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

HEALTH AFFAIRS

AUG 25 2008

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 25 2008

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 25 2008

The Honorable Robert C. Byrd
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

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

HEALTH AFFAIRS

AUG 25 2008

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 25 2008

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Duncan Hunter
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 25 2008

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John M. McHugh
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 25 2008

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 25 2008

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed annual report responds to the requirement in Section 731 of the National Defense Authorization Act for Fiscal Year (FY) 2007 that requires a report on a list of claims processing requirements under the TRICARE program that differ from claims processing requirements under the Medicare program.

In the FY 2007 annual report, the Department identified seven claims processing differences between the TRICARE program and the Medicare program. Of those seven differences, the Department provided business cases to retain four and committed to addressing the remaining three through further analysis and consideration for possible inclusion in the Third Generation of TRICARE (T-3) Managed Care Support contracts.

This report provides an update on those three claims processing differences and the detailed business cases conducted in the past year. We intend to resolve two of these differences with provisions in the T-3 contracts. The Department identified no new claims processing differences for this report cycle.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable C. W. Bill Young
Ranking Member

Report to Congress

Fiscal Year 2008

Standardization of Claims Processing
Under TRICARE Program
and Medicare Program

REPORT TO CONGRESS

STANDARDIZATION OF CLAIMS PROCESSING UNDER TRICARE PROGRAM AND MEDICARE PROGRAM

INTRODUCTION

This second annual report is in response to Section 731(d) of the National Defense Authorization Act for Fiscal Year 2007 (NDAA for FY 2007). This section required the Secretary of Defense to submit an annual report beginning not later than October 1, 2007 to the congressional defense committees setting forth a complete list of the claims processing requirements under the TRICARE program that differ from the claims processing requirements under the Medicare program. Each report is to include a business case for each claims processing requirement which is different between the two programs that justifies maintaining such requirement under the TRICARE program.

BACKGROUND

In the Department's FY 2007 report, the Department defined the scope of this project as covering claims processing from the point at which services have been rendered to the time the claims have been paid or denied. Three distinct phases were identified during the analysis of this process.

1. Provider or Beneficiary Claim Preparation and Submittal Requirements;
2. Claim Processing and Notification to Provider and/or Beneficiary; and
3. TRICARE Claims Data Requirements.

Analysis of each phase supported the identification of the commonalities in the claims processing methodologies of the two programs, as well as the differences. In the first report for FY 2007, seven differences were identified and detailed business cases were conducted to determine the feasibility of changing TRICARE's claims processing methodologies to better align with those of Medicare. Of the seven claims processing requirements identified, the business cases for four supported the Department retaining the current TRICARE claims processing methodology. Review of those four business cases continues to support the Department's decision to retain these differences. The remaining three differences, addressed in this report, needed further analysis for possible inclusion in the Third Generation of TRICARE Managed Care Support contracts (T-3). There were no new claims processing differences identified during the past year.

CLAIMS PROCESSING REQUIREMENT DIFFERENCES RETAINED BASED ON FY 2007 REVIEW AND ANALYSIS

Electronic Claims Submission Requirement

The Department continues to encourage electronic claims submission through its managed care support contract requirements and has included it as a requirement in the T-3 contracts.

Nonstandard Claim Forms

The Department will continue to accept nonstandard claim forms due to the need to accept claims directly from TRICARE beneficiaries.

Other Health Insurance (OHI) Payment Calculation Program

Even though the TRICARE OHI calculation for claims processing is more extensive than Medicare's, the Department will not change to the Medicare OHI calculation as this would result in increased costs for the TRICARE beneficiaries and potentially increase the overall TRICARE program health care costs.

Explanation of Benefits (EOB)

There is insufficient justification for the Department to incur any additional costs by returning to prescriptive requirements for TRICARE EOBs. Although non-prescriptive with regards to the EOB format, in the T-3 contracts the Department is allowing the contractors the choice of providing a monthly summary EOB in lieu of an EOB for each individual claim processed, which is more in alignment with the summary EOB requirements of the Medicare program.

CLAIMS PROCESSING REQUIREMENT DIFFERENCES IDENTIFIED IN THE FY 2007 REPORT TO BE ADDRESSED THROUGH FURTHER REVIEW AND ANALYSIS

Claims Editing Software

Claims Processing Jurisdiction

Institutional Outpatient Claims Processing

Detailed business cases for each of these three claims processing differences are provided in the next section of this report.

BUSINESS CASE

Phase 1: Provider or Beneficiary Claim Preparation and Submittal Requirements

CLAIMS EDITING SOFTWARE

Background:

Health care payers throughout the U.S. use claims editing software to ensure that services have been billed in accordance with industry standard procedure coding practices and the payer's coverage policies. Incorporation of code checking into health care claims processing has become an important factor in prevention of overpayments and health care fraud. The challenge in adopting code checking is ensuring the product used is comprehensive and sufficiently targeted to each health plan to properly reimburse payers while maximizing savings.

Medicare

In 1994 the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) contracted for development of National Correct Coding Initiative (NCCI) software for auditing outpatient claims. The NCCI edits were created specifically for Medicare's population.

TRICARE

To meet the congressional mandate (Section 2304 (g)(l)(B) of Title 10 of the United States Code) and the Federal Acquisition Regulations (FAR) Part 7 to move from prescriptive contracts to an outcome or performance-based approach, the current TRICARE contracts awarded in August 2003 did not dictate a particular claims editing software. Instead, each contractor was allowed to use best business practice for code checking in order to bring the best commercial approach to the TRICARE program. The contractors were at liberty to select the product or process they believed would best achieve the TRICARE requirements for accurate claims payment and fraud or abuse prevention. Each of the current Managed Care Support Contractors selected the ClaimCheck® claims editing software product, and its use has resulted in substantial cost avoidance (such as $87 million in 2003, $95 million in 2004, $184 million in 2005, $268.2 million in 2006, and $290 million in 2007).

In order to align with Medicare, the Department is expecting to implement the national Outpatient Prospective Payment System (OPPS), which includes the use of Medicare's NCCI software for auditing outpatient institutional claims in November 2008. In addition, the Managed Care Support Contractors will continue to have the option of

applying their best business practice in selecting claims editing software for professional services.

Justification for Difference:

- In addition to using Medicare's NCCI, the Department will also allow the Managed Care Support Contractors to use a commercial claims editing software, e.g., ClaimCheck®. The Department will continue to allow commercial claims editing software in order to continue to avoid substantial additional health care costs.

Conclusion:

The Department will require the contractors to use Medicare's NCCI claim editing software edits for all outpatient institutional claims, which aligns the TRICARE and Medicare programs. In addition, the contractors also have the option of using ClaimCheck® or another commercial claims editing software for professional services claims.

BUSINESS CASE

Phase 2: Claim Processing and Notification to Provider and/or Beneficiary

CLAIM PROCESSING JURISDICTION

Background:

Medicare

The Medicare fee-for-service program processes claims based on the location where services were rendered (provider address). Under this system, providers deal with only one claims processor. Medicare Advantage plans are responsible for paying for emergency and urgent care for their enrollees regardless of where the enrollee obtains the services. If a Medicare Advantage enrollee is traveling outside of the Medicare Advantage service area and requires emergency or urgent care, the claims are sent to the Medicare Advantage plan and paid by that plan. Routine care received outside of the Medicare Advantage service area, unless authorized by the Medicare Advantage plan in advance, is not paid by either the Medicare Advantage plan or the Medicare fee-for-service program.[1]

TRICARE

Due to the at-risk nature of the TRICARE contracts, jurisdiction for claims processing is determined by the region where the beneficiary is enrolled or maintains residency as reflected in the Defense Eligibility Enrollment Reporting System (DEERS), similar to the Medicare Advantage program.

This past year the Department commissioned an Independent Government Cost Estimate (IGCE) to determine the feasibility of changing the claim processing jurisdiction requirement in the T-3 Managed Care Support contracts to be similar to the Medicare fee-for-service program requirement. The IGCE identified a number of potential cost and customer service issues with changing the claims processing responsibility from the beneficiary's region identified in DEERS to the region where the services were rendered. The analysis found that there would be significant one-time implementation costs for any future contractor to design its claims processing system to accept claims based on servicing provider address as opposed to beneficiary enrollment or DEERS residence. Additionally, changing this requirement would mean both the region identified in DEERS for the beneficiary and the region where the care is rendered would have significant roles in the overall administration of these claims - from referrals and authorizations to claims follow-up inquiries, appeals, and/or grievances from beneficiaries or providers. As a result, two contractors would end up sharing

[1] Medicare Managed Care Manual Chapter 4, Section 130.2

responsibility across a wide range of potential issues involving a claim. Since 1.8 million TRICARE claims a year are out-of-area, it is very likely all the contractors would need to establish dedicated units responsible for supporting these claims, which would increase the administrative costs of the TRICARE contracts.

Another significant area of concern is the impact changing to the Medicare fee-for-service model would have on customer service. TRICARE beneficiaries expect and deserve to have all their questions and concerns addressed by their regional contractor. By involving another contractor in the out-of-area claims processing scenario, the risk of confusion for the beneficiary is significantly increased, resulting in beneficiary dissatisfaction.

Justification for Difference:

- The TRICARE program's processing of out-of-area claims is in alignment with Medicare Advantage plans, but not aligned with the Medicare fee-for-service program.

- Aligning with the Medicare fee-for-service program would create significant one-time implementation costs estimated to be approximately six million dollars. Future contractors would have to design their claims processing system to accept claims based on servicing provider address as opposed to beneficiary enrollment region or DEERS address.

- This change would require both the contractor for the region where the beneficiary is enrolled and the contractor for the region where the beneficiary received care to have significant roles in the overall administration of these claims, from referrals and authorizations to claims payment to follow-up inquiries, appeals, and/or grievances from beneficiaries or providers. We estimate the ongoing administrative costs would be approximately eight million dollars, an expense currently not incurred.

- One of the tenets of the TRICARE program is superior customer service. Beneficiaries expect and deserve to have all their questions and concerns addressed by their regional contractor. By involving another contractor in the out-of-area claim processing scenario, the risk of confusion for the beneficiary is significantly increased, resulting in beneficiary dissatisfaction.

Conclusion:

In T-3 Managed Care Support contracts, the TRICARE program's out-of-area jurisdiction claims processing is aligned with the Medicare Advantage program out-of-area claims processing rules. Changing the out-of-area claims processing methodology to that of the Medicare fee-for-service program methodology has the potential to increase the cost to the TRICARE program and negatively impact TRICARE customer service.

Therefore, the Department intends to continue to align with the Medicare Advantage program's methodology for processing out-of-area claims.

BUSINESS CASES

Phase 2: Claim Processing and Notification to Provider and/or Beneficiary

INSTITUTIONAL OUTPATIENT CLAIMS PROCESSING.

Background:

Medicare

The Medicare program has historically processed institutional outpatient services in the same manner as institutional inpatient services by requiring revenue codes to identify reimbursement for services.

TRICARE

The TRICARE program requires the same revenue codes as Medicare to process institutional inpatient services. However, due to limitations in the TRICARE legacy Health Care Service Record (HCSR) database, contractors were required to cross-walk the revenue codes to procedure codes for institutional outpatient services in order to develop a correct reimbursement HCSR. This additional cross-walk to report institutional outpatient services was necessary because the HCSR system could not differentiate between "inpatient" and "outpatient" institutional charges since the same coding classification of revenue codes was used for both services. With the development of the TRICARE Encounter Data (TED) record, it is now possible for the Department to eliminate this approach for reporting institutional outpatient claims. However, this will involve significant reprogramming of the TED system, as well as the contractors' systems.

Justification for Difference:

- Due to system limitations and reprogramming cost, the Department was not able to adopt the Medicare institutional outpatient claims processing procedures in the current contracts. With the implementation of the TRICARE Encounter Data System (TEDS), the Department is able to align its claims processing for institutional outpatient services with the Medicare program. Funding for system changes necessary to eliminate this nonstandard approach used in the TRICARE program for processing outpatient institutional claims has been included in the FY Program Objective Memorandum 2010. Upon receipt of funding, the changes will be implemented in the T-3 Managed Care Support contracts.

Conclusion:

The Department will adopt Medicare's institutional outpatient claims processing methodology in the T-3 contracts. To accomplish this change, the requirement has been included in the FY 2010 POM.

The following summarizes the seven differences which exist between the TRICARE and Medicare programs and the Department's position on each of these differences:

CLAIMS PROCESSING REQUIREMENT DIFFERENCES RETAINED BASED ON FY 2007 REVIEW AND ANALYSIS

1. Electronic Claims Submission. The Department does not plan to seek authority to require TRICARE providers to file claims electronically, but will continue to encourage this practice through the Managed Care Support contract requirements in both the current and T-3 contracts.

2. Nonstandard Claims Forms. The Department already uses the standardized claims forms and formats from providers within the U.S., but will continue to accept non-standard claims forms from beneficiary claims.

3. Other Health Insurance Payment Calculation. The Department will not change to the Medicare OHI calculation as this would result in increased penalty to TRICARE beneficiaries and potentially increase the overall TRICARE program health care costs.

4. Explanation of Benefits. The Department is allowing the contractors the choice of providing a monthly summary EOB in lieu of an EOB for each individual claim processed, which is more in alignment with the summary EOB requirements of the Medicare program.

CLAIMS PROCESSING DIFFERENCES IDENTIFIED IN THE FY 2007 REPORT ADDRESSED FOR INCLUSION IN THE T-3 MANAGED CARE SUPPORT CONTRACTS

5. Claims Editing Software. In order to further align with Medicare's claims processing methodologies, the Department will use the Medicare National Correct Coding Initiative editing software along with commercial claims editing software e.g., ClaimCheck® for institutional outpatient claims. Implementation is expected to begin in November 2008.

6. Claims Processing Jurisdiction. The TRICARE program is in alignment with Medicare Advantage program out-of-area claims processing. The Department will not adopt the Medicare fee-for-service out of jurisdiction claims processing methodologies.

7. Institutional Outpatient Claims Processing. The Department will adopt this approach in the T-3 contracts, once funding is received.