



June 2014

DEFENSE HEALTH CARE

More-Specific Guidance Needed for TRICARE's Managed Care Support Contractor Transitions

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GAO Highlights

Highlights of [GAO-14-505](#), a report to congressional requesters

Why GAO Did This Study

DOD provides health care through TRICARE, its regionally structured health care program. In each of its regions (North, South, West), DOD uses contractors to manage health care delivery through civilian providers, among other tasks. UnitedHealth—an organization new to TRICARE—was awarded the contract in the West region. After health care delivery began, UnitedHealth experienced problems fulfilling some requirements and delivering care to TRICARE beneficiaries.

GAO was asked to review the West region's transition to UnitedHealth. This report provides information on (1) the extent to which TMA provided guidance and oversight of the new contractor's transition period in preparation for health care delivery; and (2) how, if at all, TMA's guidance and oversight during the transition period contributed to issues with health care delivery. GAO reviewed and analyzed TMA guidance, contract requirements, and other relevant documentation, and interviewed TMA and UnitedHealth officials.

What GAO Recommends

GAO recommends that DOD review and revise as necessary, its transition guidance to strengthen its oversight and ensure that future managed care support contractors have sufficient information to successfully complete transition requirements. DOD concurred or partially concurred with GAO's recommendations, but disagreed with some of GAO's findings. GAO maintains that the information presented is accurate, and recommendations valid as discussed in the report.

View [GAO-14-505](#). For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.

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DEFENSE HEALTH CARE

More-Specific Guidance Needed for TRICARE's Managed Care Support Contractor Transitions

What GAO Found

The recent transition of TRICARE's managed care support contractors (contractors) in the West region did not go smoothly and highlighted numerous deficiencies in guidance and oversight by the TRICARE Management Activity (TMA)—the Department of Defense's (DOD) office responsible for awarding and managing these contracts at the time of GAO's review. For example, TMA did not ensure that its outgoing and incoming contractors used the same version of transition guidance, resulting in problems that were left largely to the contractors to resolve. Additionally, TMA's guidance lacked sufficient specificity for some requirements, such as the development of a referral management system that could interface with the referral systems used by the regions' military treatment facilities—a system that was also not tested prior to health care delivery, unlike other critical system interfaces. In addition, TMA lacked a process for holding the contractor accountable when transition requirements were delayed or not met. TMA officials explained that the regional contracts are performance-based, meaning that most—but not all—of the contract requirements include an expected outcome, but the manner in which that outcome is to be achieved is left to the contractor. As a result, TMA officials stated that, regardless of their concerns, it was difficult to hold UnitedHealthcare Military & Veterans Services (UnitedHealth) accountable until the requirement was actually missed. However, as GAO has previously reported, important attributes of a performance-based contract include features that allow for the evaluation of a contractor's performance. UnitedHealth's contract contained these features, and as a result, GAO believes that this performance-based contract structure did not diminish TMA's responsibility for providing sufficient oversight to ensure that the contractor was performing as required.

TMA's inadequate guidance and insufficient oversight contributed to problems with health care delivery. UnitedHealth experienced difficulty in meeting some of its requirements early on, disrupting continuity of care for some beneficiaries and potentially resulting in unnecessary costs. For example, the lack of guidance on developing a referral management interface contributed to problems with the processing of specialty care referrals. Consequently, the requirement for beneficiaries to obtain a referral authorization for specialty care was temporarily waived—a move that the Army estimated could cost DOD over a million dollars as beneficiaries may have obtained more specialty care from civilian providers than from military treatment facilities. Further, insufficient oversight related to UnitedHealth's determination of the number of staff needed to man its call center contributed to a delayed resolution in meeting telephone response time requirements. As a result, it was not until the third month of health care delivery that UnitedHealth was able to meet its requirement to answer 90 percent of calls within 30 seconds. These and other problems ultimately resulted in TMA holding the contractor accountable through the use of corrective action requests and financial penalties.

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Abbreviations

DHA	Defense Health Agency
DOD	Department of Defense
MTF	military treatment facility
TMA	TRICARE Management Activity
TRO	TRICARE Regional Office

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June 18, 2014

The Honorable Patty Murray
Chairman
Committee on Budget
United States Senate

The Honorable Mark Begich
United States Senate

In fiscal year 2013, the Department of Defense (DOD) offered health care services to almost 9.6 million eligible beneficiaries in the United States and abroad through TRICARE, its regionally structured health care program.¹ Under TRICARE, beneficiaries can obtain health care through DOD's direct care system of military hospitals and clinics, referred to as military treatment facilities (MTF), or through its purchased care system of civilian providers. DOD contracts with private sector companies—referred to as managed care support contractors (contractors)—to develop and maintain civilian provider networks and provide other services, such as specialty care referrals, enrollment, medical case management, claims processing, and customer service.²

Each TRICARE region in the United States (North, South, and West) has a TRICARE Regional Office (TRO) that helps oversee the contractors' performance, including monitoring network quality and adequacy, and customer-satisfaction outcomes. On October 1, 2013, DOD's Defense Health Agency (DHA) became responsible for acquiring, administering, and overseeing TRICARE's managed care support contracts—

¹Generally, eligible beneficiaries include active duty personnel and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and retirees and their dependents and survivors. Active duty personnel include Reserve component members on active duty for at least 30 days.

²DOD awarded one managed care support contract for the TRICARE program in each of its three U.S. regions.

responsibilities formerly handled by the TRICARE Management Activity (TMA).³

Under the current, third generation of managed care support contracts, health care delivery was scheduled to begin nationwide on April 1, 2010.⁴ However, due to sustained bid protests for each of the contracts and TMA's implementation of related corrective actions, health care delivery started at different times in each of the TRICARE regions.⁵ TRICARE's West region was the last of the three regions to transition to the third generation of managed care support contracts with a health care delivery start date of April 1, 2013.⁶ Unlike the North and South regions, which were awarded to incumbent contractors, the West region was awarded to UnitedHealthcare Military & Veterans Services (UnitedHealth)—an organization that was new to TRICARE.⁷ Additionally, this was the first transition to a nonincumbent contractor since the start of the TRICARE program. After health care delivery began, UnitedHealth experienced a

³Prior to October 1, 2013, TMA oversaw the TRICARE program. In response to increasing pressure on its budgetary resources, DOD established the DHA on October 1, 2013, to assume management responsibility of numerous functions of its medical health system, including the former TMA, which was eliminated on that date. For additional information about the establishment of DHA, see GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability*, [GAO-14-49](#) (Washington, D.C.: Nov. 6, 2013).

⁴TRICARE's first- and second- generation managed care support contracts were awarded in 1996/1997 and 2003, respectively.

⁵A bid protest is a challenge to the award or proposed award of a contract for procurement of goods and services or a challenge to the terms of a solicitation for such a contract. An offeror—a competitor for a government contract—who was not awarded a contract may challenge a federal agency's award or proposed award of a contract based on an alleged violation of statute or regulation. Such a challenge, known as a "post-award bid protest," may be filed with the contracting agency (referred to as an agency-level protest), the U.S. Court of Federal Claims, or GAO. GAO's bid protest function—in contrast to its audit function—is an adjudicative process that is carried out by attorneys in GAO's Procurement Law group, who prepare bid protest decisions resolving disputes concerning the awards of federal contracts.

⁶The managed care support contract's health care delivery date in the North region was April 1, 2011, and in the South region it was April 1, 2012.

⁷UnitedHealth is a subsidiary of the UnitedHealthcare Group. According to its website, the UnitedHealthcare Group is a diversified insurance company that has several lines of business, including private health insurance. Prior to competing for the third generation of managed care support contracts, UnitedHealth had no previous experience as a managed care support contractor.

number of well-publicized problems, reported by DOD and the media, performing certain required services for TRICARE beneficiaries, including difficulties with the development of its provider network and the processing of referrals to specialty providers—problems that, according to TMA officials, the incumbent contractors in the North and South regions did not experience.⁸

Questions have been raised concerning the problems that transpired after the West region's transition to UnitedHealth. You asked us to examine whether UnitedHealth was fully prepared for the transition to deliver health care, among other issues, including UnitedHealth's outreach to beneficiaries and providers during this time. This report provides information on (1) the extent to which TMA provided guidance and oversight of the new contractor's transition period in preparation for health care delivery; and (2) how, if at all, TMA's guidance and oversight during the transition period contributed to issues with health care delivery. We also provide information on UnitedHealth's outreach to beneficiaries and providers during the transition period and the first 6 months of health care delivery. (See app. I.)

To determine the extent to which TMA provided guidance and oversight of the new contractor's preparation for health care delivery, we reviewed and analyzed TMA's guidance on how the transition period was to be structured, including the roles of TMA and TRO-West in overseeing UnitedHealth's transition. We also reviewed TMA's relevant guidance and documents for managed care support contract transitions to identify requirements for the transition-in of a new contractor and the transition-out of an outgoing contractor. Additionally, we applied federal standards for internal control, including risk assessment activities to identify risks and analyze their possible effect, and other activities—such as documentation of significant events—to help ensure that ongoing monitoring is effective.⁹ We interviewed officials from TMA, including the Transitions Director from the Policy and Operations Directorate and the Contracting Officer from the Acquisition Management and Support

⁸Beneficiaries who use TRICARE Prime—the managed care option—must enroll, and are assigned a primary care manager from either an MTF or the civilian provider network. Primary care managers may provide the beneficiaries with referrals to specialty care if the MTFs are unable to provide that care themselves.

⁹GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

Directorate, both in TMA's Aurora, Colorado office (TMA-Aurora), as well as the Transition Manager and Contracting Officer's Representative from TRO-West, to obtain their perspectives on transition activities, including oversight provided to UnitedHealth during this period.¹⁰ We also interviewed officials at UnitedHealth to discuss activities that occurred during the transition period, including the extent to which they collaborated and communicated with TRO-West officials. TriWest Healthcare Alliance Corporation (TriWest), the contractor for the West region prior to UnitedHealth, was no longer the contractor when we started our review, and as a result, we did not interview TriWest officials about the transition.¹¹

To determine how, if at all, TMA's guidance and oversight during the transition period contributed to issues with health care delivery, we reviewed and analyzed documents, including UnitedHealth's contract requirements and documents that described the oversight responsibilities for TMA-Aurora and the TROs. We interviewed officials from TMA, including both the Contracting Officer from TMA-Aurora and the TRO-West officials who provide day-to-day oversight of the contract, to discuss how transition activities affected health care delivery. We also discussed how the problems that occurred after health care delivery were addressed, including how TMA used corrective action requests, award fees, and performance guarantees to hold the contractor accountable. Our work focused on activities and interactions through the first 6 months of health care delivery, which ended on October 1, 2013. Because we conducted the majority of our audit work prior to the establishment of the DHA on October 1, 2013, we refer to TMA throughout most of this report. When relevant, we refer to DHA for activities that occurred after that time.

We conducted this performance audit from August 2013 to June 2014 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.

¹⁰TMA's acquisition and contracting staff are based primarily in Aurora, Colorado.

¹¹TriWest's contract as the West region's contractor ended on March 31, 2013.

Background

Under TRICARE, DOD contracts with private sector health care companies to supplement the care provided by military hospitals and clinics. These contracts, which are referred to as managed care support contracts, are generally performance-based contracts. For such contracts, most, but not all, of the requirements include an expected outcome, but the manner in which that outcome is to be achieved is left to the contractor. Contractors are given discretion in determining how best to meet the government's performance objectives. For example, the managed care support contract states that the contractor must maintain an adequate network of providers, and the contractor is responsible for determining how it will accomplish that objective, including how many providers will be in its network.

TMA expected to award the third generation of managed care support contracts in each of the three regions in 2009, but bid protests and other actions resulted in delays. In the North region, the final contract was awarded in May 2010 to the incumbent contractor, Health Net Federal Services, after its bid protest against TMA's initial decision to award the contract to Aetna Government Health Plan was sustained. In the South region, the final contract was awarded in February 2011 to the incumbent contractor, Humana Military Healthcare Services, after its bid protest against TMA's initial decision to award the contract to UnitedHealth was sustained.¹²

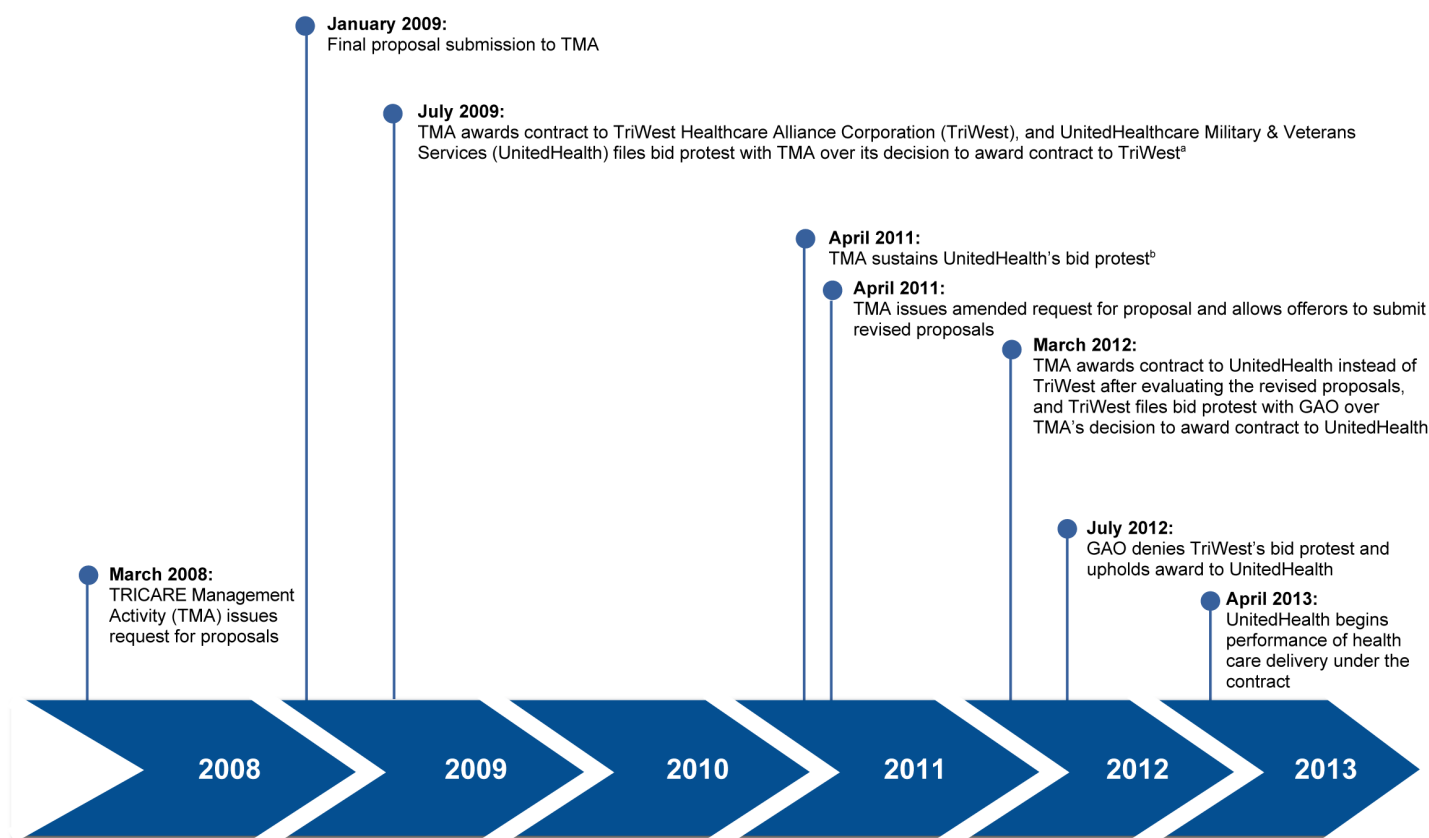
As we reported in March 2014, there were two bid protests in the West region.¹³ The first protest was an agency-level protest filed by UnitedHealth in July 2009 challenging the award to TriWest. This protest was sustained and included a recommendation that TMA reevaluate proposals and make a new source selection decision. In implementing this recommendation, TMA allowed offerors to submit revised proposals. TMA then reviewed the revised proposals and, based on this review, awarded the contract to UnitedHealth. After TMA announced the new award, a second West region protest was filed by TriWest in March 2012.

¹²For additional information on the third generation of TRICARE's managed care support contracts and the associated bid protests, see GAO, *Defense Health Care: Acquisition Process for TRICARE's Third Generation of Managed Care Support Contracts*, [GAO-14-195](#) (Washington, D.C.: Mar. 7, 2014).

¹³See [GAO-14-195](#).

GAO denied the second protest and upheld UnitedHealth as the contractor for the West region. (See fig. 1.)

Figure 1: Timeline of Events for the Award of TRICARE's Third-Generation Managed Care Support Contract for the West Region



Source: GAO. | GAO-14-505

^aTMA held UnitedHealth's July 2009 West region protest in abeyance while TMA took corrective action following a sustained bid protest in the South region, where UnitedHealth was also an offeror. Because the request for proposal for the third-generation managed care contracts stated that the same offeror could not win contract awards in more than one region, UnitedHealth's West region protest would have become moot if it received the South region award following TMA's evaluation of revised proposals. After TMA awarded the South region contract to Humana in February 2011, UnitedHealth's agency-level protest in the West region was revived.

^bIn the sustained agency-level bid protest, TMA's Contracting Officer recommended that TMA reevaluate proposals and make a new source selection decision.

The process for implementing the third generation of managed care support contracts involves transitioning health care delivery from the outgoing contractor to the incoming contractor. The transition involves planning, managing, and monitoring to ensure continuity of services for

TRICARE beneficiaries and providers. The transition period officially begins when the managed care support contract has been signed by DOD and the contractor, and it ends on the health care delivery start date.¹⁴ For the West region, UnitedHealth's transition period was slightly less than 9 months; it began on July 3, 2012, and was completed on March 31, 2013, with the health care delivery start date of April 1, 2013.

TMA has guidance for the management and oversight of managed care support contract transitions, as well as for the incoming and outgoing contractors. TMA's management of all of the third-generation contract transitions, including the managed care support contract transitions, is governed by TMA's *Concept of Operations for TRICARE T-3 Transitions Work Group (Concept of Operations)*.¹⁵ In addition, for oversight of the contractor's performance, TMA uses the *TRICARE Acquisitions Directive (Acquisitions Directive)*, which establishes roles and responsibilities for both TMA and TRO officials and a chain of command to address contractor nonconformance.¹⁶ According to this directive, the Contracting Officer is ultimately responsible for the oversight of the contractor's performance. The Contracting Officer's Representative assists the Contracting Officer with this effort by working with other TRO officials to monitor the contractor's performance.¹⁷ The TRO is responsible for the day-to-day monitoring of the contractor's performance during both contract transition and health care delivery.¹⁸

The managed care support contract also contains guidance and requirements for the contractor's portion of the transition. The contract requirements are organized into seven areas, which are considered the

¹⁴The transition-in period may vary based on the time necessary to conduct the subsequent acquisition and whether incumbents succeed themselves. According to 10 U.S.C. § 1095c(b), DOD is generally required to allow nonincumbents a 9- to 12-month transition-in period. A 10-month transition-in period is considered by the industry to be the minimum time necessary for nonincumbents to transition in.

¹⁵See TMA, *Concept of Operations for TRICARE T-3 Transitions Work Group* (2008).

¹⁶See TMA, *TRICARE Acquisition Directive*, TAD 42-02, revision 000 (Falls Church, Va.: Feb. 16, 2012).

¹⁷The Contracting Officer's Representative is a TRO employee who is located in the TMA-Aurora office along with the Contracting Officer.

¹⁸For the West region transition, TRO-West was responsible for the day-to-day monitoring.

key focus areas during the transition period because of their importance in delivering health care; they are provider network, referral management, enrollment, medical management, claims processing, customer service, and management. (See table 1.) The contract is also supplemented by four TRICARE manuals, including the *TRICARE Operations Manual*, which includes guidance for both the outgoing and the incoming contractors, among other requirements.¹⁹

Table 1: The Seven Key Focus Areas for TRICARE Managed Care Support Contract Transitions

Areas	Description
Provider network	The contractor shall provide a managed, stable, high-quality network, or networks, of individual and institutional health care providers that supplements the clinical services provided to beneficiaries in military treatment facilities (MTF).
Referral management	The contractor is required to process all referrals to specialty providers and right of first refusals for the MTF in accordance with TRICARE manuals. Right of first refusal is defined as providing the MTF with an opportunity to review each referral from a civilian provider to determine if the MTF has the capability and capacity to provide the medical care and services previously identified in the document that dictates the relationship between the contractor and the MTF.
Enrollment	The contractor shall perform all enrollments, including correcting enrollment discrepancies when necessary.
Medical management	The contractor shall ensure that the care it provides, including mental health care, is medically necessary and appropriate and complies with the TRICARE benefits contained in regulations. The contractor shall use its best practices in managing, reviewing, and authorizing health care services. In addition, the contractor shall operate case management programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which evidenced based clinical management programs exist.
Claims processing	The contractor shall establish, maintain, and monitor an automated information system to ensure claims are processed in an accurate and timely manner and meet the functional system requirements as set forth in the TRICARE manuals that explain how to process claims.
Customer service	The contractor shall provide comprehensive, readily accessible customer service that includes multiple, contemporary avenues of access (for example, e-mail, World Wide Web, telephone, and facsimile) for the beneficiary. This includes providing telephone access for beneficiaries to use when they have inquiries regarding their TRICARE benefit.
Management	The contractor shall establish and maintain experienced and qualified key personnel and sufficient staffing and management support to meet contractual requirements, including ensuring that the information systems that interface with the Department of Defense employ the proper security settings.

Source: GAO analysis of the Department of Defense’s managed care support contract. | GAO-14-505

¹⁹The other three manuals relate to TRICARE systems, reimbursement, and policies. These manuals, while separate documents, are incorporated as part of the contract itself.

TMA's Guidance on Contract Transitions Was Inadequate, and Its Oversight Was Insufficient

TMA's Transition Guidance Was Inadequate for Both TRO-West and UnitedHealth

Transition Guidance for TRO-West

TMA provided some guidance to both TRO-West and UnitedHealth for the West region's managed care support contract transition, but the guidance was inadequate because it lacked sufficient specificity on how to both oversee the transition and meet certain transition requirements.

Although TRO-West was responsible for the day-to-day management of UnitedHealth's transition, it lacked specific guidance from TMA on how to provide oversight, particularly when the contractor had difficulty meeting transition requirements. According to TMA-Aurora officials, the *Concept of Operations* is the official guidance for managing the transition of all third-generation TRICARE contracts, including the managed care support contracts. We found that this seven-page document outlines a basic approach for the transitions, including a general management structure. However, it does not provide information on the specific roles and responsibilities for managing the day-to-day transition process. It also does not contain guidance for addressing any problems that may occur, including a process for holding the contractor accountable when transition activities are delayed and interim milestones are not met. Separately, the *Acquisitions Directive* provides a basic approach for overseeing a contractor's performance, including performance during a transition period. However, we found that this high-level five-page document also lacks specificity on how and when to hold a contractor accountable for not meeting requirements. For example, it notes that the Contracting Officer has the authority to issue a corrective action request in response to the contractor's nonconformance, but does not provide sufficient detail on what level of nonconformance would require such response, nor how long the Contracting Officer should wait before sending it.

In July 2012, TMA-Aurora officials developed the *TMA Transition User Guide* to supplement the *Concept of Operations*, which provided more-specific information on how to implement its approach for managing

Transition Guidance for UnitedHealth

contract transitions.²⁰ At over 140 pages in length, this guide established a more-detailed structure for the transition process, including key management roles and responsibilities for TMA-Aurora and TRO-West officials, as well as timelines for important meetings and lessons learned from previous contract transitions. However, similar to the *Concept of Operations* and the *Acquisitions Directive*, it does not address how TRO-West officials should provide oversight of the contractor's activities, including what to do when the contractor is not on track to meet requirements.

We found that TMA's transition guidance to UnitedHealth as an incoming contractor was also inadequate primarily because UnitedHealth's transition requirements were more specific than those of the outgoing contractor, and TMA did not adequately address these differences. The managed care support contracts include transition guidance for both the incoming and the outgoing contractors that is outlined in the TRICARE manuals, most notably the *TRICARE Operations Manual*.²¹ However, UnitedHealth's contract included the 2008 version of the manual, while the contract for the outgoing contractor included the 2002 version. Despite our attempts to obtain an explanation, TMA-Aurora and TRO-West officials could not clearly explain to us why the two contractors were not required to follow the same transition guidance.

The different versions of the manual contributed to information gaps for UnitedHealth, which UnitedHealth officials said was an important factor that delayed development of their civilian provider network. Specifically, UnitedHealth had intended to duplicate at least 95 percent of TriWest's provider network to create a more seamless transition for beneficiaries, but to accomplish this, it needed specific information from TriWest that it expected to receive as part of the transition. UnitedHealth's transition guidance stated that the outgoing contractor was required to provide the incoming contractor with copies of a provider certification file no later than 30 days after contract award to be updated on a monthly basis until the

²⁰The *Transition User Guide* was first used for the West region's transition, and is expected to be used for other TRICARE contract transitions. See TMA, *TMA Transition User Guide* (July 2, 2012).

²¹Both the contract and the TRICARE manuals also guide requirements after health care delivery begins.

start of health care delivery.²² However, TriWest's transition guidance only contained a reference to a provider certification file, but did not define its contents, link it to other provider files specifically mentioned, or stipulate a time frame for producing it. Instead, TriWest's guidance stated more generally that the outgoing contractor was required to provide full cooperation and support to the incoming contractor and was silent on when the provider certification file had to be delivered.²³ TriWest did not provide this file within 30 days, but UnitedHealth and TriWest officials were able to reach a compromise about the provision of the needed information. As a result, TriWest provided UnitedHealth with a provider certification file in late August 2012. However, this was almost a month later than UnitedHealth expected to receive the information based on its transition guidance. Furthermore, UnitedHealth officials told us that because there was no guidance on the transfer of the provider certification file between incoming and outgoing contractors, they received a file with nearly 700,000 provider records without any data definitions. As a result, UnitedHealth officials told us that they had to spend several months working with the data to make them usable for their purposes. In this instance, the lack of consistent transition guidance for the outgoing and incoming contractors affected the incoming contractor's ability to meet transition requirements. Federal standards for internal control note that an agency is responsible for the establishment and monitoring of performance measures—which would include ensuring consistent transition guidance.²⁴

TMA's transition guidance to UnitedHealth also lacked sufficient specificity for some of the seven key focus areas it had identified in the contract as being important for health care delivery, such as referral management. TRICARE has a unique referral process that provides MTFs with the right of first refusal when TRICARE Prime beneficiaries are referred for specialty care—a practice that helps maximize the use of the military's direct care system. As a result, contractors would need to have

²²See *TRICARE Operations Manual 6010.56-M* (Aurora, Colo.: Feb. 1, 2008), chapter 1, section 7, paragraph 4.3.11. The provider certification files would contain demographic information on the outgoing contractor's network of civilian providers, including the numbers of providers, their specialties (if any), and addresses.

²³See *TRICARE Operations Manual 6010.51-M* (Aurora, Colo.: Aug. 1, 2002), chapter 1, section 8, paragraph 4.4.3.1.

²⁴See [GAO/AIMD-00-21.3.1](#).

a referral management system that could electronically interface with the referral management systems used by the region's MTFs to facilitate this process. However, the TRICARE manuals do not contain guidance for the contractors on how to establish this interface. In contrast, DOD provides detailed guidance for establishing interfaces with other, more centralized DOD systems, such as the guidance for interfacing with the Defense Enrollment Eligibility Reporting System.²⁵ A TRO-West official explained that the lack of specific guidance for a referral management interface is likely due to the fact that the military services use different referral management systems, and there is no central DOD system for this process. At the time, the military services used one of two referral management systems.²⁶ UnitedHealth officials told us that they did not learn about the MTFs' different systems until a month into the transition period, which affected their timeliness in developing an automated referral management system to interface with the systems used by the region's MTFs. Additionally, during that time, there were also discussions within DOD to adopt one of these referral management systems for use across all of the military services by March 2013. As a result, UnitedHealth officials told us that they developed a referral management system that could receive faxed referrals from the MTFs with the expectation that they would develop an automated interface once more information was available about which single referral management system DOD would adopt.²⁷

In addition, unlike some other key focus areas, including customer service (call centers) and claims processing, TMA did not test UnitedHealth's referral process prior to health care delivery. According to both TRO-West and UnitedHealth officials, this testing was not conducted because it was not required by transition guidance. Both TRO-West and UnitedHealth officials agreed that such testing would have been beneficial for determining whether their interface would work at the start of health care

²⁵The Defense Enrollment Eligibility Reporting System is a database that contains the service-related and demographic data that are used to determine eligibility for military benefits, including health care, for all active duty servicemembers, military retirees, and the dependents and survivors of active duty servicemembers and military retirees.

²⁶The Army used one type of referral management system, the Air Force used another type of referral management system, and the Navy used the same system as the Air Force's, in addition to manual faxing.

²⁷A TRO-West official told us that as of November 2013 each of the military departments was using the same referral management system.

delivery. Providing sufficient specificity for, and testing, this system and other systems identified as critical for health care delivery would better align with federal standards for internal control, which recommend that once an agency has identified areas of risk, such as referral management, it should analyze those areas, formulating an approach to manage and mitigate them.²⁸

TMA's Oversight of UnitedHealth's Transition Was Insufficient

TMA-Aurora and TRO-West officials provided insufficient oversight of the West region's contractor transition because they took limited action in response to the concerns they identified and did not resolve their concerns promptly. Specifically, the Contracting Officer and TRO-West officials provided oversight by following the structured process outlined in the *TMA Transition User Guide*. For example, they held specific types of meetings defined in the guide, such as a "kick-off meeting" with UnitedHealth officials shortly after the transition period began to discuss high-level transition strategies; meetings were also held to discuss interfacing DOD and UnitedHealth computer systems. Additionally, TRO-West officials reviewed UnitedHealth's weekly transition reports and participated in weekly meetings with UnitedHealth officials to discuss their progress in meeting transition requirements. TRO-West officials did not maintain formal agency records of these weekly meetings, and they could only provide us with examples of handwritten notes of the discussions that transpired. Although the notes provide a general outline of topics discussed, they lack the degree of specificity that would allow us to determine, without making assumptions, the nature of any concerns raised by TRO-West officials or how UnitedHealth responded. We therefore determined that these notes provided insufficient evidence of the agency's oversight actions during the transition period.²⁹

Due to delays in the awarding of the contract, the Contracting Officer told us that there were discussions with TRO-West and UnitedHealth officials as early as July 2012 about whether the transition period should be extended. According to the Contracting Officer, a decision was ultimately

²⁸See [GAO/AIMD-00-21.3.1](#).

²⁹According to generally accepted government auditing standards, evidence is not sufficient or appropriate when using the evidence carries an unacceptably high risk that it could lead the auditor to reach an incorrect or improper conclusion. See GAO, *Government Auditing Standards*, [GAO-12-331G](#) (Washington, D.C.: December 2011), paragraph 6.71(b).

made in September 2012 to continue with the expected plan, after UnitedHealth officials assured TMA that they would be able to meet the transition requirements by the start of health care delivery—an assurance that UnitedHealth officials confirmed. The Contracting Officer told us that none of these discussions were documented because the decision not to extend the transition period did not represent a change from what was already required. Although TRO-West officials told us that there were no indications at the time that the health care delivery start date should be delayed, these officials later told us that they had limited data on which to base their determination, in part because it was so early in the transition period. According to federal standards for internal control, sufficient information should be identified and captured in a time frame that permits program managers (such as the Contracting Officer or TRO-West officials) to make effective decisions.³⁰ Without such pertinent information, the Contracting Officer and TRO-West officials cannot ensure that they made an informed determination about whether to extend the transition period.

Despite not delaying the health care delivery start date, TMA-Aurora and TRO-West officials told us that they had concerns with UnitedHealth's determination of how it would meet, and its progress toward meeting, several of the transition requirements. TRO-West officials told us that because the contract is performance-based, they had difficulty holding the contractor accountable until an actual requirement was missed, and were only able to express their concerns regarding the progress to UnitedHealth's officials. However, TRO-West officials could not provide sufficient documentation of these conversations with UnitedHealth. In addition, while we recognize that under a performance-based contract an agency does not provide detailed instructions to the contractor on how to meet its requirements, we do not believe that a performance-based contract diminishes TMA's responsibility to provide an oversight structure for managing the contractor's performance during the transition period. As we have previously reported, important attributes of a performance-based contract include measurable performance standards and a quality assurance plan for evaluating the contractor's performance.³¹ The

³⁰See [GAO/AIMD-00-21.3.1](#).

³¹For more information on performance-based contracts, see GAO, *Contract Management: Guidance Needed for Using Performance-Based Service Contracting*, [GAO-02-1049](#) (Washington, D.C.: Sept. 23, 2002).

contract with UnitedHealth contains these features. Taken together, these contract provisions created an obligation on the part of the department to provide sufficient oversight to ensure that the contractor was performing as required.

Although TRO-West monitored UnitedHealth's progress and had concerns about its performance, it did little to resolve them, and could not always provide documentation of the communication of these concerns to UnitedHealth. In one instance, TRO-West officials told us that they were concerned about UnitedHealth's ability to meet call center requirements because they were concerned about the staffing numbers that UnitedHealth had proposed. Specifically, UnitedHealth was required to hire a sufficient number of staff to answer customer service calls from beneficiaries and providers within prescribed time frames. However, the determination of how many staff to hire was ultimately UnitedHealth's decision.³² UnitedHealth officials told us that in order to determine how many call center staff were needed, they estimated the efficiency of their call center staff and applied that to an estimated volume of customer service calls, which was based on TriWest's daily average plus an additional 50 percent to factor in a heavier call volume for the start of health care delivery. UnitedHealth officials told us that they were unable to obtain staffing numbers from TriWest because the numbers were proprietary. However, TRO-West officials told us that based on their comparisons of UnitedHealth's call center staffing numbers to those of TriWest's, they expressed concerns to UnitedHealth about the adequacy of its call center staffing estimate. TRO-West officials said that UnitedHealth officials replied that their staffing numbers should be sufficient, but if needed, they would be able to transfer staff from other departments to provide coverage. However, UnitedHealth officials did not recall these discussions in our interviews, and TRO-West officials could not provide documentation that they took place. TRO-West's approach was inconsistent with federal standards for internal control, which state that management should have a strategy for documenting significant

³²The contract prescribes several requirements related to the answering of customer service calls, including that 90 percent of calls should be answered by a customer service representative within 30 seconds. See *TRICARE Operations Manual 6010.56-M*, chapter 1, section 3.

events, which would include TMA's communication of concerns about the contractor's performance in meeting requirements.³³

When UnitedHealth missed deadlines for transition requirements, TMA either did not take, or was slow to take, formal action, and it did not sufficiently document all of its informal actions. For example, TRO-West officials told us that on several occasions, starting in November 2012, they expressed concerns to UnitedHealth that it was not progressing sufficiently with meeting two of the requirements related to the development of its provider network. Specifically, UnitedHealth was required to have both its network of civilian providers (including primary care managers and other provider specialties) signed to contracts and the providers' relevant information entered into its databases 60 days prior to health care delivery.³⁴ Although UnitedHealth provided updates in its weekly transition reports on its progress in meeting these requirements, including assurances to TRO-West officials that they would be met, it did not ultimately meet the requirements on time. TRO-West officials told us that after the requirements were not met, they held informal discussions with UnitedHealth officials during weekly transition meetings to determine how UnitedHealth would come into compliance. Although TRO-West officials could not provide sufficient documentation of these discussions, they were able to provide examples of emails sent to UnitedHealth about these concerns. According to the Contracting Officer, he did not take formal action at that time in order to allow TMA-Aurora and TRO-West officials to exercise other informal mechanisms for resolving the issue. UnitedHealth did not complete this requirement until June 2013—more than 4 months late.

Although UnitedHealth was not always timely in meeting transition requirements, it did not face any financial penalties as a result. According to its contract, UnitedHealth was eligible for a transition-in payment of \$10 million to be paid in two increments, with the last payment following completion of all transition requirements.³⁵ The Contracting Officer told us that because the contract did not specify that the transition-in payment

³³See [GAO/AIMD-00-21.3.1](#).

³⁴See *TRICARE Operations Manual 6010.56-M*, chapter 1, section 7, paragraph 2.2.1.

³⁵The transition-in payment is a negotiated incentive to UnitedHealth for completing the transition. While all of the contractors are eligible for transition-in payments, the amount of the payment is negotiated as part of the contract and varies by region.

Inadequate Guidance and Insufficient Oversight during the Contractor Transition Contributed to Health Care Delivery Problems, but Ultimately Led to Greater Oversight

was subject to timely completion of the transition requirements, TMA's interpretation was that it had to award the payment without regard to whether the contractor met the transition's timeliness requirements. However, our previous work has found that performance-based contracts should include incentives—either positive or negative, or a combination of both—to encourage better quality performance.³⁶ In this instance, TMA determined in December 2013 that UnitedHealth completed all of its transition requirements—about 8 months after health care delivery began. TMA subsequently awarded UnitedHealth the remainder of its transition-in payment in February 2014.

TMA's inadequate guidance and insufficient oversight of UnitedHealth's transition contributed to problems at the start of health care delivery, which in turn led to the disruption in the continuity of care for some beneficiaries and potentially cost the department millions of dollars, according to Army officials. Specifically, inadequate guidance and insufficient oversight contributed to UnitedHealth's health care delivery problems, including those related to its provider database, referral processing, and call center responsiveness. As a result of these difficulties, TMA-Aurora and TRO-West officials increased their oversight of UnitedHealth, took steps to hold the contractor accountable for the problems that had transpired, and updated the guidance (*TMA Transition User Guide*).

Provider database: The different versions of transition guidance and insufficient oversight contributed to information gaps for UnitedHealth, which UnitedHealth officials said was an important factor that led to its difficulties in creating its provider database. UnitedHealth did not have information for all its civilian network providers entered into its provider database until June 2013—more than 4 months after the contract deadline of January 30, 2013. Referrals and claims related to these providers had to be put on hold until UnitedHealth officials could complete the data entry process. Additionally, at the start of health care delivery, UnitedHealth officials told us that they had not entered information on

³⁶See [GAO-02-1049](#).

primary care managers for 113,000 TRICARE Prime beneficiaries,³⁷ and some of these beneficiaries had to be temporarily reassigned to a new primary care manager.³⁸ When UnitedHealth had completed entering information about its primary care managers 3 weeks after the start of health care delivery, the beneficiaries who had been reassigned were moved back to their original primary care manager if they requested it.

Referral processing: The absence of transition guidance on developing a referral management interface contributed, in part, to UnitedHealth's difficulties in establishing an automated referral management system, which inconvenienced beneficiaries and was potentially costly for the government. Because DOD had not decided which referral management system would be used in the region, UnitedHealth officials told us that they could only receive faxed referrals from MTFs during the first few months of health care delivery. This situation contributed to inordinate processing delays along with a higher-than-expected number of referrals and staff who were not as efficient as anticipated. Specifically, UnitedHealth expected its staff to process about 7,000 referrals a day. Instead, during the first few days of health care delivery, they processed about 2,500 per day. On May 2, 2013, the director of TMA issued a temporary waiver of the requirement for TRICARE Prime beneficiaries to obtain referral authorizations for specialty care. This waiver was initially effective for the first 6 weeks of health care delivery starting on April 1, 2013, and was subsequently extended through July 2, 2013. Officials from the Army estimated that these waivers could cost the department over a million dollars in lost resources because they impeded the right of first refusal for the MTFs, which potentially resulted in more beneficiaries' obtaining specialty care from civilian providers, costing the government additional money. During this time, UnitedHealth hired more staff and increased its efficiency at processing referrals, and in July 2013—about 4 months after the start of health care delivery—it was able to meet and exceed the contract requirement of processing 90 percent of referrals within 2 workdays. While UnitedHealth has not yet met its requirement to

³⁷Beneficiaries who use TRICARE Prime—a managed care option—must enroll and are assigned a primary care manager (generally, a primary care physician, internal medicine physician, or general practitioner physician), who either provides care or authorizes referrals to specialists.

³⁸If beneficiaries had a primary care manager whose information had not yet been entered into UnitedHealth's provider database, they were only temporarily reassigned to a different primary care manager if they called to inquire about this issue.

process 100 percent of all referrals within 3 workdays, it is currently processing 99 percent of referrals within this time frame.³⁹ In addition, UnitedHealth officials told us that they currently use both automated and fax referral systems, depending on the MTF.

Call centers: TMA's oversight of UnitedHealth's plans for staffing its call centers was insufficient, which contributed to a delayed resolution of UnitedHealth's performance problems, which lasted until the third month of health care delivery. Specifically, UnitedHealth experienced difficulties in answering telephone calls within the required time frame on the first day of health care delivery. This was based, in part, on insufficient numbers of call center staff and staff who were not as efficient as UnitedHealth had anticipated, along with a higher-than-predicted call volume. For the month of April 2013, UnitedHealth officials expected about 23,500 calls each day, and they hired the number of staff they thought they would need to answer 90 percent of these calls (21,150) within 30 seconds, as required by the contract. However, during the first month of health care delivery, the daily number of calls received was about 24,000, and the number of calls answered within the required time frame ranged from a low of about 2,200 calls (9 percent) to a high of almost 16,000 calls (67 percent). To meet telephone response time requirements, UnitedHealth told us that they used staff from its other departments, subcontracted for additional staff, and hired more staff to alleviate the call center problems.⁴⁰ Once UnitedHealth hired and trained more call center staff, the staff from other departments and its subcontractor were returned to their previous responsibilities. UnitedHealth began meeting its telephone response time requirements in June 2013.

After the problems related to network providers, referral processing, and call centers transpired, TRO-West increased its oversight by sending UnitedHealth formal correspondence related to its failure to meet specific contractual requirements. After consulting with TRO-West officials, the Contracting Officer issued the first of three related corrective action

³⁹See *TRICARE Operations Manual 6010.56-M*, chapter 1, section 3, paragraph 1.2.1.

⁴⁰UnitedHealth subcontracted with several entities to meet the requirements of its contract. One of those entities, Health Net—the managed care support contractor in the North region—assisted with the hiring of about 100 staff to help alleviate call center problems.

requests—a written request for action describing missed contractual requirements—to UnitedHealth on April 5, 2013, for the referral delays and other issues. This corrective action request cited problems with referral processing and the entry of information about primary care managers into UnitedHealth’s provider database. Further, the request asked that UnitedHealth submit a corrective action plan—a plan demonstrating how the requirements would be met—as soon as possible. While the effect of these issues on the call centers was mentioned, the call center response times were not addressed in this request. However, the Contracting Officer determined that UnitedHealth’s initial response was vague and inadequate. As a result, he repeated the corrective action request process two more times in April 2013. Finally, on May 1, 2013, UnitedHealth submitted a corrective action plan that was deemed adequate by the Contracting Officer.

Additionally, based on UnitedHealth’s performance during the first 6 months of health care delivery, TMA-Aurora and TRO-West officials determined that UnitedHealth would be financially penalized through performance guarantees and award fees in accordance with contract requirements.

Performance guarantees: The West region managed care support contract includes performance guarantees, which are financial penalties based on the contractor’s performance in meeting certain requirements. Specifically, if a contractor does not meet requirements in six areas related to customer service and claims processing, such as answering 90 percent of phone calls from beneficiaries within 30 seconds and processing 100 percent of claims within 90 days, they are financially penalized. However, these six areas do not include all of the contract requirements that TMA identified for the seven key focus areas, such as referrals and provider network adequacy. Therefore, these guarantees do not reflect the contractor’s performance in those areas. TMA calculates whether the contractor meets these guarantees on a quarterly basis. If the contractor does not meet the requirement, TMA-Aurora uses a contractually defined formula to determine how much money it will be penalized. For the first and second quarter, TMA-Aurora officials determined that UnitedHealth would be penalized about \$134,000. A

majority of this penalty resulted from its failure to answer 90 percent of all customer service calls within the required 30 seconds.⁴¹

Award fee: The West region managed care support contract also includes financial incentives through an award fee, which is calculated twice a year and is based on the contractor's provision of exceptional service that is above and beyond contractual requirements. The determination of the award fee is based on a combination of the results of satisfaction surveys conducted of MTFs, beneficiaries, and providers on the contractor's performance (50 percent of the award fee) and an evaluation of the performance (the other 50 percent of the award fee).⁴² The survey portion of the award fee requires that a contractor must receive a composite score of 4.5 or higher on a scale of 6 to receive any portion of the payment. UnitedHealth received a composite score of 4 for the first 6 months of health care delivery. For the portion of the award fee based on an evaluation of UnitedHealth's performance, a panel of TMA officials, including both TMA-Aurora and TRO-West officials, determined that there were no occurrences where UnitedHealth's performance exceeded contractual requirements. Consequently, the panel recommended in December 2013 that UnitedHealth should not receive any portion of the over \$7 million potential award fee for the first 6 months of health care delivery.⁴³

In an effort to prevent similar transition difficulties in the future, TMA-Aurora officials updated the *TMA Transition User Guide* in May 2013 with several of the lessons learned from the West region transition, including ensuring that the contractor has pertinent information about all primary care managers entered into its provider database prior to the start of health care delivery and testing the contractor's referral interface prior to that date. However, while these updates are helpful, this guide remains

⁴¹While all of the contractors are evaluated using the same six criteria, the maximum amount the contractor could be penalized is negotiated as part of the contract and may vary by region. UnitedHealth's penalty was taken in April 2014.

⁴²The evaluation of the contractor's performance is conducted by several TMA officials, including the Contracting Officer, and these officials subjectively evaluate whether UnitedHealth exceeded contract requirements related to several areas, including maintaining an efficient referral management.

⁴³On an annual basis, the potential award fee for UnitedHealth is about \$15 million. While all of the contractors are evaluated using the same criteria, the amount of the award fee is negotiated as part of the contract and may vary by region.

limited because it is not sufficiently specific, and some of these changes would likely need to be formally incorporated into the managed care support contracts.

Conclusions

The transition of managed care support contractors in the West region did not go smoothly. Many problems arose that negatively affected TRICARE beneficiaries and potentially resulted in additional costs for DOD. UnitedHealth was the first new managed care support contractor since the TRICARE program began, and its transition highlighted numerous deficiencies in TMA's guidance and oversight. In particular, insufficient guidance on transition oversight contributed to a complacent approach by TRO-West officials, who did little to hold the contractor accountable during the transition, aside from holding informal conversations that were not always sufficiently documented. While TRO-West officials also cited the performance-based contract as a basis for their approach, this type of contract does not diminish their responsibility to provide an oversight structure to manage the contractor's performance in meeting requirements. Furthermore, TMA failed to ensure that the incoming and outgoing contractors used the same version of transition guidance, resulting in information gaps that were left largely to the contractors to resolve, contributing to UnitedHealth's delay in meeting transition requirements related to its provider network. And, while TMA did consider the possibility of extending the transition period, TRO-West officials cited a lack of sufficient information to make an informed decision at the time the decision was being considered. Moreover, the transition guidance for UnitedHealth also lacked sufficient detail for some requirements, including the development of a critical interface for managing specialty care referrals, which was not pretested to ensure that it was fully operational prior to health care delivery, unlike pretesting that was done for other system interfaces.

The confluence of these factors led to a particularly problematic start for health care delivery in TRICARE's West region, as evidenced by events such as call center failures and inordinate delays in processing specialty care referral authorizations. The latter problem necessitated that TMA waive its authorization requirements for 3 months—a costly workaround for DOD. Despite these difficulties, approximately 10 months after the start of health care delivery, TMA paid UnitedHealth the remainder of its \$10 million transition-in payment after UnitedHealth completed its transition requirements. Eventually, TMA did begin taking steps to hold the contractor accountable for the problems that surfaced, including the use of corrective action requests and financial penalties. In an effort to

prevent similar problems in future transitions, TMA also modified the guidance provided in the *TMA Transition User Guide*. However, the effectiveness of this modification is unclear because this guidance is not sufficiently specific and would likely require contractual changes. Without adequate guidance, DHA—which assumed oversight responsibility for TMA in 2013—cannot provide reasonable assurance that its efforts to oversee future managed care support contract transitions will be effective in ensuring that contractors are prepared for health care delivery, including meeting all contract requirements and appropriately serving their TRICARE beneficiaries.

Recommendations for Executive Action

To ensure that DHA provides appropriate levels of oversight and accountability to future managed care support contractor transitions, we recommend that the Secretary of Defense require the Director of DHA to review existing transition guidance, and revise as needed, to include sufficient specificity about

1. A requirement that all significant oversight communication between the TRO and the contractor be sufficiently documented, particularly communication regarding concerns about the contractor's ability to meet transition requirements and deadlines;
2. A requirement that the TROs and Contracting Officers have sufficient data and information from the contractor at a defined point in time to make an informed determination about whether to extend the transition period;
3. A process for identifying and monitoring all key focus areas, including the pretesting of key functions and interfaces prior to the start of health care delivery; and
4. A course of action for holding the contractor accountable for problems that transpire in meeting transition requirements or deadlines.

In addition, to ensure that future managed care support contractors have the information they need to successfully complete transition requirements and are fully prepared for health care delivery, we recommend that the Secretary of Defense require the Director of DHA to

5. Ensure that both the incoming and the outgoing contractors are using consistent versions of transition guidance;
6. Revise the contractors' transition guidance to contain clear definitions and an appropriate level of specificity, particularly for key focus areas identified by DHA, such as referral management; and

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7. Conduct a review of whether the transition-in payment should be designed to incentivize timely completion of transition requirements and deadlines.

Agency Comments

We provided a copy of this report to DOD for review and comment. DOD stated that we made two specific assertions that it wanted to clarify: (1) that TMA guidance and oversight during the transition period contributed to issues with health care delivery; and (2) that this is the first transition to a nonincumbent contractor since the start of the TRICARE program. In addition, with regard to the recommendations, DOD either concurred or partially concurred with all of our recommendations. DOD's written comments are reprinted in appendix II.

We disagree with DOD's statement that our report mischaracterized these two issues. With regard to our statement that TMA guidance and oversight during the transition period contributed to issues with health care delivery, DOD states that the report misinterprets two distinctly separate transition requirements: establishing an adequate provider network and transferring provider certification files for claims processing. While we understand that the establishment of an adequate network is the responsibility of the incoming contractor, our report notes that UnitedHealth expected to use the provider certification files from the outgoing contractor to help establish its own provider network. However, differences in specificity between the two versions of transition guidance for the incoming and outgoing contractors contributed to the delay of the transfer of these files. Furthermore, UnitedHealth spent several months working with the provider certification data they eventually received in order to make the data usable for its purposes—all of which contributed to UnitedHealth's delay in establishing an adequate provider network within required time frames. Ultimately, UnitedHealth did not meet its requirement to complete network development and load all of the provider files 60 days prior to health care delivery. TMA was slow to take action—waiting more than 2 months to send a corrective action request related to this missed requirement. Because UnitedHealth did not have information for all its civilian network providers entered into its provider database at the start of health care delivery, referrals and claims related to these providers had to be put on hold until UnitedHealth officials could complete the data entry process, potentially impacting beneficiaries' access to health care. Additionally, at the start of health care delivery, UnitedHealth officials told us that they had not entered information on primary care managers for 113,000 TRICARE Prime beneficiaries and that some of these beneficiaries had to be temporarily reassigned to a new primary

care manager until the data entry process was complete. Based on this evidence, we disagree with DOD's statement that issues arising from the transfer of the provider certification files would not impact access to health care delivery. We also disagree with DOD's statement that our finding to the contrary is an assertion rather than an objective assessment of the facts.

DOD also wanted to clarify our statement that the transition to the West region's contractor was the first transition to a nonincumbent contractor since the start of the TRICARE program. DOD noted that TMA has successfully transitioned a nonincumbent contractor for the delivery of health care services on numerous occasions. We believe that DOD misinterpreted our statement, because for the purposes of our report, we use the term "contractor" to refer to a managed care support contractor. Aside from citing MetLife Federal Dental Plan as an example, DOD listed three other contractors that previously participated in the first generation of TRICARE managed care support contracts. However, none of them participated in a TRICARE managed care support contract transition as a nonincumbent.⁴⁴ Therefore, we believe that our statement that UnitedHealth's transition in the West region represented the first transition to a nonincumbent managed care support contractor since the TRICARE program began is accurate.

In addition, DOD made the point that our report did not recognize numerous occasions when TMA representatives conducted onsite readiness reviews and pretesting activities and that it was important to note the government exacted numerous financial and other sanctions on UnitedHealth because of its inability to meet contract requirements. Our report acknowledges that TMA conducted readiness reviews and some pretesting activities. However, as stated in our report, TMA did not pretest UnitedHealth's referral process, which TRO-West officials told us would have been beneficial for determining whether the referral process would work prior to health care delivery. Furthermore, we believe it is important

⁴⁴The three other examples of contractors were Sierra Military Health System, Health Net Federal Services, and Anthem Alliance for Health, Inc. Although Sierra Military Health System and Anthem Alliance for Health, Inc., were contractors under the first generation of TRICARE managed care support contracts, neither participated in the transition to the second generation of contracts. In addition, Health Net Federal Services—formerly Foundation Federal Health Services—has been a contractor since the first generation of TRICARE contracts, and as a result, it has not participated in a TRICARE managed care support contract as a nonincumbent.

to stress that TMA did not exact any financial or other sanctions during transition. Specifically, as our report discusses, UnitedHealth was not always timely in meeting the transition requirements, yet it was not financially penalized. TMA did not issue any corrective action or financially related sanctions until after health care delivery. To date, TMA has provided evidence of two financially related sanctions—performance guarantees and award fees—which were discussed in our report. However, these financially related sanctions were for missed requirements that took place after health care delivery began, and were not imposed as a result of the missed transition requirements.

DOD concurred or partially concurred with each of our recommendations. However, DOD disagreed with some of the related findings upon which these recommendations were based. Additionally, despite its concurrence, DOD did not always provide details on how it plans to implement our recommendations. DOD's specific responses to each of our recommendations are as follows:

- DOD partially concurred with our first recommendation to require that all significant oversight communication between the TRO and the contractor be sufficiently documented. While DOD agreed with the substance of this recommendation, it disagreed with our finding that it could not provide us with sufficient documentation of the communication of its concerns to UnitedHealth about its ability to meet transition and performance requirements and deadlines. DOD noted that it provided thousands of pages of comprehensive documentation of both formal and informal correspondence with UnitedHealth—essentially stating that it is already meeting this recommendation and implying that no additional action is necessary. While we agree that DOD was able to provide documentation of its oversight, not all of it reflected its communication of specific concerns with UnitedHealth. For example, DOD could not provide documentation regarding its concerns about the call center staffing that UnitedHealth had proposed—discussions that UnitedHealth officials did not recall during our interviews. Further, the documentation of DOD's communications with UnitedHealth was largely dependent upon handwritten notes, which were difficult to understand without extensive explanation by DOD officials. We therefore continue to believe that our recommendation remains valid.

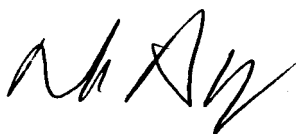
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- DOD concurred with our second recommendation to require that the TRO and Contracting Officers have sufficient data and information to make an informed determination about whether to extend the transition period. DOD's comments indicate that it has already undertaken steps to implement this action, but did not provide any time frames for when this activity would be complete.
 - DOD concurred with our third recommendation to require a process for the identification and monitoring of all key focus areas, including the pretesting of key functions. DOD noted in its comments that prior to our review, DHA began redefining contract requirements for transition and oversight. DOD added that this effort would include revised transition requirements for pretesting. In addition, DOD stated that an independent contractor will be used to assess key systems, interfaces, and performance.
 - DOD partially concurred with our fourth recommendation to review existing transition guidance and revise as needed to include sufficient specificity and accountability for meeting transition requirements or deadlines. DOD noted that during its review of existing transition guidance, it will consider whether specific guidance for the Contracting Officer is needed. Although DOD stated that contract administration matters require a certain degree of discretion and business judgment, we found that the Contracting Officer was inconsistent in using his authority to take formal action against UnitedHealth when it missed transition requirements. We therefore believe that implementing this recommendation is critical to ensure that future transitions—particularly those of nonincumbent contractors—proceed without incident.
 - DOD concurred with our fifth recommendation to ensure that both the incoming and the outgoing contractors are using consistent versions of transition guidance. However, DOD also noted in its comments that the progression from the 2002 manuals to the 2008 manuals did not create a wholesale change between the two versions and that the use of the two versions was not a contributory factor in the difficulties that transpired during the transition. While we agree that the changes in the manuals were not necessarily wholesale, there was a difference in the level of specificity, which UnitedHealth said contributed to problems with its transition. Specifically, the 2008 version noted that the outgoing contractor was required to provide the incoming contractor with copies of a provider certification file no later than 30 days after contract award, to be updated on a monthly basis until

the start of health care delivery. However, the 2002 version contained only a reference to the provider certification file, and did not define its contents, link it to other provider files specifically mentioned, or stipulate a time frame for producing it. Further, the 2002 version stated more generally that the outgoing contractor was required to provide full cooperation and support to the incoming contractor. Therefore, we continue to believe that the differences in the two versions of the manuals created an information gap, which UnitedHealth officials identified as an important factor that delayed development of its civilian provider network, and that action to respond to our recommendation is needed.

- DOD concurred with our sixth recommendation that the contractors' transition guidance should be revised to contain clear definitions and an appropriate level of specificity, particularly for key focus areas identified. DOD stated that the key focus areas with the associated risk for each area should be clearly identified with the appropriate level of specificity by DHA, while still ensuring that the contract language is not overly prescriptive to allow contractors to use best business practices. While we understand DOD's concern about not being overly prescriptive, we believe our findings illustrate why having clear definitions and sufficient specificity is vital to ensuring that future transitions are successful, and why action is needed.
- DOD also concurred with our seventh recommendation to conduct a review of whether the transition-in payment should be designed to incentivize timely completion of transition requirements and deadlines. In addition, DOD stated that the transition requirements should have both positive and negative incentives for the contractor to achieve satisfactory progress.

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. The report is also available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in appendix III.

A handwritten signature in black ink, appearing to read 'Debra A. Draper'.

Debra A. Draper
Director, Health Care

Appendix I: UnitedHealth’s Education and Outreach Efforts during Transition and the First 6 Months of Health Care Delivery

UnitedHealth began its transition to become the West region’s managed care support contractor on July 3, 2012, with health care delivery starting on April 1, 2013. As part of its contract, UnitedHealth is required to conduct outreach and hold briefings for beneficiaries at various military sites throughout its region and develop a provider education program that is designed to enhance providers’ awareness of TRICARE. In addition, all materials used to educate beneficiaries and providers on TRICARE must be approved by the Department of Defense.

In February 2013, UnitedHealth began providing briefings to beneficiaries about various aspects of TRICARE, including health coverage information related to retirement, dependents, and deployment. (See table 2 for briefings conducted through the first 6 months of health care delivery.) In addition, UnitedHealth distributed welcome packages to all beneficiary households in the region, which included a welcome letter and a brochure produced by the TRICARE Management Activity.

Table 2: Number of Beneficiary Briefings and Attendees from February 2013 through September 2013

Month	Number of briefings ^a	Number of attendees
February ^b	89	5,676
March	344	20,207
April	505	23,255
May	520	22,895
June	508	23,693
July	490	22,919
August	548	44,235
September	547	32,598
Total^c	3,551	195,478

Source: GAO analysis of documentation from UnitedHealth. | GAO-14-505

^aThe information at these briefings varied, including information about retirement, family members’ use of TRICARE, and deployment.

^bAccording to UnitedHealth officials, they began briefing beneficiaries on February 16, 2013, ahead of the scheduled April 1, 2013, departure of the outgoing contractor.

^cThis reflects the total number of beneficiary briefings and attendees from February 19, 2013, through September 30, 2013, the first 6 months of health care delivery.

The type of education that UnitedHealth offered to providers depended on whether the provider was new to UnitedHealth. Providers new to UnitedHealth received a general orientation about both TRICARE and UnitedHealth. Existing UnitedHealth providers received an orientation that included similar materials, but was premised on the providers’ familiarity

with UnitedHealth and its network programs and tools. In addition, UnitedHealth officials began conducting briefings to educate providers about TRICARE in February 2013. (See table 3 for briefings conducted through the first 6 months of health care delivery.)

Table 3: Number of Provider Briefings and Attendees from February 2013 through September 2013

Month	Number of briefings ^a	Number of attendees
February ^b	11	202
March	90	7,654
April	81	8,228
May	55	4,470
June	65	2,490
July	79	6,274
August	78	879
September	96	4,855
Total^c	555	35,052

Source: GAO analysis of documentation from UnitedHealth. | GAO-14-505

^aThese briefings were held as webinars or town hall meetings with providers.

^bAccording to UnitedHealth officials, the provider briefings began on February 1, 2013, which is when the provider materials from the West region's TRICARE Regional Office became available.

^cThis reflects the total number of provider briefings and attendees from February 1, 2013, through September 30, 2013, the first 6 months of health care delivery.

Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

28 May 2014

Ms. Debra Draper
Director, Defense Healthcare
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense response to the U.S. Government Accountability Office (GAO) Draft Report GAO-14-505, "DEFENSE HEALTH CARE AGENCY: More Specific Guidance Needed for TRICARE's Managed Care Support Contractor Transitions," dated April 30, 2014 (GAO Code 291157).

We would like to thank the GAO for providing the opportunity to address the recent report on TRICARE's West Region contract transition and the conclusions presented. The review was conducted at the request of the Honorable Patty Murray and the Honorable Mark Begich, United States Senators, to review issues related to transition activities by UnitedHealthcare Military and Veterans. GAO defined this request to capture a review of how the TRICARE Management Activity (TMA) provided guidance and oversight of the transition in preparation for health care delivery; and how, if at all, TMA's guidance and oversight during the transition contributed to issues with health care delivery. While we appreciate the GAO's recommendations, the agency would like to clarify the following two assertions stated in the report: a) TMA guidance and oversight during the transition period contributed to issues with health care delivery; and, b) this is the first transition to a non-incumbent contractor since the start of the TRICARE program.

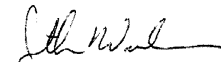
GAO contends inadequate guidance and insufficient oversight from TMA contributed to UnitedHealthcare Military and Veterans' difficulties meeting certain requirements, including creating its provider database which contributed to issues with healthcare delivery. The report misinterprets two distinctly separate transition requirements: establishing an adequate provider network and transferring provider certification files for claims processing. It is the sole responsibility of the incoming contractor to create an adequate provider network. UnitedHealthcare Military and Veterans' lack of success in developing an adequate network caused healthcare delivery issues. Similarly, transfer of provider certification files from the outgoing to the incoming contractor is essential for claims processing. Issues arising from such transfers might cause provider dis-satisfaction due to delay in payment of claims but would not impact access to healthcare delivery. The outgoing contractor attempted to accomplish the transfer of these provider certification files but UnitedHealthcare Military and Veterans was not prepared to receive them.

TMA has successfully transitioned a non-incumbent contractor for the delivery of healthcare services on numerous occasions. Examples of non-incumbent contractors are Sierra Military Health System, HealthNet Federal Services, Anthem Alliance for Health, Inc., and MetLife Federal Dental Plan. Thus, the West Region transition was not the first of its kind since the start of the TRICARE program.

I would like to mention that the report did not fully recognize numerous occasions when TMA government representatives conducted onsite readiness reviews and pretesting activities. It is important to note the government exacted numerous financial and other sanctions on UnitedHealthcare Military and Veterans because of their inability to execute contract requirements. Because of government dissatisfaction with their performance, UnitedHealthcare Military and Veterans implemented corrected action plans and removed senior leadership. Subsequent to these interventions, the government began to see an improvement in UnitedHealthcare Military and Veterans performance.

In conclusion, the report provides recommendations the Defense Health Agency will utilize to improve the healthcare transition process. DoD's response to this GAO's specific recommendations are enclosed. Thank you for the opportunity to respond.

Sincerely



Jonathan Woodson, M.D.

Enclosures:

- 1) Summary of Recommendations and DoD responses

**GAO DRAFT REPORT
DATED APRIL 30, 2014
GAO-14-505 (GAO CODE 291157)**

“DEFENSE HEALTH CARE: More Specific Guidance Needed for TRICARE’s Managed Care
Support Contractor Transitions”

**DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION**

RECOMMENDATION 1: The U.S. Government Accountability Office (GAO) recommends that the Secretary of Defense require the Director of Defense Health Agency (DHA) to review existing transition guidance, and revise as needed, to include sufficient specificity about a requirement that all significant oversight communication between the TRICARE Regional Office (TRO) and the contractor be sufficiently documented particularly communication regarding concerns about the contractors’ ability to meet transition requirements and deadlines.

DoD RESPONSE:

Partially Concur. Agree that all significant oversight communication between the government and the Contractor should be sufficiently documented, in particular, communication regarding concerns about the contractor’s ability to meet transition and performance requirements and deadlines. We disagree that sufficient documentation was not provided. During the West Region TRICARE Third Generation Transition review, Defense Health Agency provided GAO thousands of pages of comprehensive documentation by the government on formal and informal correspondence, to include meeting notes, emails, and voluminous transition oversight committee briefings slides that detailed the interaction between the government and the contractor. This documentation was provided by approximately 50 government personnel to include subject matter experts through senior leadership. We disagree with GAO determination that the documentation provided was insufficient evidence of the agency’s oversight actions.

RECOMMENDATION 2: The GAO recommends that the Secretary of Defense require the Director of DHA to review existing transition guidance, and revise as needed, to include sufficient specificity about a requirement that the TROs and Contracting Officers have sufficient data and information from the contractor at a defined point in time to make an informed determination about whether to extend the transition period.

DoD RESPONSE:

Concur w/Comment. We agree that transition guidance should include a methodology for ensuring data and information is available at milestone decision points to make an informed determination regarding the option to extend a transition period. We also agree that the TRICARE Regional Offices and Contracting Officers need sufficient data and information at a defined point in time to make an informed determination about whether to extend the contract period, and all other stakeholders need this same information (i.e., availability must also be made to program managers and leadership responsible for decision making). Prior to the GAO’s

review, DHA began redefining how requirements are written. This re-structuring of the transition and oversight is being made at the consultation and recommendation of Defense Acquisition University. Appointment of a Transition and Contracting Oversight Workgroup has been charted to define transition and oversight requirements.

RECOMMENDATION 3: The GAO recommends that the Secretary of Defense require the Director of DHA to review existing transition guidance, and revise as needed, to include sufficient specificity about a process for identifying and monitoring all key focus areas, including the pre-testing of key functions and interfaces prior to the start of the health care delivery.

DoD RESPONSE:

Concur w/Comment. Agree that a process for identifying and monitoring all key focus areas/requirements should be included in the transition guidance, including the pre-testing or benchmarking of key functions and interfaces prior to the start of the health care delivery. Furthermore, we believe the ability to perform the key focus areas/requirements should be evident during the evaluation of the contractor's bid. During the acquisition phase, contractor critical processes should be assessed for risk and deemed to meet requirements based on detailed industry performance in the submission packages. Additionally, in the acquisition phase, the government should select key critical areas to pre-test. For example, benchmark or pre-testing performed under the West Region TRICARE Third Generation transition included claims, stress-testing of eligibility checks, systems interfaces, enrollment and Primary Care Manager functions. In addition, the identification of key dependencies and milestones is a foundation of the updated requirements which are being developed. Of course, certain factors cannot be recreated in stress and benchmark testing (e.g., 40,000 live calls to a call center with inexperienced, untrained staff and unprepared systems). Again, prior to the GAO's review, the Defense Health Agency began re-defining how requirements are written. The revised transition requirements will include demonstration, testing, and benchmarking. In addition, the use of an Independent Validation and Verification contractor will be used to assess key systems and systems interfaces and performance.

RECOMMENDATION 4: The GAO recommends that the Secretary of Defense require the Director of DHA to review existing transition guidance, and revise as needed, to include sufficient specificity about a course of action for holding the contractor accountable for problems that transpire in meeting transition requirements or deadlines.

DoD RESPONSE:

Partially concur. While existing transition guidance will be reviewed for adequacy, the agency will consider whether specific instruction is needed to direct contracting officers when to take corrective action.

The report states that TRICARE Management Activity transition guidance "notes that the Contracting Officer has the authority to issue a corrective action request in response to the contractor's nonperformance, but does not provide sufficient detail on what level of

nonconformance would require such response, nor how long the Contracting Officer should wait before sending it.” Such contract administration matters require a certain degree of discretion and business judgment with which Contracting Officers are invested, trained, and trusted to exercise. Additionally, we are defining the key processes and ensuring the contractor can demonstrate the readiness of these key functions transition period. In addition, the contractor’s failure to fully meet defined critical milestones will result in significant penalties. The contractors will be held accountable for any performance shortfalls on critical functions.

RECOMMENDATION 5: The GAO recommends that the Secretary of Defense require the Director of DHA to ensure that both the incoming and outgoing contractors are using consistent version of transition guidance.

DoD RESPONSE:

Concur. Defense Health Agency uses four manuals (Operations, Policy, Systems, and Reimbursement) to UnitedHealthcare Military & Veterans provide specific guidance to purchased care contractors. These manuals are incorporated by reference into the respective purchased care contracts. The previous Managed Care Support Contractor for the West Region (TriWest) used the 2002 version of the manuals. The current Managed Care Support Contractor for the West Region (UnitedHealthcare Military & Veterans) uses the 2008 version of the manuals. These two manuals contain basically the same transition requirements for incoming and outgoing transition requirements. These manuals are continually updated as appropriate and the updates are then incorporated into the various purchased care contracts by modification. The 2008 version of the manuals are essentially a continuation of the 2002 version of the manuals. The reason for implementing the 2008 version was to reestablish a base line for the TRICARE Third Generation (T-3) suite of purchased care contracts based on the 2002 versions and to also address those requirements that are unique to the T-3 suite of contracts. The progression from the 2002 manuals to the 2008 manuals did not create a wholesale change between the two versions of the manuals and the use of the two versions was not a contributory factor.

RECOMMENDATION 6: The GAO recommends that the Secretary of Defense require the Director of DHA to revise the contractors transition guidance to contain clear definitions and an appropriate level of specificity, particularly for key focus areas identified by DHA, such as referral management.

DoD RESPONSE:

Concur w/Comment. Agree that the government should clearly identify the key focus areas with the associated risk for each area and provide the appropriate level of specificity for those key focus areas identified by DHA, while at the same time ensuring that the contract language is not overly prescriptive to allow contractors to use best business practice. In regard to referral management and other areas, the emphasis should be on clear definitions and specificity in the government referral system and in expectations for interface by the contractor.

RECOMMENDATION 7: The GAO recommends that the Secretary of Defense require the Director of DHA to conduct a review of whether the transition-in payment should be designed to incentivize timely completion of transition requirements and deadlines.

DoD RESPONSE:

Concur w/Comment. Agree that the contract transition requirements should be designed to incentivize timely completion of transition requirements and deadlines. However, the incentives should encompass both positive and negative incentives for the contractor to achieve satisfactory progress against pre-established milestones.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Debra Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Danielle Bernstein; Jacquelyn Hamilton; Jeffrey Mayhew; Laurie Pachter; and Bill Woods made key contributions to this report.

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