moreover, none of the draft contract surveillance plans for the primary foreign-claims-processing contracts included performance measures to address the accuracy of claims payments for overseas health care.

Internal Controls. TMA needed additional internal controls to prevent overseas-claims-processing contractors from making duplicate payments and overpayments on TRICARE claims. Existing controls over duplicate payments were detective in nature rather than preventative. Moreover, additional controls were needed to reduce the likelihood of overpayments resulting from paying administrative charges that should not have been paid as well as other payment-processing errors.

Controls Over Duplicate Payments. Our statistical sample of 347 episodes of care (526 claims) identified 24 duplicate claims payments.

On the basis of these 24 payments, we estimate that the overseas-claims-processing contractors made duplicate payments totaling $7.5 million in FY 2004 and FY 2005. These duplicate payments were the result of a number of lacking internal controls and processing errors including:

- absence of an auto reject control for duplicate institutional claims,
- use of multiple provider numbers for a single provider,
- absence of a requirement that beneficiaries provide proof of payment, and
- presence of processor overrides of system controls.

Auto Reject of Duplicate Institutional Claims. Currently, the TRICARE Operations Manual requires that duplicate claims for professional charges, such as physicians' fees, be subject to automatic rejection. The foreign-claims-processing contractor did not have an automatic reject in place to prevent duplicate claims for hospital inpatient care. Instead, these claims were set aside for manual review. The claims-processing system should not allow two hospital inpatient claims for the same patient on the same date to occur; the TRICARE Operations Manual should be revised accordingly. Automatic rejects of duplicate claims for inpatient care should help prevent duplicate claims payments in the future.

Single Provider Record. Contractor system edits for duplicate claims are generally based on matching key fields, including the provider identification number. We notified TMA Officials in December 2006 of potential duplicate claims payments. As the prime contractor for the TRICARE South Region, Humana conducted its own review during the course of this audit (in March 2007) and identified 1,465 duplicate provider records in its subcontractor's processing system. The subcontractor created duplicate provider records when a provider's billing address changed or if the provider name did not have an exact match in the system. In March of 2007, Humana instructed its subcontractor to inactivate the duplicate provider numbers and use a cross-reference to a single provider record.

We reviewed databank entries for the providers we visited in the Philippines and found a provider with 14 different provider numbers. As of July 2007, nine of the numbers were still listed as active in the Purchased Care Detail Information System, the databank housing DoD claims-processing information. Table 2 demonstrates the multiple names and provider numbers used for the same facility.

Table 2. Multiple Provider Names and Numbers for St. Luke's Medical Center

Name	Provider Number	Status of Number
St. Luke's Medical Center	PHA000151	Active
St. Luke's Medical Center	PHL003611	Active
St. Luke's Medical Center Inc.	PHL041046	Active
St. Lukes Hosp. Professional	PHL000749	Inactive
St. Lukes Hospital	PHA000134	Active
St. Lukes Medical Center	PHL001006	Active
St. Lukes Medical Center	PHL001643	Active
St. Lukes Medical Center	PHL002514	Inactive
St. Lukes Medical Center	PHL002852	Inactive
St. Lukes Medical Center	PHL003184	Inactive
St. Lukes Medical Center	PHL007128	Active
St. Lukes Medical Center	PHL009280	Inactive
St. Lukes Medical Center	PHL042027	Active
St. Lukes Medical Center Inc.	PHL003483	Active

We do not believe there are valid reasons for having more than one provider number. Limiting providers to a single provider number should help prevent duplicate payments and should help the claims processor identify any duplicate payments made.

Beneficiary Receipts. Requiring that beneficiaries submit proof of payment when seeking reimbursement from TRICARE should help ensure beneficiaries are paid only after they have paid the provider. Claims under investigation are disproportionately those submitted by overseas beneficiaries. According to the TMA Program Integrity Office, 1,503 TRICARE beneficiaries located overseas are under suspicion of submitting fraudulent TRICARE claims, compared with only 134 beneficiaries in the continental United States. TMA officials did state that the percentage of beneficiaries who submit their own claims is much higher overseas than in the continental United States. However, neither the TMA manuals (Policy, Operations, and Reimbursement) nor the contract specifications for the overseas-claims-processing contractors require overseas beneficiaries to submit proof of payment with their claims when seeking direct reimbursement.

Generally, the claim form submitted determines whether the provider or the beneficiary receives payment. According to TMA and

contractor representatives, the DD[2] Form 2642 is a claim form designed to be used by the beneficiary, whereas the UB[3] 04 (previously UB 92) and CMS[4] 1500 (previously HCFA[5] 1500) forms are designed to be used by providers. Thus, generally when a DD Form 2642 is used, the claims processor sends the payment to the beneficiary. However, the TRICARE Policy Manual states that the claims processor, regardless of the type of form used, should send health care payments directly to providers in Europe unless otherwise indicated on the claim. Although beneficiaries must attach a provider statement supporting the charges, there is no requirement to show proof of payment. This practice may have contributed to instances of payments to beneficiaries when payments should have been made to the providers. For seven claims in our statistical sample, processors paid both the beneficiary and the provider. Through discussions with TRICARE officials in Europe, we learned of approximately 460 claims that were incorrectly paid to the beneficiaries. According to TMA officials, these incorrect payments occurred because of a systems problem; however, had these claims been submitted with receipts, the claims processors might have been alerted to the systems problem before payment. According to the U.S. Army European Regional Medical Command, payment delays to providers may reduce access to care if providers are no longer willing to treat TRICARE beneficiaries. Our statistically sampled claims included 50 payments to beneficiaries, yet only 23 beneficiaries (46 percent) submitted receipts with those claims.

Requiring receipts will help ensure providers are reimbursed, potentially improving beneficiary access to care. If providers are forced to write off amounts due from TRICARE patients because of nonpayment, providers may be less willing to treat TRICARE patients in the future. Requiring receipts may increase provider willingness to see TRICARE patients and help lower the risk of improperly reimbursing beneficiaries.

Limitations on Processor Overrides. Processors paid eight claims in our statistical sample twice because the processor of the claim had the ability to override system edit checks for duplicate claims for professional services. Processors were not comparing actual claim documentation and were making payment decisions based on summary data. We identified multiple claims for the same services billed at different amounts. System edit checks had identified these claims as possible duplicates, but the claims processor had paid the claims anyway, after overriding the system control. Currently, the TRICARE Policy Manual requires review only of inpatient hospital claims exceeding $10,000 and professional service claims exceeding $5,000 for medical necessity. We believe override capability should be limited to supervisory personnel. At a minimum, override exception reports should be generated and reviewed by management regularly.

[2] Department of Defense.

[3] Uniform Business.

[4] Centers for Medicare & Medicaid Services.

[5] Health Care Financing Administration.

Controls to Prevent Overpayments. Our statistical sample of 347 episodes of care (526 claims) identified 26 overpayments. On the basis of the 26, we estimate that the overseas-claims-processing contractors made inaccurate payments totaling $7.1 million in FY 2004 and FY 2005. These erroneous payments were also made due to lacking internal controls and processing errors, including:

- absence of specific guidance for payment of administrative charges and other fees,
- misinterpretation of foreign claims,
- absence of cost containment for overseas health care provided to TRICARE beneficiaries,
- a potential conflict of interest,
- mathematical errors, and
- payment of value-added taxes on exempt medical services.

Specific Guidance for Administrative Charges and Other Fees. Claims processors inappropriately paid administrative charges and fees on 19 of the 526 overseas health care claims in our sample. These charges were typically included in the charge for the procedure code billed to TRICARE. Administrative charges paid included costs for use of the telephone, admission and discharge fees, accompanying person fees, charges for private rooms, and currency exchange fees. Current TRICARE policy states administrative charges listed separately on foreign claims are to be denied for payment. Neither TMA nor any of the contractors interviewed could produce a list of administrative charges that should not be paid on foreign claims. Policy and contractor work instructions should be clarified to include specific examples of what constitutes an acceptable administrative charge.

Interpretation of Foreign Claims by Specialists. Three of the overpayments in the statistical sample occurred because the claims processor was not carefully reviewing and translating the claims. For example, a German provider sent a corrected bill along with a bill marked "cancelled/credit." The processor accepted the claims as two distinct bills and paid both. In addition, two German claims in our statistical sample contained procedure codes that the German social health care system does not permit to be billed together (meaning one of the codes incorporates the services of the other). During the audit, the foreign-claims-processing contractor implemented a control to route claims from specific countries to processors knowledgeable of country billing practices. Before implementing this control, claims were routed to processors on a first-in, first-out basis. This control should help reduce payment inaccuracies.

Cost Containment. The TRICARE Global Remote Overseas (TGRO) contractor was not applying cost containment measures required by its contract. The TGRO contract provides TRICARE coverage to active duty personnel and their family members residing in remote overseas locations. TMA policy for payment of foreign claims is generally to pay the billed charges. However, the TGRO contract specifically requires the contractor to negotiate fee schedules with network providers. If fee schedules cannot be negotiated, the contractor is to limit the reimbursement to the CHAMPUS[6] maximum allowable charge[7] for the Washington, D.C., area, unless extenuating circumstances exist. According to TMA General Counsel, the fact that the health care services are provided in a remote location does not constitute extenuating circumstances because the entire contract covers remote overseas locations.

Our statistical sample included 36 paid TGRO claims. No documentation was submitted with any of the claims to substantiate extenuating circumstances. Of the 36 paid claims, we were able to review 17 for cost containment by requesting and reviewing the provider fee schedule. For claims related to outpatient services for which we did not receive a fee schedule, we compared the billed charges with the CHAMPUS maximum allowable charges for the Washington, D.C., area. Three of the claims exceeded the provider fee schedule; 6 claims exceeded the CHAMPUS maximum allowable charge for the Washington, D.C., area; and 19 claims could not be reviewed because either the services billed were inpatient services (the contract does not address cost containment for inpatient services) or the claim was improperly coded by the contractor, and we could not determine which CHAMPUS maximum allowable charge to apply. For our statistical estimates, we treated those 19 claims as though they were processed correctly, and our estimates are therefore conservative. Finding B addresses the adequacy of the provider fee schedules.

Review for Conflict of Interest. We also identified a potential conflict of interest. The statistical sample included a claim processed by the TGRO contractor submitted by a clinic owned by the TGRO contractor. The contract statement of work requires the TGRO contractor to manage case referrals for TRICARE beneficiaries as well as to provide cost containment. We searched the TGRO contractor's Web site and the TMA claims database and found $2.9 million in claims payments made to 21 facilities owned by the contractor from FYs 2004 through 2007. This potential conflict of interest should be reviewed by TMA officials to ensure the contractor is performing its fiduciary duties as a Government contractor.

[6] The TRICARE program was formerly referred to as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

[7] A CHAMPUS maximum allowable charge is a maximum reimbursement rate that applies to a procedure for a given locality in the United States or Puerto Rico.

Checks for Mathematical Errors. The statistical sample identified three claims that had errors in currency conversions or errors in provider bills not caught by the claims processors. In addition to errors on claims in the statistical sample, we identified mathematical processing errors totaling $160,822 during Phase One of the audit. One processor added an extra digit to the amount paid, increasing the payment from $13,933 to $133,933. We believe these errors further support the need to implement performance standards for claims accuracy to reduce such erroneous payments.

Country-Specific Policies on Value-Added Taxes. By reviewing the provider bills supporting the claims in our statistical sample, we identified 12 claims for which the claims processors paid taxes. These charges were typically included in the charge for the procedure code billed to TRICARE. Processors made payments for value-added tax in Spain, where medical services are exempt from tax. For our statistical projections, we considered the payment of taxes appropriate in other countries.

In countries such as Germany, billings for value-added tax on health care services are complex. Durable medical equipment is taxed at 7 percent, while pharmaceuticals and medical services are taxed at rates as high as 19 percent, except for private hospitals in certain instances. In Germany, billing for value-added taxes on medical services is appropriate if the care is provided in a facility with more than a 60-percent private patient workload. We do not expect U.S. claims-processing contractors to be knowledgeable about public and private hospitals in Germany or the attributes of their patient workload, but believe TMA should seek modification of the Status of Forces Agreement to exempt health care services provided to TRICARE patients from value-added taxes. Currently, purchases of goods and services by our active-duty Service members stationed in Germany are exempt from value-added taxes.

A Status of Forces Agreement (SOFA) is an agreement between the United States and a foreign country in which the United States stations military forces. A SOFA is intended to clarify the terms under which the military is allowed to operate. A SOFA is concerned with the legal issues associated with military individuals and property, such as entry into and exit from the country, tax liabilities, postal services, and civil and criminal jurisdiction over military bases. TRICARE could reduce overseas health care costs by seeking exemption from value-added taxes for health care provided to TRICARE beneficiaries. We brought this option to the attention of TMA on April 11, 2007. As a result, TMA is exploring modification of the SOFA with Germany to exempt TRICARE claims payments from German value-added taxes.

Contract Oversight. TMA did not establish contract surveillance plans for three of its six contracts for processing overseas health care claims until well after the contracts were awarded, including the primary contract for overseas claims

processing. Further, these three surveillance plans were in draft form and not finalized as of August 2007. A quality assurance surveillance plan is used to measure contractor performance and to ensure that the Government both receives the quality of services called for under the contract and pays only for the acceptable level of services received. As shown in Table 3, more than 3 years passed before TMA developed a surveillance plan for the foreign-claims-processing contract.

Table 3. Contract Award and Surveillance Plan Dates

Contract	Award Date	Date of Draft Quality Assurance Surveillance Plan
TRICARE South Region (Subcontract)	September 2003	June 2007
TGRO	December 2002	October 2006
TRICARE Puerto Rico	February 2004	May 2006

Further, the limited contract performance measures we were able to identify in the draft plans assessed either the quality of care provided (for example, how quickly a call for referred care was answered) or the speed with which a claim was processed. Performance measures did not address the accuracy of contractor payments.

The TRICARE Operations Manual, Chapter 1, Section 3, includes a standard for accurate payment of TRICARE claims. The standard states that the absolute value of payment errors shall not exceed 2 percent of the total billed charges. This standard is reiterated in the TRICARE South Region contract (performance guarantee section), stating that erroneous payments from a sample selection for TMA quarterly audit shall not exceed 2 percent. According to the contract, if the 2-percent error rate is breached, the Government may withhold 10 percent of the value of payment errors in excess of the 2-percent standard. However, foreign claims are not included in the TMA assessment of the contractor's performance. Inclusion of foreign claims may help detect lacking internal controls and prevent future erroneous payments. Although our sample projections cannot be applied to individual contractors, the error rate in our statistical sample was approximately 11 percent.

Recoupment Procedures. The Overseas Program has had limited success recouping overpayments. In FYs 2005 and 2006, TMA was successful in recouping only 62 percent of inaccurate claims payments. Data provided by the largest processor of overseas health care claims for the Overseas Program show that, from FYs 2005 through 2006, $1.12 million in inaccurate payments was identified, yet only $0.7 million was recouped from TRICARE beneficiaries or providers. Further, TMA has not used offsets in Europe (where 53 percent of overseas TRICARE beneficiaries reside) to assist in reclaiming erroneous

payments from providers. Offsets allow the contractor to deduct amounts owed by providers from future claims payments.

The use of offsets in Europe could significantly improve the Overseas Program's recoupment rate. TRICARE Officials in Europe expressed concern that the accounting systems of third-party billing agencies in Europe cannot accommodate the use of offsets. In Germany, third-party billing agencies provide payment upfront to providers for their health care claims, typically less a small percentage for the third-party billing agency's services. TRICARE Officials in Europe maintain that the German health care system imposes liability for outstanding health care payments on the recipient instead of on the provider. Therefore, if an offset is used against a German provider who uses a third-party billing agency, the patient could remain liable to the third-party billing agency for payment. However, in our first report on the Overseas Program, Report Number D2006-051, dated February 10, 2006, "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance," we recommended that TMA stop forwarding claims payments to third-party billing agencies. Sending claims payments to providers instead of to third-party billing agencies in Europe may alleviate the accounting problem in Europe. Because the majority of overseas beneficiaries reside in Europe, implementing offsets for TRICARE claims from Europe could significantly improve the Overseas Program's recoupment rate.

Conclusion

We estimate that TMA made inaccurate payments totaling about $14.6 million for overseas health care claims during FYs 2004 and 2005. On the basis of the statistical sample, we estimate that TMA made $7.5 million in duplicate payments and $7.1 million in overpayments during FYs 2004 and 2005 for overseas TRICARE claims. TMA could reduce the risk of making these inaccurate payments by ensuring the contractors processing overseas claims have adequate internal controls that would prevent duplicate and other overpayments. Further, establishing and implementing contract surveillance plans that include payment accuracy standards and measurements should also reduce the risk of erroneous payments. Additionally, using offsets in Europe should help TMA recoup funds from providers that have received duplicate or overpayments. By strengthening internal controls, establishing sound contract surveillance plans, and improving recoupment procedures, we project that TMA could put about $4.95 million of Defense Health Program funds to better use each year and $29.7 million during execution of the FYs 2008 through 2013 Future Years Defense Plan.

Duplicate payments and overpayments made through the Overseas Program may need to be reported in accordance with Public Law 107-300, "Improper Payments Information Act of 2002," November 26, 2002. According to the Act, improper payments totaling 2.5 percent of program payments or totaling $10 million annually must be included in the Annual Performance and Accountability Report to the President and Congress. For those payments exceeding $10 million annually, the agency head must also provide a report discussing the cause of the improper payment(s) and the step(s) taken to hold agency managers accountable for reducing future improper payments.

Recommendations, Management Comments, and Audit Response

A. We recommend that the Director, TRICARE Management Activity:

1. Revise Chapter 12 of the TRICARE Policy Manual to require at a minimum:

a. Use of a single identification number for foreign providers.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred and stated TMA has taken steps to eliminate multiple identification numbers.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

b. Automatic rejects for duplicate claims for hospital inpatient charges.

Management Comments. The Assistant Secretary of Defense (Health Affairs) nonconcurred. He stated that automatic rejects may incorrectly deny claims that involve patients who have been transferred to another department within a hospital or to another hospital. In technical comments to the finding, the Assistant Secretary stated that this does not occur often. Additionally, the Assistant Secretary stated that none of the TRICARE domestic claims subcontractors used an automated system to reject duplicate inpatient institutional claims. The Assistant Secretary stated that the foreign-claims-processing contractor has implemented steps to reduce the likelihood of duplicate payments.

Audit Response. The Assistant Secretary's comments are nonresponsive. According to the Assistant Secretary, inpatient transfers do not occur often. We do not believe the exception should dictate the rule. Use of an automatic edit reject would not prevent the contractor from paying legitimate claims; however, it should require supervisory review. Although TMA does not use auto rejects for hospital inpatient claims, it uses them for professional services. Lastly, during our audit, we discovered that one of the three primary contractors that process overseas claims had such an edit check in place. Therefore, we request that the Assistant Secretary reconsider his position on the recommendation to revise Chapter 12 of the TRICARE Policy Manual and provide additional comments in response to the final report.

c. Limitations on overrides of duplicate edit checks.

Management Comments. The Assistant Secretary of Defense (Health Affairs) nonconcurred. He stated, however, that steps have been taken to minimize the use of overrides, including daily reviews, modification of instructions, and training.

Audit Response. Although the Assistant Secretary did not agree with the recommendation, the actions he outlined in the comments meet the intent of the recommendation.

d. Proof of payment for beneficiary claims.

Management Comments. The Assistant Secretary of Defense (Health Affairs) nonconcurred. He stated that requiring receipts would cause problems because some providers do not provide proof of payment, and it is difficult to determine the validity or accuracy of the proof of payment. Moreover, he said, beneficiaries in the United States are allowed to submit claims without proof of payment.

Audit Response. The Assistant Secretary's comments are nonresponsive. We agree that proof of payment cannot be limited to receipts from host-nation providers. Proof of payment could include a beneficiary's cancelled check or a credit card statement. We reviewed Federal Employee Health Benefits Program brochures and found three companies--Aetna, Optima Health, and M.D. IPA--that required beneficiaries to submit proof of payment prior to reimbursement for overseas health care claims. Further, we disagree with the statement that beneficiaries in the United States do not have to submit proof of payment. TRICARE requires active-duty Service members stationed overseas who receive health care within the United States to submit proof of payment with claims when seeking reimbursement. In addition, TRICARE requires its beneficiaries to submit proof of payment for claims for pharmacy items purchased in the United States. We share the Assistant Secretary's concerns about determining the validity of receipts; however, requiring proof of payment should help discourage beneficiaries from seeking reimbursement when they did not pay the claim. If beneficiaries are reimbursed and do not pay providers, these providers may cease to provide care for TRICARE beneficiaries, resulting in reduced access to care. We therefore request that the Assistant Secretary reconsider his position on the recommendation to revise Chapter 12 of the TRICARE Policy Manual and provide additional comments in response to the final report.

e. Use of offsets in Europe.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred and stated that TRICARE began using offsets in Europe in October 2007 and will update the TRICARE Policy Manual, Chapter 12, to reflect this change.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

f. Clarification of unacceptable administrative charges on foreign claims.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred and stated that the Contracting Officer provided the foreign-claims-processing contractor with guidance on processing administrative fees. He said further clarification will be provided in an updated TRICARE Policy Manual, Chapter 12.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

2. Direct use of the UB 04 (previously UB 92) and HCFA 1500 provider forms for claim submissions from European providers.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that universal claim forms will be required for all provider submissions with the follow-on overseas contract.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

3. Establish surveillance plans for each overseas-claims-processing contract, and include in each plan performance measurements and incentives based on the accuracy of claims payments.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating plans are currently in place or are being finalized.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

4. Review activities performed by the TRICARE Global Remote Overseas contractor to determine whether its ownership of facilities providing health care to TRICARE beneficiaries constitutes a conflict of interest.

Management Comments. The Assistant Secretary of Defense (Health Affairs) neither concurred nor nonconcurred. The Assistant Secretary stated that both the Contracting Officer and the Office of General Counsel have concluded that, although there is no personal or organizational conflict of interest, there is the appearance of a potential general conflict of interest. The Contracting Officer will work with the TRICARE Global Remote Overseas contractor to mitigate the appearance of a conflict of interest and will address these concerns in the follow-on TRICARE Overseas contract.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

5. Coordinate with the Office of General Counsel and take action to exempt TRICARE payments from value-added taxes in Germany and other countries as deemed appropriate.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that TRICARE has been added to the list of agencies allowed to obtain a value-added tax exemption and is working to satisfy local requirements of eligibility and documentation.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

6. Send notifications to all overseas processing contractors of updates to Status of Forces Agreements regarding payment of value-added taxes for health care services.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that TMA would evaluate the best mechanism to exempt its health care from value-added taxes. The Assistant Secretary further stated it is unlikely that any SOFA updates will be required.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

7. Determine reporting requirements under the Improper Payments Act for payment inaccuracies by the Overseas Program.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that the Defense Contract Audit Agency was scheduled to determine the agency's reporting requirement under the Improper Payments Act in the fall of 2007.

Audit Response. Although the Assistant Secretary concurred, his comments are partially responsive. We believe that having the Defense Contract Audit Agency perform regular audits is a good initiative to report future results to satisfy the Improper Payments Act. However, the Assistant Secretary's comments did not address the duplicate payments and overpayments cited in this report and whether they will be reported under the Improper Payments Act. We request that the Assistant Secretary provide additional comments in response to the final report.

Additional Comments and Audit Response

Management Comments. The Assistant Secretary of Defense (Health Affairs) tasked Humana Military Health Services to review the claims payment discrepancies cited in our report. The Assistant Secretary provided Humana's comments in a separate e-mail. Humana did not agree that certain claims were duplicate payments or overpayments. Humana disagreed with 42 of the 50 claims. Of the 24 duplicate payments, Humana stated that 19 were not duplicates. Of the 26 overpayments, Humana stated that 23 were not overpayments.

Auditor Response. We identified 24 duplicate payments and 26 overpayments in our statistical sample. During our review, we considered any claim paid more than one time, even if later recouped, to be a duplicate payment. The audit team verified each of these claims with WPS personnel during a 2-week site visit. Having reviewed Humana's comments, we stand by our results. If additional meetings are needed to further discuss these claims, we are willing to attend.

Based on information provided by management regarding the contractor's collection of duplicate payments, we reduced the potential monetary benefits associated with duplicate payments. We reduced the potential monetary benefits associated with duplicate payments from $22.5 million to $8.5 million, by applying the historical recoupment rate

provided by the foreign-claims-processing contractor. Consequently, we lowered the total potential monetary benefits for finding A from $43.8 million to $29.7 million.

The Assistant Secretary of Defense (Health Affairs) did not indicate concurrence or nonconcurrence with the potential monetary benefits in relation to the finding. We request that the Assistant Secretary of Defense (Health Affairs) comment on the potential monetary benefits in the final report.

B. Price Caps on Payments of Claims for Professional Services and Hospital Inpatient Charges

TMA has price caps on claims payments for health care in the Philippines and Puerto Rico. TMA plans to revise the Philippines price caps and implement price caps in Panama. We believe TMA could further control health care costs by:

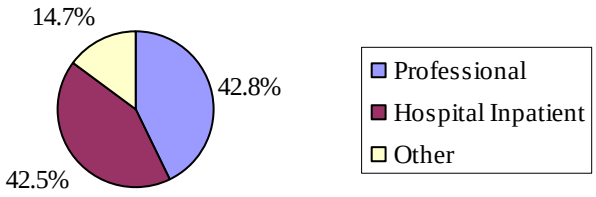
- establishing price caps for professional services and hospital inpatient claims in countries with a high dollar value of claims payments and countries that have significant increases in health care costs,
- ensuring that all TRICARE claims, including TRICARE Global Remote Overseas claims, submitted in each country are subject to the same price caps, and
- implementing price caps in Guam and the U.S. Virgin Islands that are based on those used by the Centers for Medicare & Medicaid Services.

Proceeding with the price cap initiatives in the Philippines and Panama and expanding similar price caps in other countries could result in TMA annually putting at least $16 million of Defense Health Program funds to better use, totaling $96 million during the execution of the FYs 2008 through 2013 Future Years Defense Plan.

Overview

TRICARE Reimbursement Criteria. The Code of Federal Regulations, Title 32, Part 199.14, "Provider Reimbursement Methods," establishes guidelines for paying providers for health care rendered in the United States and Puerto Rico. Chapter 12, Section 10.1, of the TRICARE Policy Manual, 6010.54-M, August 1, 2002, states that, with the exception of the Philippines, Puerto Rico, and prescription drugs in Panama and Costa Rica, the reimbursement of overseas claims for health care is to be based on billed charges. In addition, the Director of TMA "shall determine the appropriate reimbursement method or methods to be used in the extension of [TRICARE] benefits for otherwise covered medical services or supplies provided by hospitals or other institutional providers, physicians or other individual professional providers, or other providers outside the United States." The policy manual states that claims for care in Puerto Rico are to be reimbursed following guidelines for the continental United States. Chapter 6, Section 4, of the TRICARE Reimbursement Manual requires that claims filed for services in Puerto Rico follow a payment system using diagnostic-related groups for the reimbursement of hospital inpatient claims.

Types of Claims. Claims generally cover one of three categories: professional services, hospital inpatient charges, or claims for other charges. A professional services claim includes a physician's fees for performing certain procedures. A claim for hospital inpatient charges includes the use of hospital facilities, equipment, and supplies. In addition to claims for professional services and hospital inpatient charges, other claims may include charges for pharmaceuticals, durable medical equipment devices, and other items. We reviewed only claims for professional services and hospital inpatient charges. A provider, hospital, beneficiary, or third-party billing agency may submit a claim for professional services, hospital inpatient charges, or charges that fall in the other category. Total health care costs for the Overseas Program were $210.9 million in FY 2006. The figure below shows that 85 percent of the claims paid in FY 2006 were for professional services and hospital inpatient claims according to WPS, the TRICARE overseas contractor.



Overseas Claims Paid in FY 2006

Overseas Program Health Care Costs

Despite TMA's initiatives, Overseas Program health care costs continue to rise in selected countries. TMA has implemented several controls that limit payments on Overseas Program claims for professional services and hospital inpatient charges.

- In February 2004, TMA modified the TRICARE Policy Manual to implement price caps on Philippine professional services using price caps in place at the time in Puerto Rico.

- In September 2004, TMA initiated a per diem reimbursement system in the Philippines that limited payment for inpatient hospitalization charges to a fixed daily rate (per diem) based on the patient's diagnosis.

- In January 2007, the Assistant Secretary of Defense (Health Affairs) approved the implementation of revised price caps for professional services and hospital inpatient charges for the Philippines and established price caps on professional services and hospital inpatient charges in Panama. The price caps were anticipated to be in place by January 1, 2008.

We applaud TMA for taking actions to control health care costs by revising price caps in the Philippines and implementing price caps in Panama. We believe that TMA should also implement price cap controls on claims for professional

services and hospital inpatient charges in other countries with a high dollar value of claims payments and in countries with significant increases in health care costs. According to TMA claims data, payments rose significantly during the past few years in several countries. Table 4 shows nine countries with significant increases in amounts paid from FYs 2003 through 2006.

Table 4. Countries With Significant Increases in Claims Amounts Paid
(FYs 2003 through 2006)*

Country or Territory	Value of Total Paid Claims				Percent Change, FYs 2003 Through 2006
	FY 2003	FY 2004	FY 2005	FY 2006	
Brazil	$88,587	$124,120	$310,850	$410,592	363.5%
Germany	62,583,848	73,338,685	83,145,687	81,328,852	30.0
Korea, Republic	1,641,966	1,992,484	2,612,197	3,549,822	116.2
Mexico	1,246,945	2,044,245	3,120,246	2,086,120	67.3
Singapore	603,605	1,642,666	2,278,501	2,013,790	233.6
Spain	588,295	701,944	990,051	1,012,009	72.0
Thailand	482,777	904,079	1,202,991	1,356,078	180.9
United Kingdom	6,390,809	8,248,498	11,503,054	13,037,387	104.0
U.S. Virgin Islands	482,820	915,532	1,635,761	1,550,896	221.2

*Data were obtained in July 2007.

Table 4 shows that paid claims in Singapore and the U.S. Virgin Islands both increased by more than 200 percent from FY 2003 through FY 2006. While eight of the nine locales in Table 4 had payments of more than $1 million in FY 2006, other countries with payments of less than $1 million have seen significant increases. For example, paid claims increased by more than 350 percent in Brazil from FY 2003 through FY 2006. While claims payments for care received in these countries may appear small, payments may exceed $1 million annually in the near future. The amount paid as shown in Table 4 may appear to have fallen in some locales in FY 2006, as it did in the U.S. Virgin Islands; however, these data cover only part of FY 2006 because the information was obtained as of July 2007, and providers and beneficiaries had another 3 months to submit claims for FY 2006 care. Other countries also showed increases from FY 2003 through FY 2005. For example, paid claims in Mexico and Thailand increased by about 150 percent from FY 2003 through FY 2005.

Additional Controls Needed Over Health Care Costs

Implementing price caps on claims for professional services and hospital inpatient charges could result in TMA annually putting at least $16 million of Defense Health Program funds to better use, totaling $96 million during the execution of

FYs 2008 through 2013 Future Years Defense Plan.[8] TMA has price caps on professional services and hospital inpatient charges in the Philippines and Puerto Rico. In addition, it has plans to revise price caps for the Philippines and implement price caps for Panama. TMA could further control health care costs by:

- implementing professional services price caps in the Philippines and Panama as planned and in other countries,
- implementing hospital inpatient price caps in the Philippines and Panama as planned and in other countries,
- ensuring that the same price caps within each country are applied to all claims, including TRICARE Global Remote Overseas claims, and
- developing and implementing price caps in Guam and the U.S. Virgin Islands using price caps established by the Centers for Medicare & Medicaid Services.

Price Caps on Professional Services. By implementing professional services price caps in seven countries, TMA could annually put at least $9 million of funds to better use. TMA limits professional services in Puerto Rico and areas within the United States to the lesser of billed charges or CHAMPUS maximum allowable charges. A CHAMPUS maximum allowable charge is a maximum reimbursement rate that applies to a procedure for a given locality in the United States or Puerto Rico. TMA began using the Puerto Rico CHAMPUS maximum allowable charges to reimburse claims for professional services in the Philippines in February 2004.

TMA maintains a national CHAMPUS maximum allowable charge list that contains the average reimbursements for more than 7,000 procedures. Many of these amounts are derived from price caps developed by the Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services administers the Medicare program and provides health insurance to individuals age 65 or older, individuals with certain disabilities, and individuals with end-stage renal disease. The TMA January 2007 price caps on claims for professional services in the Philippines and Panama are based on the average of existing price caps on professional services in the United States (national CHAMPUS maximum allowable charge averages) converted using a country-specific cost of living factor: the World Bank's purchasing power parity (PPP) index. According to the World Bank, the PPP is defined as "the number of currency units required to purchase the amount of goods and services equivalent to what can be bought with one unit of the currency of the base country, for example the U.S. dollar."[9] The

[8] Savings for professional services were based on the top 20 procedures (those with the highest allowable amounts) for the seven countries with the highest claims amounts paid. Total savings for hospital inpatient charges were calculated for the seven countries with the highest PPP-indexed savings. We obtained data for FYs 2004 through 2006 from TMA in July 2006. Claims can be submitted up to 1 year after the date of service. Therefore, the data cover all of FY 2004 and parts of FYs 2005 and 2006. As a result, our potential monetary benefits are conservative.

[9] World Bank International Comparison Program 2003-2006 Handbook.

World Bank created the PPP index to allow individuals to compare the prices of the same items in more than 150 countries. TMA plans to implement the CHAMPUS maximum allowable charges in the Philippines and Panama over 2 years to give host-nation providers time to adjust to the reimbursement rates.

Table 5 shows the difference between what was allowed and what would have been allowed if the PPP index had been used on professional services from the start of FY 2004 through July 2006 in selected countries for certain procedures.[10,11]

Table 5. Difference Using PPP-Indexed CHAMPUS Maximum Allowable Charges[1] for the Top 20 Procedures in Selected Countries
(FY 2004 through July 2006)[2]

Country	Actual Allowed Charges	Allowed Charges Using PPP CMAC[3]	Difference Using PPP CMAC[4]	Difference as a Percent of Actual Allowed Charges
Germany	$74,943,261	$49,460,609	$25,482,652	34.0%
Italy	2,734,983	1,225,012	1,509,971	55.2
Mexico	821,983	296,333	525,650	63.9
Panama	4,481,168	1,728,903	2,752,265	61.4
Philippines[5]	2,265,226	1,138,101	1,127,125	49.8
Singapore	1,066,867	265,100	801,767	75.2
United Kingdom	6,129,765	2,129,831	3,999,934	65.3
Total	**$92,443,253**	**$56,243,889**	**$36,199,364**	**39.2%**

[1]We did not include TRICARE Global Remote Overseas claims in this analysis because the TRICARE Global Remote Overseas contractor was not using full procedure coding and would skew the calculation of potential monetary benefits. We did not include U.S. territories in the analysis.

[2]We obtained data for FYs 2004 through 2006 from TMA in July 2006. Claims can be submitted up to 1 year after the date of service. Therefore, the data cover all of FY 2004 and parts of FYs 2005 and 2006. As a result, our calculations are conservative.

[3]PPP-indexed CHAMPUS maximum allowable charges.

[4]We calculated the difference by first determining the PPP value for each country (by multiplying the national reimbursement rate by the PPP country index supplied by the World Bank's International Comparison Program). We then compared the PPP value with the TRICARE-allowed amount for each procedure.

[10] The claims data provided by TMA did not provide the amount paid for a particular procedure code; however, the data did provide the amount that TRICARE allowed. The allowed amount may be reduced by other factors, such as the share that the beneficiary must pay. After deductions are made from the allowed amount, TRICARE pays the difference. Therefore, we reduced the allowed amount by the full 25 percent beneficiary cost share to determine a conservative amount of funds that TMA could put to better use.

[11] We selected the top seven countries with the highest amounts paid. The top 20 procedure codes varied among the seven countries based on the procedures with the highest charges allowed by TRICARE.

[5]Because TMA implemented price caps on professional services in the Philippines in February 2004, the analysis was performed only on claims submitted on or after February 2004.

Because Table 5 shows the difference for only the top 20 procedures in each of the top seven countries, the potential monetary benefits should be even greater than shown. As seen in Table 5, TMA could have reduced the TRICARE-allowed amounts by at least 39 percent. In fact, TMA could have reduced the allowed amounts in five of the seven countries by more than 50 percent. The difference of $36 million shown in Table 5 is based on allowed charges.[12] Assuming that beneficiaries paid the full 25-percent cost share for all charges, TMA could have realized potential monetary benefits of at least $27 million in paid claims during a 3-year period; therefore, by implementing professional services price caps, annually TMA could put more than $9 million of funds to better use. In addition, these price caps theoretically could have reduced the beneficiaries' out-of-pocket expenses by lowering their cost shares.

Revised Price Caps for Professional Services in the Philippines. The changes TMA proposes to the price caps for professional services in the Philippines should result in prices that more realistically reflect the costs of health care. During our prior audit of the Overseas Program, we noticed that claims payments made for health care in the Philippines rose from $2.87 million in FY 1998 to $64.19 million in FY 2003, while the number of beneficiaries remained stable. In February 2004, TMA began limiting claims in the Philippines for professional health care services, such as doctor visits, using the already established Puerto Rico CHAMPUS maximum allowable charges. However, the costs of health care in the Philippines are substantially lower than in Puerto Rico. According to the World Health Organization, the cost for a 20-minute doctor's office visit at a health center in the Philippines is between $7.46 and $8.11, compared with the Puerto Rico CHAMPUS maximum allowable charge of $43.94 for a similar visit.[13] Applying the planned professional fee schedule in the Philippines, converted using the PPP, should eliminate the disparity. The proposed PPP-indexed CHAMPUS maximum allowable charge in the Philippines would lower the reimbursement from $43.94 to $13.63 in the second year of implementation. Table 6 compares claims payments for the five most commonly performed surgical procedures in the Philippines from FYs 2004 through 2006.

[12] We obtained data for FYs 2004 through 2006 from TMA in July 2006. Claims can be submitted up to 1 year after the date of service. Therefore, the data cover all of FY 2004 and parts of FYs 2005 and 2006. As a result, our potential monetary benefits are conservative.

[13] The Puerto Rico CHAMPUS maximum allowable charge as of January 1, 2007.

Table 6. Fees for Top 5 Most Frequently Performed Philippine Surgical Procedures: Comparing Puerto Rico CHAMPUS Maximum Allowable Charges and PPP-Indexed CHAMPUS Maximum Allowable Charges
(as of January 1, 2007)

Procedure	Puerto Rico CMAC*	PPP-indexed CMAC
Incision and drainage of abscess	$75.90	$18.80
Destruction by any method of lesions	50.13	12.66
Destruction by any method of warts	67.20	17.51
Insertion of intraperitoneal cannula	107.24	25.16
Hemodialysis	59.03	13.49

*CHAMPUS maximum allowable charge

As shown in Table 6, Puerto Rico reimbursement amounts are significantly higher than the PPP-indexed Philippine-specific amounts for the procedures shown.

Price Caps on Professional Services in Panama. In January 2007, the Assistant Secretary of Defense (Health Affairs) approved a plan to institute new professional services price caps in Panama using the PPP method. The new amounts are anticipated to be effective in January 2008. We agree with the plan to implement professional services caps in Panama.

Our statistical sample included eight Panama claims for professional services that were submitted with procedure codes. All eight of the claims had charges that exceeded the CHAMPUS maximum allowable charges for the Washington, D.C., area by a total of $6,481.22 (61 percent). According to the World Bank's PPP index for Panama, Panama health care costs should be 40 percent less than costs in the United States. Setting price caps using the PPP index would more accurately align the reimbursement amounts. During a visit to Panama, we obtained a price list from one of the three primary hospitals providing care to TRICARE beneficiaries. Thirty of the forty-five professional service prices we reviewed were higher than the Washington, D.C., TRICARE reimbursement amounts. For example, the Panama hospital price list stated that an electrolyte panel costs $43.18, whereas this procedure is reimbursed at only $11.26 according to CHAMPUS maximum allowable charges for Washington, D.C. The price list also stated that an x-ray exam of the spine costs $106.68, whereas this procedure is reimbursed at only $77.00 using the Washington, D.C., maximum allowable charges.

Additionally, claims data (excluding claims for active duty personnel in overseas remote locations under the TRICARE Global Remote Overseas contract) show that TRICARE has allowed charges for 15-minute doctor's office visits that far exceed what is normal and customary for Panama. The World Health Organization reported that a similar office visit there should cost between $25 and $28. Table 7 shows the ranges TRICARE allowed for 15-minute office visits provided from FY 2004 through July 2006.

Table 7. Reimbursement for an Intermediate Doctor's Office Visit of 15 minutes in Panama, FY 2004 Through July 2006[1]

Allowed Range	Number of Procedures	Percent of Procedures[2]
$0.01 to $39.99	12	1.0%
$40.00 to $50	965	80.3
$50.01 to $100	38	3.2
$100.01 to $200	165	13.7
More than $200	21	1.7

[1]We obtained data for FYs 2004 through 2006 from TMA in July 2006. Claims can be submitted up to 1 year after the date of service. Therefore, the data cover all of FY 2004 and parts of FY 2005 and 2006. We did not include TRICARE Global Remote Overseas claims.

[2]Percentages do not equal 100 due to rounding.

TMA allowed charges of $40 to $50 for 80 percent of the office visits, and for 15 percent of the office visits, it allowed more than $100, as shown in Table 7. Had TMA applied the PPP index to the CHAMPUS maximum allowable charge, it would have allowed $36 for an office visit. An office visit in Panama is $36 when the PPP index is applied to the CHAMPUS maximum allowable charge. Using the proposed CHAMPUS maximum allowable charge should help ensure that TMA-allowed charges for health care services in Panama, including office visits, are closer to what is reasonable and customary in that country. If these professional services price caps had been applied in the Philippines, Panama, and other countries, TMA could have realized potential monetary benefits of at least $27 million in paid charges during a 3-year period. TMA could realize additional potential monetary benefits by implementing hospital inpatient price caps.

Price Caps on Hospital Inpatient Charges. By implementing price caps on hospital inpatient charges in seven countries, annually TMA could put about $7 million of funds to better use. TMA generally pays hospital inpatient claims for the full amount billed. However, TMA limits hospital inpatient claims in Puerto Rico based on a payment system using diagnostic-related groups that is also used by TMA in the United States. In September 2004, TMA began limiting Philippines hospital inpatient claims using a Philippine-specific per diem system. Hospital inpatient per diem systems, such as the Philippines system, are designed to pay a maximum daily rate based on the primary diagnosis. When a claim is submitted, TRICARE pays the lesser of the per diem rate or billed charges. In January 2007, the Assistant Secretary of Defense (Health Affairs) approved the revision of the Philippines per diem system and the implementation of a per diem system in Panama using the PPP index. We agree with the revision of the Philippines per diem system and the implementation of the Panama per diem system.

We applied the PPP index to seven countries in the Overseas Program and found that TMA could realize substantial potential monetary benefits. Table 8 shows the potential monetary benefits for seven countries from using the

PPP-indexed per diem rate for FY 2004 through July 2006. These data do not include any claims processed by the TGRO contractor because it was using summary procedure codes rather than detailed codes. As shown in Table 8, we determined that TMA could have put more than $21 million of funds to better use for the seven countries with the highest PPP savings during a 3-year period; therefore, by implementing price caps on hospital inpatient charges, TMA could annually put more than $7 million of funds to better.

Table 8. Savings on Hospital Inpatient Claims From Using PPP-Indexed Price Caps: Top Seven Countries by Savings, FY 2004 Through July 2006[1]
(in millions)

Country[2]	Total Paid	PPP Savings[3]	PPP Savings as a Percent of Total Paid
Panama	$19.1	$7.9	41.4%
Philippines[4]	12.3	5.5	44.7
United Kingdom	14.3	4.1	28.7
Germany	84.4	1.4	1.7
Mexico	3.0	1.2	40.0
Italy	4.4	1.0	22.7
Costa Rica	1.4	0.5	35.7
Total	**$138.9**	**$21.7**[(5)]	**15.6%**

[1]We obtained data for FYs 2004 through 2006 from TMA in July 2006. Claims can be submitted up to 1 year after the date of service. Therefore, the data cover all of FY 2004 and parts of FY 2005 and 2006. As a result, our calculations of potential monetary benefits are conservative.

[2]We did not evaluate the price caps for Puerto Rico using the PPP index because there are already price caps on professional services and hospital inpatient charges there. These rates have been established by the Centers for Medicare & Medicaid Services, and TRICARE has generally adopted these rates.

[3]We calculated the PPP savings by first determining the PPP value for each country (by multiplying the national reimbursement rate by the PPP country index supplied by the World Bank's International Comparison Program). We then compared the PPP value with the TRICARE-allowed amount for each procedure.

[4]Because TMA implemented price caps on professional services in the Philippines in February 2004, the analysis was performed only on claims submitted on or after February 2004.

[5]The actual total is approximately $21.7 million. The rounded country amounts equal $21.6 million.

Price Caps on Hospital Inpatient Charges in the Philippines. TMA implemented a per diem system in September 2004 to limit the reimbursement of Philippine hospital inpatient charges. However, the per diem system rates were based on inflated claims of a third-party billing agency that accounted for 80 percent of the health care claims in the Philippines.

During a visit to the Philippines, we spoke with several hospitals and physicians. We obtained a price schedule for a heart bypass operation at one of the major hospitals in Metro Manila. The package included 10 days in a semi-private room and critical care unit for $9,125. The package included medicines; laboratory procedures; pulmonary procedures; scans; blood procedures; and professional fees of the cardiologist, cardiovascular surgeon, anesthesiologist, and pulmonologist. Under the current Philippine per diem system (as of August 1, 2007), TMA would have reimbursed this care at $20,330 ($2,033 per day), $11,205 more than the package price schedule. Further, the hospital's surgical package included the physician's fees, whereas under the per diem system, physician fees would have required additional payments. Using the revised per diem rates approved by the Assistant Secretary of Defense (Health Affairs) and converting them with the PPP index should bring hospital inpatient prices more in line with what is customary and reasonable in the Philippines.

TMA created the hospital inpatient per diem rates using actual claims data collected for a year in the Philippines. Table 9 shows four examples of the rate differences between the current and future per diem reimbursement systems.

Table 9. Current and Future Philippine Per Diem Rates

Diagnosis	Current Per Diem	Future Per Diem*
Tuberculosis	$614	$423
Peptic Ulcer	680	432
Kidney Stone	1385	453
Asthma	922	419

*Based on the second-year TMA Philippine PPP index factor of 0.229.

As shown in Table 9, the future per diem rates will be lower. As shown in Table 8, TMA could have reduced its claims payments by more than $5.5 million per year in the Philippines if the PPP index had been used on hospital inpatient claims from FY 2004 through July 2006.[14]

Price Caps on Panama Hospital Inpatient Charges. As of August 1, 2007, TMA generally paid claims in Panama for hospital inpatient charges in full as billed. However, in January 2007, the Assistant Secretary of Defense (Health Affairs) approved a plan to implement PPP-indexed price caps on hospital inpatient charges in Panama, a plan that is expected to be implemented in January 2008. We agree that TMA should implement price caps in Panama to institute more realistic reimbursement rates. We determined that TMA could have reduced its claims payments by more than $7.9 million (or 41 percent) if the PPP index had been used on hospital inpatient claims from FY 2004 through July 2006 for Panama as shown in Table 8.

[14] We obtained data for FYs 2004 through 2006 from TMA in July 2006. Claims can be submitted up to 1 year after the date of service. Therefore, the data cover all of FY 2004 and parts of FYs 2005 and 2006. As a result, our potential monetary benefits are conservative.

Price Caps on Hospital Inpatient Charges in Other Countries. We believe TMA is moving in the right direction with implementing hospital inpatient price caps in the Philippines and Panama. However, hospital inpatient health care caps are also needed in countries with a high dollar value of claims payments and countries with significant increases in health care costs. We applied the PPP index to other countries in the Overseas Program and found a need to better align prices. In addition to the Philippines and Panama, Table 8 shows TMA could have reduced its claims payments by more than $8 million ($21.7M - $7.9M - $5.5M) from FY 2004 through July 2006. TMA could have reduced payments on claims in Costa Rica, Italy, Mexico, and the United Kingdom by 36 percent, 23 percent, 40 percent, and 29 percent, respectively. The application of the PPP index to hospital inpatient claims in Germany reduced payments by only 1.7 percent. Therefore, it appears that the PPP index is in line with current hospital inpatient claims in Germany.

TRICARE Global Remote Overseas Price Caps. The TGRO contractor was not performing detailed coding or negotiating adequate fee schedules for TGRO claims as required by the contract. We believe that, as TMA develops and implements price caps, it should apply these price caps to TGRO. However, until the TGRO contractor fully codes health care claims, applying such price caps will be difficult. Further, in those countries where price caps are not established, the lack of detailed coding prevents TMA from evaluating whether the TGRO contractor is adequately containing costs, as discussed in finding A.

Procedure Coding by the TGRO Contractor. The TGRO contractor uses only 31 possible codes in processing TGRO claims for procedures, even though more than 7,000 procedure codes are available. Therefore, we did not include TGRO claims in much of our price cap analysis because the TGRO contractor did not fully code claims, and any claims analysis relying on restricted coding would have provided skewed results. The TMA Office of General Counsel ruled in June 2007 that the existing contract required the TGRO contractor to fully code claims. To determine the effect of the restricted coding, we reviewed procedures coded as 15-minute office visits. According to TMA TGRO claims data for FY 2004 through July 2006, there were 592 instances in which a 15-minute office visit was billed at or above $500. These 592 instances amounted to $794,068.71, averaging $1,341.33 per visit—more than 1,882 percent higher than the current Washington, D.C., CHAMPUS maximum allowable charge (as of August 1, 2007) of $67.69. Using restricted coding makes it difficult, if not impossible, to apply price caps or cost containment measures. Additionally, meaningful analysis cannot be performed to identify inflated claims and other improper billing practices.

Fee Schedules Used by the TGRO Contractor. Fee schedules negotiated between the TGRO contractor and two of the three hospitals used by TRICARE beneficiaries in Panama City, Panama, had fees that were excessive. Specifically, for one of the two Panama fee schedules that the TGRO contractor negotiated, more than 87 percent of the procedures were priced higher than the Washington, D.C., maximum allowable charges, and more than 73 percent were higher than the Alaska maximum allowable charges, even though the PPP index indicates that prices should be about 60 percent of the U.S. national average. For example, the hospital charged $70 for an inpatient consultation, whereas the

Washington, D.C., charge was $39.33 and the Alaska charge was $47.94. Our review of the other hospital's negotiated fee schedule showed that its fees were also well above the allowable charges in Alaska. For the seven procedures that exceeded $4,000, all were higher than the Alaska reimbursable amounts by at least 377 percent. We believe TGRO claims processed through the TGRO contractor should be subject to the same price caps that limit non-TGRO claims. Additionally, in countries where price caps are not implemented, TMA should periodically review the reasonableness of the TGRO contractor fee schedules.

Reimbursement Limits in Guam and the U.S. Virgin Islands. TMA should apply Medicare and Medicaid-based reimbursement limits to Guam and the U.S. Virgin Islands. As previously mentioned, TMA develops many of its CHAMPUS maximum allowable charges based on those established by the Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services has established reimbursement limits for the United States, Puerto Rico, Guam, and the U.S. Virgin Islands. According to TMA data, TRICARE paid claims totaling about $3 million each for Guam and the U.S. Virgin Islands between FY 2004 and July 2006. Using the Centers for Medicare & Medicaid Services' rates for a 15-minute office visit, TMA could have reduced its allowed charges in Guam and the U.S. Virgin Islands by more than $400,000 (63 percent) from FY 2004 through July 2006. We believe that TMA should treat Guam and the U.S. Virgin Islands as it does Puerto Rico and establish CHAMPUS maximum allowable charges.

Conclusion

TMA should implement controls over claims for professional services and hospital inpatient charges using price caps rather than paying claims in full as billed. TMA also needs to ensure that all contractors processing overseas claims apply price caps and fully code claims. We applaud recent plans by TMA to revise Philippine price caps and establish price caps in Panama using a country-specific cost index (PPP index) and believe TMA should continue with the implementation of those price caps. However, we believe TMA should expand price caps to other countries with a high dollar value of claims payments and to other countries that have significant increases in health care costs. In countries that already have a structured, nationalized health care system, such as Germany, TRICARE could adopt the price cap structure already in place. However, if TMA chooses to use the foreign national health care system instead of the per diem system, it should require that overseas-claims-processing contractors understand the system and properly apply it. Additionally, all claims, including TGRO claims, for one country should be subject to the same price caps. Moreover, TMA needs to establish and use CHAMPUS maximum allowable charges for Guam and the U.S. Virgin Islands based on Centers for Medicare & Medicaid Services price caps in those countries—much as it has done for Puerto Rico. Implementing the recommendations in this finding could result in TMA annually putting at least $16 million of Defense Health Program funds to better use, totaling $96 million during the execution of the FYs 2008 through 2013 Future Years Defense Plan.

Management Comments on the Finding and Audit Response

Management Comments. The Assistant Secretary of Defense (Health Affairs) stated that Table 4 does not address whether exchange rate fluctuation was considered with the increases in claims payments.

Audit Response. We did not look at the differences caused by exchange rate fluctuation. Table 4 provided a picture of increases over the past few years. For example, claims payments in Singapore rose from about $604,000 in FY 2003 to $2.279 million in FY 2005, a 277-percent increase. The statistics in Table 4 provide the reader with the magnitude of some of the increases in health care costs in the Overseas Program. We did not base our finding and potential monetary benefits on these statistics; rather we used actual claim information (procedures and diagnosis codes) in the TRICARE claims database.

The Assistant Secretary of Defense (Health Affairs) did not indicate concurrence or nonconcurrence with the potential monetary benefits in relation to the finding. We request that the Assistant Secretary of Defense (Health Affairs) comment on the potential monetary benefits in response to the final report.

Recommendations, Management Comments, and Audit Response

B. We recommend that the Director, TRICARE Management Activity:

1. Proceed with the implementation of improved price caps on professional services and hospital inpatient charges in the Philippines.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that TRICARE is proceeding with implementing price caps in the Philippines. However, the Assistant Secretary stated an implementation date has not been determined.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

2. Proceed with establishing price caps on professional services and hospital inpatient charges in Panama.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that TRICARE is proceeding with implementing price caps in Panama. However, the Assistant Secretary stated an implementation date has not been determined.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

3. Expand price caps in high-dollar-volume countries and countries that have significant increases in health care costs.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that TRICARE will consider expanding price caps to other countries as soon as it determines the impact of price caps in the Philippines and Panama.

Audit Response. Although the Assistant Secretary of Defense (Health Affairs) concurred with the recommendation, the comments are partially responsive because the Assistant Secretary agreed only to consider price caps, not to implement them. We understand that price cap schedules or the mechanics may have to be adjusted, but price caps should be implemented in selected countries to reimburse claims at prices that are customary and reasonable. We request that the Assistant Secretary reconsider his position on Recommendation B.3. and provide additional details and timeframes in response to the final report.

4. Ensure that price caps apply to all foreign health care claims, including TRICARE Global Remote Overseas beneficiary claims, and where price caps are not implemented, periodically review the reasonableness of both the fee schedules used by overseas contractors and the prices that providers are charging for health care services.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the recommendation to apply price caps to payments for services received by all beneficiaries including TGRO beneficiaries. The Assistant Secretary stated that there may be an occasion to exceed the price cap amount based on extenuating circumstances.

Audit Response. The Assistant Secretary's comments satisfy the intent of the recommendation.

5. Develop and apply CHAMPUS maximum allowable charges for Guam and the U.S. Virgin Islands based on Centers for Medicare & Medicaid Services price caps used in those countries.

Management Comments. The Assistant Secretary of Defense (Health Affairs) did not concur or nonconcur, but stated that TRICARE will "explore" the Medicare and Medicaid-based limits for Guam and the U.S. Virgin Islands.

Audit Response. The comments are partially responsive because the Assistant Secretary agreed only to explore the use of Medicare and Medicaid-based limits. We believe price caps are warranted for Guam and the U.S. Virgin Islands, and the mechanics already exist without further exploration. Although the total amount of health care claims in Guam and the U.S. Virgin Islands may have totaled only $6 million in FY 2004 through July 2006, without price caps health care costs could significantly increase. As shown in our prior audit report on TRICARE Overseas claims (Report Number D-2006-051, "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance Plans," February 10, 2006), health care costs in the Philippines rose sharply from $2.87 million in FY 1998 to $64.19 million in FY 2003 even though the number

of TRICARE beneficiaries remained stable over that period. TMA did not begin implementing price caps in the Philippines until February 2004. We request that the Assistant Secretary reconsider his position on Recommendation B.5. and provide additional details and timeframes in response to the final report.

Appendix A. Scope and Methodology

We conducted this performance audit in accordance with generally accepted government auditing standards from August 2005 through September 2007. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We suspended the audit from October 2005 through April 2006 to assist the U.S. Attorney's Office, Western District of Wisconsin.

We met with TMA personnel in Alexandria, Virginia, and Aurora, Colorado, to gather information regarding the Overseas Program. We met with personnel from each of the three TAOs--Europe, Latin America and Canada, and Pacific--and personnel from the TRICARE Regional Office South. We met with contractors responsible for overseas claims processing including: WPS in Madison, Wisconsin; International SoS (ISOS) in Philadelphia, Pennsylvania; and Palmetto Government Benefits Administration (PGBA) in Florence, South Carolina, to document their claims-processing and reimbursement procedures. We discussed TRICARE eligibility requirements and beneficiary population statistics with Defense Manpower Data Center personnel. We met with personnel from the U.S. Army European Regional Medical Center and U.S. Air Force Europe to discuss overseas health care issues unique to the European region. We also visited participating hospitals, physicians, or third-party billing agencies in all three TRICARE overseas regions to gather information regarding their billing procedures for TRICARE-eligible beneficiaries. Specifically, we met with 5 hospitals, a private insurance company, and the Philippine College of Surgeons in the Philippines; 6 hospitals, 5 physicians, and 3 third-party billing agencies in Panama; and 4 hospitals, 16 physicians, and 2 third-party billing agencies in Germany.

We reviewed public laws, the Code of Federal Regulations, as well as DoD and TMA regulations to identify the procedures and requirements established for the Overseas Program related to claims submission, claims reimbursement, and price caps. Specifically, we reviewed the Code of Federal Regulations, Title 32, Chapter 2, Part 199.17, "Civilian Health and Medical Program of the Uniformed Services – TRICARE Program," revised July 1, 2005, as well as TRICARE Policy Manual 6010.54-M, August 1, 2002; TRICARE Operations Manual 6010.51-M, August 1, 2002; and TRICARE Reimbursement Manual 6010.55-M, August 1, 2002. We also reviewed supporting documentation submitted by providers and third-party billing agencies for TRICARE claims, contractor reimbursement data, and provider fee schedules. The dates of the documents reviewed ranged from April 26, 1996, to July 31, 2007.

Use of Technical Assistance. We consulted the DoD OIG Quantitative Methods Division (QMD) for assistance in obtaining a population of episodes of care for Overseas Program claims and developing a stratified statistical random sample of the episodes of care. QMD also assisted the team in calculating potential monetary benefits using professional services and hospital inpatient price caps for selected overseas countries.

Accuracy of Claims Payments. To test the accuracy of claims payments, we used a statistical sample. In addition, during Phase One of this audit, we reviewed about 600 claims submitted by Health Visions Corporation and identified 6 claims for which the claims processor had made significant overpayments. We included these claims in our Phase Two audit report but did not include them in the statistical sample to determine the accuracy of payments, nor did we include the six claims in estimates of potential monetary benefits.

Statistical Sample. The audit team used a statistical sample to identify the magnitude of inaccurate and duplicate payments for Overseas Program claims. We requested and obtained TMA Purchased Care Detail Information System (PCDIS) data for overseas care with dates of service from FY 2004 through July 2006. We provided these claims data to QMD for sample selection. Because the data were collected in July of 2006 and TRICARE health care claims may be submitted up to 12 months past the date of service, our audit results may not reflect all claims submitted with dates of service within this time period, especially for FY 2006. Therefore, we requested that QMD remove the partial FY 2006 claims data from the statistical sample.

The resulting population used to develop the statistical sample included 362,167 episodes of care equaling 428,775 claims for overseas care provided from FY 2004 to FY 2005. QMD personnel selected the statistical sample based on episodes of care. An episode of care involves one or more claims for care of a single patient and has the same dates for the beginning and end of care. The use of episodes allowed us to identify when multiple claims were filed and paid for the same care. QMD divided the sample into four categories (Table A-1).

Table A-1. Categories (Strata)

Category of Episode	Episodes	Claims	Sample Episodes	Total Charge Allowed by TRICARE (in millions)
Single claim, more than $100, less than or equal to $1,000	261,213	261,213	58	$81.949
Multi claim, more than $100, less than or equal to $1,000	42,305	98,852	44	24.989
Single claim, more than $1,000	50,766	50,766	160	189.515
Multi claim, more than $1,000	7,883	17,944	85	39.885
Total Scope	**362,167**	**428,775**	**347**	**$336.338**

We used the QMD statistical sample selection of 347 episodes (526 claims) to gather claims documentation from WPS, ISOS, and PGBA, the contractors responsible for claims processing. The statistical sample selection excluded pharmacy claims and claims with less than $100 allowed per episode of care. The amount allowed is determined by claims processors based on TRICARE policy. Beneficiary copayments and deductibles are subtracted from the allowed amount to calculate the amount payable to the beneficiary or the provider. We analyzed paid claims for payment accuracy by comparing the original provider bills of service with corresponding third-party claims, processor documentation, PCDIS data, and TRICARE4U claims system data (where applicable) to identify mathematical errors, potential duplicate payments, noncovered administrative charges, and other overpayments. We did not review claims for underpayments. We considered this approach conservative because underpayments are also payment errors and would increase the error rate identified by our statistical sample. We did not validate with beneficiaries that the services billed were actually rendered.

Methodology of Projections. QMD projected the number of episodes of care and the corresponding dollar amounts when an inaccurate payment was made from FYs 2004 through 2005. The projections were based on a 95-percent confidence level. Table A-2 summarizes the projected value of all inaccurate payments that were identified within the statistically sampled episodes. Table A-3 shows the projected value of all nonduplicative inaccurate payments, and Table A-4 shows the projected value of all duplicative inaccurate payments.

Table A-2. Projected Value of Inaccurate Payments of All Types

	Lower Bound	Point Estimate	Upper Bound
Value	$6,486,432	$14,563,444	$22,640,455
Episodes	7,936	39,429	70,830

Table A-3. Projected Value of Overpayments (Nonduplicative Inaccurate Payments)

	Lower Bound	Point Estimate	Upper Bound
Value	$1,841,835	$7,066,537	$12,291,239

Table A-4. Projected Value of Duplicative Inaccurate Payments

	Lower Bound	Point Estimate	Upper Bound
Value	$1,311,446	$7,496,907	$13,682,368

We assumed that the results from the 2-year statistical sample were representative of annual inaccurate payments. We determined the annual amount of inaccuracies by dividing the 2-year statistical sample results by 2. We obtained the 6-year Future Years Defense Plan estimate for nonduplicative inaccurate payments by dividing the point estimate shown in Table A-3 by 2 and then

multiplying the annual nonduplicative inaccurate estimate by 6. We obtained the 6-year Future Years Defense Plan estimate for duplicative inaccurate payments by dividing the point estimate shown in Table A-4 by 2, applying the actual nonrecoupment rate of 38 percent as provided by the foreign-claims-processing contractor, and then multiplying that annual duplicate inaccurate estimate by 6. The nonrecoupment rate indicated that the foreign-claims-processing contractor was unsuccessful in recouping 38 percent of duplicate payments in FY 2005 and FY 2006.

Price Caps. During Phase One of this audit, we expressed concern that TMA institutional price caps in the Philippines may have been too high. During Phase Two we focused on identifying potential monetary benefits using revised professional services and hospital inpatient price caps in the Philippines and other countries. We requested and obtained TMA claims data for care provided outside the United States from FY 2004 through July 2006. Because of the size of the set of claims data, we requested the assistance of QMD personnel. QMD removed TRICARE Global Remote Overseas claims from the data set because the contractor did not use full coding and would have skewed the price cap analysis. Different methodologies were used to analyze professional services and hospital inpatient charges because of the layout of the data.

Professional Services. We identified seven countries with the highest amount of paid claims for professional services from FY 2004 to July 2006. For each of the seven countries, we identified the 20 procedures with the highest amount allowed. We examined the allowed amounts for each procedure rather than paid because the data provided by TMA showed only allowed amounts by procedure. Using the U.S. national CHAMPUS maximum allowable charge obtained from TMA, personnel from QMD attached the national CHAMPUS maximum allowable charge to each procedure in the data extract. We calculated the PPP CHAMPUS maximum allowable charge for each procedure by multiplying the national CHAMPUS maximum allowable charge by the country-specific PPP index. We then compared the allowed amounts for the procedure with the country-specific PPP-indexed CHAMPUS maximum allowable charge to determine any differences. For Philippines claims, we reviewed claims that were processed after the professional service price caps for that country were implemented (February 1, 2004). If the allowed amount was more than the PPP CHAMPUS maximum allowable charge would have been, then the PPP CHAMPUS maximum allowable charge was subtracted from the allowed amount to determine the difference. To determine the potential monetary benefits TMA could achieve, we deducted 25 percent from the difference to account for the cost share the retired beneficiaries are required to pay. Our estimate is conservative because it assumes for each claim the beneficiary paid a 25-percent cost share, even though this is not the case because beneficiaries do not have to pay cost shares after they reach their out-of-pocket limit for the year (up to $3,000). Further, TGRO beneficiaries do not pay cost shares. To determine the annual potential monetary benefits, we divided the total amount by 3 years.

Hospital Inpatient Claims. Personnel from QMD identified the patient diagnosis code for each hospital inpatient claim in the TMA claims data. Using the proposed U.S. national per diem system established by TMA, each hospital inpatient claim was given a national per diem amount based on the three-digit

diagnosis. We applied the PPP index to the national per diem amounts to create country-specific per diem amounts. We then compared the amounts paid for each claim to the PPP-indexed country-specific per diem amount to determine the amount potentially overpaid, based on the developed price cap. If the amount paid was less than the PPP-indexed country-specific per diem amount, there were no potential monetary benefits calculated. If the amount paid was more than the PPP-indexed country-specific per diem amount, then the PPP-indexed country-specific per diem amount was subtracted from the amount paid to determine potential monetary benefits. For Philippines claims, we reviewed claims that were processed after the inpatient institutional price caps for that country were implemented (February 1, 2004). For each country, we added the potential monetary benefits to determine the amount of funds TMA could have put to better use. To determine the annual potential monetary benefits, we divided the total amount by 3 years.

Because the data were pulled in July 2006, only 9 months of FY 2006 had passed. In addition, TMA allows claims to be submitted up to 1 year after care was provided. Therefore, the FY 2006 data had another 15 months and the FY 2005 data had another 3 months to be considered a complete year. Also, the calculations did not include any TRICARE Global Remote overseas claims submitted by ISOS during this period. Thus, the potential monetary benefits using professional services and hospital inpatient price caps are conservative.

We did not review pharmacy, air ambulance, or durable medical equipment price caps, unbundling of medical services, other health insurance payments, accuracy of cost shares, or duplicate DoD/Veteran Affairs payments because of time constraints and limited audit resources.

Use of Computer-Processed Data. We used PCDIS claims data as a basis for our statistical sample to identify duplicate payments, overpayments, and other payment discrepancies, as well as for price cap analyses. To determine the adequacy of computer-processed data, we gathered and compared claims documentation with the information entered into PCDIS. For the 526 claims reviewed as part of our statistical sample, 519 (99 percent) matched the information in PCDIS. Most of the differences between PCDIS and the claims the company submitted could be explained and generally were not inaccuracies.

Government Accountability Office High-Risk Area. GAO has identified several high-risk areas in DoD. This report provides coverage of the high-risk areas "DoD Financial Management" and "DoD Support Infrastructure Management."

Prior Coverage

During the last 5 years, the Government Accountability Office (GAO) and the Department of Defense Inspector General (DoD IG) have issued 3 reports discussing TRICARE claims payment controls. Unrestricted GAO reports can be accessed on the Internet at http://www.gao.gov. Unrestricted DoD IG reports can be accessed at http://www.dodig.mil/audit/reports.

GAO

GAO Report No. GAO-05-773, Defense Health Care: "Implementation Issues for New TRICARE Contracts and Regional Structure," July 27, 2005

GAO Report No. GAO-04-69, Defense Health Care: "TRICARE Claims Processing Has Improved but Inefficiencies Remain," October 15, 2003

DoD IG

DoD IG Report No. D-2006-051, "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Insurance Plans Report," February 10, 2006

Appendix B. TRICARE Overseas Payments Made by Check

Overseas Program payments made by checks in the Philippines were stolen and subsequently altered. During the audit we notified TMA that, even though it has taken a number of steps in addressing the theft of TRICARE checks in the Philippines, it should explore using electronic funds transfer (EFT) when paying claims. As of August 2007, the TRICARE Policy Manual prohibits claims processors from using electronic means of claims payments in the Philippines. However, in May 2007 TMA requested the foreign-claims-processing contractor to explore using EFT when paying overseas claims.

Electronic Payments. EFT is a system of transferring money from one bank account directly to another without any paper money changing hands. EFT can be routed from one bank to another bank or routed from one bank to an automated clearinghouse (ACH) then to the destination bank. The automated clearinghouse is a secure payment transfer system that connects financial institutions and holds payments while awaiting clearance at the final banking destination. ACH serves as validation for an EFT payment to ensure that there is permission from the payee for such a transaction and that funds are available as well as verification of the final banking destination. The utilization of ACH for EFT is an added layer of security that eliminates some of the processing fees typically charged in bank to bank transfers.

TRICARE Payments Made by Checks. According to DCIS and TMA referrals submitted between February 2005 and June 2006, there were 44 payments stolen and/or altered and 30 submissions of false claims. One such altered payment was mailed to a provider for the amount of $256.50, but was changed to $7,256.50. The individual then added his name as payee on the check, and the check was cashed. The false claim submissions cited in the referrals were submitted by individuals acting as eligible beneficiaries, submitting claims for services not rendered. Each claim had a statement, such as, "Please forward payment to my new address because the hospital has been paid in full." The new address was that of the suspect. Claims payments from these recurring issues cited in the referrals totaled more than $1.3 million, as shown in the table below.

Philippine Fraud Referrals

Type	Number	Amount
Stolen or altered checks endorsed and cashed	44	$583,092
False Claims	30	752,859
Total	**74**	**$1,335,951**

Currently, the TRICARE Policy Manual prohibits claims processors from using electronic means of claims payments in the Philippines. Because TRICARE does not have a secure method of delivery, we believe provider payments are still prone to theft from the Philippines postal system.

The TRICARE foreign-claims-processing contractor recognized that claims payments (checks) sent to providers and beneficiaries were being stolen and altered. In an attempt to prevent the theft and alteration of payments, the foreign-claims-processing contractor made several changes in how it sent TRICARE checks to the Philippines. Specifically, the claims processor stated that it began in:

- 2002/2003 using regular white envelopes instead of business envelopes and handwrote its return address using an employee's name to disguise the check;

- August 2004 sending payments in Philippine pesos destined for designated problem areas in the Philippines through a courier service, while payments in U.S. currency were sent through the postal system; and

- March 2006 sending beneficiary checks in U.S. currency through the courier service as well.

Despite these actions, payments continued to be stolen and altered. According to the claims processor, between April and August of 2006, 56 checks were delivered by the courier to two individuals who had photocopied the U.S. identification cards of the intended beneficiary recipients and convinced the courier they were authorized to take receipt of the checks.

Electronic Payment Initiatives. In May 2007, TMA requested the primary TRICARE Overseas contractor to examine implementing the use of automated clearinghouse payments for overseas claims, including those filed in the Philippines. We believe TMA should continue to explore the use of electronic funds transfer. Since 1996, the Department of Defense and other Federal agencies have taken a number of actions to expand the use of electronic payments. Specifically:

- The FY 2002 President's Management Agenda included an initiative to promote expanding electronic government to reduce operating costs.

- Public Law 104-134, "The Debt Collection Improvement Act of 1996," and section 3332, title 31, United States Code (31 U.S.C. 3332), "Required Direct Deposit," January 3, 2005, require that Federal agencies generally make wage, salary, and retirement payments to beneficiaries using electronic funds transfer.

- DoD Regulation 7000.14-R, "Department of Defense Financial Management Regulations (FMRs)," Volume 7C, Chapter 7, November 2000, requires payments by EFT for all active duty, reserve, retired, and annuitant payments, unless the recipient states that he or she does not have a financial institution or authorized payment agent. The

regulation also states that all retirees, separated military personnel and Survivor Benefit Plan annuitants shall provide EFT information or certify in writing that they do not have a financial institution. However, those at an address in a foreign country where EFT is not available are exempt from the regulation until EFT becomes available.

- In February 2006, the Defense Financial and Accounting Service implemented the International Direct Deposit initiative to allow U.S. military retirees and annuitants living abroad to securely receive pay electronically to where they reside without wire transfer fees.

As of August 2007, the Defense Finance and Accounting Service implemented the International Direct Deposit program in 43 countries including Germany, Italy, Mexico, Panama, and the United Kingdom. Although the International Direct Deposit program as of August 2007 does not include the Philippines, the Social Security Administration reported in June 2007 that 99 percent of its approximately 20,000 Philippine payments were sent electronically through U.S. banks using direct deposit. The use of electronic funds transfer could prevent the physical theft of TRICARE Overseas Program payments made by checks.

Appendix C. Criteria

In addition to criteria cited within the report, the following additional criteria apply to the Overseas Program.

Code of Federal Regulations. Code of Federal Regulation, Title 32, Part 199.11, "Overpayments Recovery," revised July 1, 2005, defines erroneous payments as expenditures of government funds which are not authorized by law. The legislation provides examples of erroneous payments including payments for care provided to an ineligible person, payment for care that is not an authorized benefit, payment for duplicate claims, and mathematical errors. This part also mandates collections of erroneous payments by administrative offset in every instance in which it is feasible, provided demand for payment has been sent to the debtor and remains unsatisfied after three attempts for collection.

Code of Federal Regulation, Title 32, Volume 2, Part 199.14, "Provider Reimbursement Methods," revised July 1, 2005, states that hospitals outside of the United States, the District of Columbia, and Puerto Rico are excluded from the normal payment system allowing the Director to determine the appropriate reimbursement method or methods to be used for covered medical services or supplies provided by institutional facilities outside the U.S. Additionally, this Regulation requires that reimbursement be the lower of the billed charge or the local CHAMPUS maximum allowable charge for covered medical services or supplies provided by noninstitutional facilities outside the U.S.

Improper Payments Act. Public Law 107-300, "Improper Payments Information Act of 2002," dated November 26, 2002, defines improper payments as any payment made: to ineligible recipients, for ineligible services, for services not received, or for any duplicate payment. This Act requires the head of each agency to perform an annual review to identify all programs and/or activities that may be susceptible to significant improper payments.

TRICARE Manuals. The provisions of the TRICARE Policy Manual, TRICARE Reimbursement Manual, and TRICARE Operations Manual only apply to the Overseas Program when specifically stated in Chapter 12 of the Policy Manual or in the contract requirements.

Policy Manual. TRICARE Policy Manual 6010.54-M, Chapter 12, "TRICARE Overseas Program (TOP)," August 1, 2002, outlines general guidance for overseas claims processing related to claims payments (including adjustments and recoupments), reimbursement, eligibility, claim audits, coding, and electronic fund transfers. The Policy Manual prohibits reimbursement for services specifically excluded under the TRICARE Program. The manual also states the foreign-claims-processing contractor shall not reimburse administrative charges billed separately on claims. Chapter 12, Section 11.1 states reimbursement of Philippine professional claims shall be the lower of the billed charges or the Puerto Rico CHAMPUS maximum allowable charges. Chapter 1, Section 34 of the TRICARE Reimbursement Manual states that hospital claims will be limited using a per diem system. Regarding electronic fund transfers, according to the

Policy Manual, the contractor shall provide EFT payment to a U.S. or overseas bank on a weekly basis upon provider request, except in the Philippines.

Operations Manual. TRICARE Operations Manual 6010.51-M, August 1, 2002, provides general guidelines related to duplicate claims, fraud, and timeliness and accuracy. According to the Operations Manual, contractors are expected to employ their own systems to prevent, detect, and resolve duplicate payment conditions because TMA's Duplicate Claims System is simply an adjunct to contractor systems and detects and displays only the most common duplicate conditions. Additionally, the Operations Manual requires that contractors develop and maintain internal management controls necessary to prevent theft, embezzlement, fraud, or abuse and ensure payment errors do not exceed two percent of the total billed charges.

Reimbursement Manual. TRICARE Reimbursement Manual 6010.55-M, August 1, 2002, provides the guidelines under which providers and beneficiaries are reimbursed for health care services provided under TRICARE.

Appendix D. Claims-Processing Contracts for the Overseas Program

Six contracts support the Overseas Program, with contractors processing more than 1 million overseas TRICARE claims per year. Most foreign claims are processed under the TRICARE Managed Care Support Contract for the South Region. In addition to traditional foreign claims (claims for health care provided to TRICARE beneficiaries who reside overseas in nonremote locations except for active-duty Service members and family and Medicare-eligible individuals living in Puerto Rico) processed under the TRICARE South Region contract, an overseas claim may be processed under five other contracts.

Managed Care Support Contracts

There are three regional Managed Care Support Contracts, one for each of the North, South, and West regions of the United States. Each provides TRICARE health care coverage to eligible beneficiaries assigned to the corresponding region for care provided within the region or while the beneficiary is traveling or on temporary duty overseas. Claims originating from care provided overseas are processed and paid under the respective Managed Care Support Contract for the region in which the beneficiary resides following the guidelines outlined in Chapter 12 of the TRICARE Operations Manual. So, in addition to traditional foreign claims processed and paid under the Managed Care Support Contract, South Region, some Overseas Program claims may be processed and paid under the Managed Care Support Contracts.

TRICARE Global Remote Overseas Contract

The TGRO Contract provides TRICARE coverage to active-duty Service personnel and their family members residing in remote overseas locations. TRICARE's Global Remote Overseas Program includes 240 locations in 143 countries worldwide. The TGRO contractor is responsible for providing and maintaining a credentialed provider network, negotiating rates with those providers, and managing beneficiary care referrals for these remote locations. The TGRO contractor receives and processes claims from overseas providers, remits payment to the provider, and then seeks reimbursement from TMA through submission of an electronic claim to the foreign-claims-processing contractor under the Managed Care Support Contract, South Region.

Puerto Rico Contract

The Puerto Rico Contract provides a managed health care system for all active-duty Service personnel and their family members assigned to Puerto Rico.

The TRICARE Operations Manual defines Puerto Rico as a remote location. The contractor is responsible for providing and maintaining a credentialed provider network and managing beneficiary care referrals for Puerto Rico. The Puerto Rico contractor receives and processes claims from Puerto Rico providers, remits payment to the provider, and then seeks reimbursement from TMA through submission of an electronic claim to the foreign-claims-processing contractor under the Managed Care Support Contract, South Region. Under the Puerto Rico contract, the contractor is also responsible for transportation services and negotiation of reimbursement rates equal to or less than the CHAMPUS maximum allowable charge.

TRICARE Dual Eligible Fiscal Intermediary Contract

The TRICARE Dual Eligible Fiscal Intermediary Contract covers the processing of all TRICARE claims for services rendered in the United States and in U.S. territories (Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands) to individuals who have dual eligibility under both TRICARE and Medicare. The contractor processes all dual eligible claims regardless of where the beneficiary resides. In general, TRICARE is the last payer after Medicare and any other coverage.

The type and location of the beneficiary determine jurisdiction over a specific claim. For example, purchased care claims for active-duty Service members located in Puerto Rico (an area designated as remote) are processed under the TRICARE Puerto Rico Contract, while a retired Service member's claim from Puerto Rico is processed under the South Region subcontract for foreign claims. If, however, the retired Service member in Puerto Rico is eligible for, and enrolled in Medicare, the claim is processed under the TRICARE Dual Eligible Fiscal Intermediary Contract. Overseas health care claims for active-duty Service members located in areas designated as remote (other than Puerto Rico) are processed under the TGRO contract. Lastly, overseas health care claims for beneficiaries who reside in the United States receiving health care while traveling overseas (including Puerto Rico) are processed under the Managed Care Support Contract for the region in which they reside (North, South, or West). Claims from all other beneficiaries and locations overseas are considered traditional foreign claims and are processed under the South Region subcontract for foreign claims.

While there are six contracts, there are seven claims-processing jurisdictions. Claims from two jurisdictions (traditional foreign claims and claims from beneficiaries residing in the TRICARE South Region who receive health care overseas) are processed and paid under one contract, the Managed Care Support Contract, South Region.

Table D-1. Overseas Program Contractors

Contract	Prime Contractor	Subcontractor
TRICARE Puerto Rico	HMHS	PGBA
TRICARE Dual Eligible Fiscal Intermediary	WPS	None
TRICARE Global Remote Overseas	ISOS	None
Managed Care Support Contract, South Region	HMHS	PGBA WPS*
Managed Care Support Contract, North Region	HNFS	PGBA
Managed Care Support Contract, West Region	TriWest	WPS

* Subcontract for foreign claims

Remote area claims, claims processed under the TGRO and PRC contracts, are processed in two steps. The TGRO and PRC contractors first process the claim for case management and cost containment, and then submit the claim to the MCSC-South subcontractor for reimbursement and creation of the official claim record into the Purchased Care Detail Information System (PCDIS). Table D-3 shows the total payments made to health care providers and beneficiaries and the associated administrative costs under the Overseas Program:

Table D-2. Overseas Program Payments*
(in millions)

	FY 2005		FY 2006	
Jurisdiction	Health Care Costs	Administrative Payments	Health Care Costs	Administrative Payments
CONUS Managed Care Support – North, South, and West	$0.5	$0.0	$3.2	$0.1
TRICARE Global Remote Overseas	14.8	8.0	21.2	9.7
Puerto Rico	3.9	2.4	5.1	4.4
TRICARE Dual Medicare Eligible	6.4	0.3	7.6	0.4
All other foreign	161.7	12.1	173.8	12.0
Totals	**$187.3**	**$22.8**	**$210.9**	**$26.6**

*Excludes pharmacy contract payments for the Overseas Program.

Appendix E. Summary of Potential Monetary Benefits

Recommendation	Type of Benefit	Amount of Benefit	Account
A	Funds Put to Better Use	Recurring benefits of $4.95 million annually from minimization of erroneous payments including duplicates and overpayments ($29.70 million during execution of the FYs 2008 through 2013 Future Years Defense Plan)	97X0130
B	Funds Put to Better Use	Recurring benefits of $16 million annually from implementing overseas health care price caps ($96 million during execution of the FYs 2008 through 2013 Future Years Defense Plan)	97X0130

Appendix F. Status of Management Comments

The following table shows the status of management comments on each of the recommendations, potential monetary benefits, and internal control weaknesses. The table includes management's position, the audit determination of responsiveness of the comments, and whether additional comments are requested.

Status of Management Comments

	Management Position			Audit Determination of Responsiveness of Planned Actions			Additional Comments Requested	
Recommendation Number	Agree	Disagree	Not Stated	Fully	Partially	Nonresponsive	Yes	No
A.1.a.	X			X				X
A.1.b.		X				X	X	
A.1.c.		X		X				X
A.1.d.		X				X	X	
A.1.e.	X			X				X
A.1.f.	X			X				X
A.2.	X			X				X
A.3.	X			X				X
A.4.			X	X				X
A.5.	X			X				X
A.6.	X			X				X
A.7.	X				X		X	

Status of Management Comments (cont'd)

Recommendation Number	Management Position			Audit Determination of Responsiveness of Planned Actions			Additional Comments Requested	
	Agree	Disagree	Not Stated	Fully	Partially	Nonresponsive	Yes	No
B.1.	X			X				X
B.2.	X			X				X
B.3.	X				X		X	
B.4.	X			X				X
B.5.			X		X		X	
Potential Monetary Benefits			X			X	X	
Management Control Weaknesses			X			X	X	

Appendix G. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)/Chief Financial Officer
    Deputy Chief Financial Officer
    Deputy Comptroller (Program/Budget)
Assistant Secretary of Defense (Health Affairs)
Director, Program Analysis and Evaluation

Department of the Navy

Auditor General, Department of the Navy
Naval Inspector General

Department of the Air Force

Auditor General, Department of the Air Force

Other Defense Organizations

Director, Defense Contract Audit Agency
Director, Defense Finance and Accounting Service

Non-Defense Federal Organization

Office of Management and Budget

Congressional Committees and Subcommittees, Chairman and Ranking Minority Member

Senate Committee on Appropriations
Senate Subcommittee on Defense, Committee on Appropriations
Senate Committee on Armed Services
Senate Committee on Homeland Security and Governmental Affairs
House Committee on Appropriations
House Subcommittee on Defense, Committee on Appropriations
House Committee on Armed Services
House Committee on Oversight and Government Reform
House Subcommittee on Government Management, Organization, and Procurement, Committee on Oversight and Government Reform
House Subcommittee on National Security and Foreign Affairs, Committee on Oversight and Government Reform

Assistant Secretary of Defense (Health Affairs) Comments

Final Report Reference

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

NOV 0 7 2007

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL
PROGRAM DIRECTOR, READINESS AND
OPERATIONS SUPPORT

SUBJECT: Comments on Draft Report on Controls Over the TRICARE Overseas Program (Project No. D2005-D000LF-0267.000)

Thank you for the opportunity to review and provide comments on the draft report "Controls Over the TRICARE Overseas Healthcare Program," Project No. D-2005-D000LF-0267.000, dated September 28, 2007.

Overall, we concur with the report's findings and conclusions. Several of the report's recommendations are currently being addressed, or will be incorporated into the follow-on TRICARE Overseas Program contract.

Specific comments to the draft report findings and recommendations are attached. Please feel free to direct any questions to Mr. Mike Talisnik (functional) at (703) 681-0039, and Mr. Gunther Zimmerman (Government Accountability Office/Inspector General Liaison) at (703) 681-3492.

S. Ward Casscells, MD

Attachment:
As stated

Final Report Reference

DEPARTMENT OF DEFENSE INSPECTOR GENERAL
DRAFT REPORT
Project No. D2005-D000LF-0267.000

"Controls Over the TRICARE Overseas Healthcare Program"

DEPARTMENT OF DEFENSE COMMENTS

Agency comments are indicated below according to sections in the draft report.

Recommendation A: *(page 14)* "We recommend that the Director, TRICARE Management Activity:

1. Revise Chapter 12 of the TRICARE Policy Manual to require at a minimum:

   a. use of a single identification number for foreign providers,

   b. automatic inpatient edit checks for duplicate claims,

   c. limitations on overrides of duplicate edit checks,

   d. proof of payment receipts for beneficiary claims,

   e. use of off-sets in Europe, and

   f. clarification of unacceptable administrative charges on foreign claims.

2. Direct use of the UB 04 (previously UB 92) and HCFA 1500 provider forms for claim submissions from European providers.

3. Establish surveillance plans for each overseas claims-processing contract and include in each plan performance measurements and incentives based on the accuracy of claims payments.

4. Review activities performed by the TRICARE Global Remote Overseas Contractor to determine whether its ownership of facilities providing health care to TRICARE beneficiaries constitutes a conflict of interest.

5. Coordinate with its Office of General Counsel and take action to exempt TRICARE payments from value-added taxes in Germany and other countries as deemed appropriate.

6. Send notifications to all overseas processing contractors of updates to Status of Forces Agreements regarding payment of value-added taxes for health care services.

7. Determine reporting requirements under the Improper Payments Act for payment inaccuracies by the TRICARE Overseas Program."

Department of Defense Response:

1. a. The TRICARE Management Activity (TMA) concurs. Action has already been initiated on this recommendation--eliminating multiple identification numbers--which will contribute toward the reduction of duplicate payments.

1. b. TMA non-concurs. The implementation of an auto reject of institutional claims could possibly create problems for patient transfers, since these claims will show the same date of service for two institutional claims. An auto reject program could possibly incorrectly deny these claims. However, a manual review process would reveal that the patient was transferred to a more appropriate facility/level of care on the same day. Due to the variety of billing practices observed overseas, we cannot assume that foreign billing is similar to billing in the United States (U.S.). We feel that the requirement as currently written is appropriate and should not be revised at this time. Furthermore, none of the other TRICARE domestic claims subcontractors use an automated system to detect potential duplicate inpatient institutional claims. Finally, we believe that there have been a number of steps taken by the overseas claims processing contractor to minimize the potential of duplicate payments.

1. c. TMA non-concurs. The overseas claims processing contractor has taken steps to minimize the use of overrides. Process improvements have been put into place to include daily audits performed on the staff who work all potential duplicates. Implementation of written work instructions regarding the review of duplicate edits was updated in Wisconsin Physicians Service's (WPS's) online reference materials on February 2, 2007. Duplicate edit processors were trained, reinforcing the new work instructions in the online reference materials which included reviewing and comparing original documentation and completing a detailed comparison of claims for similar claims. These improvements require a more rigid review of claims through the comparisons of actual claim images rather then relying on specific data elements. WPS quality assurance procedures were also modified, and daily focused audits began on claims that required duplicate review by a processor. These audits are reviewed by WPS overseas staff on a weekly basis, reviewed by Humana Military Healthcare Services (HMHS), and reported to TMA. WPS is also in the process of making programming changes so that only certain processors will have the ability to use the duplicate override bypass. The Department will consider including in the follow-on contract potential override reporting requirements as well as supervisory overrides.

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1. d. TMA non-concurs. It is understood that what the report recommendation translates as "proof of payment" are receipts from the provider when a beneficiary files for reimbursement. This will be problematic since some host nation providers do not give a receipt for services rendered. Additionally, there is no proof that the receipt, if issued, is valid or accurate. In the continental U.S., the current practice is to allow beneficiaries to submit claims for civilian care delivered without proof of payment.

1. e. TMA concurs. Implementation of European offsets is scheduled to begin in October 2007 for recoupments associated with the contractor Analysis Improvement Plan initiated in February 2007. Updated manual language has been drafted and will be provided to the contractor for implementation. Language will be updated in the TRICARE Policy Manual, Chapter 12.

1. f. TMA concurs. The overseas claims processing contractor was provided Contracting Officer direction, approving the reimbursement of administrative fees from German providers based on local regulations to itemize all charges on their bills. Further clarification will be provided related to identification of acceptable administrative charges and updated in the TRICARE Policy Manual, Chapter 12.

2. TMA concurs. The universal claims forms will be required for all host nation provider claims submissions effective with the follow-on overseas contract.

3. TMA concurs. TRICARE Regional Office (TRO)-South (Aurora) has developed a comprehensive overseas claim performance assessment plan to monitor claims processing requirements cited in the TRO-South contract and applicable TRICARE manuals. This plan has been approved by the TRO-South Regional Director and signed by the appropriate contracting office. The plan is scheduled to be implemented on November 1, 2007. The TRICARE Global Remote Overseas (TGRO) surveillance plan was finalized in March 2007 and has been used in several audits performed by the TRICARE Area Offices. The TRICARE Puerto Rico plan continues to be developed.

4. The TMA TGRO Contracting Officer was tasked to review the report's recommendation and provide a determination whether the TGRO contractor, with its ownership of facilities and providing health care to TRICARE beneficiaries, constitutes a conflict of interest. The Contracting Officer's determination is that the ownership by the TGRO contractor of its clinics does not constitute a personal conflict of interest pursuant to 32 Code of Federal Regulation 199.9(d) nor an organizational conflict of interest as defined by the Federal Acquisition Regulation 9.5. The TMA Office of General Counsel (OGC) concurs in this determination. Further, OGC has indicated that use of the TGRO contractor's clinics does create an appearance of a potential general conflict of interest which should be mitigated. As recommended by the Contracting Officer, TMA will work with the TGRO contractor to mitigate the appearance of the potential general

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conflict of interest and will address this concern in the follow-on TRICARE overseas contract.

5. TMA concurs. Exemption from the Value Added Tax (VAT) based on the Status of Forces Agreement (SOFA) is honored by the vendor on a voluntary basis. TRICARE has been added to the list of agencies that are allowed to obtain VAT exemption and is currently working on processes to facilitate local requirements for proof of eligibility and documentation.

6. TMA concurs. In general, the majority, if not all of the countries in Europe do not levy a tax on health care services. In Germany, for example, a health care institution does not tax for services rendered unless they are a private institution receiving over 60 percent of their income from private payers. By SOFA agreement, many countries provide the possibility of VAT exemption for medical goods and select services, but obtaining this exemption is bound by local laws and processes. TRICARE will evaluate the best mechanism for maximizing the ability to obtain possible VAT exemption. It is unlikely that any SOFA updates on this issue will be required or possible.

7. TMA concurs. Any input to the Improper Payment Act will be determined by regular audits conducted by the Defense Contract Audit Agency (DCAA). The DCAA is scheduled to begin its audit activities of TRO-South contract foreign claims processing sometime in Fall 2007. Additionally, TRO-South will continue to conduct regular performance reviews of our foreign claims processing procedures.

Additional information: Attached is a spreadsheet[1] put together by HMHS that responds to the 50 claim numbers cited in the draft report that refer to both duplicate and overpayments. Note that HMHS, in many cases, does not agree that a given claim was an overpayment or duplicate.

Recommendation B: *(page 27)* "We recommend that the Director, TRICARE Management Activity:

page 31

1. Proceed with the implementation of improved price caps on professional services and hospital inpatient charges in the Philippines.

2. Proceed with establishing price caps on professional services and hospital inpatient charges in Panama.

[1] This document is password protected and the document and password will be provided to the DoD IG.

Document was provided separately and was not included in this report.

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3. Expand price caps in high dollar volume countries and countries that have significant increases in health care costs.

4. Ensure that price caps apply to all foreign health care claims, including TRICARE Global Remote Overseas beneficiary claims, and where price caps are not implemented, periodically review the reasonableness of both the fee schedules used by overseas contractors and the prices that providers are charging for health care services.

5. Develop and apply CHAMPUS maximum allowable charges for Guam and the U.S. Virgin Islands based on Centers for Medicare and Medicaid price caps used in those countries."

Department of Defense Response:

1. TMA concurs. TMA is continuing to proceed with implementing price caps on professional services and hospital inpatient charges utilizing the purchasing power parity (PPP) methodology in the Philippines. The PPP price cap implementation date has not yet been determined.

2. TMA concurs. TMA is also continuing to proceed with implementing price caps on professional services and hospital inpatient charges utilizing the PPP methodology in Panama. The PPP price cap implementation date has not yet been determined.

3. TMA concurs. Expansion of professional services and hospital inpatient price caps, utilizing the PPP methodology, will be considered after an analysis of the impact on access to care and actual monetary savings in the Philippines and Panama has been completed.

4. TMA concurs that the prices caps will apply to payments for services received by all beneficiaries including the TGRO population whenever possible. However, it may be necessary to exceed the price cap allowable amount to guarantee access for Active Duty Service Members and command sponsored Active Duty family members when extenuating circumstances necessitate.

5. TMA will explore the application of Medicare and Medicaid-based reimbursement limits for Guam and the U.S. Virgin Islands.

Technical Comments:

(Page 6) The report states, "The claims-processing system should not allow two hospital inpatient claims for the same patient on the same dates to occur…" This could happen when a beneficiary is transferred from one facility to another (both would charge the same day of transfer) or if a beneficiary is transferred from one speciality department to

another based upon a change in diagnosis resulting in a different disease-related group code. While this does not occur often, it can and does occur.

(Page 17) Table 4 identifies countries with significant increase in claims amount. It is not mentioned whether or not the exchange rate fluctuation was considered in this data, nor does it list the overall health care increase in the respective country as a comparison.

page 21

Attachment:
As stated

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