

Audit



Report

DATA SUPPORTING THE FY 1998 DOD MILITARY RETIREMENT
HEALTH BENEFITS LIABILITY ESTIMATE

Report Number 99-127

April 7, 1999

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Acronyms

CHCS

Composite Health Care System



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April 7, 1999

MEMORANDUM FOR UNDER SECRETARY OF DEFENSE (COMPTROLLER)
UNDER SECRETARY OF DEFENSE (PERSONNEL AND
READINESS)

SUBJECT: Audit Report on Data Supporting the FY 1998 DoD Military Retirement
Health Benefits Liability Estimate (Report No. 99-127)

We are providing this report for information and use. We conducted the audit in response to the Chief Financial Officers Act of 1990 and the Federal Financial Management Act of 1994. We considered management comments on a draft of this report in preparing the final report.

Comments received on a draft of this report conformed to the requirements of DoD Directive 7650.3 and left no unresolved issues. Therefore, no additional comments are required.

We appreciate the courtesies extended to the audit staff. Questions on the audit should be directed to Mr. Charles J. Richardson, at (703) 604-9582 (DSN 664-9582) (crichardson@dodig.osd.mil) or Mr. Walter R. Loder, at (703) 604-9534 (DSN 664-9534) (wrloder@dodig.osd.mil). See Appendix B for the report distribution. The audit team members are listed inside the back cover.

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Report No. 99-127
(Project No. 8FA-2016)

April 7, 1999

Data Supporting the FY 1998 DoD Military Retirement Health Benefits Liability Estimate

Executive Summary

Introduction. The audit (one in a series of audits to review the reliability of data elements used in the estimate of the Military Retirement Health Benefits Liability) was performed in support of the Chief Financial Officers Act of 1990 (Public Law 101-576) and the Federal Financial Management Act of 1994 (Public Law 103-356). Public Law 103-356 requires DoD and other Government agencies to prepare financial statements for FY 1996 and each succeeding year. The DoD FY 1998 financial statements reported a \$223 billion unfunded liability for DoD military retirement health benefits for FY 1998. The FY 1998 liability was based on the FY 1997 \$218 billion estimate, projected to September 30, 1998. In addition, the \$223 billion unfunded liability was 24 percent of the \$948.5 billion of liabilities included on the DoD-wide financial statements and 8 percent of the estimated \$2.7 trillion of the Federal Employee and Veteran Benefits payable. Military retirement health benefits are post-retirement benefits that DoD provides to military retirees and other eligible beneficiaries through the Civilian Health and Medical Program of the Uniformed Services and DoD military treatment facilities. Eligible beneficiaries also may obtain medical care from the private sector under the Civilian Health and Medical Program of the Uniformed Services. The Civilian Health and Medical Program of the Uniformed Services accounts for \$51 billion of the \$223 billion unfunded military retirement health benefits liability and the remaining \$172 billion of the liability is for medical care that the DoD military treatment facilities will provide to eligible beneficiaries.

Objectives. The overall audit objective was to assess the reliability and completeness of the data used to calculate the DoD Military Retirement Health Benefits Liability for FY 1998. Specifically, we reviewed the outpatient visit data contained in the Composite Health Care System for reliability and completeness. Additionally, we reviewed the management controls as they related to the objective.

Results. The quality of the Composite Health Care System outpatient visit data was unreliable for use in developing the military retirement health benefits liability estimate. As a result, we were unable to substantiate the validity and completeness of the Composite Health Care System outpatient visit data that the Office of the Actuary, DoD, will use to support the calculation of the FY 1998 actuarial estimate of the military retirement health benefits liability. Outpatient medical care services at DoD military treatment facilities represented more than \$100 billion of the \$223 billion unfunded military retirement health benefits liability for FY 1998. Therefore, the failure to ensure the accuracy of the outpatient data that will be used to calculate an estimate of the unfunded liability for FY 1998 constitutes a significant impediment to achieving unqualified audit opinions on both the DoD and Government-wide financial statements for FY 1999 and future years. The Office of the Assistant Secretary of Defense (Health Affairs) is initiating actions to address the issues identified in this audit report. See the Finding for details of the audit results.

The lack of controls over the Composite Health Care System outpatient data was a material control management control weakness. See Appendix A for details.

Summary of Recommendations. We recommend that the Assistant Secretary of Defense (Health Affairs) develop and implement a data quality assurance program for recording and reporting the Composite Health Care System outpatient workload and related documentation, develop and implement standardized appointment data elements for similar medical care in like clinics, and conduct follow-up tests to determine if the quality controls and standardized appointment data elements have improved.

Management Comments. The Assistant Secretary of Defense (Health Affairs) concurred with the recommendations, stating that increased quality assurance and management control programs were being developed for all the Military Health System information systems. In addition, a Tri-Service group was established to develop DoD standardized appointment types, and ongoing management review and monitoring of quality controls will be incorporated in the design of the data quality assurance program. However, the Assistant Secretary did not fully concur with the finding, stating that the Composite Health Care System outpatient visit data is reasonably reliable for use in developing the military retirement health benefits liability estimate. See the Finding for the complete discussion of management comments and Management Comments for the complete text of the comments.

The Air Force agreed also responded and agreed with the recommendations, stating that the new Air Force Instruction 41-210, Patient Administration Functions, contains management control guidance to help establish a consistent approach to ensuring the reliability of outpatient data. In addition, the new Air Force Instruction 41-210 addresses a data quality assurance program implementation at each Air Force military treatment facility and reinforces the importance and requirement to audit outpatient visit data to ensure reliability.

Audit Response. The Assistant Secretary's comments to the recommendations were responsive. However, we do not agree with the Assistant Secretary's comments that the outpatient visit data is reasonably reliable. The Assistant Secretary's comment that there was a need for data quality controls and that there was a material management control weakness contradicts the reasonably reliable statement. We appreciate the cooperative efforts of the Assistant Secretary to improve the accuracy and quality of the information from all of the information system.

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Background

Requirements for Financial Statements. Public Law 101-576, "The Chief Financial Officers Act of 1990," as amended by Public Law 103-356, "The Federal Financial Management Act of 1994," requires DoD and other Government agencies to prepare consolidated financial statements for FY 1996 and each succeeding year.

Requirements for Financial Statement Audits. Under the Chief Financial Officers Act of 1990, the Inspector General, DoD, is responsible for the audit of the financial statements of DoD. The General Accounting Office is responsible for the audit of the consolidated financial statements of the U.S. Government.

Office of Management and Budget Form and Content Guidance. Office of Management and Budget Bulletin No. 97-01, "Form and Content of Agency Financial Statements," October 16, 1996, provides general and specific guidance to agencies of the Government on the preparation of financial statements. Office of Management and Budget Bulletin No. 97-01 established guidance for reporting pensions, other retirement benefits, and other post-employment benefits. DoD other retirement benefits include all retirement benefits other than pension plan benefits. Office of Management and Budget Bulletin No. 97-01 further states that entities that are responsible for accounting for "other retirement benefits" should calculate and report the liabilities and related expenses in accordance with the Statement of Federal Financial Accounting Standard No. 5, "Accounting for Liabilities of the Federal Government," September 1995.

Materiality of Liability. FY 1997 was the first year that DoD reported the unfunded liability for the DoD military retirees medical health benefits on the DoD-wide consolidated financial statements. DoD reported a \$218 billion unfunded liability for DoD military retirement health benefits for FY 1997 and a \$223 billion unfunded liability for FY 1998. The FY 1998 \$223 billion unfunded liability was 24 percent of the \$948.5 billion of liabilities included on the DoD-wide financial statements and 8 percent of the estimated \$2.7 trillion of the Federal Employee and Veteran Benefits Payable. The Civilian Health and Medical Program of the Uniformed Services accounts for \$51 billion of the \$223 billion unfunded military retirement health benefits liability and the remaining \$172 billion of the liability is for medical care that the DoD military treatment facilities will provide to eligible beneficiaries. Therefore, the DoD military retirement medical health benefits liability is material to the DoD-wide financial statements and Federal Government financial statements.

Armed Forces Medical Care. United States Code Annotated, Title 10 Armed Forces, "Chapter 55-Medical and Dental Care," requires DoD to provide a uniform program of medical and dental care for uniform service members, certain former members of those services, and for dependents.

Military Treatment Facilities. Approximately \$171 billion of the \$223 billion FY 1998 estimated military retirement health benefits liability represented future outpatient and inpatient medical care that the DoD military treatment facilities are expected to provide to eligible beneficiaries. DoD military treatment facilities include hospitals and clinics. DoD has 104 military treatment facilities

designated as host sites for the Composite Health Care System (CHCS). A host site is a DoD military treatment facility with a CHCS server. The remaining \$51 billion of the \$223 billion liability will be provided through the TRICARE program. The TRICARE program provides health care through civilian medical providers.

CHCS Outpatient Data Supports Liability Calculations. The Office of the Actuary, DoD, relies on outpatient visit data that the DoD military treatment facilities record within the CHCS, to calculate the DoD military treatment facilities portion of the estimated liability. The CHCS is a comprehensive medical information system that DoD developed to provide automated support to its military treatment facilities. The CHCS is composed of integrated modules that facilitate the collection and input of data at the point of medical care.

The Office of the Actuary, DoD, developed a methodology that uses CHCS outpatient visit data to calculate an estimated average cost to provide outpatient care in DoD military treatment facilities to eligible beneficiaries by selective age categories. Outpatient medical care includes visits by an authorized patient to a separate, organized clinic or specialty service for examination, diagnosis, treatment, evaluation, consultation, counseling, and medical advice.

Contract and Actuarial Technical Support. The Office of the Actuary, DoD, is responsible for the valuation of the military retirement health benefits liability. Milliman and Robertson, Inc., an actuary and consultant firm, was contracted to assist the Office of the Actuary, DoD, in calculating an estimate of the unfunded liability for the military post-retirement health care benefits through FY 2000.

The contractor calculated the \$218 billion estimate for the FY 1997 military retirement health benefits liability based on the same data used to compute the initial FY 1997 \$210 billion liability estimate. The \$210 billion liability increased for the following reasons:

- The claims cost data used to develop the \$218 billion estimate were projected an extra year to October 1, 1997, using the medical trend assumption of 2.5 percent for FY 94 through 95 from the FY 1997 report.
- The \$218 billion estimate was based on a method of spreading cost over years of service rather than as a level percentage of payrolls. Spreading cost over years of service is the method specified in Statement of Federal Financial Accounting Standard No. 5.

Objectives

The overall objective was to assess the reliability and completeness of the data used to calculate the DoD Military Retirement Health Benefits Liability for FY 1998. Specifically, we reviewed the outpatient visit data contained in the Composite Health Care System for reliability and completeness. Additionally, we reviewed the management controls as related to the objective. See Appendix A for a discussion of the audit scope and methodology, our review of the management control program, and a summary of prior audit coverage related to the audit objectives.

Management Controls Over Military Treatment Facilities Outpatient Visit Data

The quality of the CHCS outpatient visit data was unreliable for use in developing the military retirement health benefits liability estimate. The CHCS outpatient visit data was unreliable because the Office of the Assistant Secretary of Defense (Health Affairs) did not develop and implement management controls in the form of a quality assurance program for CHCS outpatient visit data. Further, standardized appointment data elements for similar clinics were not developed for recording outpatient visit data in the CHCS. As a result, we were unable to substantiate the validity and completeness of the CHCS outpatient visit data that the Office of the Actuary, DoD, will use to support the calculation of the FY 1998 actuarial estimate of the military retirement health benefits liability. The DoD military treatment facilities outpatient medical care services represented more than \$100 billion of the \$223 billion FY 1998 military retirement health benefits liability. The inability to ensure the accuracy of the CHCS outpatient visit data constitutes a significant impediment to achieving unqualified audit opinions on both the DoD and Government-wide financial statements for FY 1999 and future years. The Office of the Assistant Secretary of Defense (Health Affairs) is initiating actions to address the issues identified in this audit report.

Guidance for Counting Outpatient Visits

Outpatient visits are countable visits made by authorized personnel to medical clinics. DoD 6010.13-M, Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities, October 1995, and DoD 6010.13-M, Change 1, July 9, 1997, established guidance for determining countable visits. This guidance requires that the DoD military treatment facilities clinics satisfy three criteria before counting a visit as a valid outpatient visit:

- There must be interaction between an authorized patient and a healthcare provider.
- Independent judgment about the patient's care must be used, assessment of the patient's condition must be made, and any one or more of the following must be accomplished:
 - examination,
 - diagnosis,
 - counseling, or
 - treatment.

- The DoD military treatment facilities must include adequate documentation in the patient's authorized record of medical treatment. At a minimum, the documentation must include the date of the visit, name of clinic, reason for visit, assessment of the patient, description of the interaction, disposition, and the signature of the healthcare provider. In all instances, the DoD military treatment facilities must maintain a clear and acceptable audit trail.

In addition, telephone consultations that meet the DoD criteria are also counted as visits.

Quality of CHCS Outpatient Workload Data is Unreliable

We reviewed 998 CHCS outpatient visits and determined that 606 of these did not satisfy the DoD criteria for determining countable visits (see Table 1). For example, 506 of the 606 unsupported CHCS outpatient visits that we reviewed, did not satisfy the DoD criteria as a countable visit because the patient's medical records did not contain documentation needed to verify the occurrence of one or more visits to an authorized outpatient clinic. The other 100 errors were due to a variety of reasons such as double counting of visits and counting invalid telephone consultations.

Table 1. Outpatient Visit Comparison

<u>Military Treatment Facilities</u>	<u>CHCS Outpatient Visits</u>	<u>Unsupported Visits</u>
Pensacola Naval Hospital	430	272
Walter Reed Army Medical Center	244	122
Wilford Hall Air Force Medical Center	<u>324</u>	<u>212</u>
Totals	<u>998</u>	<u>606</u>

In addition, CHCS outpatient visits classified as telephone consultations did not satisfy the DoD countable visit criteria. For example, we reviewed 61 CHCS telephone consultation records from the Wilford Hall Medical Center to determine validity. Of the 61 telephone consultation records reviewed, 36 were incorrectly recorded in CHCS as countable outpatient workload units. Our analysis of the 36 invalid telephone consultations identified that the outpatient workload units were not countable for some of the following reasons:

- telephone consultations involved no interaction between a healthcare provider and a patient, such as messages that were left on answering machines,
- telephone consultations were counted for scheduling patient's appointments, and
- telephone consultations were counted for the refill of prescriptions, rather than prescription renewals, which are countable outpatient visits.

Level of management controls. The level of management controls over CHCS outpatient visits varied by DoD military treatment facilities. There was no consistent approach to ensuring the reliability of the outpatient data. Of the five DoD military treatment facilities CHCS host sites visited, two had implemented limited management controls to ensure the reliability of the CHCS outpatient visit data. The Portsmouth Naval Medical Center and the Wilford Hall Air Force Medical Center implemented limited management controls. Walter Reed Army Medical Center, Blanchfield Army Community Hospital, and the Pensacola Naval Hospital had not established management controls to ensure the reliability of the CHCS outpatient workload data.

DoD military treatment facilities that implemented management controls. The Portsmouth Naval Hospital, Data Quality and Analysis Department, has two staff members that visit clinics to evaluate daily operations and review outpatient visit data. The Wilford Hall Medical Center, Resource Management Office, has one staff member that conducts, on a part-time basis, limited reviews of the quality of CHCS outpatient visits. Additionally, the Wilford Hall Medical Center, Health Records Compliance Element, has one staff member annually review, on a part-time basis, the quality of documentation contained in the outpatient medical records to comply with the Joint Commission on Accreditation of Healthcare Organizations standards. The Joint Commission on Accreditation of Healthcare Organizations is the nation's predominant standards setting and accrediting body in healthcare that evaluates and accredits healthcare entities as to quality of care. The Joint Commission on Accreditation of Healthcare Organizations requires adequate documentation for patient medical records. Although these reviews are commendable, they are not adequate to ensure the reliability of the CHCS outpatient visit data. For example, the Resource Management Office and the Health Records Compliance Element staff do not perform reconciliations between CHCS outpatient visit data and the supporting documentation contained in the patient medical records. We did not perform tests of management controls at the Portsmouth Naval Hospital.

Need for CHCS Outpatient Workload Data Quality Assurance Program

The Office of the Assistant Secretary of Defense (Health Affairs) and specifically the Project Management Office for the CHCS had not provided guidance for developing and implementing a CHCS outpatient visit quality assurance program. A data quality assurance program should consist of management's policies and procedures to provide reasonable assurance that CHCS outpatient visit data are being reliably recorded and reported. In addition, the CHCS outpatient visit quality assurance program should clearly delineate the specific steps that management designed and prescribed to provide reasonable assurance that its policies and procedures will be implemented and goals achieved.

An effective quality assurance program over the reliability of the CHCS outpatient visits data will provide the DoD military treatment facilities reasonable assurance that the medical records contain the patient's complete medical history documentation. In addition, a complete medical history will

provide the DoD military treatment facilities a clear and acceptable audit trail between the CHCS outpatient visit data and the patient's medical records. An adequate audit trail will also improve the auditability of the CHCS outpatient workload data for compliance with financial statement requirements.

At a minimum, effective management controls to ensure the reliability of the CHCS outpatient visit data should include ongoing reviews of:

- patient medical files for proper documentation and reconciliation with CHCS,
- end-of-day workload reports for accuracy, and
- telephone consultations for workload validity.

The results of these reviews should be monitored and reported to higher level management.

Standardization of Data Elements for Appointments

The DoD military treatment facilities management controls over CHCS outpatient visits were also inadequate because Office of the Assistant Secretary of Defense (Health Affairs) did not develop standardized appointment data elements for clinics that provide comparable medical care. The individual clinics within the DoD military treatment facilities assign the data element codes based on clinical needs and preferences, rather than standard DoD guidance. Appointment type is an example of a data element.

We compared appointment type data elements that the Blanchfield Army Community Hospital, Fort Campbell, Kentucky; Pensacola Naval Hospital, Pensacola, Florida; and Wilford Hall Air Force Medical Center, San Antonio, Texas, DoD military treatment facilities assigned to their allergy, audiology, cardiology, dermatology, ophthalmology, and optometry clinics. Our analysis identified that appointment type data elements varied widely by DoD military treatment facilities and by clinics.

There was little consistency and standardization of appointment types used between the three DoD military treatment facilities and their 6 clinics. Specifically, there were a total of 541 appointment types used between the 6 clinics. However, there were only 3 instances where the appointment types were common among the 3 DoD military treatment facilities and the 6 clinics (see Table 2 for the details). Some of the differences between the total number of appointment types are attributable to the level of medical care that the clinics provide to authorized patients.

Table 2. Appointment Type Variations

<u>Clinics</u>	<u>Number of Appointment Types</u>			<u>Total</u>	<u>Number of Common Appointment Types</u>
	<u>Blanchfield</u>	<u>Pensacola</u>	<u>Wilford Hall</u>		
Allergy	12	26	26	64	1
Audiology	21	12	48	81	0
Cardiology	9	33	97	139	0
Dermatology	16	14	38	68	1
Ophthalmology	40	24	46	110	0
Optometry	<u>24</u>	<u>29</u>	<u>26</u>	<u>79</u>	<u>1</u>
Totals	122	138	281	541	3

Standard Appointment Data Elements Improve Comparability. The DoD military treatment facilities inability to establish standard appointment data elements creates problems for managing, controlling, and analyzing CHCS outpatient data. DoD officials may not be able to perform cost-effectiveness studies of particular medical procedures based on appointment types because the appointment type codes vary between installations for similar medical care. In addition, the inability to establish standard appointment data elements may create a potential reliability problem by causing the CHCS outpatient data to be misstated. For example, Wilford Hall Medical Center, Audiology Clinic classified ward rounds as a countable outpatient visits. However, DoD guidance states that ward rounds are not countable visits. Therefore, standard appointment data elements will reduce the cases where the DoD military treatment facilities clinics include noncountable outpatient visits such as ward rounds in CHCS as countable outpatient visits.

Management Efforts to Improve CHCS Outpatient Data

The Office of the Assistant Secretary of Defense (Health Affairs) is initiating actions to correct the impediments to achieving an unqualified audit opinion identified in this audit report. The calculation of an estimate of the military retirement health benefits liability is part of the DoD effort to develop alternative methods for achieving an unqualified audit opinion. A military retirement health benefits working group, composed of representatives from the Under Secretary Defense (Comptroller); the Assistant Secretary of Defense (Health Affairs); the Office of the Actuary, DoD; the Inspector General, DoD; and the General Accounting Office; have held a series of meetings to address the concerns of incomplete and unreliable CHCS outpatient workload data.

Health Affairs Officials briefed the Military Department Surgeon Generals on the audit results and established management controls over outpatient data as a high priority. Also, Health Affairs officials plan to develop and issue a management plan for correcting data-related management controls deficiencies.

CHCS Outpatient Data Impact on Financial Statements

DoD management is making progress to correct data-related management controls deficiencies that are impediments to DoD achieving an unqualified audit opinion. However, the CHCS outpatient data does not provide a reliable database for developing the liability estimate and if used to develop the liability estimate would represent an impediment to our review and oversight of the actuarial liability computation. This problem constitutes a significant impediment to achieving unqualified audit opinions on both the DoD and Government-wide financial statements for FY 1999 and beyond.

Management Comments on the Finding and Audit Response

Assistant Secretary of Defense (Health Affairs) Comments. The Assistant Secretary of Defense (Health Affairs) partially concurred with the overall conclusion that the CHCS data was unreliable for use in developing the Military Retirement Health Benefits liability estimate. The Assistant Secretary stated that the CHCS outpatient workload data could be validated through additional documentation not found in the patient's medical record. The Office of the Assistant Secretary of Defense (Health Affairs) and TRICARE Management Activity has tested this assumption using corroborative evidence that they feel will better determine the reliability of CHCS outpatient data. In addition, the Assistant Secretary believes that the CHCS outpatient workload data used was reasonably accurate and complete for calculating the health benefits liability estimate.

Air Force Comments. The Department of the Air Force agreed with the material management control weaknesses identified in the audit report. The Air Force stated it will assist the Office of the Assistant Secretary Defense (Health Affairs) in the development and implementation or reestablishment of management controls, as necessary, to improve the quality of the Air Force data.

Audit Response. We agree that failure to include documentation in the patient medical record is a serious deficiency. However, we do not agree that other corroborative data can be used to substantiate the workload data. Corroborative evidence outside the patient record only suggest that a specific visit may have occurred. However, it is not simply that a visit occurred, the nature of the visit must meet certain specific criteria before it can be counted as a valid workload visit. Both, the type of care and administrative data should be documented in the patient medical record. We believe official patient medical records should be the source of verification that visits meets workload criterion. The collection of corroborative evidence outside the patient medical record is often an impractical exercise that diverts the attention of senior officials at health care facilities to provide the data from untested sources. The exercise to obtain such data stresses the administrative capacity of the Military Treatment Facilities involved. Such stress could ultimately bring pressure on the record reviewers to

accept inferior evidence, such as entries in the Ambulatory Data System, as reasonable support. The Ambulatory Data System, recently implemented, is acknowledged by Health Affairs as an incomplete data source. Further, the Assistant Secretary's assertions do not address the fact that 10 percent of the claimed visits were totally erroneous. We also agree with management that there was no effective quality assurance program to ensure that the CHCS data was accurate. Without an effective quality assurance program, over the CHCS data, we conclude that the CHCS data is unreliable.

Recommendations and Management Comments

We recommend that the Assistant Secretary of Defense (Health Affairs):

1. Develop and implement a data quality assurance program for recording and reporting the Composite Health Care System outpatient workload data and related documentation. For example, the quality assurance program should include review of Composite Health Care System end-of-day workload reports for accuracy, reconciliation of the workload data with appropriate medical file documentation, and a follow-up process to assess corrective actions.

Assistant Secretary of Defense (Health Affairs) Comments. The Assistant Secretary of Defense (Health Affairs) concurred and will be developing increased quality assurance and internal management control programs for all Military Health System information systems.

Air Force Comments. The Air Force agreed with the recommendation and stated that the new Air Force Instruction 41-210, Patient Administration Functions, contains guidance on the implementation of management controls to help establish a consistent approach to ensuring the reliability of outpatient data.

2. Develop and implement standardized appointment data elements in the Composite Health Care System for similar medical care in like clinics.

Assistant Secretary of Defense (Health Affairs) Comments. The Assistant Secretary of Defense (Health Affairs) concurred and established a Tri-Service workgroup to develop DoD standardized appointment types that all clinics in the Military Health System would use.

Air Force Comments. The Air Force agreed that the lack of standardized appointment elements in the Composite Health Care System is a serious problem and has Air Force Medical Service representatives working with the TRICARE Management Activity on various committees to address these issues.

3. Conduct tests to determine if the quality controls and standardized appointment data elements have improved after implementation of recommendations 1 and 2.

Assistant Secretary of Defense (Health Affairs) Comments. The Assistant Secretary of Defense (Health Affairs) concurred, stating that ongoing management reviews and monitoring of quality controls will be incorporated in the design of the overall data quality assurance program.

Air Force Comments. The Air Force agreed, stating that the new Air Force Instruction 41-210 addresses a data quality assurance program at each Air Force military treatment facility.

Appendix A. Audit Process

Scope

Work Performed. Our audit focused on the review of the underlying data supporting the outpatient visit data that the military treatment facilities recorded in the CHCS. DoD has 104 DoD military treatment facilities designated as CHCS host sites. DoD military treatment facilities designated as a CHCS host site may have CHCS reporting responsibilities for one or more military treatment facilities. For example, the Walter Reed Medical Center is responsible for reporting the CHCS outpatient visit data for the Dewitt Army Community Hospital, Fort Belvoir, Virginia. We conducted our review at five DoD military treatment facilities CHCS host sites:

- Walter Reed Army Medical Center, Washington, D.C.;
- Blanchfield Army Community Hospital, Fort Campbell, Kentucky;
- Pensacola Naval Hospital, Pensacola, Florida;
- Portsmouth Naval Medical Center, Portsmouth Virginia, and the
- Wilford Hall Air Force Medical Center, San Antonio, Texas.

For FY 1997 outpatient workload, 103 of the 104 DoD military treatment facilities serving as CHCS host sites reported 33 million CHCS visits to clinics. The National Naval Medical Center, Bethesda, Maryland, visits were not available in time to be included in this report. The five DoD military treatment facilities CHCS host sites that we visited reported 6.2 million of the 33 million outpatient visits (19 percent). Therefore, we selected the five DoD military treatment facilities CHCS host site locations discussed in this report for review because we wanted audit coverage of each of the Military Departments and because of the volume of outpatient medical care that these DoD military treatment facilities provided to eligible beneficiaries.

We reviewed the procedures for recording and reporting outpatient workload data in the CHCS. Specifically, we selected and reviewed patient's authorized records of medical treatment to determine whether the DoD military treatment facilities recorded countable outpatient visits in accordance with DoD criteria. We conducted this portion of our review at the Walter Reed Army Medical Center, Pensacola Naval Hospital, and the Wilford Hall Air Force Medical Center CHCS host sites.

During FY 1998, DoD reported a \$223 billion unfunded actuarial estimate for the military retirement health benefits liability on the DoD and the Government-wide consolidated financial statements. Approximately \$172 billion of the \$223 billion of the FY 1998 estimated military retirement health benefits liability accrued from future outpatient and inpatient medical care that the DoD military treatment facilities are expected to provide to eligible beneficiaries.

Limitations to Audit Scope. We limited our tests of management controls over the CHCS outpatient visit data to medical records that the Walter Reed Army Medical Center, Pensacola Naval Hospital, and Wilford Hall Air Force Medical Center had on-hand at the time of our review. We limited our review because some patient medical records that supported outpatient visits data were not readily available for review because they were:

- located at other DoD military treatment facilities,
- in the custody of the patient, or were
- unavailable for other reasons.

Methodology

Use of Computer-Processed Data. We used the FY 1997 computer-processed data that the military treatment facilities used to record and report clinical workload data. We did not validate the reliability of the CHCS management system because we limited our use of the data to testing management controls and to obtaining an understanding of the procedures that the Office of the Actuary, DoD, used to calculate the liability. However, not validating the reliability of the CHCS system did not affect the results of this audit.

DoD-wide Corporate Level Government Performance and Results Act Goals. In response to the Government Performance Results Act, the Department of Defense has established 6 DoD-wide corporate level performance objectives and 14 goals for meeting these objectives. This report pertains to achievement of the following objectives and goals.

Objective: Fundamentally reengineer the Department and achieve a 21st century infrastructure. **Goal:** Reduce costs while maintaining required military capabilities across all DoD mission areas. (DoD-6)

DoD Functional Area Reform Goals. Most major DoD functional areas have also established performance improvement reform objectives and goals. This report pertains to achievement of the following functional area objectives and goals.

Objective: Strengthen internal controls. **Goal:** Improve compliance with the Federal Managers' Financial Integrity Act. (FM-5.3)

General Accounting Office High Risk Area. The General Accounting Office has identified several high risk areas in the DoD. This report provides coverage of the Defense Financial Management high risk area.

Audit Type, Dates, and Standards. We performed this financial-related audit from May 1998 through December 1998 in accordance with auditing standards issued by the Comptroller General of the United States, as implemented by the Inspector General, DoD. We included tests of management controls considered necessary.

Contacts During the Audit. We visited or contacted organizations within DoD. Further details are available on request.

Management Control Program

DoD Directive 5010.38, "Management Control Program," August 26, 1996, requires DoD organizations to implement a comprehensive system of management controls that provides reasonable assurance that programs are operating as intended and to evaluate the adequacy of those controls.

Scope of Review of Management Control Programs. We reviewed the management control programs to identify the quality control programs and control techniques to ensure that outpatient visit data were accurately recorded. In addition, we reviewed the Under Secretary of Defense (Personnel and Readiness) FY 1997 Annual Statement of Assurance and management's self-evaluation as it applied to controls over recording and reporting outpatient clinical workload data.

Adequacy of Management Controls. We identified material management control weaknesses, as defined by DoD Directive 5010.38. The Office of the Assistant Secretary of Defense (Health Affairs) did not develop and implement management controls to ensure the reliability of CHCS outpatient workload data. The Walter Reed Army Medical Center, Wilford Hall Air Force Medical Center, and the Pensacola Naval Hospital management controls did not ensure that adequate documentation supported the outpatient clinical workload data recorded in the CHCS. The recommendations in this report, if implemented, will improve management decisions and the accuracy and completeness of the outpatient clinical workload data that the Office of the Actuary, DoD, uses to calculate and estimate the military retirement health benefits liability reported to DFAS Indianapolis Center for inclusion in the Statement of Financial Position for future years. A copy of this report will be provided to the senior officials responsible for management controls at the DoD military treatment facilities.

Adequacy of Management's Self-Evaluations. Management's self-evaluations did not identify the specific material management control weaknesses identified by the audit because the DoD military treatment facilities evaluations did not address quality controls of the CHCS outpatient workload data.

Summary of Prior Audit Coverage

During the past 5 years, the General Accounting Office issued two audit reports and the Inspector General, DoD, issued one audit report discussing the DoD Military Retirement Health Benefits Liability and CHCS issues, respectively.

General Accounting Office

The General Accounting Office issued two reports during FY 1994 through FY 1996 related to the CHCS.

GAO/AIMD-96-39, "Defense Achieves Worldwide Deployment of Composite

Health Care System," April 5, 1996

GAO/AIMD-94-61, "Defense's Tools and Methodology for Managing CHCS Performance Need Strengthening," July 5, 1994

Inspector General

Inspector General, DoD, Report No. 99-010, "DoD Military Retirement Health Benefits Liability for FY 1997," October 13, 1998.

Appendix B. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)
Deputy Chief Financial Officer
Deputy Comptroller (Program/Budget)
Under Secretary of Defense (Personnel and Readiness)
Assistant Secretary of Defense (Health Affairs)
Office of the Actuary, DoD
Assistant Secretary of Defense (Public Affairs)
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Department of the Army

Assistant Secretary of the Army (Financial Management and Comptroller)
Surgeon General, Department of the Army
Auditor General, Department of the Army
Commander, Walter Reed Army Medical Center
Commander, Blanchfield Army Community Hospital

Department of the Navy

Assistant Secretary of the Navy (Financial Management and Comptroller)
Surgeon General, Department of the Navy
Auditor General, Department of the Navy
Commander, Pensacola Naval Hospital
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Department of the Air Force

Assistant Secretary of the Air Force (Financial Management and Comptroller)
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Other Defense Organizations

Director, Defense Contract Audit Agency
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Director, Defense Finance and Accounting Service Indianapolis Center
Director, Defense Logistics Agency
Director, National Security Agency
Inspector General, National Security Agency
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Non-Defense Federal Organizations and Individuals

Office of Management and Budget
General Accounting Office
National Security and International Affairs Division
Technical Information Center

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 Governmental Affairs
House Committee on Appropriations
House Subcommittee on Defense, Committee on Appropriations
House Committee on Armed Services
House Committee on Government Reform
House Subcommittee on Government Management, Information, and Technology,
Committee on Government Reform
House Subcommittee on National Security, Veterans Affairs, and International
Relations, Committee on Government Reform

Assistant Secretary of Defense (Health Affairs) Comments



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

5 MAR 1999

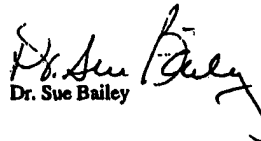
MEMORANDUM FOR DIRECTOR, FINANCE AND ACCOUNTING DIRECTORATE
OFFICE OF THE INSPECTOR GENERAL, DOD

SUBJECT: Audit Report on Data Supporting the FY 1998 DoD Military Retirement Health
Benefits Liability Estimate (Project No. 8FA-2016)

This memorandum is in response to your request for management comments on the subject draft audit report. This office generally concurs with all of the recommendations in the report, and partially concurs with the overall conclusion that the quality of the Composite Health Care (CHCS) system outpatient visit data was unreliable for use in developing the military retirement health benefits liability estimate. We believe that the outpatient workload data from CHCS can be validated through additional documentation not found in the patient's medical record, and the current information is reasonably accurate and complete for calculating the health benefits liability estimate.

The audit report provides a valuable tool to highlight and emphasize the need for improving data quality throughout the Military Health System (MHS). The identification of management control material weaknesses will be addressed immediately and is a high priority for OASD (Health Affairs). We will establish and implement quality assurance programs and internal management controls necessary to increase the reliability of the CHCS outpatient workload and other data in the MHS automated systems.

We understand the importance of an unqualified audit opinion on the Government-wide financial statements, and will develop and implement the recommendations in the draft audit report to improve the quality of our data. We will continue to work with the DoD Office of the Actuary, DoDIG, Comptroller and GAO to review and develop alternative methodologies to calculate the retirement liability in order to obtain an unqualified audit opinion. Thank you for the opportunity to provide comments on this draft report. Our specific comments and recommendations are in the attachment. The point of contact for this matter is Mr. Ed Chan. He may be reached by phone at (703) 681-1724 or e-mailed at edmund.chan@tma.osd.mil.


Dr. Sue Bailey

Attachment:
As Stated

**IG DRAFT AUDIT REPORT - DATED December 23, 1998
(PROJECT NO. 8FA-2016)**

“Data Supporting the FY 1998 Military Retirement Health Benefits Liability Estimate”

**OASD (HEALTH AFFAIRS) AND TRICARE MANAGEMENT ACTIVITY (TMA)
COMMENTS TO THE AUDIT RESULTS**

In general, Health Affairs (HA) and TRICARE Management Activity (TMA) concur with most of the findings and recommendations in the draft audit report. However, we believe that the Composite Health Care system outpatient visit data is reasonably reliable for use in developing the military retirement health benefits liability estimate.

The review of the CHCS outpatient visits found that a substantial number of visits were not documented in the patient's outpatient medical record. This is a serious finding and needs to be corrected through increased oversight and development of management controls to ensure compliance with established policies. However, we believe there is considerable and sufficient documentation in other than the outpatient medical record that provides validation of a CHCS visit. Over the past few months, we tested our assumptions at three medical centers. Most recently, representatives from the Office of the Actuary, DoDIG, GAO, and Health Affairs met with staff at the National Naval Medical Center (NNMC), Bethesda, Maryland. We obtained the assistance of the local CHCS host administrator, an Ambulatory Data System (ADS) expert, and several health care providers.

All of the visitors to NNMC agreed that there is considerable corroborative data regarding a patient visit even when a medical record is not available. We are currently working with the DoDIG and GAO to design a patient-based statistical sampling plan to measure the reliability and completeness of the Military Health System's CHCS outpatient visits. In addition to documentation in the medical outpatient record, the DoDIG and GAO are reviewing the acceptability of other information from electronic and clinic maintained documents. The outcome of this survey would better determine the reliability of the CHCS outpatient data and support visit validation. We also plan to use the sampling results to measure the impact on the estimate of the outpatient portion of the retiree health liability related to MTF care.

Management Controls Over Military Treatment Facilities Outpatient Visit Data

Guidance for Counting Outpatient Visits. CONCUR

The current visit criteria used in the Medical Expense and Performance Reporting System manual was developed in 1995. The guidance for determining countable visits is being revised to reflect changes in the health care environment. The Military Health System (MHS) is in the process of transitioning to the electronic record and the hard copy medical record will be obsolete within a few years. The revised visit definition will need to more clearly define adequate documentation to include the acceptance of electronic or computerized documentation and indicate where additional validating documentation can be found.

Quality of CHCS Outpatient Workload Data is Unreliable. PARTIALLY CONCUR

We agree that the MHS needs to develop and increase management controls to improve the accuracy and quality of the information from all of our information systems. However, for the purpose of calculating the liability estimate, unless CHCS visit miscalculations are disproportionately spread across active duty or retirees, the overall calculation will be reasonably accurate. The DoD Actuary Office and TMA will be conducting a randomized survey of the FY 98 CHCS outpatient visits to assess the quality of the data and develop a data sensitivity analysis to adjust the estimate if necessary.

Most of the unsupported CHCS outpatient visits that were reviewed did not satisfy the DoD criteria as a countable visit because the patient's medical record did not contain the proper documentation. However, other sources for documentation that the visits occurred were not investigated. These sources include convenience files that the physicians maintain, documentation in the file rooms, and other electronic documentation such as Ambulatory Data System (ADS) records. The inclusion of these other documents will substantially increase the validation of the visit counts.

Other errors such as double counting of visits and counting invalid telephone consultations reflect a need to ensure appropriate education and training. Clear direction and standard procedures for making appointments and counting telephone consults will need to be communicated to all individuals using the CHCS system.

Need for CHCS Outpatient Workload Data Quality Assurance Program. CONCUR

Development of consistent management controls and quality assurance program to ensure the reliability of data from MHS automated systems is a major priority in the MHS. The Office of Health Affairs and the TRICARE Management Activity have begun the process to establish DoD wide management control and quality assurance programs. A Data Quality Integrated Program Team composed of HA, TMA and Service representatives has been established that will be responsible for developing quality assurance programs for the MHS automation systems. A project master plan is being developed with milestones and schedules for all key stakeholders. Routine reporting on the status of the phases and the milestones to the Milestone Decision Authority (MDA) and the Deputy Surgeons General will be required.

Standardization of Data Elements for Appointments. CONCUR

In the past, MTFs have been given the latitude to develop their appointment systems to suit their needs and individual situations at the local level. Over the years the individual creativity of each Service and each MTF within the Services led to the current situation where we have an excessive number of appointment types throughout the MHS with many different names to describe the same encounter.

The number of appointment types needs to be reduced to simplify the appointing process and allow for better comparisons of facilities and performance measurement. Standardization is a

complex project that requires a uniform set of business rules and other structural/policy changes before it can be accomplished. It will also require high level support, resources, and a lot of site preparation (data clean up) to be implemented properly.

Standardized Appointment Data Elements Improve Comparability. CONCUR

Standardized appointment types will help to ensure a uniform approach to workload accountability because the critical data elements within the clinic and appointment type profiles, e.g., Workload Type: (count vs. non-count) can be set the same for all Services. This will facilitate consistency between the Services and MTFs when workload counts are necessary for cost calculations such as the retirement liability calculation.

Develop and implement standardized appointment data elements. CONCUR

In January 1999, work began to establish standardization of appointment types to fit current business practices throughout DoD. The Tri-Service workgroup is in the process of developing a plan, using an Integrated Product Team approach, to implement the standardized appointment types and data elements beginning within Region 1. An implementation plan will be developed by summer 1999. The goal is to implement the standardized appointment types, data elements, and clinic names across the MHS.

RECOMMENDATIONS:

1. Develop and implement a data quality assurance program for recording and reporting the Composite Health Care system outpatient workload data and related documentation.
Concur. The Office of the Assistant Secretary of Defense (Health Affairs) and the TRICARE Management Activity are developing increased quality assurance and internal management control programs for all MHS information systems.
2. Develop and implement standardized appointment data elements in the Composite Health Care system for similar medical care in like clinics.
Concur. A Tri-Service workgroup has been established to develop DoD standardized appointment types to be used by all clinics in the Military Health System.
3. Conduct tests to determine if the quality controls and standardized appointment data elements have improved after implementation of recommendations 1 and 2.
Concur. Ongoing management review and monitoring of quality controls will be incorporated in the design of the data overall quality assurance program.

Material Control Weakness -- Comments

The draft audit report identified material management control weaknesses. First, it states that the Office of the Assistant Secretary of Defense (Health Affairs) did not develop and implement management controls to ensure the reliability of CHCS outpatient workload data.

Concur. The TRICARE Management Activity will oversee the establishment and implementation of a comprehensive strategy for management controls that provides reasonable assurance that the CHCS outpatient workload is reliable. This will include a system of guidance, instructions, procedures, and appropriate management oversight to ensure that the management controls are operational.

The Walter Reed Army Medical Center, Wilford Hall Air Force Medical Center, and the Pensacola Naval Hospital management controls did not ensure that adequate documentation supported the outpatient clinical workload recorded in CHCS.

Concur. The quality assurance program and management controls will be implemented throughout the MHS and a standardized system will be available to ensure the reliability of the outpatient clinical workload in

Department of the Air Force Comments



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE



MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL FOR AUDIT

1441 2 1999

FROM: HQ USAF/SG
110 Luke Avenue, Room 400
Bolling AFB, DC 20332-7050

SUBJECT: Audit Report on Data Supporting the FY 1998 DoD Military Retirement
Health Benefits Liability Estimate (Project No. 8FA-2016), (dated 23 Dec 98)

We have reviewed the Inspector General (IG) Audit Report (Project No. 8FA-2016) and the following comments are provided to recommendations:

Recommendation 1: Develop and implement a data quality assurance program for recording and reporting the Composite Health Care System (CHCS) outpatient workload data and related documentation. For example, the quality assurance program should include review of CHCS end-of-day workload reports for accuracy, reconciliation of the workload data with appropriate medical file documentation, and a follow-up process to assess corrective actions.

Response: Concur. The new AFI 41-210, Patient Administration Functions, contains guidance on the implementation of management controls to help establish a consistent approach to ensuring the reliability of outpatient data. Specifically, product line managers (PLM) will be appointed at each MAJCOM and medical treatment facility (MTF) to be held responsible and accountable for the data. In addition, local audit procedures will be reestablished at the MTF level to validate the occurrence of a recorded CHCS outpatient visit. The revised AFI is expected to be published this summer. ECD: July 1999.

Recommendation 2: Develop and implement standardized appointment data elements in CHCS for similar medical care in like clinics.


Response: Concur. The lack of standardized appointment data elements in CHCS is a serious concern; however this issue is beyond our direct control. We fully support the efforts by the TRICARE Management Activity (TMA) to standardize data elements across the Military Health Services System (MHSS). We have Air Force Medical Service (AFMS) representatives working with TMA on various committees to address these issues.

Recommendation 3: Conduct tests to determine if the quality controls and standardized appointment data elements have improved after implementation of recommendations 1 and 2.

Response: Concur. The new AFI 41-210 will address a data quality assurance program implementation at each Air Force MTF and it will reinforce the importance and requirement to audit outpatient visit data to ensure reliability. ECD: July 1999.

Adequacy of Management Controls. Concur with the material management control weaknesses identified in the audit report. Adequate control procedures will help improve management decisions and the accuracy and completeness of outpatient clinical workload data. We will assist OASD(HA) in the development and implementation or reestablishment of management controls throughout the MBSS, as necessary, to improve the quality of our data.

I applaud the IG efforts to identify these data quality discrepancies through their audit procedures. My POC for these issues is Col Michael J. Fitzwater, DSN 240-3982.


MICHAEL K. WYRICK
Major General, USAF, MSC
Deputy Surgeon General

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The Finance and Accounting Directorate, Office of the Assistant Inspector General for Auditing, DoD, produced this report.

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