

**Defense Health Agency
FY 2014-2015 Risk Assessment
Military Health Benefits Program
For Improper Payment Reporting**

Background

The Improper Payment Elimination and Recovery Improvement Act of 2012 (IPERIA) requires agencies to follow steps to determine whether the risk of improper payments is significant and provide valid annual estimates of improper payments for its programs. Beginning in FY14, "significant improper payments" are defined as gross annual improper payments in the program exceeding both 1.5 percent of program outlays and \$10,000,000 of all program or activity payments made during the fiscal year reported or \$100,000,000, regardless of the improper payment percentage of total program outlays. (For fiscal years prior to FY14, the cut off was 2.5 percent). For all programs and activities susceptible to significant improper payments, agencies shall determine an annual estimated amount of improper payments made in those programs and activities.

Prior Government Accountability Office (GAO) and DoD Inspector General (DoD IG) audit reports raised questions about the Department's risk assessment in association with improper payments identification. The risk considerations presented herein resolve the audit recommendation to conduct a risk assessment in compliance with IPERIA to identify programs susceptible to significant improper payments.

DoD Programs

Beginning in FY 2006, the Office of Management and Budget (OMB) determined that all DoD payments are susceptible to the risk of improper payments based on the large volume of transactions and high dollar amounts of annual disbursements. Since that time, the Department has reported on the following programs:

- (1) Military Retirement
- (2) Military Pay
- (3) Civilian Pay
- (4) Travel Pay
- (5) Commercial Pay
- (6) Military Health Benefits

The Defense Health Agency (DHA) conducts reviews for the following Military Health Benefits TRICARE purchased care contracts (TPCCs):

- a. Managed Care Support Contracts (MCSC)
 - 1) North Region – HealthNet Federal Services (HNFS)
 - 2) South Region – Humana Government Business Inc. (HGB)
 - 3) West Region – UnitedHealth Military Veterans Services (UHMVS)
- b. TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)
- c. TRICARE Pharmacy Program (TPharm)
- d. TRICARE Overseas Program (TOP)
- e. Active Duty Dental Program (ADDP)

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Methodology

The DHA prescribes requirements for accurate payment of claims under the TRICARE health benefits program in various sections of the TRICARE manuals (i.e., Policy, Reimbursement, Operations and Systems). These requirements to pay claims correctly involve all aspects of the program, including beneficiary/patient TRICARE eligibility, healthcare benefit and/or TRICARE enrollment status, regional jurisdiction, provider types, other health insurance, benefits/exclusions, referrals/authorizations, duplicate payment avoidance and medical necessity. DHA provides considerable software and file updates that the TPCCs must apply to their systems in order to correctly pay claims. Updates such as Diagnosis Related Group (DRG), Outpatient Hospital Prospective Payment System (OPPS), Current Procedural Terminology (CPT-4), CHAMPUS Maximum Allowable Charge (CMAC), etc., help ensure that claims are paid correctly. To this end, the DHA also makes available to TPCCs the No Government Pay List (NGPL) which specifies services which are never a benefit, or only a benefit under certain conditions, and access to a host of TRICARE Rates and Reimbursement information (<http://www.tricare.mil/tma/Rates.aspx>).

To validate the accuracy of claims payment and contractor compliance with TRICARE policy and reimbursement guidelines, Code of Federal Regulation directives, and specific TPCC contract requirements, DHA has contracted with an External Independent Contractor (EIC). The EIC is responsible for identifying improper payments as a result of TPCC's non-compliance with TRICARE policy, benefit, reimbursement and coding requirements, by conducting an independent, impartial review of reimbursement determinations, claims processing procedures, and TRICARE payment record coding procedures developed and utilized by TPCCs.

To identify improper payments and/or identify incorrect payment record coding errors, the EIC manually re-adjudicates the TPCCs' claims processing procedures by reviewing medical, dental and pharmacy claims forms (i.e. CMS 1500, UB 04, DD 2642) and additional claims processing documentation e.g., Explanation of Benefit (EOB) forms, Defense Enrollment and Eligibility Reporting System (DEERS) patient/beneficiary eligibility and TRICARE enrollment program information, provider network discount agreements, provided to the EIC by the TPCC, that substantiates their claims processing and reimbursement determinations.

Post payment compliance reviews are conducted by the EIC on a recurring quarterly, semi-annual or annual basis and as contractually defined in the EIC and TPCC contracts. To validate the accuracy of the EICs compliance review procedures/techniques, DHA Government and Government contracted Program Analysts (who specialize in TRICARE policy, reimbursement, coding and contract requirements) conduct internal quality assurance reviews of claims previously reviewed by the EIC. Internal DHA reviews are performed on at least one review cycle per TPCC in each EIC contract option period.

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Risk Identification and Assessment

The DHA risk identification and assessment process determines if TPCC and/or healthcare programs are susceptible to improper payments. The risk is defined as “high”, or “significant” if the improper payments and rate exceed (1) both 1.5 percent of program outlays and \$10M or (2) \$100M regardless of percent; “medium” if improper payments and rate exceed either 1.5 percent of program outlays or \$10M; and “low” if improper payments and rate are both less than 1.5 percent of program outlays and \$10M.

1. Risk Identification – **Prepayment** Reviews

a. **Risk Identification Source** – TPCC Claims Processing Prepayment Edits and Manual Prepayment Review Procedures

b. **Risks Identified**

- Duplicate Claim Denials
- Prepayment Reviews
- ClaimCheck – claim editing software
- High Dollar Claim Reviews – As defined by TPCC
- Beneficiary/Patient Eligibility Validation
- Prior Authorization/Referral Validation
- Other Health Insurance/Third Party Liability (OHI/TPL) Verification/Development
- Timely Filing
- Sanctioned Provider/Beneficiary List
- Program Integrity – TPCC Contract and TRICARE Manual Requirements
- Re-bundling/Mutually Exclusive Edits
- Pharmacy Daily Claim Audits
- Excluded Providers
- Behavioral and Home Health
- Durable Medical Equipment/Parenteral Enteral Nutrition
- Extended Care Health Option (ECHO) program eligibility
- Invalid Diagnosis Code
- Outpatient Prospective Payment System
- Catastrophic Cap and Deductible Data File Discrepancies
- Pricing Discrepancies
- Patient/Beneficiary Eligibility Discrepancies
- Provider Data Discrepancies
- Ambulatory Surgery (reimbursement methodologies)
- Medicaid Claims
- Out of Jurisdiction (require claims to be transferred to appropriate/responsible TPCC)

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c. Results (self-reported by TPCCs)

Prepayment Activity	Costs Avoided
Prepayment Duplicate Denials	\$683,857,124
Re-bundling/Mutually Exclusive Edits	\$81,132,944
Prepayment Reviews	\$15,350,778
Pharmacy Daily Claim Audits	\$435,163
Excluded Providers	\$1,100,000

To avoid improper payments, DHA requires TPCCs to use commercial ClaimCheck or equivalent claims auditing software when processing healthcare claims under the TRICARE Program. The DHA also expects TPCCs to use industry best practices in order to pay claims correctly, which lead to the use of a variety of software packages such as zip code mapping software and requires prepayment review for certain providers/beneficiaries who are known to be at-risk for fraudulent behavior. In addition, DHA requires TPCCs to develop front end edits in their claims processing systems to ensure claims are paid in accordance with TRICARE policy, reimbursement guidelines and any additional or unique contract requirement. Periodically, DHA Government Program Analysts and contract representatives visit the TPCCs on-site locations to ensure that Government directives, guidelines and contract requirements are being followed.

Each TPCC has individual and proprietary business procedures that are utilized to ensure the accuracy of claims payment prior to the reimbursement of a healthcare payment. Some of the prepayment processes/procedures to prevent improper payment include the following:

- **Prepayment high dollar claims review:** For TPCCs this audit is conducted just prior to payment, after all manual and system reviews have been completed and t. High dollar claim review edits apply to all TPCC's, however, based on individual contract requirements or claim types, high dollar thresholds may vary across contracts. Based on the TPCC established high dollar claim threshold(s), 100% of claims meeting the criteria (i.e., \$25,000 for inpatient institutional and all other claims over \$5,000) are reviewed. The review is conducted by senior staff and covers all aspects of the claim similar to the EIC's compliance review process.
- **Prepayment claim audits:** Random claim samples below the high dollar threshold are conducted to review the entire claim and potential payment amount before payment is made.
- **Employee Audits:** new employees/trainees have 100% of their work audited before it moves from their work queue to the next phase within the TPCCs claims processing system. Fully trained staff is also audited (but not at 100% like new employees). These audits help decrease potential human errors.

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- **System changes:** in addition to testing, on the day a system change is implemented, key staff has specific functions and reports that are reviewed throughout the claim cycle to identify any unintended consequences of the system change, resulting in prompt resolution.

Prepayment claim reviews by TPCCs entail the random selection of claims using an automated in-line processing that defers claims for manual review by a quality assurance (QA) analyst. TPCCs design their systems to meet individual contract requirements, but for the most part systems are designed to allow a QA team to request claims to audit by associate, provider, procedure code, diagnosis code, dollar range or other user-defined criteria. The TPCC prepayment claim reviews are a manual review process performed to ensure the accuracy of claims processing. QA analysts or associates audit claims against a checklist of numerous attributes, including but not limited to, patient and provider eligibility, TRICARE policy, authorization and referral requirements, duplicate payment, reimbursement methodology and correct reimbursement calculations. Prepayment reviews ensure the identification of claim payment errors and allows system correction of required, prior to claim adjudication.

2. Risk Identification – **Postpayment** Reviews

a. **Risk Identification Source** – External Compliance Review Findings.

b. **Risks Identified**

- Authorization/Preauthorization Needed
- Benefit Determination Unsupported
- Billed Amount Incorrect
- Cost-Share/Deductible Error
- Development Claim Denied Prematurely
- Development Required
- Duplicate Services Paid
- Eligibility Determination - Patient
- Eligibility Determination - Provider
- Medical Emergency Not Substantiated
- Medical Necessity Not Evident
- Non-Availability Error
- Other Health Insurance (OHI) - Government Liability Miscalculated
- OHI Payment Omitted
- Payee Wrong - Sponsor/Patient
- Payee Wrong - Provider
- Participating/Nonparticipating Error
- Pricing Incorrect
- Procedure Code Incorrect
- Signature Error
- Timely Filing Error
- Diagnosis Related Group (DRG) Reimbursement Error

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- Contract Jurisdiction Error
- Benefit Determination Wrong
- Claim Not Provided
- Claim Not Auditable
- Incorrect At Risk System
- Other – as noted

c. Results

FY 2013 External Compliance Claim Review Findings Results						
Program	Total Outlays (\$B)	IP % of claims subject to audits¹	Extrapolated IP Total² (\$M)	IP Exceed \$100M?	IP exceed 1.5% of Program Outlays / and \$10M?	Risk Assessment (Low/ Medium/ High)
*MCSC	\$11.2	1.01%	\$96.4	Yes	No/Yes	High
TDEFIC	\$3.1	0.60%	\$16.4	No	No/Yes	Medium
*TOP	\$0.22	1.66%	\$4.5	No	Yes/Yes	Medium
TPharm	\$6.5	0.66%	\$30.3	No	No/Yes	Medium
*ADDP	\$0.2	1.86%	\$2.2	No	Yes/No	Medium
TOTAL	\$21.2	0.87%	\$149.8	Yes	No/Yes	High
Notes:						
1 – Claims above low-dollar thresholds are subject to audits. The low-dollar threshold is \$100 for MCSC, TDEFIC, TOP, and ADDP claims, \$30 for pharmacy electronic retail claims, and \$10 for pharmacy paper claims. The IP % of claims subject to audits does not represent the entirety of Total Outlays because some outlays do not meet the low-dollar threshold.						
2 – The Extrapolated IP Total represents claims in the audit universe above the low-dollar threshold.						

For FY 2013, the overall improper payment rate was estimated to be 0.87% (representing \$149.8M) and thus, the risk of improper payment is determined “significant” per IPERA. The purchased care contracts and various TRICARE programs are potentially susceptible to improper payments based on the high volume of payments made and the complexity of various reimbursement methodologies used when processing healthcare claims. The above risk assessment is based on results from the quarterly and semi-annual EIC compliance reviews. As a result, all DHA purchased care contracts and healthcare delivery programs will continue to be subject to review for improper payments.

For FY2013, DHA revised its methodology for calculating the absolute payment error rate. Historically (FY2012 and prior), DHA used the *billed amount* rather than the *paid amount* as the denominator when calculating the DHA error rate. This was intentional and was contractually required to derive a total payment error rate that combined *paid claims* and *denied claims*. Using the *paid amount* for denied claims that were denied in error would result in an increase to the absolute payment error (numerator) but zero change to the payment amount (denominator), which inflated the overall Payment Error Rate. However, per audit DoD IG and GAO recommendations/findings, DHA has modified the formula to calculate the Payment Error Rate for IPIA/IPERA reporting purposes.

While the DHA has contracted with an EIC to provide an independent, impartial post payment review of TPCC processed healthcare claims, the DHA also requires TPCCs through

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policy or contract requirements to develop post pay procedures to also identify and recovery improperly paid claims. Part of the TPCC postpayment contract review requirement is to utilize the DHA Duplicate Claims System (DCS). The DCS is a web-based application developed by DHA to automate the resolution of potential and/or actual duplicate claim payments retrospectively, supporting the TPCCs claims resolution process. The system facilitates the identification of actual and/or potential duplicate claims payments, the initiation and tracking of recoupments, and the removal of duplicate records from the DHA TRICARE Encounter Data (TED) database. The system also generates operational and management reports.

Potential and/actual duplicates are based on specific match criteria applied to each TED record and record line item. TED records meeting the match criteria are made available to the TPCCs in a monthly download and are researched/worked daily by the TPCCs. The DCS improves DHA and the TPCCs accountability of actual duplicate payments retrospectively through the tracking of the amounts identified for recoupment, amounts received from refunds or offsets, and adjustments or cancellations submitted upon receipt of the refunded or offset overpayments.

Sampling Methodology

Based on various DoD IG and GAO audit recommendations, DHA implemented the following changes to its FY 2013 and 2014 sampling plan:

DHA conducts several compliance reviews to identify payment accuracy and monitor accurate data collection. Payment accuracy compliance reviews include two sample types: a **payment** sample (to ensure payment accuracy by identifying underpayment and overpayments) and a **denied payment** sample (to ensure proper claim denial). In addition, an **occurrence** sample is performed to ensure data accuracy reported by contractors. Paid samples are conducted as a stratified random sample based on paid amounts; denied samples are conducted as a stratified random sample based on billed amounts; and occurrence samples are conducted as a simple random sample with no stratification. DHA continually evaluates the accuracy and design of its sampling methodologies for all contracts and implements revisions should they be warranted by audit universe distributions or the outcome of audit results.

Respective of DHA contract requirements, samples are drawn on either a quarterly or semi-annual basis and include *underwritten* and *non-underwritten* healthcare claims. In addition to quarterly and semi-annual compliance reviews, annual healthcare cost (AHCC) audits are performed on the MCSCs to determine the total overpayment amount for healthcare costs (*underwritten only*) that is recovered at the end of each option period.

Payment Sample: Paid samples are conducted to identify improper payments and measure payment accuracy. Depending on the TRICARE contract type (i.e., MCSC, TDEFIC, TOP, etc.), the universe for a paid sample may contain between several hundred thousand to 30 million claims. All claims with government payment amount above a high-dollar threshold (i.e. \$200,000) are reviewed, and claims below this threshold are randomly sampled based on

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stratification of the government payment amount. The high-dollar threshold may fluctuate from one audit to the next, depending on the composition of the claims payment universe.

Payment Sample Stratification: Samples for paid claims include between four and 12 strata, depending on the composition of the claims in the universe. Mathematical formulas are utilized to identify optimal strata boundary points, and sample sizes are calculated to meet (or exceed) an estimate with a minimum of 90% confidence plus or minus 2.5 percentage points (as stipulated in the OMB Circular A-123, Appendix C guidelines).

Denied Payment Sample. The primary purpose of the denied payment samples is to ensure that health care/supplies are not being denied inappropriately (which may represent obstacles in TRICARE beneficiaries' access to care) by TPCCs. Records that encompass the denied payment sample universe are limited to records with government payment amounts equal to zero. All claims with a billed amount above a high-dollar threshold are reviewed, and claims below this threshold are randomly sampled based on stratification of the billed amount. Depending on the contract type, a denied audit universe may contain between several thousand to over 1 million claims.

Denied Payment Sample Stratification. The denied payment sample is similar in design to the payment sample; the primary difference is that the denied sample is stratified based on *billed amount* since the *paid amount* for a denied claim is equal to \$0.

Data Accuracy Controls

In addition to the Payment and Denied Payment samples, DHA conducts reviews to ensure that accurate data is reported by the TPCCs. Occurrence samples are intended to monitor and evaluate the accuracy of TED record coding by the TRICARE contractors, as opposed to determining the accuracy of claims payment. These records are selected via a simple random sample. A flat sample size (of up to 350 records) is selected for each occurrence sample, and each record in the sample contains approximately 90+ data fields that are audited for accuracy. Results from occurrence samples are used to monitor data accuracy only and *do not* affect the improper payment error rates (however, TPCCs are required to correct any improper payments identified as a result of EIC occurrence reviews).

DHA Program Integrity Fraud and Abuse Program

The DHA Program Integrity (PI) Mission is to manage anti-fraud and abuse activities for the DHA to protect benefit dollars and safeguard eligible beneficiaries. DHA PI is the central coordinating office for allegations of fraud and abuse within the Defense Health Program; develops and executes anti-fraud/abuse policies and procedures; provides oversight of contractor program integrity offices and activities; develops fraud/abuse cases for criminal prosecutions and civil litigation; coordinates investigative activities and exchanges information with the Department of Justice (DOJ), law enforcement agencies, state and federal agencies, and private plans; and initiates administrative remedies to enforce provisions of law, regulation and policy.

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The DHA contractually requires all TPCCs to maintain a TRICARE dedicated program integrity unit responsible for anti-fraud activities within their designated region. Contract requirements include responsibilities for fraud and abuse prevention/detection, case development, use of fraud detection software, prepayment and postpayment evaluation of claims, anti-fraud activity reporting, provider suspensions, and provider termination/reinstatements. Contractors utilize a robust number of anti-fraud controls to include prepayment edits, prepayment review (select providers/beneficiaries), prepayment and post payment duplicate auditing, and anti-fraud data mining.

To manage the oversight of TPCCs program integrity responsibilities, the DHA Program Integrity (PI) Contractor Oversight Branch has assembled a team of subject matter experts (SMEs) responsible for monitoring and assessing TPCC performance. This includes evaluating the TPCCs compliance with the program integrity terms and conditions of their contract, quality standards for case referrals, and delivery of work products. SMEs maintain and review contractor Standard Operating Procedures for compliance purposes.

As required by contract and TRICARE operational directives, TPCCs submit quarterly Fraud/Abuse summary reports to DHA PI that provide information regarding contractor program integrity activities (e.g., cases initiated, cases closed, administrative actions, cost avoidance savings, recoveries, etc.). These reports allow DHA PI to examine and review contractor cost avoidance/recoveries throughout the year in areas such as prepayment review denials, recoupments, duplicate claim denials, and other areas due to anti-fraud efforts. From these reports, DHA PI assesses if contractor resources are being utilized efficiently and effectively. Review of the reports also provides a “check and balance” system to help identify any anomalies in the reported data.

In addition, the DHA PI Contract Oversight Branch conducts the following activities as part of its TPCC oversight responsibilities:

- Quarterly On-Site Visits – SMEs visit 1 TPCC contract site per quarter, allowing a minimum of one onsite evaluation of each contractor every 18-months. SMEs observe and evaluate areas such as anti-fraud corporate strategy and commitment, use of anti-fraud software, case development techniques, training, and medical review in real-time setting.
- Quarterly Roundtable Discussions – The DHA PI Contract Oversight Branch and the DHA PI Investigative Oversight Branch each host quarterly roundtable sessions with TPCCs. Roundtable discussions promote teamwork and best approaches to fraud detection, prevention, and collaboration. Key to these sessions are discussions on best business practices, TRICARE policies and procedures, ongoing TPCC training/education of staff, opportunities for proactive/preventive measures, emphasizing effective lines of communication,

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auditing techniques, and identifying opportunities to improve performance and efficiencies. Roundtable sessions are primarily held via telephone conference.

- Contractor Case Referral Evaluations – DHA PI conducts an evaluation on all case referrals received from TPCCs. The purpose of the evaluation is to determine if the referral is in posture to be forwarded to law enforcement and to provide the TPCCs with feedback regarding the technical aspects of the referral.

To encourage early identification of fraud, DHA PI engages in multiple proactive activities designed to identify areas that may be vulnerable to fraudulent and abusive billings. DHA PI develops areas of focus and analyzes claims data to identify outliers. Recognizing the importance of sharing information with the investigative community, DHA PI (often a presenter) regularly attends task force meetings, information sharing meetings, and health care fraud meetings. These meetings foster collaborative anti-fraud efforts across government agencies and private organizations.

DHA PI Activity Report: During calendar year (CY) 2013, 388 active investigations were managed, 212 cases were opened, and 931 leads/requests for assistance were responded to. DHA received and evaluated a record number of 438 new *qui tams*. A *qui tam* is a provision of the Federal Civil False Claims Act (FCA) that allows private citizens, known as relators, to file lawsuits on behalf of the U. S. Government alleging that private companies (usually their employer) have submitted fraudulent claims for government payment. The private whistleblowers who file these *qui tam* lawsuits receive a percentage of the settlement or judgment amount if a settlement or judgment is reached. <http://www.tricare.mil/fraud/>

<i>DHA PI Major Activities for CY 2013</i>	
Cases Opened	212
<i>Qui Tam</i> Responses	438
Cases Referred to Defense Criminal Investigative Service (DCIS)	48
Cases Referred to Military Criminal Investigative Organization's (MCIO's) and Others	63
Judgment, Settlements, Prosecutions	43
Requests for Assistance / Leads	931
Providers Sanctioned	3,334
Balance Billing / Violations of Participation Agreements	191

It is DHA's position that Improper Payment reporting requirements do *not* extend to health care claims which are intentionally fraudulently submitted. OMB Circular A-123, Part III clarifies that under the improper payment reporting requirements, a payment based on a fraudulent claim that may be referred to DOJ for litigation is separate and distinct from an improper payment, and is thus handled differently. The primary basis for this belief rests in an understanding that reporting of such information could and would expose investigative and

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litigation pending actions to public disclosure, and would alert the person(s) of interest who are committing fraud and under investigation.

Other significant reasons why DHA does not include fraud in improper payment reports include:

- ✓ Fraud is an intentional criminal act.
- ✓ Fraud is lying on the claim form and stealing from the government.
- ✓ Fraud is a deception, a misrepresentation. Claims' processing of a "clean claim" occurs in a relatively short time frame in order to meet federal payment requirements so as not to cause financial harm to the providers or to the beneficiaries.
- ✓ Fraudulent claims are designed to appear as a "clean claim." They appear legitimate and are specifically designed to bypass security safeguards put in place to prevent improper payments.
- ✓ It would be incorrect and damaging to categorize fraud as an improper payment. Doing so could have far reaching implications and would significantly interfere with DHA's anti-fraud efforts and with DOJ prosecutorial actions on our behalf.
- ✓ If a government entity issues a public statement putting fraud into the same context as a "mistake or improper payment," criminals would avoid prosecution. A common defense for defendants is that they just made an error and they just want to return the "improper payment." Defense attorneys would leverage this ready-made argument to overcome strong evidence against their clients.

Corrective Action Plans

DHA purchased-care contracts are designed to include payment accuracy performance standards for processing military health benefit claims. Specifically, if improper payments exceed the payment accuracy performance standard as stipulated in TRICARE policy manuals or the potentially more stringent contract performance standards, the TPCC may be subject to either financial penalty or financial incentives. TPCCs payment accuracy performance is analyzed during the EIC quarterly and semi-annual compliance reviews. In addition to quarterly and semi-annual compliance reviews, annual reviews are conducted on claims representing underwritten healthcare costs that are paid by the managed-care support contractors (MCSCs). Confirmed overpayments are projected to the sample universe, and the MCSCs are liable for the total extrapolated error amount.

For the past several years, TPCCs have been held to payment accuracy performance standards with either contract financial penalties or incentives, depending on the contract type and requirement(s). This contract design encourages contractors to keep payment error rates as low as possible to avoid financial penalties, or to obtain increased contract financial awards. Actual error rates have been consistently less than one percent. This contract design, combined with numerous pre-payment and post-payment controls, effectively curtails improper payments by the Department's purchase-care contractors and ensures the Government's risk for improper payments in the military health benefits program is minimized.

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It should be noted that the formula was changed for this year's report to calculate the Department's overall improper payment error rate for the military health benefits program. Specifically, the error rate was calculated as a percentage of dollars paid versus dollars billed, and the errors identified in random samples were extrapolated using a weighted formula. Accordingly, the FY 2013 error rate should *not* be directly compared with prior years.

DHA TPCCs are monetarily incentivized or dis-incentivized, through contractual payment accuracy performance standards, to reduce and/or eliminate improper payments. The fewer improper payments the contractors make, the less money is deducted from their contractual reimbursements. Additionally, details of the EIC compliance reviews are shared with the purchased-care contractors, DHA Program Offices, purchased-care contract Contracting Officers (CO) and Contracting Officer Representatives (CORs) to coordinate appropriate corrective action plans with the respective purchased-care contractor.

- Upon completion of an EIC compliance review, respective contractors review results, formulate an action plan to mitigate future findings and derive a process to avoid future improper payments.
- If warranted, contractor claims processing systems are modified to meet the Department's healthcare policy, reimbursement, or benefit requirements.
- If there is the potential that additional healthcare claims were processed in error, ad hoc reports are pulled and adjustment actions are taken as appropriate.

Each TPCC has its own business process for evaluating compliance review results and conducting root cause analyses to ensure the accuracy of future claims payment and developing internal corrective action plans. If required, DHA COs and CORs issue contractor corrective action plans to remedy and track noncompliance with TRICARE healthcare policy/regulations, and purchased-care contract requirements.

DHA Controls

The DHA has had contracts with payment accuracy performance standards for many years, wherein the contractor is required to meet TRICARE policy or contractual payment accuracy performance standards as a result of the quarterly or semi-annual EIC compliance reviews. Historically (prior to FY 2013) the DHA payment accuracy performance standard for TPCCs was 2%, however; under the recently awarded TRICARE Third Generation T-3 contracts the DHA lowered the payment accuracy performance standard from 2% to 1.75%. While these performance standards are "base lines" for contractor performance, DHA Program Offices (i.e. TOP, TDEFIC, etc.) have developed more stringent contract payment accuracy performance requirements for some TPCC contracts.

As an example the DHA TDEFIC Program Office developed contract requirements which lowered the TDEFIC's payment accuracy performance standard to 1.5%. In addition, contract incentives were developed that allowed the contractor to earn financial incentives if the contractor decreases its payment accuracy rate to 1% or below. If achieved the contractor would

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be financially incentivized to receive 50% of an incentive fee. The contractor is further incentivized if the payment accuracy rate is lowered further to between 0.5% and 0.75%, if achieved the contractor is awarded 75% of the award fee, and if the payment accuracy is lowered to less than 0.5%, the contractor is awarded 100% of the available award fee. Other TPCC have similar contract enhanced payment accuracy performance standards, however those contractors are either financially incentivized for lowering the payment accuracy rate or dis-incentivized for not meeting the enhanced contract performance standard(s).

In addition to the quarterly and semi-annual compliance reviews, the DHA maintains a zero tolerance policy in relation to the MCSC Annual Health Care Cost (AHCC) compliance reviews. Overpayments identified as a result of the AHCC audit are extrapolated to the AHCC audit universe and the MCSC is liable for the extrapolated overpayment error amount. This contractual design provides a built-in incentive for contractors to continually perfect their claims processing system.

Over the years the DHA EIC compliance reviews have produced an error rate that are far less than the historical DHA 2% and current 1.75% performance standard or OMB's previous 2.5% and current 1.5% performance thresholds. Errors in health care claims processing can potentially be related to improperly submitted claims by the healthcare provider community, as well as a minimal degree of human error by the TRICARE contractor's claims processor(s) which is expected when handling/processing a significant volume of claims (approximately 196.5 million in FY 2013) and under the tight time parameters established by the Prompt Payment regulations and the DHA's claims processing timeliness performance standards. The FY 2013 improper payment rate (reported as FY 2014) for the military health benefits was estimated to be \$424.0 million or 2.0%. The actual performance was significantly less: 0.87% or \$149.8 million. These projected errors represent claims above the low dollar thresholds for EIC compliance reviews.

Numerous prepayment (i.e., claims auditing software, TRICARE documentation policies) and post-payment controls (i.e., DCAA contract audits, recovery activities - Medicare cost report and internal contractor post-payment audits) are built into the military health benefits' contract requirements and contractor's claims processing systems to minimize improper payments. Every TRICARE claim is adjudicated against this system of checks and balances. The TPCCs are required to utilize the specialized claims auditing software containing specific auditing logic designed to ensure appropriate coding on professional service claims and eliminate overpayments. The software does not set coverage/benefit policy; it merely audits claims for appropriate code combinations.

Another control is the prepayment review required under the TPCC contracts. The contractors use this strategy to prevent payment for questionable billing practices. Prepayment review allows for a closer examination of the services rendered and may require the provider to submit medical documentation to support the services billed. In addition, the DHA requires each contractor to have a fraudulent claims investigation or anti-fraud unit to identify and investigate any pattern of suspicious or potential fraudulent billings. Recoupment from cases identified,

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combined with proactive casework by DHA are additional benefit dollars returned to the program.

For improper payments made against non-underwritten health care (claims for which the Government assumes the financial risk), the contractors are required to establish accounts receivable and attempt to collect reimbursements from the providers. If reimbursements are not received, the contractors retain the accounts receivable to offset against future claims from the subject providers. Individual claims of \$600 or less are held by the contractors indefinitely, in accordance with the contract. Claims greater than \$600, if not collected or offset, are referred to the DHA General Counsel after 150 days for offset with the Department of Treasury. In FY 2013, the DHA General Counsel cross serviced to Treasury 587 cases valued at \$2,038,469.93 and collected \$1,359,875.40.

DHA Overpayments Recaptured Outside of Payment Recapture Audits Reporting -

The DHA utilizes a number of different mechanisms to prevent, identify, and collect improper payments; to include contract claims auditing by an EIC and internal DoD agencies for all TPCC payments.

(1) Recapture Auditing. The DHA maintains an extensive post-payment review process for identifying improper payments in the TPCC pay arena. Reference AFR Table 6 - Overpayments Recaptured Outside of Payment Recapture Audits for details of overpayment recoveries as a result of the MCSC AHCC audits.

TPCC overpayments identified for recovery are attributable primarily to EIC performance reviews, TPCC internal recovery audit efforts, and contract claim reconciliation. Selected high dollar value payments are reviewed manually and periodic independent reviews of TPCC payments improve improper payment detection, correction and prevention efforts.

Agency-wide TPCC payments comprise a large volume of transactions with high dollar values. Therefore, DHA maintains vigilance to ensure payment accuracy. In addition to the post-payment reviews in place, DHA also utilizes various internal manual and automated prepayment initiatives to prevent over- and under-payments.

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Reference the attached Table 1. Improper Payment Reduction Outlook which summarizes the DHA - Military Health Benefits improper payment reduction outlook and total program outlays (payments) for FY 2013 and FY2014 and outlay estimates for FY 2015 through FY 2017.

***Notes to Accompany Improper Payment Reduction Outlook Table**

Note 1: DHA reports 12 months in arrears; therefore its FY 2014 reporting represents FY 2013 data. It should be noted that the formula was changed in FY 2014 to calculate DHA's overall improper payment error rate. Specifically, the error rate was calculated as a percentage of

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dollars paid versus dollars billed, and the errors identified in random samples were extrapolated using a weighted formula. Accordingly, the FY 2014 error rate should not be directly compared with prior years. For comparison, the formula used for prior years would yield an improper payment error rate of 0.17% for DHA for FY2014.

Note 2: DHA uses 1.75% as its out-year target because that is the contractual performance standard. The FY 2015-2017 outlays estimates were calculated using the OMB CPI-U Annual Averages and Percent Change Table. As DHA reports 12 months in arrears, the FY 2014 CPI-U medical percent change was used to calculate the FY 2015 outlay estimates, while the FY 2015 and 2016 medical percent changes were used to calculate the FY 2016 and 2017 outlay estimates, respectively.

Note 3: DHA Outlays do not include expenditures for United States Federal Health Program (USFHP); Women, Infants, & Children (WIC); or TRICARE Dental Program (TDP), because these are audited by the Defense Contracting Auditing Agency (DCAA).

Note 4: The Improper Payment rate for DHA represents claims over low-dollar thresholds, which vary by contract (\$100 for Managed Care, TOP, TDEFIC, and ADDP; \$30 for electronic retail pharmacy claims; and \$10 for paper pharmacy claims).

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ADDITIONAL INFORMATION FOR OUSD(COMPTROLLER)

Notes to Accompany Recovery Auditing Reporting As Required In Financial Management Regulations (FMR) Department of Defense (DoD) 7000.14-R, Volume 10, Chapter 22, Subsection 2204

Note 4: Paragraph 220401.

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Note 5: Paragraph 220402. DoD must report in accordance with the annual update to OMB Circular A-136, Financial Reporting Requirements. The following is normally required:

Subparagraph A. General description, evaluation of the steps taken, and the methodology applied to carry out their cost-effective recapture audit program.

In addition to audits and recovery activities under the DoD Recovery Audit Program, the DHA also utilizes a combination of contractual payment performance standards for military health benefit claims processing, internal audits, and a post payment review by external independent claims auditors which have worked successfully for many years and has been referred to as a model contractual design to maintain integrity in government contracting. Under these contracts the DHA negotiates a target cost per year, for each individual regional contractor.

DHA maintains an extensive post-payment review process for identifying improper payments in the military health benefits pay arena. Part of this review process includes the post payment duplicate claim software which retrospectively identifies duplicate payments made by TPCCs. This software further identifies suspect and possible post pay duplicates which are not detectable on a pre-pay basis.

Selected high dollar value payments are also reviewed manually, and periodic independent reviews of military health benefit payments improve improper payment detection, correction, and prevention efforts. This process utilizes post-payment review techniques performed both internally and by an external independent contracted claims auditing firm who evaluates claims data on a quarterly, semi-annual and annual basis.

Military health benefit overpayments identified for recovery are also attributable to internal recovery audit efforts and contract reconciliation. To accomplish this, the DHA utilizes a number of different mechanisms to prevent, identify, and collect improper payments for all military health benefit payments.

Additionally, claims are paid against two different categories of beneficiaries: "At risk" is an identification of the funds utilized to provide care for dependents of uniformed services personnel and retirees and their eligible dependents, while "Not at risk" funds are those costs for medical services provided to uniformed service personnel, whom the DHA reimburses the contractor for 100%.

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Statistically valid compliance reviews (i.e. audits) are completed on a reoccurring quarterly, semi-annual and annual basis depending on the specific contract requirement. Industry standards and the Improper Payment Improvement Act (IPIA) recognize that errors will occur in payment processing. Based on results of compliance reviews, DHA TRICARE contractors may receive a monetary penalty for any erroneous payment rates exceeding the TRICARE 1.75% payment accuracy performance standard (or unique contract requirement with an allowable error rate lower than the IPIA standard of 1.5%).

Overpayment errors identified by the EIC during the MCSC AHCC audits are extrapolated to the entire AHCC audit universe and the MCSC is held financially responsible. In addition to contract financial disincentives for failing to meet the 1.75% claims processing payment accuracy performance standard, under the quarterly claims processing compliance reviews, MCSCs are also required to repay the government for any erroneous payments identified. This contract design provides a built-in incentive for contractors to make efforts to continually improve internal controls and edits.

Subparagraph B. Total cost of the DoD Component's recapture activities and audits.

The DHA contracts with an EIC to conduct quarterly, semi-annual and annual claims processing compliance reviews at a standard claim rate that increases with each contract option period. For FY 2013 the cost to perform the quarterly and semi-annual compliance reviews was \$4.4 million and \$0.5 million to perform the MCSC AHCC audits. In addition, under TRICARE contractual design, all military health benefit recovery activities are integrated into the TRICARE contracts with financial incentives and disincentives related to performance which varies by contract region.

Subparagraph C. The total amount of payments subject to review will include a description and justification of the classes of payments excluded from the payment recapture audit contractors, with an explanation of why recapture audits were not performed on all programs and activities, i.e., if not cost-effective.

For FY 2013 the military health care cost subject to additional recovery activities was \$20,479,687,549.30

Justification of the classes of payments excluded from the payment recapture audits:

- (1) The Designated Providers (Uniformed Services Family Health Plan) DHA's Risk Assessment has identified this program as "Low". The program pays for each patient's care on a per member per month basis, providing a set amount to the contractor based on the number of members. The contractor is 100% responsible for improper payments; there is no shared risk with the Government. Defense Contract Audit Agency (DCAA) conducts reconciliations to validate correct capitated payments for enrolled population. Government liability is limited to the amount paid to the contractor regardless of the cost of health care services.

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- (2) Special Supplemental Food Program for Women, Infants, and Children Overseas (WIC Overseas Program). DHA's Risk Assessment has identified this program as "Low Risk". Under the WIC Overseas Program specific TRICARE beneficiaries, including pregnant women, breastfeeding women, postpartum women, infants, and children are provided supplemental foods and nutrition education when active duty families meet certain income thresholds. WIC serves as an adjunct to good health care during critical times of growth and development, in order to prevent the occurrence of health problems, including drug and other substance abuse, and to improve the health status of program participants. The benefit is similar to the benefit provided under the U.S. Department of Agriculture (USDA) administered Women, Infants, and Children (WIC) Program within the U. S.
- (3) TRICARE Dental Program (TDP). DHA's Risk Assessment has identified this program as "Low Risk". The TDP contract offers a worldwide dental benefit to eligible family members of active duty service members and Selected Reserve and Individual Ready Reserve sponsors and their eligible family members. The TDP is a premium based-program where the Government contributes a portion of the premium for certain plan types. The Contractor is at risk for 100% of the claims payment risk in the CONUS. In OCONUS locations, the Government pays Command Sponsored enrollee's cost-shares for all covered services other than orthodontics, prosthodontics and other restorative care. The contractor is at risk on OCONUS claims for the allowable portion of the billed charge for covered services, less applicable cost shares. DCAA conducts beneficiary eligibility audits annually.
- (4) TRICARE Retiree Dental Program (TRDP). DHA's Risk Assessment has identified this program as "Low Risk". The TRDP contract offers a worldwide dental benefit to eligible retired service members and their family members, retired National Guard or Reserve members and their family members, Medal of Honor Recipients and their families and surviving family members of deceased active or retired service members. Like the TDP the TRDP is a premium based program; OCONUS coverage is available to eligible beneficiaries under the Enhanced-Overseas TRDP; the contractor is at risk for 100% of claims payment in CONUS and OCONUS. DCAA conducts beneficiary eligibility audits annually.

Subparagraph D. The actual amount of payments reviewed for FY 2013 for the quarterly and semi-annual compliance reviews was \$17,291,114,792.22 and \$1,616,831,666.33 for the MCSC AHCC audits for a total of \$18,907,946,458.50

Subparagraph E. The amounts actually recaptured during the current fiscal year. The amounts identified for payment recaptured audits must be separated between current year and prior years. Please note that voluntary or unsolicited refund dollar amounts must be separated from amounts identified through payment recapture activities. In addition, recoveries must also be separated between internal and external PRA activities:

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Subparagraph F. To the extent possible, any underpayments identified through the payment recapture audit process should be corrected by the Component. Components may include provisions that authorize payments to payment recapture auditors for underpayments identified:

Contractually and by TRICARE policy, any erroneous payments, including underpayments or overpayments, identified as the result of the EIC compliance reviews or as a result of the contractor's internal control process, must to be corrected accordingly.

Subparagraph G. A summary of the disposition of recaptured funds in accordance with OMB Circular A-123, Appendix C and OMB Circular A-136.

Overpayment recoveries are returned to the military health benefits program.

Subparagraph H. The amounts outstanding and determined to not be collectible, including the percent each category represents of the total overpayments identified for recapture to include:

1. An aging schedule of the amounts not currently recovered or not under a repayment agreement and,
2. Justification for any amounts that have been determined to be uncollectible;

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Subparagraph I. A corrective action plan that addresses and links directly to the root causes of error identified;

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Subparagraph J. A general description and evaluation of any management improvement program carried out pursuant to this guidance;

Not applicable.

Subparagraph K. Instances of potential fraud discovered through payment recapture audits and recovery activities must be reported in accordance with Volume 5, Chapter 6, paragraph 060203.

Negative report.