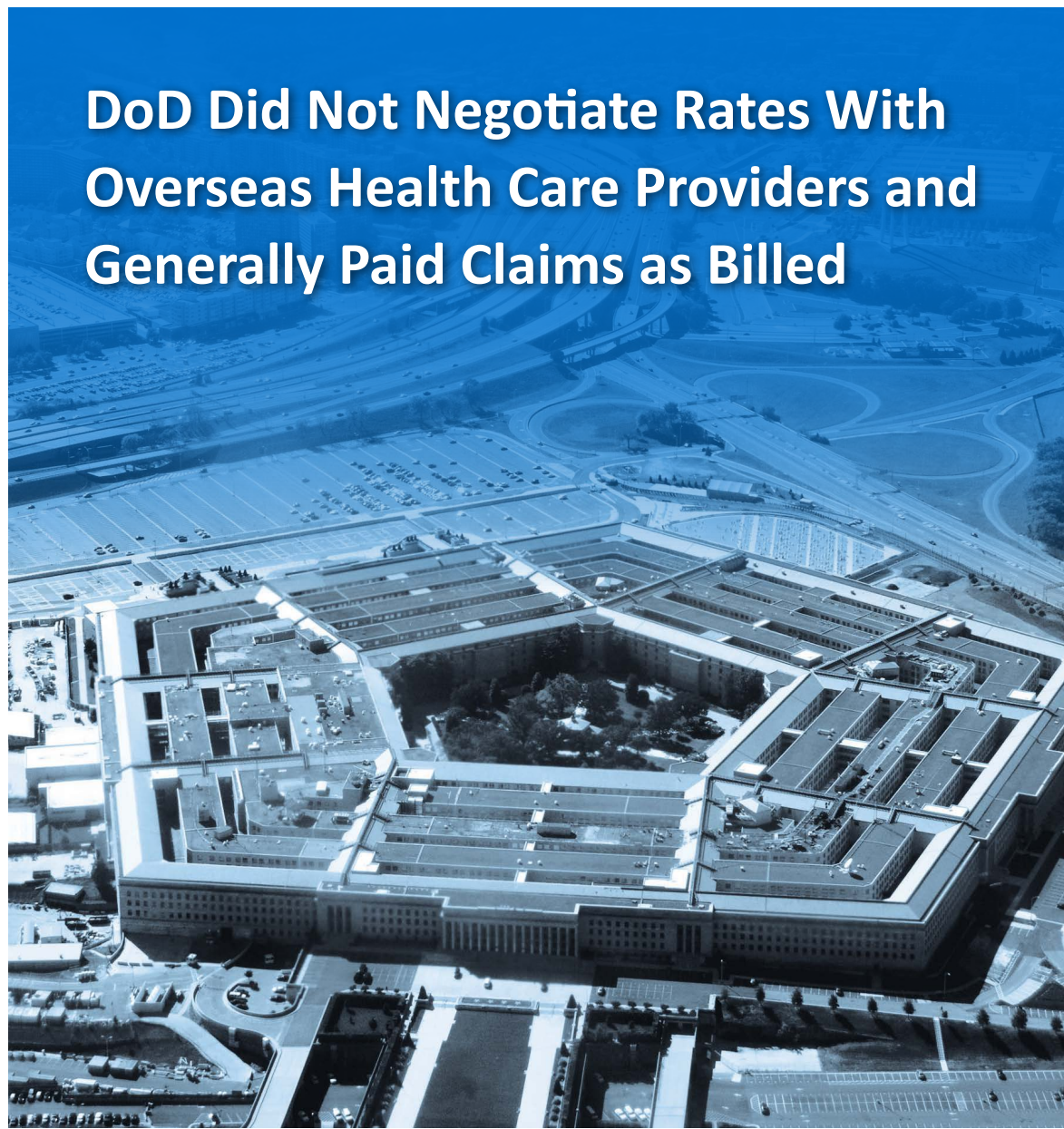




INSPECTOR GENERAL

U.S. Department of Defense

APRIL 1, 2014



DoD Did Not Negotiate Rates With Overseas Health Care Providers and Generally Paid Claims as Billed

INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

Report Documentation Page

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Results in Brief

DoD Did Not Negotiate Rates With Overseas Health Care Providers and Generally Paid Claims as Billed

April 1, 2014

Objective

We determined the extent to which the TRICARE Management Activity (TMA), through the TRICARE Overseas Program (TOP) contractor, negotiated and adhered to reasonable rates for health care services provided in overseas locations.

Finding

TMA and TOP contractor officials did not negotiate rates in any of the 163 overseas locations, which represented \$238 million in health care payments in FY 2012. Also, TMA officials did not include language in the TOP contract requiring the contractor to negotiate rates with overseas providers. TRICARE payments increased from \$21.1 million in FY 2009 to \$63.8 million in FY 2012 or about 203 percent in six high-dollar-volume locations without negotiated rates or other cost containment measures.

According to the Chief of the TOP Office, TMA did not negotiate rates because TRICARE represented a small market overseas; the contractor would not be able to successfully negotiate rates based on local practices and constantly changing market volumes; negotiating rates could have a negative impact on providing access to quality care to active duty service members and their dependents; and requiring the TOP contractor to negotiate rates would have increased the cost of the

Finding Continued

contract. However, TMA officials did not have documentation to support these reasons. Additionally, TMA officials did not have a process in place to negotiate rates. Without negotiating rates or implementing other cost containment measures, TMA potentially paid more than necessary for health care services provided by overseas providers and missed potential opportunities to obtain the best value for health care services.

Recommendations

We recommend that the Assistant Secretary of Defense (Health Affairs) initiate action to either establish negotiated rates with high-dollar-volume overseas providers or implement other cost containment measures in high-dollar-volume locations with significant increases. Also, the Assistant Secretary should establish procedures to negotiate rates directly with the TRICARE Overseas Program contractor when the contractor provides service as a health care provider.

Management Comments and Our Response

The Assistant Secretary of Defense (Health Affairs) comments partially addressed Recommendation 1.a, and stated he would include a requirement for a study in the follow-on TOP contract to assess the impact of negotiated rates on access to care in South Korea and the United Kingdom. He did not agree to negotiate rates or implement cost containment measures depending on the findings of the study. Also, he did not agree to any actions for Bahrain, Turkey, and Japan. He stated that he intends to implement maximum allowable rates in U.S. Territories. The Assistant Secretary did not address the specifics of Recommendation 1.b. We request additional comments on these recommendations by May 1, 2014. Please see the Recommendations Table on the back of this page.

Recommendations Table

Management	Recommendations Requiring Comment	No additional Comments Required
Assistant Secretary of Defense (Health Affairs)	1.a, 1.b	

Please provide comments by May 1, 2014.



**INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500**

April 1, 2014

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: DoD Did Not Negotiate Rates With Overseas Health Care Providers and Generally Paid Claims as Billed (Report No. DODIG-2014-052)

We are providing this report for your review and comment. The TRICARE Management Activity did not negotiate rates in any of the 163 overseas locations, which represented \$238 million in health care payments in FY 2012. Without negotiating rates or implementing other cost containment measures, the TRICARE Management Activity potentially paid more than necessary for health care services provided by overseas health care providers.

We considered management comments on a draft of this report when preparing the final report. DoD Directive 7650.3 requires that recommendations be resolved promptly. Comments from the Assistant Secretary of Defense (Health Affairs) partially addressed Recommendation 1.a, and did not address the specifics of Recommendation 1.b. Therefore, we request additional comments on Recommendations 1.a. and 1.b. by May 1, 2014. Also, the final comments should include an expected date of completion for any actions that will be taken.

Please send a PDF file containing your comments to audyorktown@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We cannot accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 604-8905. If you desire, we will provide a formal briefing on the results.

A handwritten signature in cursive script, reading "Amy J. Frontz".

Amy J. Frontz
Principal Assistant Inspector General
for Auditing

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Acronyms and Abbreviations

Introduction

Objective

Our objective was to determine the extent to which the TRICARE Management Activity (TMA), through the TRICARE Overseas Program (TOP) contractor, was negotiating and adhering to reasonable rates for health care services provided in overseas locations. See Appendix A for a discussion of the scope and methodology and prior coverage.

Background

TRICARE Management Activity

TMA, a field activity under the guidance and direction of the Assistant Secretary of Defense (Health Affairs) (ASD[HA]), managed the TRICARE program under which health care services are provided to DoD beneficiaries through September 30, 2013. DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013, disestablished TMA and transferred TMA's functions, including managing the TRICARE program, to DHA on October 1, 2013. The TRICARE program combines the resources of the Military Health System with networks of civilian health care professionals, institutions, pharmacies, and medical suppliers to ensure service members and their family members receive health care. TMA provided health care services to TRICARE beneficiaries in the North, South, West, and Overseas health service regions.

TRICARE Overseas Program

The TOP is DoD's health care program that provides health care support services to more than 580,000 TRICARE beneficiaries outside of the 50 states and the District of Columbia. TMA contracting officials awarded the overseas health care support contract H94002-10-D-0001 (TOP contract) on October 16, 2009, to International SOS Assistance, Inc., to assist TRICARE Area Offices and medical treatment facilities with the implementation of a health care delivery system to integrate the military direct care system with host nation (overseas) provider networks. The TOP contract had an estimated award value of about \$269.1 million, if all 5 option years were exercised. The base year period of performance began November 1, 2009; however, health care delivery did not begin until September 1, 2010. The contract is in the 4th option year and, according to the contracting officer's representative for the TOP contract, \$363.8 million has been expended as of September 11, 2013. The TOP contractor subcontracted with Wisconsin Physicians Service (WPS) to provide claims processing services.

Prior Audit Report Showed Need for Additional Controls in TRICARE Overseas Program

DoD Inspector General (DoD IG) Report No. D-2008-045, "Controls Over the TRICARE Overseas Healthcare Program," February 7, 2008, stated that TMA officials could further control health care costs by establishing price caps for professional services and hospital inpatient claims in countries with high-dollar-volumes of claims and in countries that experience significant increases in health care costs; ensuring that all TRICARE claims, including TRICARE Global Remote Overseas claims, filed in a given country were subject to the same price caps; and implementing price caps in Guam and the U.S. Virgin Islands that were based on those used by the Centers for Medicare and Medicaid Services. If TMA implemented price caps on claims for professional services and hospital inpatient charges, TMA could annually put at least \$16 million of Defense Health Program funds to better use.

Review of Internal Controls

DoD Instruction 5010.40, "Managers' Internal Control Program Procedures," May 30, 2013, requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the effectiveness of the controls. We identified an internal control weakness where TMA officials did not have a process in place to negotiate rates. We will provide a copy of the final report to the senior official responsible for internal controls at the Office of the Assistant Secretary of Defense (Health Affairs).

Finding

Missed Potential Opportunities to Reduce Payments to Overseas Health Care Providers

TMA and TOP contractor officials did not negotiate rates in any of the 163 overseas locations,¹ which represented \$238 million in health care payments in FY 2012. TMA implemented cost containment measures² to establish maximum allowable rates in Panama, the Philippines, and Puerto Rico; however, TMA generally paid claims as billed for overseas health care without any cost containment measures in other locations. Also, TMA officials did not include language in the TOP contract requiring the contractor to negotiate rates with overseas providers. Overseas health care payments for six of the high-dollar-volume locations³ without cost containment measures increased from \$21.1 million in FY 2009 to \$63.8 million in FY 2012, more than 203 percent.

The Chief of the TOP Office stated that TMA did not negotiate rates because (1) TRICARE represented a small market overseas; (2) the contractor would not be able to successfully negotiate rates based on local practices and constantly changing market volumes; (3) negotiating rates could have a negative impact on providing access to quality care to active duty service members and their dependents; and (4) requiring the TOP contractor to negotiate rates would have increased the cost of the contract. However, TMA officials did not have documentation to support these reasons. Additionally, TMA officials did not have a process in place to negotiate rates.

Without negotiating rates or implementing other cost containment measures, TMA potentially paid more than necessary for health care services provided by overseas providers and missed potential opportunities to obtain the best value for the health care services.

¹ The 163 overseas locations represented those locations where TMA made payments in FY 2012, as shown collectively in Tables 1 and 2. Appendix B shows overseas locations where TMA made payments in FY 2009 to FY 2012.

² For the purposes of this report, cost containment measures are methods used to limit costs by negotiating rates, and adhering to maximum allowable rates and inpatient per diem rates.

³ The high-dollar-volume locations are the overseas locations without cost containment measures that significantly increased from FY 2009 to FY 2012.

Contract Did Not Require Negotiation of Rates

TMA officials did not include language in the TOP contract requiring the contractor to negotiate rates with overseas providers. The TOP contract states,

In the absence of specific reimbursement rates mandated by TMA, the Contractor may negotiate reimbursement rates with host nation providers. The Contractor may also negotiate rates in locations where TMA has directed a specific reimbursement rate; however, the negotiated rate cannot exceed the TMA-directed rate.

However, a prior overseas contract⁴ (contract H94002-04-D-0004) stated,

3.1.4. Cost-Containment Program. The Contractor shall implement a system for cost containment of billed claims charges. All services provided under this contract, to include air evacuation and commercial transport, must be provided at a reasonable cost.

3.1.4.4. Discounts – Network Providers: The Contractor shall utilize best business practices to establish reimbursement rates at the most advantageous level (i.e. discount off billed charges) as part of its network agreements.

TMA officials were unsure of the reasons behind the change in contract language, though they believe the contract allows the TOP contractor to negotiate rates, if practical.

Even though TMA officials did not include specific language in the TOP contract requiring the negotiation of rates with overseas providers, the TOP contract required the contractor to “provide a managed, stable, high-quality network or networks of individual and institutional host nation providers which promote...best value health care for TOP enrollees in the [medical treatment facility] and remote locations.” To attain the best value in health care, the TOP contractor must deliver high-quality health care in the most economical manner while ensuring patient satisfaction with the service. Also, the TOP contract did not cite rate negotiation as a main objective of the contract and TMA officials did not include performance incentive awards for the TOP contractor to negotiate rates. As a result, TOP contractor officials did not negotiate rates for health care services in any overseas locations under the TOP contract.

⁴ The scope of service of this contract only covered certain beneficiaries, such as active duty service members, in remote overseas areas.

Claims Generally Paid Without Any Cost Containment Measures

Despite previous recommendations⁵ that addressed the need for overseas cost containment measures, TMA implemented cost containment measures in only three locations and generally paid claims without any cost containment measures in other locations. Specifically, for FY 2012, on behalf of TMA, the TOP contractor processed about 93 percent of the amount paid for overseas claims without any reductions other than for cost-shares, deductibles, or other health insurance payments.⁶ For example, an institutional provider in the United Kingdom billed TMA for an active duty service member receiving a 42-day inpatient treatment for alcohol dependence at a cost of \$34,535; the TOP contractor paid the amount in full without applying any cost containment measures.

Overseas Payments Increased in Locations Without Cost Containment Measures

TRICARE payments generally continued to increase in high-dollar-volume overseas locations without cost containment measures. Health care payments increased by 40.4 percent for overseas locations without cost containment measures, as shown in Table 1. TMA paid \$63.8 million in FY 2012 for overseas health care in six of the locations without cost containment measures (Bahrain, Turkey, South Korea, Japan, Guam, and the United Kingdom), \$42.7 million or about 203 percent more than in FY 2009 when TMA paid \$21.1 million.

⁵ DoD IG Report No. D-2008-045, "Controls Over the TRICARE Overseas Healthcare Program," February 7, 2008.

⁶ Percentage was calculated on the initial submission of health care claims to the TOP contractor.

Table 1. TRICARE Payments for Overseas Locations Without Cost Containment Measures^{1,2}

Location	FY 2009	FY 2010	FY 2011	FY 2012	Percent Change (FY09-12)
*Bahrain	\$186,875	\$543,198	\$2,661,443	\$5,468,486	2,826.3
*Turkey	1,114,534	1,718,403	3,856,781	4,789,468	329.7
*South Korea	4,855,587	7,472,837	18,587,668	20,705,672	326.4
*Japan	2,741,933	3,399,000	9,638,800	9,622,368	250.9
*Guam	2,206,403	2,611,078	3,934,796	4,585,942	107.8
*United Kingdom ³	9,962,000	10,535,811	17,914,223	18,624,491	87.0
Subtotal⁴	\$21,067,331	\$26,280,327	\$56,593,711	\$63,796,427	202.8
U.S. Virgin Islands	1,475,313	1,855,349	2,238,308	2,378,004	61.2
Italy	4,861,401	5,377,702	5,906,363	6,524,704	34.2
Singapore ³	2,136,366	2,674,315	2,533,618	2,458,930	15.1
Germany	95,451,433	102,018,090	119,005,339	104,163,890	9.1
All Other Locations (150 in FY 2012)	23,640,388	27,321,536	25,694,841	22,317,227	(5.6)
International SOS Air Ambulance (All Locations) ³	1,817,605	1,990,025	6,848,665	9,614,580	429.0
Subtotal⁴	\$129,382,506	\$141,237,018	\$162,227,134	147,457,336	14.0
Total⁴	\$150,449,837	\$167,517,344	\$218,820,845	\$211,253,763	40.4

Source: Military Health System Data Repository (MDR) as of July 2013

¹ TMA allows overseas providers to submit claims up to 3 years from the date when care was provided.

² The data in the table do not include care provided under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC). TDEFIC covers the TRICARE For Life benefit, which is available to TRICARE beneficiaries that have Medicare Part A and Part B. TRICARE For Life claims are normally filed with Medicare first and TRICARE generally pays second for care received within the U.S. or U.S. Territories; however, Medicare does not cover claims for care received outside of the U.S. and U.S. Territories.

³ The International SOS air ambulance claims were excluded from the Singapore, United Kingdom, and All Other Locations (Australia, United Arab Emirates, and Venezuela) totals and listed separately because they were originally included in the totals for care rendered in these locations, even if the air ambulance origin or destination did not include those locations.

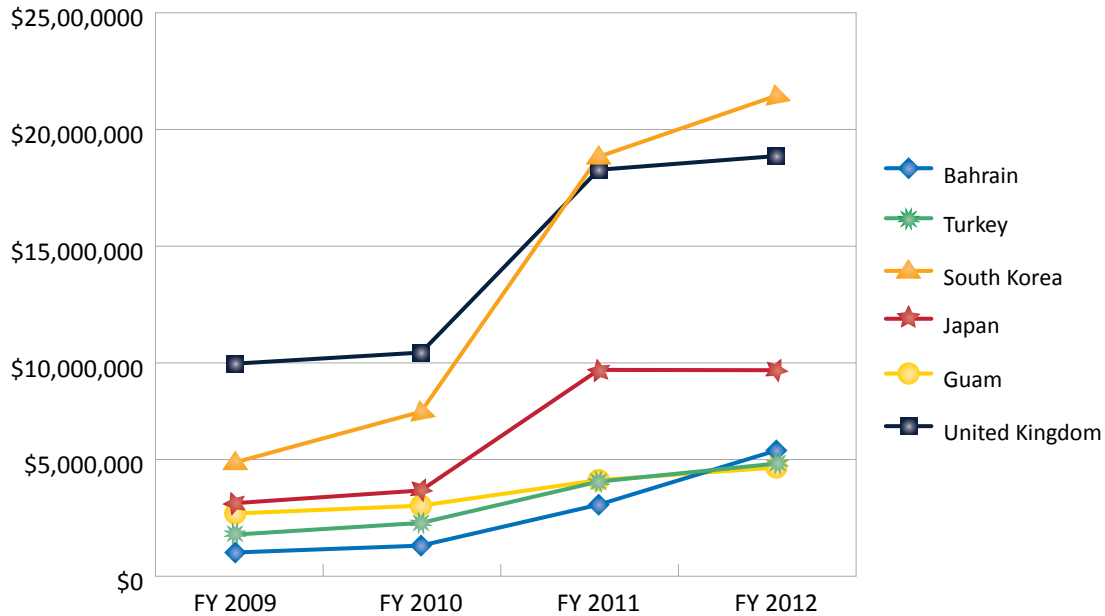
⁴ Totals may not equal due to rounding.

* Represents the high-dollar-volume locations with significant increases.

Figure 1 shows that payments for overseas health care have significantly increased for six high-dollar-volume locations. For example, TMA paid \$20.7 million for care provided in South Korea in FY 2012, an increase of about \$15.9 million from FY 2009, as shown in Table 1 and Figure 1. World Health Organization data showed that private

health care costs⁷ in South Korea increased by only 41 percent from FY 2009 to FY 2011, although TMA paid 283 percent more in that country during the same time frame. According to the Chief of TOP, some of the increases were due to policy changes, and increases in the number of claims and beneficiaries receiving care.

Figure 1. Six High-Dollar-Volume Locations With Significant Increases



Source: MDR as of July 2013

TMA payments may continue to significantly increase resulting in much higher payments over the next 5 years. Additionally, significant increases in payments could indicate fraudulent activity. For example, the DoD IG reported in 2006⁸ that payments in the Philippines substantially increased from \$2.9 million in FY 1998 to \$64.2 million in FY 2003, or 2,135 percent. TMA paid about 80 percent of the \$64.2 million to the billing Philippine corporation. In 2008, the U.S. District Court, Western District of Wisconsin, sentenced the chief executive officer from that Philippine corporation to 5 years in prison for defrauding the TRICARE program. Also, the corporation was ordered to liquidate its assets and pay \$99.9 million in restitution to the U.S. Government. In 2004, TMA officials implemented cost containment measures over payments for health care provided in the Philippines, and in FY 2012, payments totaled only about \$3.6 million.

⁷ TRICARE is considered a private health care insurance program in overseas locations.

⁸ DoD IG Report No. D-2006-051, "TRICARE Overseas Controls Over Third Party Billing Agencies and Supplemental Health Insurance Plans," February 10, 2006

Overseas Payments Decreased in Locations With Cost Containment Measures

While TMA and TOP contractor officials did not negotiate rates with overseas providers, TMA implemented cost containment measures in Panama, the Philippines, and Puerto Rico. Specifically, TMA implemented a per diem reimbursement system and maximum allowable rates to limit payments on TOP claims for institutional⁹ and non-institutional¹⁰ claims in Puerto Rico in 1992, the Philippines in 2004, and Panama in 2008. As a result, TMA paid 5.7 percent less in Puerto Rico, 67.1 percent less in Panama, and 82.1 percent less in the Philippines in FY 2012 than FY 2009, as shown in Table 2. For example, a Panama institutional provider billed TMA for a claim for a 1-day hospital stay in October 2010 for \$2,810.91, but the TOP contractor, using the inpatient per diem rate, reduced the amount allowed to \$1,381.¹¹

Table 2. TRICARE Payments for Overseas Locations With Cost Containment Measures^{1,2}

Location	FY 2009	FY 2010	FY 2011	FY 2012	Percent Change (FY09-12)
Puerto Rico	23,145,504	23,286,386	24,599,426	21,835,895	(5.7)
Panama	4,432,911	2,270,304	1,509,781	1,458,881	(67.1)
Philippines	20,207,834	6,914,361	4,021,874	3,610,817	(82.1)
Total³	\$47,786,249	\$32,471,051	\$30,131,081	\$26,905,592	(43.7)

Source: MDR as of July 2013

¹ TRICARE guidance allows overseas providers to submit health care claims for reimbursement up to 3 years from the date care was provided.

² The data in the table does not include care provided under the TDEFIC.

³ Totals for FY 2012 do not equal because of rounding.

According to the Chief of TOP, the cost containment measures were implemented as a result of findings of fraudulent billing practices. The Chief of TOP agreed that the measures reduced the costs, but she stated the measures had a negative impact on some of the TRICARE beneficiaries' access to quality health care and out-of-pocket expenses. However, TMA officials did not provide any documentation to show that negotiating rates would negatively impact access to care.

⁹ Institutional claim records usually reflect treatment by a hospital or other authorized institutional provider with the reasonable expectation that the patient will remain on inpatient status at least 24 hours. Institutional claim records may also reflect outpatient care in a Hospice or Home Health Program.

¹⁰ Non-institutional claim records reflect either inpatient or outpatient health care services exclusive of inpatient institutional facility services, including institutional care in connection with ambulatory surgery.

¹¹ The allowed amount may be further reduced by other factors such as the share that the beneficiary must pay. In this example, the patient had a cost-share of \$345.25, thus reducing the total amount that TMA paid to \$1,035.75.

Small Number of Providers Represented a Large Amount of Overseas Payments

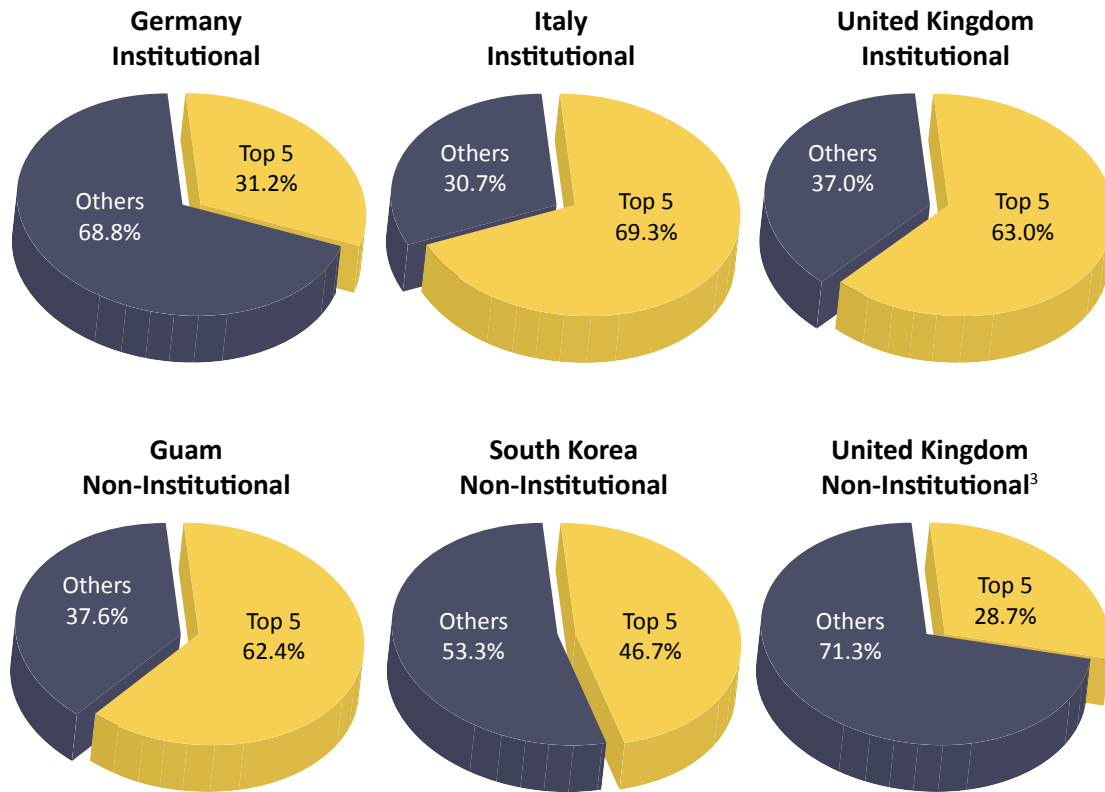
A small number of overseas providers accounted for a significant percentage of payments at overseas locations. According to the Chief of the TOP Office, the TRICARE program represented “a very small market overseas so expecting host nation providers to offer a discounted rate for a small labor intensive population would not be reasonable.” However, we identified that TMA made payments to several high-dollar-volume locations, six of which totaled \$63.8 million in FY 2012 and each of which increased by more than 85 percent from FY 2009 to FY 2012, as shown in Table 1. Additionally, we identified that only a small number of overseas providers represented a large percentage of the TRICARE payments in several high-dollar-volume locations in FY 2011, as shown in Figure 2. For example, the five highest paid providers of institutional care provided in the United Kingdom accounted for more than 60 percent of the TRICARE payments in that location. The five highest paid providers of non-institutional care provided in South Korea accounted for more than 45 percent of the TRICARE payments in that location.



Only a small number of overseas providers represented a large percentage of the TRICARE payments.

If DHA and TOP contractor officials would attempt to negotiate with the highest paid providers in the high-dollar-volume locations, DHA could significantly reduce overseas health care costs. Also, a TOP contractor official stated that the TOP contractor may be able to leverage existing relationships with providers on its commercial side to negotiate rates for care provided to TRICARE beneficiaries. The ASD(HA) should initiate action to either establish negotiated rates with high-dollar-volume overseas health care providers or implement other cost containment measures in high-dollar-volume locations with significant increases.

Figure 2. Locations Where Top Five Providers Represent Significant Percentage of Total Amount Paid in FY 2011^{1,2}



Source: MDR as of July 29, 2013

¹ TRICARE guidance allows overseas providers to submit health care claims for reimbursement up to 3 years from the date when care was provided.

² The data in the figure does not include pharmacy related claims and care provided under the TDEFIC.

³ Excludes International SOS air ambulance claims from the United Kingdom.

In addition, if DHA requires the TOP contractor to negotiate rates with overseas health care providers and the TOP contractor is also a provider of health care services, DHA officials should ensure that the TOP contractor does not negotiate rates with its own providers—TOP contractor personnel would not be independent in negotiating rates with themselves. For example, International SOS, providing service as a health care provider, submitted air ambulance claims for \$9,685,345 in FY 2012. The ASD(HA) should establish procedures to negotiate rates directly with the TOP contractor when the contractor provides service as a health care provider.

Overseas Local Practices and Market Volumes Affect Rates

According to the Chief of the TOP Office, the TOP contractor may not be able to fulfill a requirement to negotiate rates with overseas providers. TMA officials conducted an industry forum with 11 companies before final development of the TOP contract requirements. According to the Chief of the TOP Office, the general consensus among the companies was that the ability to negotiate discounted rates was dependent on local practices and the volumes provided by the client market and provider markets, which were constantly changing. Some companies mentioned that negotiation of discounted rates might be possible in some locations overseas. We agree that it may not be feasible to negotiate rates with providers in all overseas locations, as some low-dollar-volume providers may be reluctant to accept negotiated rates. However, DHA and TOP contractor officials may have success with negotiating rates with high-dollar-volume providers. By negotiating rates with high-dollar-volume providers, DoD may be able to achieve significant cost savings with limited effort while potentially limiting fraudulent claims.

No Documentation That Access to Quality Care is Affected by Negotiated Rates

The Chief of the TOP Office stated that negotiating rates could impair access to care for TRICARE beneficiaries. She explained that a major goal of the TOP contract was to ensure active duty service members and family members have access to quality care while stationed in overseas locations. The Chief of the TOP Office stated that requiring the TOP contractor to negotiate rates with overseas providers “could have a negative impact on the availability of quality host nation providers willing to care for our [active duty service members and their family members].” Although access to care is a valid concern, TMA officials were unable to provide any documentation to show that negotiating rates would impact access to care and stated that they did not formally track access to care complaints.

TMA Did Not Determine the Potential Increase in Contract Costs

TMA officials did not determine if contractor costs would result in a net increase to health care with a requirement to negotiate rates. The Chief of the TOP Office stated that requiring the TOP contractor to negotiate rates would increase contract costs. However, DHA may reduce overall costs by negotiating rates.

While TMA officials were concerned about escalating contract costs, they should also have sought opportunities to reduce rising health care costs where possible, such as negotiated rates. The previous Secretary of Defense, Leon Panetta, stated, “Health care is another important benefit, and one that has far outpaced inflation.” Health care is an area that presents opportunities to help control costs.

No Process in Place to Negotiate Rates

TMA did not have a process in place to negotiate rates. A TMA official stated that TMA officials did not establish a process because they were not negotiating rates. Additionally, in June 2013, a TOP contractor official stated that the TOP contractor had not established a process.

DoD May Have Paid More Than Necessary For Overseas Health Care

Without negotiating rates with overseas providers or implementing cost containment measures, TMA may have paid more than necessary for health care provided in overseas locations. For example, TMA may have paid a higher rate than necessary for health care provided in Guam in the following instances.

- A provider billed \$945 for a sleep study in March 2011—TMA paid the amount in full. However, the highest Medicare allowable rate for a sleep study in Guam was \$603, about 36 percent less than the full amount that TMA paid.
- A provider billed \$1,537 for a Magnetic Resonance Imaging (MRI) procedure in May 2011—TMA paid the amount in full. However, the highest Medicare allowable rate for an MRI procedure in Guam was \$629, about 59 percent less than what TMA paid.
- A provider billed \$154 for an office visit in September 2011—TMA paid the amount in full. However, the highest Medicare allowable rate for the type of office visit billed in Guam was \$82, about 47 percent less than what TMA paid.

The TOP contract states, “payment to host nation providers shall be the lesser of billed charges, the negotiated rate, or the TMA-established reimbursement rate.” Therefore, without negotiated rates or TMA-established rates, the TOP contractor generally paid overseas health care as billed. If TOP contractor officials negotiated

rates with the provider, TRICARE beneficiaries could also reduce their out-of-pocket expenses because of lowered cost-shares. On May 14, 2013, the Secretary of Defense, Chuck Hagel, stated “the Department of Defense is facing a historic shortfall in our budget for the current fiscal year” and, as a result, DoD and other Federal agencies are undergoing deep across-the-board cuts. However, TMA generally paid overseas claims as billed without attempting to reduce costs through negotiated rates or other cost containment measures. Without negotiating rates or implementing other cost containment measures, TMA potentially paid more than necessary for health care services provided by overseas providers and missed potential opportunities to obtain the best value for the health care services.

Recommendations, Management Comments, and Our Response

Recommendation 1

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

- a. Initiate action to either establish negotiated rates with high-dollar-volume overseas health care providers or implement other cost containment measures in high-dollar-volume locations with significant increases.**

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary agreed with the need to implement cost containment measures within the TOP; however, he disagreed with negotiating rates with high-dollar-volume overseas health care providers until DHA determined the impact on access to care for active duty service members and active duty family members. The Assistant Secretary stated that DHA would include a requirement for a study in the follow-on TOP contract to determine the feasibility of negotiating rates in South Korea and the United Kingdom and any resulting impact on access to care. The Assistant Secretary stated that the study would be completed within 90 days following the start of health care delivery under the follow-on TOP contract. He stated that DHA should not attempt to negotiate rates with overseas providers until there are other health care alternatives that meet TRICARE requirements in the event providers refuse to negotiate rates. The Assistant Secretary stated that DHA will implement the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge Rates in the U.S. Territories in the follow-on TOP contract.

The Assistant Secretary stated that DHA previously implemented some cost containment measures within the TOP to include foreign fee schedules in Panama and the Philippines, the requirement for the TOP contractor to determine the reasonableness of health care claims in each location, pre-payment reviews for questionable claims, post-payment reviews on all high-dollar claims, and proof of payment on all beneficiary submitted claims. The Assistant Secretary expressed concern about the rise in the costs of health care and its impact on DoD's budget. He cited multiple factors contributing to rising health care costs in the locations discussed in the report. Specifically, he stated that:

- on October 1, 2010, the TOP contractor assumed responsibility for Supplemental Health Care Program claims from the military services;
- DHA implemented, in 2010 and 2011, the TRICARE Retired Reserve and the TRICARE Young Adult Programs, which increased purchased care costs in the TOP; and
- there were increases in the number of claims and unique beneficiaries from FY 2009 through FY 2012.

The Assistant Secretary stated that DHA reviewed the rising health care costs to include analyzing claims submissions and unique beneficiary numbers. He also provided data from FY 2009 through FY 2012 with the number of claims submitted and the number of unique beneficiaries receiving care in locations where health care costs have increased. The Assistant Secretary stated that TRICARE costs increased in Bahrain, Turkey, South Korea, Japan, Guam, the United Kingdom, and Italy, as a result of increases in claims submissions and the number of unique beneficiaries that received health care, coupled with health care inflation.

The Assistant Secretary stated that Japanese providers are not willing to negotiate rates. He stated that every Japanese citizen has Japanese National Insurance and the rates for their health insurance are set by the Japanese government. Additionally, the Assistant Secretary stated that Japanese providers are bound by the same requirements when providing care to non-Japanese citizens; however, they are provided flexibility in the amount billed for health care provided to non-Japanese citizens. The Assistant Secretary stated that prior attempts to establish a network of providers resulted in an overwhelming number of Japanese providers who refused to negotiate any contract with the TOP contractor. The Assistant Secretary stated that DHA established a unique payment process to ensure TRICARE beneficiaries had access to quality health care in Japan.

The Assistant Secretary stated that German law requires that providers charge rates mandated under the German National Health Insurance. Further, he stated that German providers may charge up to 3 percent higher than the rate set by law for private insurance plans, such as TRICARE. The Assistant Secretary stated that DHA would have no leverage to negotiate rates lower than what the law currently allows because German laws control what the providers can charge.

The Assistant Secretary stated that while health care costs have decreased in Panama and the Philippines, TRICARE Standard beneficiaries have experienced a negative impact on access to care and increased out-of-pocket costs. Additionally, he stated that DoD does not have a large permanent presence in Panama and the Philippines, and TRICARE pays billed charges for health care provided to those active duty service members and their family members. He stated that inpatient facilities in Panama have refused to treat beneficiaries because TRICARE's reimbursement rates did not cover the facilities' costs to deliver health care. He also stated that patients in the Philippines have voiced the same concerns and the Philippine Demonstration Project found providers unwilling to participate in the project to meet TRICARE's requirements to accept payment based on a foreign fee schedule. The Assistant Secretary provided data that shows claims and beneficiaries have decreased in Panama, the Philippines, and Puerto Rico—another reason for reduced costs in these locations.

Our Response

Comments from the Assistant Secretary partially addressed the recommendation. Specifically, he agreed that DHA would include a requirement in the follow-on TOP contract to determine whether negotiated rates would impact access to care in South Korea and the United Kingdom. Also, he agreed to implement CHAMPUS Maximum Allowable Charges for physician services in U.S. Territories, to include Guam, which may occur during the follow-on TOP contract. However, he did not agree to initiate action to negotiate rates or implement other cost containment measures for health care provided in Bahrain, Turkey, or Japan. Further, the Assistant Secretary intends to delay the possibility of negotiating rates in South Korea and the United Kingdom until the follow-on TOP contractor performs a study to determine the impact this would have on access to health care for beneficiaries.

The study is a good first step to limit costs in South Korea and the United Kingdom; however, the Assistant Secretary did not explicitly agree to negotiate rates or implement other cost containment measures with providers in the United Kingdom and South Korea. If the study shows that negotiating rates would not significantly impact

access to care, then the Assistant Secretary should initiate action to negotiate rates with overseas health care providers in the United Kingdom and South Korea. If the study shows that negotiating rates would significantly impact access to care, the Assistant Secretary should implement some other cost containment measures in those countries. Also, DHA should modify the current TOP contract to begin the study in FY 2014 rather than waiting for the TOP contract to end on August 31, 2015.

As stated in the report, although access to care is a valid concern, TMA officials were unable to provide documentation to show that negotiating rates had resulted in access to care problems. TMA implemented a per diem reimbursement system and maximum allowable rates to limit payments on TOP claims for institutional and non-institutional claims in the Philippines in 2004 and Panama in 2008. Even though these cost containment measures were in effect from 5 to 9 years, TMA could not provide documentation of access to care problems based on these cost containment measures. Also, TMA officials stated that they did not formally track access to care complaints. Negotiations are voluntary agreements between parties. TMA has not provided any evidence to show an attempt to negotiate rates with any health care providers in overseas countries.

We recognize that claims and beneficiaries increased in Bahrain, Turkey, South Korea, Japan, Guam, and the United Kingdom. This supports the necessity to negotiate rates with overseas health care providers or implement other cost containment measures. Negotiating rates or implementing other cost containment measures, where practical, should help DoD to keep overseas health care costs at a reasonable level. From FY 2009 through FY 2012, the number of TRICARE beneficiaries for the six-high-dollar-volume locations increased only 6.1 percent according to data provided by a TMA contractor in support of the Plans and Analysis Branch, Beneficiary Education and Support Division. (See Appendix C for more details on the TRICARE beneficiary population statistics in overseas locations.) Moreover, six locations without cost containment measures generally had significant increases in the number of claims and unique beneficiaries, which is a red flag for potential fraudulent activity. The Assistant Secretary should implement cost controls in a more timely manner.

If Japanese providers are unwilling to negotiate rates, the Assistant Secretary should implement a cost containment measure to review the cost reasonableness of the claim. As shown in the report, TMA paid \$9.6 million in FY 2012 for overseas health care in Japan, \$6.9 million or about 250.9 percent more than in FY 2009 when TMA paid \$2.7 million. In FY 2013, TMA paid \$10.1 million for health care provided in Japan. Also, the TRICARE beneficiary population only increased by a marginal amount,

5.6 percent, from FY 2009 through FY 2012, according to data provided by a TMA contractor. DHA personnel should increase their oversight of overseas health care claims in Japan.

TMA payments for health care provided in Germany had a 9.1 percent increase from FY 2009 through FY 2012; therefore, we concluded that the increase was not significant enough to make a recommendation to the Assistant Secretary to negotiate rates with German health care providers.

We commend the Assistant Secretary for agreeing to implement the use of CHAMPUS Maximum Allowable Charges for physician services in the U.S. Territories such as Guam. He should also expedite negotiating rates or implementing other cost containment measures in Bahrain, Turkey, South Korea, Japan, and the United Kingdom. We request that the Assistant Secretary reconsider his position on this recommendation and provide additional comments to the final report. Also, the final comments should include an expected date of completion for any actions that will be implemented.

b. Establish procedures to negotiate rates directly with the TRICARE Overseas Program contractor when the contractor provides service as a health care provider.

Assistant Secretary of Defense (Health Affairs) Comments

The Assistant Secretary disagreed with our recommendation, stating that this recommendation is a result of the increase in aeromedical evacuation (air ambulance) costs identified. He stated that DHA has controls in place to ensure that aeromedical evacuation costs are reasonable and appropriate. Specifically, he stated that every aeromedical evacuation is reviewed and approved prior to the movement of any patient by a military flight surgeon assigned to one of the Patient Movement Requirement Centers in each of the overseas regions. Additionally, he stated that each aeromedical evacuation is audited retrospectively to ensure the movement was appropriate and followed the process for approval. The Assistant Secretary provided reasons for the increase in aeromedical evacuation costs. He stated that the aeromedical evacuation costs were reasonable based on their cost analysis and that there were adequate internal controls in place. Therefore, he stated that DHA did not need to negotiate aeromedical evacuation charges with the TOP contractor.

Our Response

The Assistant Secretary did not address the specifics of the recommendation. DHA personnel should establish procedures to negotiate rates directly with the TOP contractor when it provides services as a health care provider. Specifically, DHA personnel should ensure that the TOP contractor does not negotiate aeromedical evacuation rates, or any other health care rates, with its own providers—TOP contractor personnel would not be independent in negotiating rates with themselves.

Without negotiating rates, the contract provider could increase rates unchallenged. In fact, aeromedical evacuation costs significantly increased under the current TOP contract. Aeromedical evacuation costs escalated from \$1.99 million in FY 2010, under the prior overseas contract, to \$6.85 million in FY 2011, under the current TOP contract. These costs have remained over \$8 million annually since FY 2011, including \$8.07 million in FY 2013. Costs escalated when the aeromedical evacuation service fixed-fee table, a cost containment measure in the prior contract, was not included in the contract in effect at the time of our audit (H94002-10-D-0001). Specifically, that contract (H94002-10-D-0001) did not include language on the amount the TOP contractor could bill DoD when the contractor performs aeromedical evacuations for TRICARE beneficiaries. The prior overseas contract (H94002-04-D-0004) provided an aeromedical evacuation service fixed-fee table that cited fixed fees based on the total evacuation expenses that the contractor could reference to bill DoD for this service. For example, the TOP contractor could have billed DoD a fixed fee of \$13,500 for any aeromedical evacuation in which the “transportation and related expenses” were greater than \$75,001. DHA personnel may negotiate a similar fixed-fee table in the follow-on TOP contract for the aeromedical evacuations performed by the TOP contractor. While we recognize that there may be legitimate reasons for the cost increases in aeromedical evacuations, DHA personnel should attempt to negotiate rates directly with the TOP contractor.

We request that the Assistant Secretary reconsider his position on this recommendation and provide additional comments to the final report. Also, the final comments should include an expected date of completion for any actions that will be implemented.

Appendix A

Scope and Methodology

We conducted this performance audit from January 2013 through December 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

To accomplish our objective, we interviewed officials from TMA; the TOP contractor, International SOS; and the claims processor, WPS. We discussed whether TMA and TOP contractor officials negotiated rates with providers; potential access to care concerns related to negotiating rates; and TRICARE institutional and non-institutional cost containment initiatives including institutional per diem payment methodologies and CHAMPUS Maximum Allowable Charges. We also reviewed claims processor work instructions, claims audit reports performed by International SOS, and quarterly claims analysis performed by the TRICARE Claims Review Contractor. We visited the claims processor to obtain information on the TOP claims payment system and information related to negotiated rates. We observed the claims processing procedures and systems controls, and obtained claims payment information from the claims processor's TRICARE Manage Care System as well as documentation supporting medical claims. We obtained the Medicare allowable rates from the Centers for Medicare & Medicaid Services' Physician Fee Schedule website and determined whether TRICARE payments exceeded the Medicare allowable rate for three non-institutional procedures provided by health care providers in Guam.

We obtained data from the MDR for FY 2009 to FY 2012 to create Table 1, Table 2, Figure 1, Figure 2, and Appendix B. For Table 1, Table 2, and Figure 1, we calculated the total payments for health care provided in each location in the TOP for FY 2009 to FY 2012 by the TOP contractor. Data for the U.S. Territories were as of July 25, 2013 and data for all other locations were as of July 24, 2013 for Table 1, Table 2, Figure 1, and Appendix B. For Figure 2, we calculated the percentage of payments made to the five highest paid providers of institutional and non-institutional health care, excluding prescription drugs, compared to the entire location for FY 2011 by the TOP contractor, as of July 29, 2013. We also obtained payment information from the MDR to determine the percentage of health care claims processed by the TOP contractor that were paid as billed and the amounts billed were not reduced by cost containment measures for

U.S. Territories other than a cost-share, deductible, or other health insurance. We did not include TDEFIC claims in Table 1, Table 2, Figure 1, Figure 2, and Appendix B as Medicare is generally the primary payer for these claims.

We reviewed United States Code, the Code of Federal Regulations, as well as DoD and TMA documents from December 2002 to July 2013. We identified procedures and requirements established for the TOP related to negotiating and adhering to reasonable rates for health care services provided in overseas locations. Specifically, we reviewed applicable sections of the Title 10, United States Code, Chapter 55, Section 1097b, "TRICARE program: financial management," revised January 3, 2012; Title 32, Code of Federal Regulations, Chapter 1, Part 199, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," revised January 22, 2013; as well as various sections of the TRICARE Policy Manual 6010.57-M, February 1, 2008; TRICARE Operations Manual 6010.56-M, February 1, 2008; TRICARE Reimbursement Manual 6010.58-M, February 1, 2008; and TRICARE Systems Manual 7950.2-M, February 1, 2008. We also reviewed TOP contract H94002-10-D-0001, effective October 16, 2009, valued at about \$269.1 million and contract H94002-04-D-0004, effective December 6, 2002, valued at about \$24.5 million.

Use of Computer-Processed Data

We used computer-processed data to determine the amount paid for health care provided in overseas locations and whether health care claims were generally paid without cost containment measures. Specifically, we obtained the universe of all TOP institutional and non-institutional claims data from the MDR for FY 2011 for health care provided in the United Kingdom, Guam, and Panama. To test the reliability of the data, we reviewed medical records and claims payment information for 295 claims for health care provided in the United Kingdom, Guam, and Panama. We obtained medical claims supporting documentation for the sample items from WPS's imaging system, FileNet. We also obtained claims payment information from WPS's TRICARE Manage Care System. We compared the medical claims and payment information to the sample items to determine payment accuracy. Specifically, we compared the billed amounts, allowed amounts, paid amounts, other health insurance payments, date of service, patient deductibles, and patient cost-shares. We found only 5 of 295 claims had inaccurate payment amounts accounting for \$7,662.84 of the total amount paid of \$1,251,774.52 for the claims that we reviewed. Based on our testing, we determined that the data in Table 1, Table 2, Figure 1, Figure 2, and Appendix B were sufficiently reliable for the purposes of this report.

Use of Technical Assistance

The DoD Office of Inspector General Quantitative Methods Division provided technical support for this project, but the report does not present significant quantitative methods and results.

Prior Coverage

During the last 6 years, the DoD IG issued one report discussing cost containment measures in the TRICARE Overseas Program. Unrestricted DoD IG reports can be accessed at <http://www.dodig.mil/pubs>.

DoD IG

Report No. D2008-045, "Controls Over the TRICARE Overseas Healthcare Program,"
February 7, 2008

Appendix B

TRICARE Payments for Overseas Locations

The table below shows the amount paid by TMA for health care provided in overseas locations for FY 2009 to FY 2012 in descending order by amount paid in FY 2012.

Location ¹	FY 2009	FY 2010	FY 2011	FY 2012	Percent Change (FY09-12) ²
Germany	\$95,451,433	\$102,018,090	\$119,005,339	\$104,163,890	9.1%
Puerto Rico	23,145,504	23,286,386	24,599,426	21,835,895	(5.7)
South Korea	4,855,587	7,472,837	18,587,668	20,705,672	326.4
United Kingdom	9,962,000	10,535,811	17,914,223	18,624,491	87.0
Japan	2,741,933	3,399,000	9,638,800	9,622,368	250.9
International SOS Air Ambulance (All Locations) ³	1,817,605	1,990,025	6,848,665	9,614,580	429.0
Italy	4,861,401	5,377,702	5,906,363	6,524,704	34.2
Bahrain	186,875	543,198	2,661,443	5,468,486	2,826.3
Turkey	1,114,534	1,718,403	3,856,781	4,789,468	329.7
Guam	2,206,403	2,611,078	3,934,796	4,585,942	107.8
Philippines	20,207,834	6,914,361	4,021,874	3,610,817	(82.1)
Singapore	2,136,366	2,674,315	2,533,618	2,458,930	15.1
Virgin Islands	1,475,313	1,855,349	2,238,308	2,378,004	61.2
Belgium	1,931,948	1,645,666	2,496,621	1,927,019	(0.3)
Greece	2,011,914	1,985,146	1,945,987	1,905,063	(5.3)
Thailand	2,278,918	2,520,176	2,650,342	1,882,779	(17.4)
Spain	1,297,575	1,605,914	1,664,275	1,798,527	38.6
Australia	944,572	1,104,933	1,579,899	1,699,924	80.0
Mexico	1,480,945	1,506,466	1,638,702	1,594,148	7.6
Panama	4,432,911	2,270,304	1,509,781	1,458,881	(67.1)
Canada	1,138,218	878,551	998,510	715,330	(37.2)
France	624,097	915,710	937,149	684,009	9.6
United Arab Emirates	465,569	600,165	509,821	668,817	43.7
Costa Rica	992,096	1,093,811	400,187	642,422	(35.2)
Netherlands	1,085,750	881,870	836,011	628,138	(42.1)

Location ¹	FY 2009	FY 2010	FY 2011	FY 2012	Percent Change (FY09-12) ²
Portugal	713,552	561,126	703,986	600,289	(15.9)
Austria	322,629	596,618	428,617	480,096	48.8
Israel	328,137	350,196	376,786	410,611	25.1
Colombia	335,344	369,650	365,292	400,979	19.6
Norway	275,701	281,340	394,517	375,068	36.0
Saudi Arabia	402,245	440,417	462,338	373,740	(7.1)
China	469,446	361,817	301,576	296,674	(36.8)
Hong Kong	401,443	294,021	190,805	282,613	(29.6)
Switzerland	768,918	3,913,501	1,048,593	264,486	(65.6)
Brazil	277,484	213,212	980,151	246,164	(11.3)
Chile	290,330	250,280	236,995	238,545	(17.8)
Honduras	193,274	233,026	324,210	233,390	20.8
South Africa	149,069	322,275	265,951	215,898	44.8
Peru	169,117	304,765	158,656	184,005	8.8
El Salvador	113,447	171,692	123,553	182,792	61.1
Bahamas	235,707	245,812	175,435	173,410	(26.4)
American Samoa	204,941	166,020	130,353	172,971	(15.6)
Northern Mariana Islands	181,956	164,618	123,357	163,507	(10.1)
Jordan	117,045	112,422	114,393	129,796	10.9
Guatemala	75,079	70,113	88,782	118,286	57.5
Qatar	448,194	394,723	175,674	116,006	(74.1)
Dominican Republic	221,104	207,396	161,351	111,222	(49.7)
Ecuador	79,634	89,805	87,976	103,835	30.4
Uruguay	52,077	109,085	100,136	100,091	92.2
Marshall Islands	59,546	44,370	70,742	96,845	62.6
Luxembourg	30,490	46,739	50,781	91,580	200.4
Vietnam	24,026	29,811	54,525	83,315	246.8
New Zealand	78,923	65,036	55,054	82,305	4.3
Ireland	89,234	148,527	198,213	80,624	(9.6)
Taiwan	59,936	74,936	42,180	78,209	30.5
Lebanon	33,180	35,755	38,702	75,262	126.8
Malaysia	51,034	51,938	70,959	74,572	46.1

Location ¹	FY 2009	FY 2010	FY 2011	FY 2012	Percent Change (FY09-12) ²
Bermuda	122,074	99,319	89,493	72,085	(41.0)
Russian Federation	98,444	76,158	120,545	70,932	(27.9)
Jamaica	25,182	16,528	30,682	64,489	156.1
Kuwait	80,107	133,669	151,305	61,424	(23.3)
Argentina	36,723	72,820	78,120	61,286	66.9
Indonesia	34,143	65,910	76,268	58,141	70.3
Poland	42,111	52,435	78,172	53,458	26.9
Cayman Islands	53,562	11,422	10,433	51,352	(4.1)
Kenya	62,854	84,970	76,040	50,460	(19.7)
Nicaragua	36,171	35,479	34,146	49,805	37.7
Oman	70,495	82,868	69,370	48,317	(31.5)
Egypt	137,575	110,666	60,046	48,042	(65.1)
Venezuela	30,816	36,819	111,005	47,279	53.4
Morocco	14,391	18,713	52,767	46,884	225.8
Ukraine	13,986	8,386	22,972	43,949	214.2
Finland	70,157	30,253	33,968	40,243	(42.6)
Hungary	47,689	53,497	58,908	39,570	(17.0)
Czech Republic	36,360	51,659	44,893	38,245	5.2
Cyprus	39,771	75,377	67,225	33,265	(16.4)
Denmark	52,821	31,151	19,278	31,935	(39.5)
India	32,824	28,898	33,459	29,825	(9.1)
Sweden	365,134	93,590	46,435	25,853	(92.9)
All Other Locations (85 in FY 2012) ⁴	633,155	591,500	571,167	467,025	(26.2)
Total⁵	\$198,236,086	\$199,988,395	\$248,951,926	\$238,159,355	20.1

Source: MDR as of July 2013

¹ The data in the table does not include care provided under the TDEFIC.

² Percentages do not equal due to rounding.

³ The International SOS air ambulance claims were excluded from the Australia, Singapore, United Arab Emirates, United Kingdom, and Venezuela totals and listed separately because they were originally included in the totals for care rendered in these locations, even if the air ambulance origin or destination did not include those locations.

⁴ Locations where TMA paid less than \$25,000 in FY 2012.

⁵ Totals for FY 2009 to FY 2012 do not equal due to rounding.

Appendix C

TRICARE Beneficiary Population Statistics in Overseas Locations

In the table below are the statistics of all the beneficiaries that are eligible for TRICARE benefits that reside in overseas locations as of September 30th of the applicable fiscal year.

Location	FY 2009	FY 2010	FY 2011	FY 2012	Percent Change (FY09-12)
*Bahrain	2,824	2,814	2,855	2,908	3.0
*Turkey	1,836	1,986	1,904	1,949	6.2
*South Korea	27,309	29,525	30,574	29,389	7.6
*Japan	55,057	55,088	56,256	58,114	5.6
*Guam	8,556	8,105	8,028	7,921	(7.4)
*United Kingdom	13,781	14,224	15,178	15,781	14.5
Subtotal	109,363	111,742	114,795	116,062	6.1
U.S. Virgin Islands	448	525	416	383	(14.5)
Italy	12,103	12,658	12,235	12,257	1.3
Singapore	236	253	254	294	24.6
Germany	65,246	64,694	66,929	61,750	(5.4)
Subtotal	78,033	78,130	79,834	74,684	(4.3)
Puerto Rico	7,045	7,177	6,553	5,625	(20.2)
Panama	386	541	585	615	59.3
Philippines	10,294	10,096	9,946	9,762	(5.2)
Subtotal	17,725	17,814	17,084	16,002	(9.7)
Total	205,121	207,686	211,713	206,748	0.8

The population statistics were provided by a TMA contractor supporting the Plans and Analysis Branch Beneficiary Education and Support Division at TMA. The data is computer-processed data that has not been tested by DoD OIG auditors; therefore, the data may not be accurate.

Management Comments

Assistant Secretary of Defense (Health Affairs)



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

FEB - 5 2014

MEMORANDUM FOR DEPUTY INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Department of Defense Response to Department of Defense Inspector General Draft Report, "DoD Did Not Negotiate Rates With Overseas Health Care Providers and Generally Did Not Implement Other Cost Containment Measures," Project No. D2013-D000LF-0089.000, December 18, 2013

This is the Office of the Assistant Secretary of Defense (Health Affairs) response to the Department of Defense (DoD) Inspector General Draft Report, "DoD Did Not Negotiate Rates With Overseas Health Care Providers and Generally Did Not Implement Other Cost Containment Measures," Project No. D2013-D000LF-0089.000, December 18, 2013. We concur with the need to implement cost containment measures in the TRICARE Overseas Program (TOP). We non-concur with the recommendation to negotiate rates with high-dollar-volume overseas health care providers until we determine the impact this would have on access to care for our Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFM) stationed overseas. We also non-concur with recommendation 1 b.

I am very concerned with the rise of health care costs and the impact that these costs have on the DoD budget. As such, we continually look for opportunities to control health care costs and will continue to do so in the TOP follow-on contract. We have a number of cost containment measures already in place in the TOP and those are outlined in the attachment. However, indiscriminately requiring the TOP contractor to negotiate rates with overseas health care providers could potentially have a negative impact on the health of our military forces receiving health care overseas, increase the DoD's costs for medical evacuations and/or medical travel back to the United States, and impact the military's ability to perform its mission because ADSMs are not available because of medical travel.

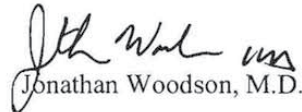
Mandating the TOP contractor to negotiate rates with overseas providers could have a serious, negative impact on the Department's ability to provide health care to the ADSMs and the ADFMs assigned in overseas locations. With the continuous drawdown of the military medical capability in many overseas locations, it is imperative that we have the ability to provide host nation care in these locations. Requiring the TOP contractor to negotiate rates in these locations without determining the impact this would have on access to care for our ADSMs and ADFMs would not be prudent. Therefore, the Defense Health Agency (DHA) will include a requirement in the follow-on TOP contract for a study to be conducted to determine if negotiating rates in South Korea and the United Kingdom would have a negative impact on access to care. Additionally, as part of our continuous analysis to determine and initiate appropriate cost containment measures, DHA will implement the use of CHAMPUS Maximum Allowable Charges (CMACs) for physician services in the U.S. Territories (America Samoa, Guam, Northern Marianas, and the U.S. Virgin Islands)

Assistant Secretary of Defense (Health Affairs) (cont'd)

in the follow-on TOP contract. [REDACTED]
[REDACTED]

The DHA has controls in place to ensure that aeromedical evacuation costs are reasonable and appropriate. Every aeromedical evacuation is reviewed and approved prior to the movement of any patient by an Active Duty Flight Surgeon assigned to one of the Patient Movement Requirement Centers in each of the overseas regions. Additionally, each aeromedical evacuation is audited retrospectively to ensure the movement was appropriate and followed the process for approval. We have provided a detailed response to the recommendation (Attachment 1).

Thank you for the opportunity to review and comment on the draft report. The points of contact for additional information are [REDACTED] (Functional) or [REDACTED] (Audit Liaison). [REDACTED] may be reached at [REDACTED], or [REDACTED]. [REDACTED] may be reached at [REDACTED], or [REDACTED].


Jonathan Woodson, M.D.

Attachment:
As stated

Assistant Secretary of Defense (Health Affairs) (cont'd)

**Department of Defense Did Not Negotiate Rates with Overseas Health Care Providers and Generally Did Not Implement Other Cost Containment Measures
Project No. D2013-D000LF-0089.000**

DEFENSE HEALTH AGENCY RESPONSE TO RECOMMENDATION

RECOMMENDATION #1:

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

- a. Initiate action to either establish negotiated rates with high-dollar-volume overseas health care providers or implement other cost containment measures in high-dollar-volume locations with significant increases.
- b. Establish procedures to negotiate rates directly with the TRICARE Overseas Program (TOP) contractor when the contractor provides services as a health care provider.

Department of Defense (DoD) RESPONSE:

- a. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) concurs with the need to implement cost containment measures in the TOP. We have previously initiated a number of cost-containment measures. These measures include the implementation of a foreign fee schedule in Panama and the Philippines, the requirement for the TOP contractor to determine if health care claims are reasonable and customary for the locality, pre-payment reviews for questionable claims, post-payment reviews on all high-dollar claims, and the requirement for all beneficiary submitted claims to include proof of payment. In addition, we will implement CHAMPUS Maximum Allowable Charge (CMAC) rates in the U.S. territories in the follow-on contract. We non-concur with establishing negotiated rates with high-dollar-volume overseas health care providers in high-dollar-volume locations with significant increases until a study can be conducted to determine the impact this would have on access to health care for the Active Duty Services Members (ADSMs) and the Active Duty Family Members (ADFMs) assigned overseas. The ASD(HA) is very concerned with the rise of health care costs and the impact that these costs have on the DoD's budget. However, indiscriminately requiring the contractor to negotiate rates could potentially have a negative impact on the health of our military forces receiving health care overseas, increase DoD's costs for medical evacuations and/or medical travel back to the United States, and impact the military's ability to perform its mission because ADSMs are not available because of medical travel.

There are a number of factors contributing to the increased health care costs in the countries identified in this draft report.

- 1) Prior to October 1, 2010, the Military Services were responsible for paying all Supplemental Health Care Program (SHCP) claims for ADSMs for Military Treatment Facility referred care. On October 1, 2010, responsibility for these claims was transferred to the TOP contractor;

Assistant Secretary of Defense (Health Affairs) (cont'd)

- 2) The TRICARE Retired Reserve and the TRICARE Young Adult Programs were implemented in 2010 and 2011, respectively. Addition of two new beneficiary categories contributed to the increase in the amount of purchased care costs for the TOP;
- 3) There has been a corresponding increase in the number of claims submitted for each of the fiscal years identified; and
- 4) There has been an increase in the number of unique beneficiaries submitting claims for each of the fiscal years identified.

When reviewing the increase in health care costs, we also analyzed the number of claims being submitted and the number of beneficiaries receiving care. We pulled data from M2 (as of August 9, 2013, and as of October 4, 2013) and in each of the countries where health care costs have increased, we noted a similar increase in the number of claims being submitted and the number of unique beneficiaries receiving care.

Bahrain:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	607	1,378	7,638	8,913
Unique Beneficiaries	244	552	2,460	3,402

The number of claims submitted increased by over 1,300 percent, and the number of unique beneficiaries seeking host nation health care increased by over 120 percent from Fiscal Year (FY) 2009 to FY 2012.

Turkey:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	2,626	2,933	3,461	2,928
Unique Beneficiaries	945	1,036	1,607	1,502

The number of claims submitted increased by 11 percent, and the number of unique beneficiaries seeking host nation health care increased by over 58 percent from FY 2009 to FY 2012.

Korea:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	6,501	9,598	20,858	27,233
Unique Beneficiaries	2,688	4,504	10,817	11,947

The number of claims submitted increased by over 300 percent, and the number of unique beneficiaries seeking host nation health care increased by over 300 percent from FY 2009 to FY 2012.

Japan:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	6,414	8,084	13,739	13,839
Unique Beneficiaries	2,893	3,783	7,299	7,482

The number of claims submitted increased by over 100 percent, and the number of unique beneficiaries seeking host nation health care increased by 158 percent from FY 2009 to FY 2012.

Assistant Secretary of Defense (Health Affairs) (cont'd)

Japanese providers are not willing to negotiate rates. Every Japanese citizen has Japanese National Insurance (JNI) and the rates for JNI are set by the government. Every visit has points assigned; for instance a routine office visit will be assigned 30 points. Each point is worth 10 yen so the visit is worth 300 yen to the provider. The patient is responsible for 30 percent of that, and the JNI pays the remainder. The Japanese government determines if and when rates will change. If Japanese providers see a non-Japanese citizen, they assign the same point value for that specific visit; however, they are allowed to determine how much the points are worth for the non-Japanese citizen. When the TOP contractor attempted to build a network in Japan, they were faced with an overwhelming number of Japanese providers who refused to negotiate any contract with the contractor. Japanese providers are unwilling to negotiate or sign any contractual document relating to providing health care. In order to ensure the ADSMs and ADFMs access to quality, cashless/claimless health care in Japan, the DHA and contractor had to establish a unique payment process to satisfy the Japanese providers.

Guam:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	2,893	3,783	7,299	7,482
Unique Beneficiaries	2,389	2,506	3,350	3,453

The number of claims submitted increased by 158 percent, and the number of unique beneficiaries seeking host nation health care increased by 44 percent from FY 2009 to FY 2012.

United Kingdom:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	11,915	12,011	14,934	14,657
Unique Beneficiaries	4,071	4,247	4,927	4,745

The number of claims submitted increased by 23 percent, and the number of unique beneficiaries seeking host nation health care increased by 16 percent from FY 2009 to FY 2012.

U.S. Virgin Islands:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	7,857	8,218	8,500	8,739
Unique Beneficiaries	1,042	1,017	1,059	1,022

The number of claims submitted increased by 11 percent from FY 2009 to FY 2012.

Italy:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	6,497	6,967	9,152	9,615
Unique Beneficiaries	3,572	3,257	4,849	5,063

The number of claims submitted increased by 48 percent, and the number of unique beneficiaries seeking host nation health care increased by 41 percent from FY 2009 to FY 2012.

Singapore:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	4,840	4,984	3,811	3,848
Unique Beneficiaries	928	899	819	822

Assistant Secretary of Defense (Health Affairs) (cont'd)

Germany:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	198,562	197,769	202,058	182,199
Unique Beneficiaries	54,778	54,939	55,959	51,392

German law mandates what German health care providers can charge patients with German National Health Insurance. The law allows providers to charge up to three percent more than the National Health Insurance mandated rates for health care provided to private pay patients (TRICARE is considered a private payer in Germany). Providers have the flexibility of determining what additional percentage (up to three percent) they will charge private pay patients, depending on the complexity of the private insurance. We require network host nation providers to be able to speak English or have someone available at the time they provide the care who can speak English and to submit claims, using American claim forms, on behalf of the beneficiary. This adds to the complexity of providing health care to TRICARE beneficiaries. Since German laws exist which control what the providers can charge, we would have no leverage to negotiate rates lower than what the law currently allows.

The data displayed above demonstrates that there has been an increase in the number of beneficiaries seeking care from host nation providers, as well as an increase in the number of claims being submitted. These increases, coupled with health care inflation in these countries, account for the increase in purchased health care costs in the TOP.

Additionally, we should not attempt to negotiate rates with providers unless we have other alternatives for providing the care if the providers refuse to negotiate their rates. We would have to ensure that if one provider declined to negotiate rates, there were other providers willing to do so who would meet our credentialing requirements and the other requirements of providing cashless/claimless health care and have the ability to speak English. In order to make this determination, we will include a requirement for a study in the follow-on TOP contract to be conducted to determine the feasibility of negotiating rates in South Korea and the United Kingdom and whether this would impact ADSMs/ADFM's access to care in those two countries.

The requirement will read as follows: [REDACTED]

“H.8. In an effort to identify potential cost containment measures, the TOP contractor shall conduct an assessment regarding the feasibility of negotiating specific provider reimbursement rates in South Korea and the United Kingdom. Within 90 days following the start of health care delivery, the TOP contractor shall submit their findings in accordance with the instructions contained in Section F.6 and Contract Data Requirements List (CDRL) SXXX, “Report on the Feasibility of Negotiating Reimbursement Rates in South Korea and the United Kingdom.” This report shall specifically address whether implementing this requirement would reasonably be expected to impact ADSM/ADFM access to care in those two countries. The report shall also address anticipated implementation costs vs. anticipated health care savings.”

Assistant Secretary of Defense (Health Affairs) (cont'd)

Additionally, the DHA will implement CMAC rate in the U.S. Territories (Guam, U.S. Virgin Islands, American Samoa, and the Northern Marianas). We intend to implement CMAC rates in these U.S. territories in the follow-on TOP contract. [REDACTED]

You state in your report that overseas payments decreased in locations with cost control containment measures. The DoD does not have a large permanent presence (assigned ADSMs and ADFMs) in Panama and the Philippines, and TRICARE pays billed charges for health care provided to those ADSMs and ADFMs. The cost containment measures implemented in the Philippines and Panama were done as a result of findings of fraudulent billing practices in those two countries. Though these cost containment measures have dramatically reduced the TRICARE purchased care costs in those two countries, it has had a negative impact on TRICARE Standard beneficiaries' access to quality health care and out-of-pocket expenses. Evidence of this is that in Panama there are inpatient facilities refusing to see any TRICARE Standard beneficiary because our reimbursement rates do not cover the cost of the care provided. TRICARE Standard beneficiaries in the Philippines also complain that either they cannot access quality health care because of the low TRICARE reimbursement rates or that their out-of-pocket expenses are exceptionally higher than TRICARE Standard beneficiaries seeking health care outside of the Philippines. As we implement the Philippine Demonstration Project, we are finding many providers in that country are unwilling to participate because of the terms of the demonstration. Not only are we requiring them to accept the TRICARE Philippine Foreign Fee Schedule and not charge TRICARE beneficiaries any additional fees, but we are also requiring them to submit the claim on behalf of the beneficiary. Providers have been reluctant to accept these constraints, which has limited access for some of our beneficiaries.

Additionally, both the number of claims paid and the number of beneficiaries who received care in the Panama, the Philippines, and Puerto Rico have shown a decrease from FY 2009 to FY 2012. The tables below identify this decrease, which accounts for a portion of the decrease in health care costs in those locations. (Data from M2 as of August 9, 2013).

Philippines:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	65,171	31,721	23,094	20,267
Unique Beneficiaries	8,617	6,744	4,947	4,106

Panama:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	14,492	9,658	9,172	7,633
Unique Beneficiaries	1,653	1,351	1,300	1,115

Assistant Secretary of Defense (Health Affairs) (cont'd)

Puerto Rico:

	FY 2009	FY 2010	FY 2011	FY 2012
Claims	259,504	270,476	274,653	234,240
Unique Beneficiaries	20,599	20,359	20,227	19,541

- b. We believe that this recommendation is a result of the increase in aeromedical evacuation costs identified. We non-concur with this recommendation. The current TOP contract requires the contractor to provide evacuation for TOP Prime/Prime Remote beneficiaries, ADSMs on leave or TDY status overseas, and CONUS Prime Family Members traveling overseas. Every aeromedical evacuation performed by the TOP contractor is approved by a military flight surgeon prior to the mission occurring, and each aeromedical evacuation case is audited on a retrospective basis to ensure the movement was appropriate and followed the required process. These internal controls are in place to insure aeromedical evacuations are appropriate and reasonable.

We recognize that there has been an increase in air ambulance claims and cost from FY 2009 to FY 2012. There are a number of factors contributing to this increase in air ambulance claims from FY 2009 to FY 2012. These factors include the following:

- 1) Prior to start of health care delivery under the TOP contract (September 1, 2010), the majority of air ambulance support was provided by the military. Under the TRICARE Global Remote Overseas contract, air ambulance support was for ADSMs/ADFMs assigned to remote locations only. Additionally, TRICARE provided few air ambulance services in the CENTCOM AOR due to the number of military evacuation missions flown there;
- 2) From 2009 to 2012, there has been a 10.5 percent reduction in the number of military aeromedical evacuation missions (in 2009, there were 2,586 aeromedical evacuation missions flown and in 2012, that number dropped to 2,315 missions). Most military evacuation missions include multiple patients. With the military's reduction of aeromedical evacuation missions, TRICARE assumed responsibility of aeromedical evacuations for those beneficiaries needing immediate air ambulance support;
- 3) We have added eight remote locations to the TOP contract since the start of health care delivery. Many of these remote locations, and those originally included in the TOP contract, have limited medical capability and/or quality of care issues. As a result, ADSMs/ADFMs sustaining life threatening injuries require evacuation to a location that can provide necessary medical care; and
- 4) According to the Research and Innovative Technology Administration, Bureau of Transportation Statistics, airline fuel cost increased by approximately 57 percent between 2009 and 2012.

It is difficult to compare air ambulance transports due to the variety of factors that contribute to the cost of each transport. Each air transport is different based on the distance between the location where the patient is picked up and the location where the patient is dropped off; the type of air ambulance required/available; the complexity of the patient's illness/injuries; the level/type of medical support required during the transport; and the

Assistant Secretary of Defense (Health Affairs) (cont'd)

medical equipment required to safely transport the patient.

In order to determine if the cost of aeromedical evacuations under the TOP contract were reasonable, we researched costs for commercial air ambulance companies in the United States and compared the cost of using those commercial air ambulance companies with the cost of actual aeromedical evacuation cases under the TOP contract.

Data Points for Comparison – International SOS Medevac Costs vs. Five Commercial Plans

COMMERCIAL MILEAGE COSTS (FIXED-WING)	COMMERCIAL LIFT-OFF BASE RATE	COMMERCIAL MISC. COSTS
#1 - \$118.98 per mile	#1 - \$11,902.82	#1 – not known
#2 - \$2.80 to \$4.50 per mile	#2 - \$800 (preparation and lift-off)	#2 - \$350 for medical equipment; \$250 per crew member per night for overnight stays (higher in Asia); \$2,500 Euro control; \$800-\$1,500 international permits; \$500-\$2,500 medical team (does not include ground ambulance charges)
#3 - \$237.00 per mile	#3 - \$16,165	#3 – not known
#4 – average \$100-\$150 per mile	#4 – average \$10,000-\$15,000	#4 – not known
#5 – average \$136 per mile	#5 – average \$12,928	#5 – not known

Plan #1 – AirHeart Air Ambulance Service (used by BCBS), Walton County (Panama City Beach), Florida – 2010 rates

Plan #2 – American Air Ambulance, worldwide – current rates

Plan #3 – CALSTAR, San Joaquin Valley, California – 2011 rates

Plan #4 – Air Methods, Eagle Med, and Air Evac LifeTeam (multiple locations in Oklahoma) – 2013 rates

Plan #5 - Arizona Air Ambulance Service Rate Schedule (AZ Dept of Health Services) – 2013 rates (average of all entities listed)

The excel spreadsheet attached depicts the cost of actual aeromedical evacuation cases under the TOP contract with the estimated costs if one of the above commercial air ambulance companies had performed the aero medical evacuation. This data demonstrates the reasonableness of the aero medical evacuation costs paid by the government to the TOP contractor. Based on this data and the internal controls in place, the DHA does not think there is any reason to negotiate aero medical evacuation charges with the TOP contractor.

Assistant Secretary of Defense (Health Affairs) (cont'd)

Actual Aero Medical Evacuation Cost Under TOP Contract Compared to Estimated Aero Medical Evacuation Cost Using Commercial Air Ambulances

Case Number	Originating City	Destination City	Total Miles (See Note 1)	TOP Contractor Cost	Commercial Air Ambulance Estimated Cost (See Note 2)				
					#1	#2	#3	#4	#5
3LON026213	Cotonou, Benin	Ramstein, Germany	6,539	\$173,426	\$789,913	\$22,459 to \$36,276	\$1,565,908	\$663,900 to \$995,850	\$902,232
3LON027012	Djibouti	Ramstein, Germany	6,651	\$146,821	\$803,239	\$23,573 to \$37,580	\$1,592,452	\$675,100 to \$1,012,650	\$917,464
3PHL032972	Andros Town, Bahamas	Fort Lauderdale, FL	364	\$16,159	\$55,212	\$5,969 to \$9,288	\$102,433	\$46,400 to \$69,600	\$62,432
3SIN020152	Jakarta, Indonesia	Singapore	1,135	\$17,761	\$25,407	\$7,788 to \$12,758	\$285,160	\$123,500 to \$185,250	\$167,288
3SIN021037	Hong Kong	Honolulu, HI	13,872	\$336,223	\$1,662,394	\$43,792 to \$70,074	\$3,303,829	\$1,397,200 to \$2,095,800	\$1,899,520
4PHL000601	San Juan, PR	Washington, DC	3,894	\$36,531	\$475,211	\$12,553 to \$21,173	\$939,043	\$399,400 to \$599,100	\$542,512

Note 1: Total miles equal miles from aircraft's homeport to patient's location to patient's destination and back to aircraft's homeport

Note 2: Estimated cost includes estimated take-off cost (base rate), estimated mileage cost, and estimated miscellaneous cost if known.

Acronyms and Abbreviations

ASD(HA)	Assistant Secretary of Defense (Health Affairs)
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DHA	Defense Health Agency
MDR	Military Health System Data Repository
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TMA	TRICARE Management Activity
TOP	TRICARE Overseas Program
WPS	Wisconsin Physicians Service

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