After Action Report

10 March 2012

From:	Jim Houtsma, Representing U.S. Military Retirees of the Philippines Group
Coordinated With:	Mr. Thomas W. Halliwell, TRICARE Area Office – Pacific Hawaii Satellite Office for Remote Pacific Islands
Enclosures:	(1) Handout, Philippines Demonstration Project (2) Proof of Payment, Differences
Event:	Meeting with TRICARE Area Office – Pacific (TAO-P) representatives and TRICARE Management Activity contractors International SOS and Wisconsin Physician Services (WPS)
Location:	Angeles City, Balibago, Pampanga, PI
Attending:	Jim Houtsma, U.S. Military Retirees of the Philippines Group Mr. Thomas W. Halliwell, TRICARE Area Office – Pacific Hawaii Satellite Office for Remote Pacific Islands HMCS Galang, TRICARE Area Office – Pacific Okinawa John H. Pabich, Vice President, WPS TRICARE Overseas Claims Chip Wilcox, General Manager, TRICARE Asia Pacific International SOS Pte Ltd
Date:	08 March 2012 (1300 – 1500 Hrs)
Objective:	Obtain updated information on TRICARE in the Philippines and discuss issues and concerns with the current program.

Narrative:

Claims

Initially Mr. Pabich briefly covered his presentation given at the three scheduled beneficiary meetings in Manila, Cebu and Angeles City. Essentially it covered known policies and processes. The one change of note was a recent TRICARE Overseas Program (TOP) contract change that extends the length of time after care that a claim can be submitted from one year to three years. The claims contractor, WPS, will also conduct a look back at old claims. Below is a complete explanation we received by email.

"To clarify, in response to the NDAA 2012, a TOP contract modification is changing the current timely filing deadline from one year from the date of service to three years from the date of service. Also, any claims dating back to December 31, 2008 and after that had previously been denied for lack of timely filing will be automatically re-processed by WPS.

But please keep in mind that some of these claims may still not be payable for other reasons, e.g., missing information. So Mr. Pabich was pointing out that beneficiaries may soon see checks and/or

EOBs relating to old claims, and even correspondence requesting additional information resulting from the re-processing of the old claims.

Mr. Pabich stated that WPS will be busy re-processing claims previously denied for timely filing reasons. He asked that beneficiaries not re-submit such claims, as that may confuse matters. Also, he asked that people wait awhile before they submit claims that were denied for other reasons (again, so they can go through the initial bolus of timely filing claims)."

This doesn't mean beneficiaries should wait for years before filing their claims, just because now they can. It is best to process claims as soon as practical, not only so your money is returned sooner, but because the circumstances of the care are still fresh in everyone's mind.

Furthermore Mr. Pabich suggested that beneficiaries not group large numbers of episodes of care into one claim. Instead he suggested grouping a few from the same provider but don't mix providers. The reason for this is when claims contain large numbers of episodes of care mixed together over six months to a year it makes processing more complex and increases the chance that something will be missed. Further the requirement they currently have to obtain a second proof of payment or that sufficient funds were withdrawn is based on the total amount of the claim and not the individual parts which could trigger this requirement. Lastly if a claim includes 15, 20 or more claims from various providers and just one provider requires certification then the entire claim is held pending the certification of that one provider which can delay processing for as much as 90 days.

Demonstration Project (Closed Network)

Mr. Halliwell briefly addressed an update to the parameters surrounding the proposed Philippine Demonstration Project, commonly known as the "Closed Network" See enclosure 1 for the handout.

Based on the new timelines it appears the project will not be viable for close to a year, maybe longer.

We expressed some concerns with the project and implementation.

1. We cautioned that using the providers address to determine the location of beneficiaries using FPO addresses will not always be accurate. Specifically a beneficiary living some distance from a major urban area may travel there to obtain care because they feel better care is available in that area. This will cause their base figures to be skewed and needs to be considered.
2. We expressed concerned that the number and quality of providers maybe limited due to the poor reputation of TRICARE and its contractors with providers, Also the history of non-payment of claims to providers who found they were not able to negotiate the complex and foreign claims requirements that are unique to the U.S. system but required of them and which will be required of the closed network providers as well.
3. We strongly suggested that, if they go forward with the closed network demonstration, that they also consider contracting with a local national PPO or HMO who would implement and manage the program in at least one of the areas as suggested by a Work Group consisting of

TMA, the Defense Criminal Investigative Service, DoD OIG and The United States Attorney's Office in the late 2004 timeframe. We expressed the obvious advantages to this being an in place network of providers and negotiated discounts of up to 20% which are standard across these groups but not offered to foreign designed systems that require foreign based claims processing. Further those in this demonstration could take their benefit with them and use network providers throughout the Philippines, unlike is planned for the primary demo. Further the discounts of 20% on inpatient care, 10% on outpatient and 5% on pharmacy would apply to copays as well saving not only TRICARE money but the beneficiary as well. Given the new extended projected start time TMA would have more than ample time to add this option as well.

4. Lastly we cautioned that due to the current lack of access to care, discussed later, TMA should expect at least a threefold increase in utilization in areas where a viable network is established.

(We believe these concerns and recommendations will be passed or discussed with the individuals responsible for the demonstration project and we should get some feedback.)

After Action Reports

The meetings that TAO-P conducts in the Philippines are generally limited to 20 participants, usually due to space constraints at the locations where the meetings are held. In some cases the average beneficiary is not allowed to attend and/or notification of the meetings is limited by the local groups that were coordinated with for the meeting. Because these meetings allow for vital and timely exchanges of information we recommended that the individuals in each area that have taken on the responsibility of organizing the meetings, RAOs and Service Organizations, be told they are expected to do After Action Reports or use other methods to make the widest possible dissemination. In the past we have not seen even one such report by any of these groups. *The group agreed that this was important and indicated that they recommend that these organizations and attendees disseminate the information to their members through meeting synopses, after action reports, bulletins or other means.*

Individual Claim Issues

We discussed issues with three separate claims. An agreement was reached to allow two of them to be resubmitted with the previously missing information. The last claim will be followed up with additional information to Mr. Pabich.

Certified Provider List Data Issues

Recent improvements to the list and our continuing concerns with the level of quality of the data and errors added to the data when new providers are added were discussed. We were assured that ISOS would continue to work on improving the quality of the data and that consideration is being given to moving the data from a spreadsheet design, flat file, to a modern database which should improve the data entry process and increase consistency. Although it took years before we saw progress on this issue we appreciate the current effort. We expressed our concern that any current attempts to design search or filter processes into the webpage would not provide the desired results as long as the data contained significant errors. This concern was acknowledged.

The issue of addresses matching between receipts and the Certified Provider List when claims are filed was discussed. We were advised that the addresses in the list are being simplified and corrected to assist beneficiaries in locating providers and they may not exactly match the address on the receipt. WPS will use the information they have to try to match the two together for claims processing. We will have to monitor this to see how this affects claims and the need for additional recertification's before we can fully concur with this change.

FOIA Claims Data

Sometime ago we gained access to TRICARE claims data through the FOIA process and requested all the claims data for the Philippines for FY2009. What we discovered was the data included some claims from the previous nine years and the data from FY2009 did not match with what TMA and their contractors claimed were the total billed and paid amounts for the same year and by large margins. We documented these discrepancies and provided them to the team and requested that they get back to us with an explanation. Because of these issues with the data we were only able to draw conclusions based on relationships within the limited FY2009 by considering it a sample of the full database.

Claims Submitted via the Secure Email System

We discussed what we consider issues with the current process. Specifically the differences in how these claims are handled and processed in relation to how mailed and faxed claims are handled and processed. Claims mailed or faxed are considered received and processing starts on the day they are received in the mail or by fax. Secure email claims are considered received when the email is opened which currently is running between two and three weeks after the email is submitted which beneficiaries may not be aware of and which delays when they can expect reimbursement. This was acknowledged by WPS and they said they were looking into various ways to improve the service.

The discussion then turned to issues with attachments to these claims where sometimes the documents received as attachments were extremely small; they looked to be the size of a postage stamp. We acknowledged that this could be an issue when the beneficiary scanned in the document as we have seen the same issue in the past when working on claims for individuals. Of course this makes the received document unusable. Another issue was the clarity of documents received by fax. Faxing can degrade the quality of the documents received depending on the quality of the fax machines at each end and the original quality of the document sent.

The following recommendations on scanned documents were discussed and agreed to so that fewer claims are returned as unreadable.

1. Always scan using the "Black and White Picture or Text" setting.
2. Look at the results of the scan and insure it is full size and the contrast between the print and background are high.
3. If the contrast is low try adjusting the scan settings to increase contrast and increasing resolution to obtain a clearer copy.

4. If you combine the scanned documents into another document such as a PDF file review the result to insure size and clarity were not compromised.

CMAC (Champus Maximum Allowable Charges) Issues

When the CMAC for the Philippines was implemented we addressed concerns with the affects of exchange rate changes since the CMAC is built on dollars and requires billed amounts to be converted to dollars and local inflation which would not match U.S. inflation. We were assured that the CMAC would be monitored and adjustments made as necessary for these changes. Since its inception the only change was based on U.S. inflation a number of years ago and none since. Since the inception of the CMAC between the devaluation of the dollar, 50 to 42, and Philippine medical inflation as documented by NSO the CMAC has lost more than 30% of its value. *We provided documentation to show this and asked the information be passed to the individuals at TMA involved in making decisions on our CMAC and hope to get some feedback.*

Requirement to break out claims by detailed procedures and itemized costing and in particular inpatient Professional Fees and Ancillary Care

This has been a major concern for us since the inception of the CMAC. Mr. Pabich indicated that this process is a major issue for paying claims but only in the Philippines and Panama since the inception of the CMACs in those areas. The problem is, because the amount paid for any procedure is now based on the CMAC, all procedures must be fully identified and costed in accordance with the complex and unique U.S. Coding and Billing system. This system is not used anywhere else in the world and is complex and the rules constantly change, mostly dictated by Medicare. Local doctors are not trained in this system and don't even see procedures in the same way as their counter parts in the U.S. So they are of little help in breaking these claims out for beneficiaries; even their U.S. counterparts can't do it and pay trained coders and claims processors to do it for them. In addition, because the local standard of practice is to bill patients using a global bill, they are also no help when asked to distribute the global bill across any procedures identified. That places the burden on the beneficiary to identify procedures, determine which local procedures should be bundled and which local procedures should be unbundled to meet the current U.S. standards. Then they must split out the global fee across these procedures and to do that they have to medically code the procedures so they can look up the CMAC rates to know how much to assign to each procedure. Of course most beneficiaries are also not trained in this system which we pointed out was demonstrated by the low rate of reimbursement for beneficiary filed claims for inpatient professional fees in FY2009 where only 7% of the billed amount was accepted.

We previously submitted alternative methods of processing and paying inpatient professional fees to Mr. Halliwell and he asked that we provide some additional information, which we are trying to obtain, to assist him in presenting these alternatives to TMA. *This issue is still outstanding and not resolved with a due out from us to Mr. Halliwell.*

Second Proof of Payment Requirements

TMA currently requires beneficiaries to prove they had the money to pay their claims when the total amount of a claim reaches a given threshold. The threshold varies depending on if the beneficiary is on what is called "Prepayment Review" or not. When these thresholds are exceeded WPS is required to request the second proof of payment; things like canceled checks, credit card receipts, ATM withdrawal receipts. This has been an issue for us for some time. Recently TMA published the rules we must follow in the TRICARE Health Matters Issue I: 2012. We have addressed this concern to service organizations for a number of years and about a year ago one of them sent us the slides from a PPT presentation they received from TMA's Program Integrity where they outlined a change in these requirements which they said took affect with the new TOP contract. So we were assured by this service organization that we would now see some relief. However the requirements Program Integrity told the service organizations we had to meet and what is reality are significantly different. See the two documents at enclosure 2. *We asked that someone explain to us why the service organizations are told one thing but we are required to comply with another.*

Low Access to Care in the Philippines

We addressed the low access to care as shown by TMA's own data for beneficiaries in the Philippines. One example was looking at their published data on total paid amounts for FY2010 per beneficiary in the Philippines of $600 and MHS data that says the average cost of pharmacy for all beneficiaries was $850 on average and $2,100 on average for TRICARE for Life beneficiaries. Since TMA acknowledges that pharmaceuticals cost the same in the Philippines as in the U.S. we would expect that the total amount paid in the Philippines for ALL care would be significantly greater than these figures rather than less. The obvious conclusion is access to care has been limited and many beneficiaries are now paying for their own care. Two of the causes, CMAC adjustments and detailed procedure identification on claims, are discussed above. *We provided the team with a detailed document on this issue and asked that someone at TMA seriously review the data with the hope they will get back to us on what they intend to do to correct this access problem.*

Enclosure 1

Philippines Demonstration Project

- 3 year demonstration to determine efficacy/acceptability of alternate approach to delivering care in RPI
- SOS will establish list of approved providers in designated locations of RPI who will file claims to WPS, agree to accept lesser of billed charges/negotiated rate/Government directed fee schedule as payment, and only charge benes for applicable Standard deductibles and cost shares according to EOB
  - ➢ Benes held harmless if charges for care from approved provider is denied, unless bene notified in writing that care is not a covered benefit prior to receiving care
- Basic premise: In order to have TRICARE pay for care received in Demo areas, benes must receive care from approved Demo providers, unless waiver received
  - ➢ Otherwise, TRICARE will not cost share on care claim
- Demo will be applicable to all Standard benes (including TFL, TRR, etc.) who reside in RPI and seek care in designated Demo locations
  - ➢ Residence determined by claim address; must be physical address, not FPO/APO
  - ➢ Demo requirements don't apply to those with address outside RPI
- Aims:

  Ensure delivery of high quality, safe care
  Enhance provider understanding of TRICARE Program
  Eliminate upfront costs for benes
  Eliminate balance billing
  Drive business to trusted, approved providers
  Reduce/eliminate need for benes to file claims
  Reduce aberrant billing activities
  Control costs and preserve TRICARE benefit
- For non-RPI residents and for care outside Demo areas, TRICARE payments still governed by existing RPI Standard rules, e.g., provider must be certified
- Benes may request waiver to receive care from non-approved providers in Demo area
  - ➢ Written requests to be submitted to SOS to be considered on case-by-case basis
  - ➢ Unless emergency care, benes encouraged to submit requests prior to care
  - ➢ Examples of reasons: continuity of care to complete episode of care in progress with non-approved provider when Demo began, or inability to obtain appointment with approved providers within appropriate access standard
  - ➢ If denied, final determination made by Director, TAO-P

- If SOS unable to recruit sufficient number/mix of approved specialists, SOS to request applicable specialty waiver(s) so benes may receive care in Demo area from non-approved providers
    - Normal RPI Standard rules would apply for non-approved provider care
- Approved providers may be removed from list for cause or admin reasons, e.g., failure to adhere to Demo rules
    - Removed Demo provider may appeal removal to SOS, then TAO-P
    - Appeal process not applicable to certified providers not selected by SOS for approved list in Demo area; SOS not required to offer inclusion to all certified providers in Demo area
- TMA to determine geographic areas for Demo and phased implementation approach/timeline, and communicate requirement to SOS 240 days before start of health care delivery under the Demo
    - At 180 days before, SOS to submit implementation plan to TMA
    - At 120 days before, SOS to submit list of approved providers to TMA (although may be phased in depending on number of Demo locations)
    - At 60 days before, SOS to provide benes with easy access to website (and any other means established by SOS) in order to view the approved provider list
- Likely Demo areas to be determined based on claims data; cities to be prioritized by:
    - # benes filing claims
    - # of claims
    - Total claims amount paid
- Demo area boundaries will be based on reasonable radius; not yet defined
- TMA and SOS to develop a communication plan to ensure benes and providers are informed regarding the Demo Project, including what cities will be included
    - Plan will include processes for educating benes/providers about Demo rules
    - SOS to develop/publish materials to educate benes/providers
    - Communications may include mailings to claims addresses of benes filing claims within last 2 years

Extracted from TRICARE HeathMatters, Issue I: 2012, page 3

Providing TRICARE with Proof of Payment

T o process your claims reimbursements quickly and efficiently, it is recommended that you submit proof of payment with all claims and the TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment form (DD Form 2642) to the TRICARE Overseas Program (TOP) claims processor, Wisconsin Physicians Service (WPS). Proof of payment is necessary for TRICARE to validate claims and safeguard benefit dollars.

When submitting your DD Form 2642, you should also include an itemized bill or invoice, diagnosis describing why you received medical care and/or an explanation of benefits from your other health insurance, if applicable. A cancelled check or credit card receipt showing payment for medical supplies or services often satisfies the proof-of-payment requirement. You may also provide records of electronic funds transfers or the provider's itemized billing statement and provider's matching official signed receipt. If you paid for your care or supplies in cash, TRICARE may ask for proof of cash withdrawal from your bank or credit union along with a receipt from your provider.

If you have questions regarding proof-of-payment requests, claims submissions or the status of a submitted claim, please contact your TOP Regional Call Center and press option 2 for claims assistance.

Additional Proof-of-Payment Requirements

Proof of payment is required for outpatient services exceeding $5,000 U.S. dollars (USD) and inpatient services exceeding $10,000 USD. However, in certain countries there are exceptions.

In Turkey, provider invoices are only generated when services are paid in full, so they are considered proof of payment. In Germany, the pharmacy stamp is provided only after you have paid in full, and is considered proof of payment (for prescription charges only).

In Japan, additional proof-of-payment restrictions apply—the host nation provider will stamp invoices, but a copy of the bank account transaction or ATM receipt is also required. If a cash gift is provided for medical care, the money should be deposited in the bank so a withdrawal receipt can be provided as proof of payment.

Extracted from a Program Integrity briefing on August 5, 2010 entitled “MISSON AND ROLE OF TRICARE PROGRAM INTEGRITY” and presented at the Communications & Customer Service Conference. We are also aware that this same presentation was provided to service organizations, how we obtained it, and probably to congress.