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PERSONNEL AND READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

NOV 13 2026

Dear Mr. Chairman:

The Department's response to House Report 119–231, pages 204-205, accompanying H.R. 3838, the Streamlining Procurement for Effective Execution and Delivery and National Defense Authorization Act for Fiscal Year 2026, "TRICARE Claim Processing Concerns," is enclosed.

This report provides the status of health insurance claim processing in the TRICARE West and TRICARE East Regions for Calendar Year 2025. By addressing these challenges and implementing the recommended best practices, the Defense Health Agency can improve future TRICARE transitions, reduce claims processing delays, and ensure high-quality care for beneficiaries.

Thank you for your continued strong support for our Service members and their families.

Sincerely,

[redacted]

Sean O'Keefe
Deputy Under Secretary of War for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to the Committee on Armed Services of the House of Representatives

TRICARE Claim Processing Concerns

November 2026

The estimated cost of this report or study for the Department of Defense (DoW) is approximately $4,000 for the 2024 Fiscal Year. This includes $400 in expenses and $3,600 in DoW labor.
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INTRODUCTION

This report is in response to House Report 119–231, pages 204-205, accompanying H.R. 3838, the Streamlining Procurement for Effective Procurement for Effective Execution and Delivery and National Defense Authorization Act for Fiscal Year 2026. It provides the status of health insurance claim processing in the TRICARE West and TRICARE East Regions for Calendar Year (CY) 2025. Specifically, the House Armed Services Committee requested:

> (1) a detailed analysis of the primary causes of TRICARE claim processing and payment delays from, including, but not limited to issues related to contractor transitions, credentialing, information systems, administrative bottlenecks, and staffing shortages;
> (2) an inventory of all TRICARE health insurance claims that were delayed in their processing from including data on the number of beneficiaries affected by care disruptions, delayed authorizations, or inability to access services due to these delays;
> (3) a summary of average claim processing times, payment timelines, and rates of delayed claims by region and contractor;
> (4) an inventory of all health providers who left the TRICARE network from, as well as the reason for their departure;
> (5) an assessment of the responsiveness and effectiveness of contractor and Defense Health Agency support channels for providers and beneficiaries, including but not limited to average hold times and response rates to inquiries;
> (6) an assessment of the key challenges faced during the TRICARE West and East Region transitions, as well as best practices and recommendations to prevent claim processing and payment delays in the future.

(1) A detailed analysis of the primary causes of TRICARE claim processing and payment delays from, including, but not limited to issues related to contractor transitions, credentialing, information systems, administrative bottlenecks, and staffing shortages

During transition and at the start of each CY the TRICARE Managed Care Support Contractors (MCSCs), Humana Military (HM) in the East Region and TriWest Healthcare Alliance (TW) in the West, implement temporary deferrals (holds) to prevent claims from processing. This is partially due to pricing updates but is also a method used to verify the operational system is processing claims accurately. Claims were categorized based on the type of service provided; once a sufficient volume of claims were reviewed and confirmed to be processing accurately in each category, they were systematically released for processing. T-5 claims began processing the third week of January 2025. Several system updates occur at the beginning of every CY including pricing, beneficiary liability, and any other TRICARE program changes in accordance with regulation and policy. It is standard practice to defer claims while these updates occur. Typically, updates occur within the first 3 weeks of the CY. Contract transitions may result in greater delays, however, timeliness requirements remain the same at the start of healthcare delivery and for the duration of the contract. During the T-5 contract transition, both HM and TW experienced challenges due to provider data discrepancies that resulted in negative impacts on beneficiaries and providers. These systemic provider data issues

led to delays in claims processing and a high volume of aged claims. From February 2025 to June 2025, both HM and TW failed to meet the contractual requirement to process 98 percent of claims within 30 days of receipt. Since July 2025 all claims processing timeliness requirements have been met by both MCSCs.

Healthcare providers are required to be TRICARE "certified" to collect payment for services rendered but are not required to be network providers. All providers seeking payment for services rendered must be TRICARE "certified." Only providers seeking "TRICARE network" status must be "credentialed." "Credentialing" entails a complete evaluation of providers' professional qualifications and other pertinent information to ensure academic and professional standards are met in accordance with TRICARE contract requirements. TRICARE "certified" providers do not need be network or "credentialed" providers to receive payment from TRICARE, thus "credentialing" is not a cause of TRICARE claim processing and payment delays. Although credentialing was not a cause of claim processing and payment delays, as noted above HM and TW's provider data discrepancies did contribute to errors in processing claims at non-network rates instead of network rates.

There were no reported or known claims processing staffing shortages for either T-5 prime contractor or with its subcontractor, PGBA, which handles claims processing operations.

(2) An inventory of all TRICARE health insurance claims that were delayed in their processing from including data on the number of beneficiaries affected by care disruptions, delayed authorizations, or inability to access services due to these delays.

Beginning in the month of February and through June 2025, both MCSCs failed to meet the contract requirement to process 98 percent of retained claims within 30 days of receipt. The following percentages reflect the volume of retained claims processed within 30 days of receipt for the months of February through June from both MCSCs:

Table 1. MCSC Retained Claims Processed Within 30 Days (February – June 2025)

Month	HM	TW
February	92.30%	91.92%
March	88.15%	89.81%
April	94.10%	91.59%
May	94.41%	92.97%
June	96.18%	96.82%

The Defense Health Agency (DHA) tracks deferred (held) claims on a weekly basis and expressed concern about the high volume of deferred claims beyond 30 days of the date of receipt reported mid-February from both MCSCs. In general, MCSCs are at risk of missing the 30-day timeliness requirement when there are more than 50K claims deferred beyond 30 days from the date of receipt. Both MCSCs try to maintain deferred claims over 30 days between 25K-30K. For the week ending February 15, 2025, TW reported 87K claims deferred beyond 30 days from the date of receipt and HM reported 99K claims deferred beyond 30 days from the date of receipt. As of March 15, 2025, TW reported 210,125 deferred claims beyond 30 days

from the date of receipt and HM reported 243,936 deferred claims beyond 30 days of receipt. For the first week of June, both MCSCs reported less than 50K deferred claims beyond 30 days of receipt and timeliness requirements have been met by both contractors since July 2025.

The West Region TRICARE MCSC, TW experienced multiple challenges in processing referrals and authorizations during the T-5 start of health care delivery, and missed contract standards, including processing 90 percent of referrals within 1 business day, 90 percent of authorization determinations within 2 business days, and achieving an accuracy standard of 95 percent. At the end of January 2025, TW had a backlog of approximately 80,000 documents that were predominately referrals and authorizations that had been received by fax. To mitigate any delays in care, on January 23, 2025, DHA implemented a temporary waiver of outpatient referral requirements for eligible TRICARE West Region beneficiaries enrolled in a TRICARE Prime plan. This waiver allowed beneficiaries to seek specialty care without requiring a referral to be sent to TW, thus minimizing any delays in care caused by any challenges TW had in processing referrals. The waiver was subsequently extended to June 30, 2025, and beneficiaries were held harmless from any point of service charges for any referral for services covered by TRICARE until September 30, 2025. Following the expiration of the waiver, while TW continued to struggle to fully meet the contractual timeliness standards for referral and authorization processing, its performance was generally within a fraction of a percentage point of meeting the required metric. While the referral processing waiver greatly mitigated any delays in care for beneficiaries seeking specialty care, it also generally removed the ability to track the timeline of a beneficiary's ability to schedule care with a specialist during that period. Because a beneficiary could seek specialty care without needing TW to process the referral, the timeliness of TW's processing could not be accurately calculated and any delay in the beneficiary seeking care would not be due to TriWest.

The East Region MCSC, HM, did not miss any referral and authorization timeliness and accuracy standards (as previously stated) in 2025.

(3) A summary of average claim processing times, payment timelines, and rates of delayed claims by region and contractor.

Both regional MCSCs failed to meet the timeliness requirement of processing 98 percent of retained claims within 30 days from February-June 2025. In April and May 2025, the West region MCSC failed to meet the timeliness requirement of processing 100 percent of retained and excluded claims within 90 days with a final result of 99.99 percent in both months. Excluded claims are retained at the discretion of the contractor for the external development of information necessary to process the claim to completion as a result of TRICARE policy or Government direction. Beginning in July all claims processing requirements have been met in both regions. Claims processing time is the period of time, in calendar days, from the receipt of a claim into the possession/custody of the contractor to the completion of all processing steps. Claims are considered processed to completion when all claims received in the current and prior months have been processed to the point where all services and supplies on the claim have been adjudicated, payment has been determined and allowable charges applied to deductible and/or denied. Table 2 indicates the number of days it took from claims receipt to claims processing to completion. There are no timeliness requirements specific to settlement of claims (issuing

payment), because this is not a reflection of MCSC performance. Table 3 indicates the number of days it took from claims processing completion to payment being issued.

Table 2. Average Processed Time (Days)/Month 2025

Month	T-5 West	T-5 East
January	16.4	13.1
February	19.6	14.8
March	17.1	14.6
April	14.2	9.1
May	9.1	7.9
June	6.9	6.7
July	6.8	6.5
August	6.2	5.9
September	6.1	5.3
October	6.0	5.3
November	6.4	5.4

Table 3. Average Settlement Time (Days)/Month 2025

Month	T-5 West	T-5 East
January	1.6	1.3
February	1.1	0.8
March	1.2	1.1
April	0.7	0.9
May	1.1	0.9
June	0.9	0.8
July	0.9	0.9
August	1.2	1.1
September*	2.9	3.4
October*	6.9	3.4
November*	4.8	3.3

**Delays in September due to end of FY activities (mandatory hold); October and November due to Government Shutdown*

(4) An inventory of all health providers who left the TRICARE network from, as well as the reason for their departure.

DHA cannot provide the number of providers that left the TRICARE network or the reasons for their departure. Since the start of health care delivery (SHCD), there has been an increase in the number of providers in both regions. DHA verified the total number of network providers increased by 25.6 percent from January 2025 through November 2025.

(5) An assessment of the responsiveness and effectiveness of contractor and Defense Health Agency support channels for providers and beneficiaries, including but not limited to average hold times and response rates to inquiries.

The T-5 contracts require: (1) A secure portal available to beneficiaries with a secure electronic one-on-one messaging feature, such as online chat or text messaging for beneficiary customer services. HM's beneficiary portal functioned well, but various features of the TW beneficiary portal hindered beneficiaries' ability to efficiently manage their needs and inquiries. (2) An incoming toll-free telephone system. There are numerous contract standards including hold time and abandonment rates. TW experienced significant issues and failed to meet average speed to answers, and abandonment rate standards during the 6 months of 2025 (T-5 SHCD). There are DHA response teams across multiple functional areas, but specific measures and standards for responsiveness and effectiveness are not tracked for DHA "support channels." DHA manages the tricare.mil website, and there were approximately 50,566,483 page views in 2025.

(6) An assessment of the key challenges faced during the TRICARE West and East Region transitions, as well as best practices and recommendations to prevent claim processing and payment delays in the future.

DHA identified the following key challenges during the TRICARE West and East Region Transitions, and best practices.

1. Insufficient Transition Period:

    - The 12-month transition period was inadequate for comprehensive testing, readiness validation, and addressing critical issues such as claims processing, provider network development and data ingestion. This compressed timeline led to "go/no-go" decisions before full operational readiness could be assessed.

    - Possible Mitigation Strategy: Extend the transition period to 18 months or adopt a phased implementation approach, starting with limited States or regions to reduce risks and allow for thorough testing.

2. Lack of Standardized Data Formats and Transfer Processes:

    - Data transfers between outgoing and incoming contractors were complicated by differing formats and methods, leading to delays and inefficiencies. This issue was particularly pronounced in the newly defined West region, where data from two outgoing contractors had to be ingested.

    - Possible Mitigation Strategy: Standardize data formats and transfer processes across all regions to streamline transitions and ensure timely ingestion and utilization of critical information.

3. Inadequate Testing of Live Systems:

    - Critical failures at the SHCD can be attributed to the inability of a new (non-incumbent) MCSC to conduct thorough, end-to-end testing of its system's functionality in an operational environment. For example, until SHCD began, the incoming MCSC could not receive nor process any live referrals from the MTFs. In addition, the incoming West region MCSC struggled to ingest and utilize the large volume of data that was transferred from the outgoing MCSCs (in different native formats) in a timely manner, which meant that critical information was not loaded to the Government and beneficiary portals at SHCD. MHS GENESIS limitations further restricted end-to-end testing.

    - Possible Mitigation Strategy: Enable and mandate live system testing during the transition period to identify and address issues before SHCD. Explore the use of test environments with live data earlier in the transition process.

4. Provider Network Development Challenges:

    - The incoming West region contractor struggled to establish a robust provider network, particularly for primary care, due to delays in provider file loading and data inaccuracies. This led to beneficiary dissatisfaction and claims processing issues.

    - Possible Mitigation Strategy: Require more comprehensive provider data accuracy audits and mandate live testing of network adequacy during Performance Readiness Validation (PRV) and Performance Readiness Assessment and Verification (PRAV). Implement stricter oversight, performance guarantees, and non-compliance penalties tied to provider network readiness.

5. Beneficiary Communication and Continuity of Care:

    - Beneficiary communication during the transition was inconsistent, leading to confusion and dissatisfaction. Additionally, gaps in continuity of care occurred due to referral and authorization delays and primary care manager reassignments.

    - Possible Mitigation Strategy: Enhance beneficiary communication strategies, including clear and timely updates. Mandate automatic extension of referrals and authorizations for 180 days post-SHCD to ensure continuity of care.

6. Electronic Funds Transfer (EFT) Challenges:

    - Some providers, particularly under the Autism Care Demonstration, did not set up EFT payment information in a timely manner, causing delays in payments.

    - Possible Mitigation Strategy: Require EFT enrollment to begin at least 60 days prior to SHCD, with communication to providers starting 120 days prior to

SHCD. Consider a temporary process for sending paper checks to providers who have not set up EFT.

7. Auto Adjudication PRV Timing:

    - The complexity of adjudication logic development caused delays in meeting the Auto Adjudication PRV timeline.

    - Possible Mitigation Strategy: Move the Auto Adjudication PRV to a later timeline to allow sufficient time for adjudication logic readiness.

8. Stress Testing and Defense Enrollment Eligibility Reporting System (DEERS) Production Simulation Environment (PRODSIM) Environment:

    - Limited stress testing and late utilization of the DEERS PRODSIM environment caused connectivity issues and delays in eligibility and premium billing services.

    - Possible Mitigation Strategy: Begin utilizing PRODSIM earlier in the transition process. Require comprehensive testing and validation.

9. TRICARE Encounter Data (TED) Provider and Claim Edits:

    - Delayed contractor code flips and unavailable TRICARE Encounter Provider (TEPRV) records caused a higher volume of TED edits.

    - Possible Mitigation Strategy: Validate the need to flip provider codes and develop a process to allow TEPRV updates for new contracts while maintaining updates for existing contracts.

10. Claims Processing Performance Guarantees:

    - Performance guarantees for claims processing were poorly written, conflicting with TRICARE Manuals and lacking clarity on responsibility and due dates.

    - Possible Mitigation Strategy: Align performance guarantee requirements with TRICARE Manuals and ensure clarity in calculations for metrics like reprocessing rates and auto-adjudication. Increase financial penalties for non-compliance.

11. PRV/PRAV Testing:

    - PRV/PRAV testing did not occur until after SHCD, limiting the ability to validate claims processing readiness in a live environment.

    - Possible Mitigation Strategy: Conduct PRV/PRAV testing during the transition period to ensure readiness before SHCD.

12. Provider Data Alignment:

    - Misalignment of provider data across contractor systems, subcontractor systems, and DHA files caused discrepancies in claims processing.

    - Possible Mitigation Strategy: Ensure provider data alignment across all systems during transition and require validation of data accuracy.

13. Claims Image and Data Transition:

    - The timeline for transitioning claims images and data was limited, causing delays due to the significant volume of records being transferred.

    - Possible Mitigation Strategy: Extend the timeline for transitioning older option periods or stagger the transition to avoid bottlenecks.

14. Claims PRV/PRAV Requirements:

    - PRV/PRAV requirements for claims processing were insufficient to validate readiness, and the lack of a fully operational test environment impacted claims system functionality.

    - Possible Mitigation Strategy: Require comprehensive PRV/PRAV testing with live data and ensure the claims system is fully operational 120 days prior to SHCD.

15. Claims Processing Metrics:

    - Metrics for claims processing were unclear, leading to confusion during evaluations.

    - Possible Mitigation Strategy: Write all metrics with defined numerators and denominators and ensure clarity in milestone dates prior to the release of the RFP. Ensure non-compliance penalties are sufficient.

CONCLUSION

By addressing these challenges, DHA can improve future TRICARE transitions, reduce claims processing delays, and ensure high-quality care for beneficiaries.