



November 2019

DEFENSE HEALTH CARE

Opportunities to Improve Future TRICARE Managed Care Support Contract Transitions

Accessible Version

Highlights of [GAO-20-39](#), a report to congressional committees

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Why GAO Did This Study

DOD contracts with private sector companies—referred to as managed care support contractors—to deliver health care services to its TRICARE program beneficiaries through networks of civilian providers. In July 2016, DOD awarded its fourth generation of TRICARE contracts, referred to as T-2017, for management of civilian providers in its two regions (East and West). For new TRICARE contracts, DOD provides a transition period—usually 9 to 12 months—for the incoming and outgoing contractors. During this time, the incoming contractors must take specific steps to prepare for health care delivery.

The John S. McCain National Defense Authorization Act for Fiscal Year 2019 included a provision for GAO to review the T-2017 transition. This report examines (1) how the requirement to implement TRICARE Select affected the transition, (2) challenges DOD experienced executing the T-2017 transition process, and (3) how DOD addressed problems after the start of health care delivery. GAO reviewed and analyzed DOD guidance, contract requirements, and other relevant documentation, and interviewed DOD officials, TRICARE contractors, and other stakeholders.

What GAO Recommends

GAO is making three recommendations to improve future contract transitions, including that DOD improve the specificity of its transition guidance and have subject matter experts review oversight requirements. DOD concurred with GAO's recommendations and identified steps the department is taking to address them.

November 2019

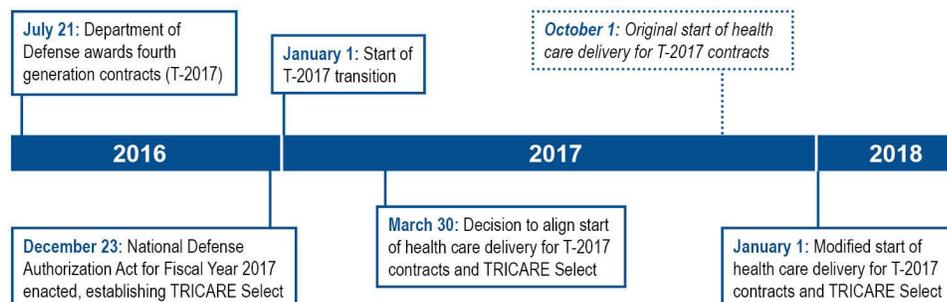
DEFENSE HEALTH CARE

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What GAO Found

The implementation of a required new health care benefit option delayed aspects of the transition to the Department of Defense's (DOD) fourth generation of TRICARE managed care support contracts (T-2017). The National Defense Authorization Act for Fiscal Year 2017 required DOD to implement TRICARE Select, a new preferred provider benefit option. As a result, DOD delayed the start of health care delivery—the date the incoming T-2017 contractors would assume responsibility for managing health care—from October 1, 2017, to January 1, 2018, to align with the mandated implementation date for TRICARE Select. DOD also delayed and lengthened a planned period for the department to make changes to beneficiary information in TRICARE's eligibility system. According to DOD and its contractors, this delay contributed to problems with enrollment processing backlogs that were not addressed until several months after health care delivery began.

Timeline of the Fourth Generation (T-2017) TRICARE Contract Transition



Source: GAO analysis of DOD information. | GAO-20-39

DOD experienced challenges during the T-2017 transition that resulted from weaknesses with its transition guidance and oversight. Specifically, DOD's guidance does not always specify the amount and types of data outgoing contractors have to share with incoming contractors. This led to contractor disagreements over data transfers, which DOD did not always resolve in a timely manner. Contractors reported that these issues contributed to problems after health care delivery began for the T-2017 contracts, such as with processing referrals. DHA also determined that some of DHA's oversight requirements, such as for specialty care referrals, were not feasible or effective, which limited some testing of contractors' readiness for health care delivery. This occurred in part because DOD's relevant subject matter experts did not review the requirements.

DOD addressed most of the problems that occurred after health care delivery began by requiring the contractors to develop and implement corrective action plans. DOD and contractors are addressing some problems that have persisted, including problems with the contractors' provider directory accuracy in both regions and claims processing in one region. DOD has an opportunity to avoid similar problems in the future by improving the specificity of its transition guidance and effectiveness of its oversight requirements.

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Abbreviations

DHA	Defense Health Agency
DMDC	Defense Manpower Data Center
DOD	Department of Defense
MTF	military treatment facility
NDA 2017	National Defense Authorization Act for Fiscal Year 2017
PCM	primary care manager
PRV	Performance Readiness Validation
PRAV	Performance Readiness Assessment and Verification

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November 21, 2019

The Honorable James M. Inhofe
Chairman
The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Adam Smith
Chairman
The Honorable Mac Thornberry
Ranking Member
Committee on Armed Services
House of Representatives

In fiscal year 2018, approximately 9.5 million servicemembers and other beneficiaries were eligible to receive health care services through TRICARE, the Department of Defense's (DOD) regionally structured health care program.¹ Under TRICARE, beneficiaries can obtain these services 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. In its TRICARE regions, DOD contracts with private sector companies—referred to as managed care support contractors—to manage its purchased care system. Their responsibilities include developing and maintaining networks of civilian providers and performing other customer service functions, such as processing claims, enrolling beneficiaries, and assisting beneficiaries with finding providers. In fiscal year 2018, purchased care accounted for about 54 percent of the total costs for health care services delivered to TRICARE beneficiaries.

Within DOD, the Defense Health Agency (DHA) is responsible for the TRICARE program, including awarding and overseeing the TRICARE managed care support contracts. In July 2016, DHA awarded its fourth generation of TRICARE contracts, referred to as the T-2017 contracts.

¹Generally, TRICARE beneficiaries include active duty personnel and their dependents, National Guard and Reserve servicemembers and their dependents, and retirees and their dependents or survivors. Active duty personnel include Reserve component members on active duty for more than 30 days.

For these contracts, DHA consolidated its three TRICARE regions (North, South, and West) into two regions (East and West). Additionally, the National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017), enacted in December 2016, required DOD to implement a number of changes to the TRICARE program—some of which affected the T-2017 contracts—including a new benefit option called TRICARE Select.²

To ensure that its incoming contractors are prepared for their new responsibilities, DHA provides a 9-to-12 month transition period between its outgoing and incoming contractors. During this time, the incoming contractors engage in specific transition activities, such as establishing a sufficient civilian provider network for their regions and setting up customer service call centers. The transition period for the T-2017 contracts began on January 1, 2017 and ended on January 1, 2018, when the incoming contractors assumed full responsibility for health care delivery under the new contract—referred to as the start of health care delivery.

If the transition is not fully successful, contractors may experience problems meeting contract requirements after the start of health care delivery. Our 2014 review of the contract transition for the third generation of contracts, referred to as the T-3 contracts, identified issues with DHA's guidance for and oversight of the transition process that contributed to problems the West region contractor experienced after the start of health care delivery.³ DHA implemented our recommendations from that report to improve its transition guidance and oversight. More recently, the department has reported that the T-2017 contractors have also experienced some problems after start of health care delivery.

The John S. McCain National Defense Authorization Act for Fiscal Year 2019 and the accompanying House Report 115-676 contained provisions for us to examine DOD's oversight of the transition of its TRICARE managed care support contracts.⁴ In this report, we

²Pub. L. No. 114-328, § 701, 130 Stat. 2000, 2180–2193 (2016). TRICARE Select is a preferred provider health plan option with enrollment requirements for beneficiaries. It is intended to modernize the TRICARE benefit and improve beneficiary access to care.

³GAO, *Defense Health Care: More Specific Guidance Needed for TRICARE's Managed Care Support Contractor Transitions*, [GAO-14-505](#) (Washington, D.C.: June 18, 2014).

⁴Pub. L. No. 115-232, § 737, 132 Stat. 1636, 1821-1822 (2018); H. Rep. No. 115-676, pt.1, at 130-131 (2018).

-
1. describe how the requirement to implement TRICARE Select affected the transition to the T-2017 contracts,
 2. examine challenges DHA experienced executing the T-2017 transition process, and
 3. describe DHA's efforts to address problems after the start of health care delivery under the T-2017 contracts.

To describe how the requirement to implement TRICARE Select affected the transition for the T-2017 contracts, we analyzed relevant DHA transition documentation related to TRICARE Select, including documentation of DHA's transition meetings and written communications with contractors, as well as the draft and final TRICARE Select policies. We also analyzed DHA's "after action" report on the T-2017 transition to identify issues related to the implementation of TRICARE Select. We interviewed officials from DHA, including the deputy director, transition managers, and contracting officers for each TRICARE region, as well as the incoming and outgoing contractors, two military services' medical commands (Army and Air Force), and the Defense Manpower Data Center (DMDC)—DOD's central access point for information on eligibility for benefits—to discuss their experience with TRICARE Select implementation during the transition.

To examine challenges DHA experienced executing the T-2017 transition process, we analyzed DHA transition requirements and guidance for the T-2017 contracts, relevant modifications to the T-2017 contracts, and relevant sections of the TRICARE Operations Manual.⁵ We also analyzed DHA's "after action" reports on the T-3 and T-2017 transitions to identify challenges with the T-2017 transition as well as actions DHA took to address lessons learned from the T-3 transition. In addition, we reviewed DHA meeting minutes, correspondence with contractors, and DHA's new oversight methods for the T-2017 transition, which included performance readiness requirements and financial penalties for not meeting certain requirements. We reviewed DHA's guidance and oversight for the TRICARE contract transitions in the context of federal standards for internal control related to implementing control activities and monitoring

⁵The TRICARE Operations Manual, which is incorporated into the TRICARE contracts, provides guidance and requirements for both the incoming and outgoing contractors. Chapter 2 of the 2015 version of the manual includes guidance and requirements for T-2017 contract transition.

for the timely resolution of issues.⁶ We interviewed officials from DHA, including DHA leadership, regional transition leads, the contracting officers for each region, communications staff, and other DHA officials, as well as the incoming and outgoing contractors and DMDC. We also interviewed stakeholders from the military services' medical commands and an organization representing TRICARE beneficiaries to obtain their perspectives on transition challenges and the impact on beneficiaries.

To describe DHA's efforts to address problems after the start of health care delivery, we analyzed relevant documentation, such as DHA's procedures for addressing contractors' deficiencies in meeting contract requirements, which included the corrective action requests issued by DHA, the corrective action plans developed by the contractors, and other related communications between DHA and its contractors. We also interviewed officials from DHA and the incoming T-2017 contractors to discuss reasons for problems after health care delivery and how the problems were addressed, including information on the status of contract requirements that the contractors were not meeting as of June 2019.

We conducted this performance audit from December 2018 to November 2019 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.

Background

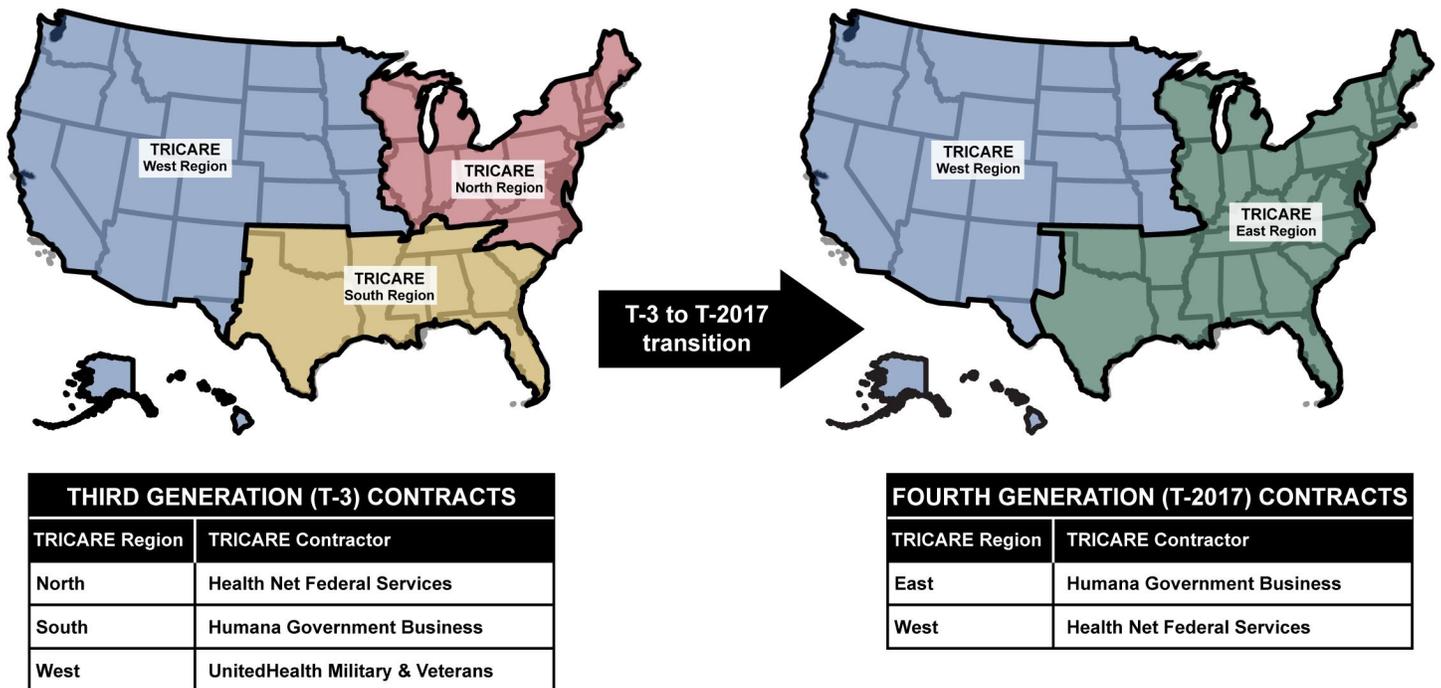
TRICARE T-2017 Contracts and Transition Process

Under T-2017, DHA reduced the number of TRICARE regions by merging the North and South regions to form the East region, which has approximately 6 million beneficiaries, while the West region remained the same with approximately 3.4 million beneficiaries (see figure 1). In July 2016, DHA awarded the East region contract to Humana Government Business, the incumbent South region contractor, and the West region contract to Health Net Federal Services, the incumbent North region

⁶GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014).

contractor.⁷ The T-2017 contracts include five 1-year performance periods and are scheduled to expire on December 31, 2022.

Figure 1: Changes in the TRICARE Regions and Contracts from the Third to the Fourth Generation of Managed Care Support Contracts



Source: Department of Defense. | GAO-20-39

As a result of the changes in regional structure, the T-2017 contract transition included a transition from Health Net Federal Services (North region) and Humana Government Business (South region) to Humana Government Business in the East region as well as a transition from UnitedHealth Military & Veterans to Health Net Federal Services in the West Region. The start of the T-2017 transition was initially planned for August 2016, with a health care delivery start date of August 2017. However, due to bid protests filed against each contract, the transition

⁷A third contractor administers purchased care outside of the United States.

start date was pushed out to January 1, 2017 with a health care delivery start date of October 1, 2017.⁸

To manage the T-2017 transition, DHA assigned individuals to lead the transition in each region, who were responsible for coordinating all major transition activities. The transition leads were supported by other staff, including contracting officers, contracting officer representatives, and subject matter experts.⁹ In addition, DHA established an organizational structure comprised of several groups to oversee the T-2017 transition from day-to-day oversight to leadership updates.¹⁰

The TRICARE Operations Manual, which is part of the managed care support contract, establishes transition guidance that includes requirements for both the incoming and outgoing contractors.¹¹ The T-2017 transition guidance focused on the incoming contractors' readiness to perform in seven critical areas: (1) provider network, (2) referral management, (3) enrollment, (4) medical management, (5) claims processing, (6) customer service, and (7) management.

For the T-2017 transition, DHA introduced two new oversight methods to ensure contractors' readiness in the seven critical areas prior to the start

⁸In the West region, the outgoing contractor, UnitedHealthcare Military & Veterans, filed a bid protest against DHA's decision to award the contract to Health Net Federal Services. In the East region, UnitedHealthcare Military & Veterans and the outgoing North region contractor, Health Net Federal Services, filed bid protests against DHA's decision to award the contract to Humana Government Business. The Comptroller General denied the bid protests on November 9, 2016. A bid protest is a challenge to the terms of a solicitation or the award of a federal contract that is adjudicated by GAO.

⁹The contracting officer has authority to direct the contractors to take specific actions and is responsible for making any modifications to the contract, if needed. Changes to TRICARE managed care support contracts are made through contract modifications—written directives from the DHA contracting officer to the contractor directing changes under the contract. The contracting officers' representatives worked with the subject matter experts as the primary liaisons and facilitators for government-contractor interactions, such as weekly meetings.

¹⁰The transition oversight organizational structure was comprised of three main groups—a Transition Task Force of transition managers, subject matter experts, and stakeholders that met every other week to oversee day-to-day implementation; a Transition Executive Committee that met monthly to make executive-level decisions; and a Transition Governance Council that met bi-monthly to keep DHA director-level leadership informed of transition activities.

¹¹The TRICARE contracts include references to all of the TRICARE manuals. The other manuals include the TRICARE Policy Manual, the TRICARE Reimbursement Manual, and the TRICARE Systems Manual.

of health care delivery. These methods and other guidance are outlined in the TRICARE Operations Manual and T-2017 contracts.

- The performance readiness validation (PRV) and performance readiness assessment and verification (PRAV)—referred to as PRV/PRAV—tested contractors’ functionality in the seven critical areas outlined in the TRICARE Operations Manual. For the PRV, contractors validated their own readiness for specific requirements within each area. For example, the contractor had to validate that it had a complete provider directory online and operational 60 days prior to the start of health care delivery at a 95 percent accuracy rate. The number of requirements varied by critical area. For the PRAV, DHA subsequently assessed and verified contractors’ validation prior to the start of health care delivery.
- DHA also established financial penalties—referred to as transition performance guarantees—for five of the seven critical areas.¹² The T-2017 contracts specify that if a contractor does not meet a transition-in requirement in any one of these five areas, DHA will assess a financial penalty (see table 1).

¹²The five areas are 1) provider networks (loading of network provider information into systems), 2) enrollment, 3) customer service (call center accuracy), 4) referral management, and 5) claims processing.

Table 1: Seven Critical Areas for the T-2017 TRICARE Managed Care Support Contract Transition and Areas with Associated Financial Penalties

Critical area	Description	Financial penalty ^a
1. Provider network	The contractor shall establish and maintain networks of individual and institutional providers for TRICARE that produce the best quality clinical outcomes for TRICARE beneficiaries. The contractor shall also maintain an online directory of network providers with a minimum of 95% accuracy.	Yes
2. Referral management	The contractor shall establish and maintain a referral management program in accordance with the TRICARE Operations Manual.	Yes
3. Enrollment	The contractor shall perform enrollments, re-enrollments, disenrollments, transfer enrollments, correct enrollment discrepancies, and assign or change the Primary Care Manager.	Yes
4. Medical management	The contractor shall establish and maintain a medical management program that includes the requirements in the TRICARE Operations Manual. The contractor shall ensure that care provided, including mental healthcare, is medically necessary and appropriate and complies with the TRICARE benefits.	No
5. Claims processing	The contractor shall maintain and establish an automated claims processing system for TRICARE claims.	Yes
6. Customer service	The contractor shall provide comprehensive readily accessible customer services for TRICARE-eligible beneficiaries and providers.	Yes
7. Management	The contractor shall establish and maintain experienced and qualified key personnel and sufficient staffing and management support to meet the requirements of the contract.	No

Source: GAO analysis of TRICARE managed care support contracts | GAO-20-39

^aThe T-2017 managed care support contracts included financial penalties for five of the seven critical areas—known as transition performance guarantees. The T-2017 contracts specify that if a contractor does not meet a transition-in requirement in any one of these five areas, DHA will assess a financial penalty.

In December 2016—prior to the start of the transition—DHA held transition specification meetings with the incoming and outgoing contractors to begin planning critical T-2017 transition activities. The incoming contractors were also required to provide DHA with an integrated master plan and an integrated master schedule outlining processes and specific steps for the transition as well as a risk management plan that identified risks to the successful execution of the contractor’s schedule. Contractors were required to provide weekly updates to DHA on the status of their transition schedule progress.

In April 2018—several months after the transition had ended—DHA produced an “after action” report to identify best practices, lessons learned, and recommendations to improve future TRICARE contract transitions. DHA is currently in the process of developing its fifth generation of contracts, referred to as the T-5 contracts.

TRICARE Select

As required by the NDAA 2017, DHA established a new preferred provider benefit option called TRICARE Select and terminated the TRICARE Standard and Extra benefit options by January 1, 2018. Prior to 2018, beneficiaries primarily had a choice between three basic options—TRICARE Prime (a managed care option), TRICARE Standard (a fee-for-service option), or TRICARE Extra (a preferred provider organization option).¹³ The TRICARE Standard and Extra options did not require beneficiaries to enroll. However, beneficiaries who choose the TRICARE Select option must enroll during an annual open enrollment period or within 90 days of experiencing a qualifying life event. Beneficiary cost sharing responsibilities were also modified for the new benefit option.¹⁴

DHA Delayed Time Frames for Key Transition Activities to Implement TRICARE Select

The implementation of TRICARE Select delayed timeframes for the T-2017 transition and was the primary challenge of the T-2017 transition, according to DHA and contractor officials. Because the T-2017 contracts were awarded prior to the enactment of the NDAA 2017, DHA had to incorporate TRICARE Select requirements into the ongoing T-2017 transition process, including developing updated guidance for contractors. As a result of the time needed to plan for and implement a new benefit, DHA delayed timeframes for the following key transition activities.

- **DHA postponed the start of health care delivery by 3 months.** DHA moved the start of health care delivery from October 1, 2017 to January 1, 2018 (see fig. 2). According to DHA officials, DHA made

¹³Active duty servicemembers are required to use TRICARE Prime. TRICARE Select is available to family members of active duty servicemembers, family members of National Guard or Reserve members who are activated for more than 30 days, certain retirees, retiree family members, survivors, and certain other eligible groups. TRICARE offers several other plans, including TRICARE Reserve Select (for certain Selected Reserve members and their dependents), TRICARE Retired Reserve (for certain retired Reserve servicemembers and their families), and TRICARE Young Adult (for servicemembers' dependents who are at least age 21 but not yet 26 years old). TRICARE also offers TRICARE for Life to beneficiaries who are eligible for Medicare and enroll in Part B. Under TRICARE for Life, TRICARE processes claims after they have been adjudicated by Medicare.

¹⁴P.L. 114-328, § 701. Pub. L. No. 114-328, § 701(a)(1).

this change to align the start of health care delivery with the implementation of TRICARE Select to minimize the impact that two, successive changes could have had on the continuity of care for beneficiaries. On March 30, 2017—three months into the transition—DHA sent a letter to the contractors informing them of this decision. DHA also directed its incoming contractors to submit modified transition schedules and risk management plans.

- **DHA had to delay the start of a planned enrollment freeze and lengthen its duration.** According to DHA officials, in a typical transition, DMDC requires 3 to 4 days to make adjustments to beneficiaries' records in the Defense Enrollment Eligibility Reporting System, including assigning beneficiaries to incoming contractors and regions for the T-2017 contracts.¹⁵ During this time, which is referred to as an enrollment freeze, contractors cannot access this system to process any enrollments. For the T-2017 transition, DHA and DMDC officials stated that, given the termination of two benefit options and the new enrollment requirements for TRICARE Select, DMDC needed additional time to adjust every beneficiary enrollment record (over 9 million). Therefore, DHA delayed the start of the T-2017 enrollment freeze from August to December 2017 and increased its duration from 3 to 4 days to 19 days—December 1-19, 2017 (see fig. 2).
- **Contractors had less time to process enrollments and make other system changes.** Once an enrollment freeze has ended, incoming and outgoing contractors have a designated period of time, referred to as a dual operations period, to process beneficiaries' enrollments and make other systems changes, such as assigning Prime beneficiaries to a primary care manager (PCM).¹⁶ Due to the extended enrollment freeze, contractors had a shorter dual operations period—less than 2 weeks in December 2017 rather than 6 to 8 weeks beginning in August 2017 (see fig. 2). According to contractors, the shorter dual operations period for T-2017 transition contributed to a backlog of enrollment requests and PCM assignments that they were unable to process prior to the start of health care delivery. To mitigate the financial effect on beneficiaries, DHA issued point of

¹⁵DMDC serves as DOD's central access point for information on benefits, including TRICARE. It manages beneficiaries' health care and personnel information in the Defense Enrollment Eligibility Reporting System database, used to determine eligibility for military benefits for all active duty servicemembers, military retirees, and their dependents.

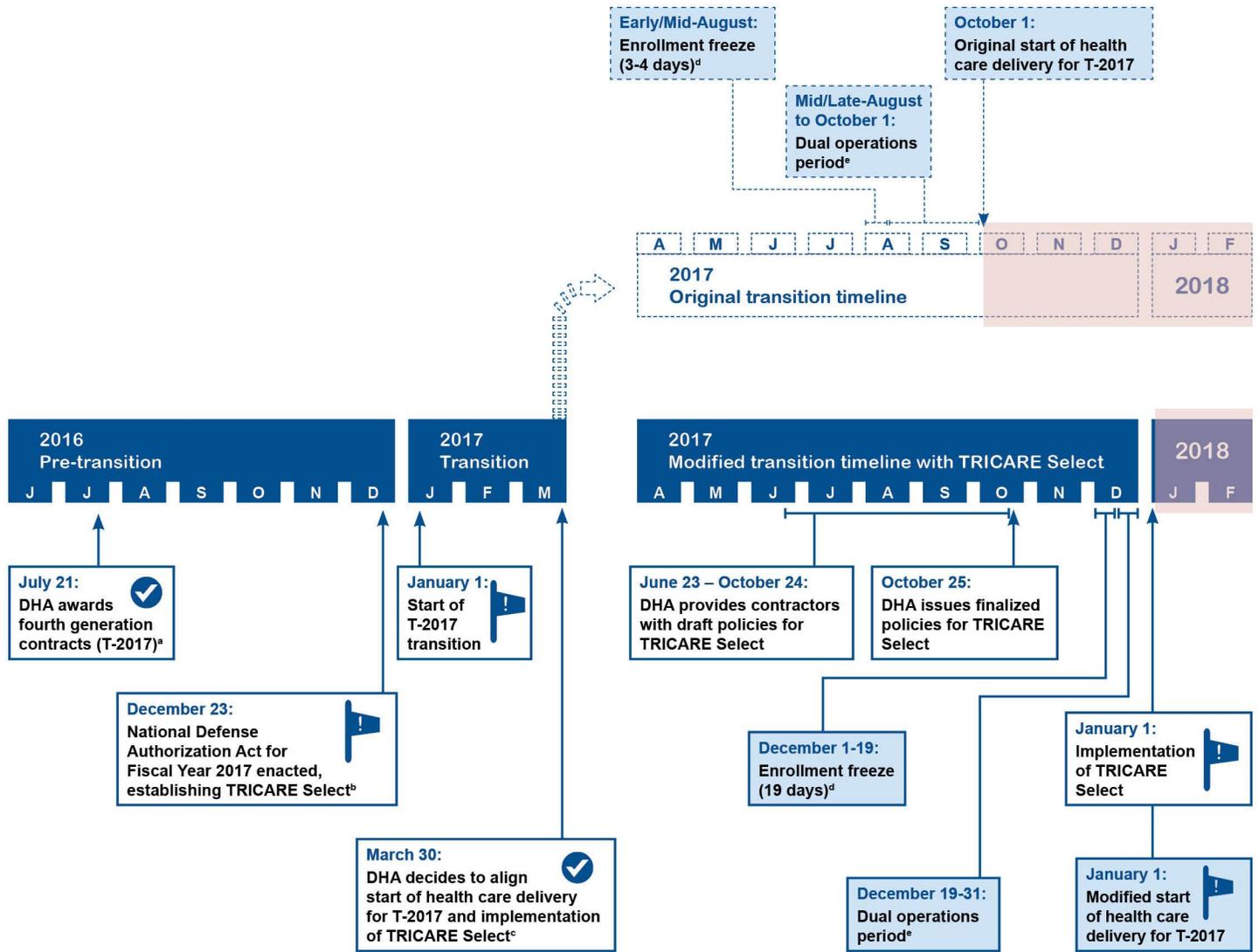
¹⁶A PCM (generally, a primary care physician, internal medicine physician, or general practitioner physician) is assigned to TRICARE Prime beneficiaries and provides care or authorizes referrals to specialists. TRICARE Select beneficiaries are not assigned a PCM.

service waivers and waived referral requirements for TRICARE Prime enrollees for both regions and provided an enrollment grace period for beneficiaries so they did not have to pay higher copayments for receiving care from non-network providers or care that was not referred by a PCM.¹⁷

- **DHA’s communications to TRICARE beneficiaries were delayed.** TRICARE Select complicated and delayed DHA’s communications to beneficiaries about TRICARE program changes, which led to customer service problems after the start of health care delivery. DHA engaged in various efforts to inform beneficiaries of the new changes, such as through website updates, blog posts, and direct mailings. However, DHA’s “after action” report acknowledged that on multiple occasions its communication division posted incorrect information on its website because of changing policy language. In addition, DHA planned to send a direct mailing to beneficiaries to inform them of TRICARE program changes in October 2017. However, DHA and DMDC officials told us that this date was delayed due to the additional time needed to prepare for TRICARE Select. As a result, DHA mailed information to beneficiaries starting in December 2017, and some beneficiaries did not receive this mailing until after the start of health care delivery, according to DHA. An organization representing TRICARE beneficiaries told us that some beneficiaries were unaware of the various benefit changes that went into effect on January 1, 2018 because of inadequate communication from DHA. Contractors also told us that the delayed communication to beneficiaries contributed to the high volume of customer service calls they received after the start of health care delivery.

¹⁷Without the waivers, beneficiaries whose enrollments were not processed until after the start of health care delivery could be charged point of service costs if they received care from a civilian provider not in the TRICARE network. The enrollment grace period allowed beneficiaries to elect to enroll in or change their TRICARE coverage anytime during calendar year 2018 outside of an annual open season enrollment period and without a qualifying life event to ensure beneficiaries had the opportunity to enroll in a TRICARE plan that best met their health care needs.

Figure 2: Timeline of the Defense Health Agency’s (DHA) Fourth Generation (T-2017) TRICARE Managed Care Support Contract Transition and TRICARE Select Implementation



Source: GAO analysis of DHA information. | GAO-20-39

^aDHA awarded the fourth generation TRICARE managed care support contracts (T-2017) to Humana Government Business for the East region and Health Net Federal Services for the West region.

^bThe National Defense Authorization Act for Fiscal Year 2017 required DHA to establish a new self-managed preferred provider option called TRICARE Select no later than January 1, 2018. It also terminated two basic health plan options—TRICARE Standard, a fee-for service option, and TRICARE Extra, a preferred provider organization option. Pub. L. No 114-328, §§ 701(a)(1) and (e), 130 Stat. 2000, 2180, 2187 (2016).

^cThe start of health care delivery is the date that incoming contractors assume responsibility for administering health care under the TRICARE contracts from the outgoing contractors.

^dDuring an enrollment freeze, the Defense Manpower Data Center stops all beneficiary enrollment activities to convert beneficiary records for the new contracts in the Defense Enrollment Eligibility Reporting System.

^eDuring a dual operations period, incoming contractors process beneficiaries' enrollments and make systems changes, such as assigning beneficiaries to a primary care manager.

DHA officials told us that they took several steps to minimize the risks these delays and the implementation of TRICARE Select created, including the use of various transition oversight meetings to discuss and track related challenges. For example, the regional transition management staff participated in a monthly Risk Review Board meeting to discuss concerns related to the schedule of transition activities, such as the impact of TRICARE Select on the time needed for performance testing in critical areas. DHA also discussed transition risks related to TRICARE Select during weekly meetings with contractors throughout the transition. Furthermore, in August 2017, DHA hosted an Enrollment Summit for all stakeholders involved with the transition and implementation of TRICARE Select, where they discussed the schedule of transition steps and the coordination needed to implement the interrelated T-2017 and NDAA 2017 requirements.¹⁸

In addition, DHA kept contractors informed about TRICARE Select as they developed the related policies. Beginning in June 2017, DHA provided contractors with draft guidance on the new benefit to keep them informed of potential changes and obtain their feedback. According to DHA, this also allowed contractors to plan for and begin implementing the program changes they would be required to make once the policies were finalized. DHA issued the final TRICARE Select policies to its contractors in late October 2017, which left contractors with less than 3 months to implement the finalized changes prior to the start of health care delivery on January 1, 2018. According to DHA officials and contractors, contractors ideally would have had the final TRICARE policies at the start of the 9-to-12 month transition period.

¹⁸Attendees included DHA's subject matter experts, contracting officers, contracting officer representatives, Strategic Communications Division, the managed care support contractors, and the military services' representatives.

Challenges Experienced during the T-2017 Transition Process Reflect Weaknesses in DHA's Guidance and Oversight

Lack of Specificity and Accuracy in DHA's Guidance Contributed to Disagreements between Contractors, Which DHA Failed to Resolve in a Timely Manner

During the T-2017 transition, outgoing and incoming contractors had disagreements over data transfers. According to DHA officials and contractors, DHA's transition guidance to contractors was not always specific or accurate regarding the amount and type of data to be shared, as well as how these data should be transferred. Furthermore, according to contractors, DHA did not always resolve contractors' guidance-related disagreements in a timely manner. Contractors said this contributed to delays in implementing some transition steps and problems after the start of health care delivery. DHA faced challenges related to the following data transfer issues:

- **Referral and authorization data.** The contractors in the West region disagreed on how many years of historical referral and authorization data the outgoing contractor would provide the incoming contractor because this was not specified in the guidance, according to the contractors and DHA's contracting officers.¹⁹ While the contractors in the East region mutually agreed on the years of data to transfer, the West region contractors did not. As a result, the incoming West region contractor reached out to DHA for resolution on August 2, 2017 by letter, and continued to discuss it with DHA officials during weekly meetings, as documented in meeting minutes we reviewed. However, DHA did not address the issue until December 12, 2017, at which point DHA rejected the incoming contractor's request for additional historical data because the outgoing contractor would not have enough time to provide it by the start of health care delivery on January 1, 2018. The incoming contractor reported that not receiving the anticipated historical referral information contributed to several problems related to referrals after the start of health care delivery.

¹⁹Beneficiaries enrolled in TRICARE Prime must generally obtain referrals for their specialty care. Contractors issue preauthorizations/authorizations for referral requests.

First, it contributed to delays in processing referrals within timeliness standards.²⁰ Second, the lack of data made it difficult for contractors to help MTFs address customer referral inquiries, which negatively affected the contractor's relationship with MTFs. Finally, the contractor had limited ability to resolve beneficiaries' customer service questions related to referrals and had to reissue authorizations for some referrals.

- **Claims data.** The incoming and outgoing West region contractors also disagreed on which elements of claims data needed to be transferred. For example, the incoming contractor requested information from the claims notes section, which the outgoing contractor stated contained some proprietary information. According to the incoming contractor, this section typically contains information important for claims processing, such as medical necessity reviews—medical record reviews to determine that health care services are appropriate for payment. When the outgoing contractor refused to provide the claims notes, the incoming contractor raised the issue several times to DHA during weekly meetings and through letters, as documented in meeting minutes and correspondence we reviewed. However, DHA determined that the outgoing contractor did not need to provide the information requested, as the non-proprietary information was available in other claims data sections. According to the incoming contractor, without access to more detailed historical information from the claims notes, there were instances in which they were unable to adjust payment determinations for certain claims paid prior to transition, which resulted in provider and beneficiary dissatisfaction.
- **Beneficiary payment information.** The incoming contractors faced challenges obtaining payment information for TRICARE beneficiaries who paid their health insurance premiums using credit cards or electronic funds transfers. According to a contracting officer, DHA initially directed the outgoing contractor to transfer beneficiary payment data to the incoming contractor. However, the outgoing contractors told us that they were unable to transfer this data due to banking laws and proprietary information security standards.²¹ DHA

²⁰The TRICARE Operations Manual requires contractors to issue an authorization or denial for 90 percent of all referral requests within two workdays and 100 percent within three workdays.

²¹The Payment Card Industry Data Security Standard is a proprietary information security standard for organizations that handle credit card payments and data, which requires protecting and restricting access to cardholders' data.

agreed that the outgoing contractors could not legally transfer this information and resolved the problem by requiring incoming contractors to reach out directly to beneficiaries to obtain the payment information. According to incoming contractor officials, this created additional, unanticipated effort, since they had to contact beneficiaries for this information directly, which diverted transition resources, such as enrollment staff, away from ongoing transition activities. In addition, contractors reported that this put certain TRICARE plan beneficiaries at risk since those who did not resubmit their payment information risked disenrollment and gaps in health care coverage. The contractors and DHA made attempts to notify affected beneficiaries that they needed to contact the contractor to reestablish their automated premium payments. However, approximately 224,000 beneficiaries' credit card or electronic funds transfer enrollments for premium payments did not continue after January 1, 2018. To give beneficiaries more time to provide this information, DHA provided a 150-day grace period for premium payments. Still, certain beneficiaries were disenrolled from TRICARE plans for failure to establish a recurring form of payment. For example, more than 15,000 beneficiaries were disenrolled in the East region.²²

In its "after action" report, DHA acknowledged that it did not always provide specific and accurate requirements for data transfers in its transition guidance and that this should be addressed for the next transition. However, the report did not address the difficulties related to resolving contractors' questions and disagreements on these issues. For example, DHA officials told us that they followed an informal process for tracking and handling issues raised by contractors during the transition, which was explained in the initial transition specifications meeting in December 2016. However, the outgoing and incoming contractors in the West region expressed concerns about this process, explaining that it was difficult to resolve issues, particularly with the amount of time it took for DHA to provide a response, such as with the referral and authorization disagreement. Federal standards for internal control note that an agency should implement control activities through policies, such as by providing guidance with greater specificity for data transfers. These standards also indicate that agencies should remediate deficiencies in a timely manner, such as the prompt resolution of contractors' guidance-related disputes

²²The affected beneficiaries were disenrolled from TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult, which require recurring forms of payment.

so as to not disrupt the transition schedule.²³ Without more specific guidance and a process that ensures timely dispute resolution, DHA risks disagreements and delays for future contract transitions, which could hinder health care delivery.

Some of DHA's Requirements for Determining Contractors' Readiness for Health Care Delivery Were Not Feasible or Effective

DHA experienced challenges executing its new T-2017 transition oversight methods—PRV/PRAV and performance guarantees—as planned because of fundamental problems with how some requirements were written and the implementation of TRICARE Select. As a result, some of the requirements were not feasible or effective in assessing contractors' readiness for health care delivery.

1. Certain PRV/PRAV requirements were not feasible as originally written or were not aligned with the corresponding performance guarantee, according to DHA officials. For example, one of the PRV requirements in the critical area of medical management focused on testing the contractors' web-based systems for exchanging information electronically with the government and providers, but this was not always possible as some information continues to be transferred in hard copy, such as by fax. In addition, the performance guarantee related to provider network development did not align with the corresponding PRV/PRAV requirements.²⁴ A DHA official told us that aligning the performance guarantee and PRV/PRAV requirements would have resulted in a higher financial penalty for one of the contractors.
2. Contractors noted that some PRV/PRAV requirements were not complete or effective measures of readiness. For example, contractors told us that requirements for claims and referrals did not effectively test the actual volume of administrative tasks that they

²³GAO-14-704G.

²⁴The financial penalty for network development did not include language on specialty care providers, as the PRV/PRAV did. The penalty was levied if contractors failed to upload primary care providers', behavioral health providers', and inpatient health facilities' information into requisite systems within certain time frames; whereas the PRV/PRAV required contractors to also upload information for specialty care providers.

would have to process after the start of health care delivery. According to the West region contractor, one of the referral PRAV tests required contractors to demonstrate that they could process 300 referrals during DHA's onsite review, whereas they typically need to process 9,000 referrals a day after the start of health care delivery.

3. The original PRV/PRAV requirements did not account for TRICARE Select, since the contracts were awarded prior to the enactment of the NDAA 2017. Furthermore, due to the delayed and extended enrollment freeze that ended on December 19, 2017, DHA determined that contractors could not demonstrate a fully operational enrollment system sixty days prior to the start of health care delivery as originally required. Additionally, the contractors had limited access to DHA's information technology systems for testing scenarios that included TRICARE Select. As a result, contractors had to test the majority of the critical areas (claims, enrollment, customer service, and referral management) with information technology systems that did not include TRICARE Select, which was not a true test of their readiness.

To address issues with feasibility and TRICARE Select, DHA modified the PRV requirements for four of the seven critical areas during transition. Specifically, DHA modified all of the PRV requirements for enrollment, referral management, and claims processing as well as one PRV requirement for medical management. DHA also waived the corresponding performance guarantees for the three of these critical areas that had such guarantees (enrollment, referral management, and claims processing). As a result, the contractors were not subjected to financial penalties for not meeting the requirements for these critical areas.

According to DHA officials, the problems with the PRV/PRAV requirements experienced during the T-2017 transition occurred in part because DHA subject matter experts did not review the requirements prior to the release of the final request for proposal.²⁵ As a result, officials said that it was not until after the contracts were awarded that subject matter experts determined that some of the requirements could not be performed as written. Nonetheless, DHA officials and contractors agreed

²⁵DHA issues a request for proposal for the TRICARE contracts, which documents DHA's requirements, including the contract type, significant contract dates, pricing arrangements, and the criteria to be used to assess offerors' proposals.

that the PRV/PRAV processes are good conceptual measures, and should continue to be used for the next transition with improvements to their feasibility and effectiveness. Having subject matter experts review contractors' readiness requirements for feasibility and contract alignment could help ensure that these requirements are appropriate measures of contractor readiness. In addition, DHA's "after action" report included feedback and lessons learned from officials and contractors on the PRV/PRAV requirements, which DHA could incorporate for future transitions. Federal standards for internal control state that an agency should internally communicate quality information to enable personnel to perform key roles in achieving objectives.²⁶ By considering lessons learned from this transition and having subject matter experts review the requirements, DHA would be able to better ensure their metrics are appropriate to prepare contractors for health care delivery.

DHA Required Contractors to Develop Corrective Action Plans to Address Problems after the Start of Health Care Delivery

DHA reported that the T-2017 contractors had overall better performance meeting contract requirements after the start of health care delivery than the two previous generations of TRICARE contracts.²⁷ Nonetheless, DHA has acknowledged that both T-2017 contractors did experience some problems meeting certain contract requirements. DHA addressed most of these problems through the issuance of corrective action requests, which require the contractors to submit and implement a corrective action plan (see table 2).²⁸ One exception where DHA did not issue formal corrective action requests was for problems both contractors experienced with processing enrollment backlogs after the start of health care delivery due to the extended TRICARE Select enrollment freeze during transition.²⁹

²⁶[GAO-14-704G](#)

²⁷Department of Defense, Defense Health Agency, *Evaluation of the TRICARE Program: Fiscal Year 2019 Report to Congress* (Washington, D.C.: February 2019).

²⁸DHA also assessed a transition performance guarantee in one region for problems meeting provider network requirements during transition.

²⁹The East region contractor told us that it processed the backlog of approximately 35,800 enrollment requests by the end of February 2018, and the West region contractor told us that it processed the backlog of approximately 17,500 enrollment requests by April 2018.

Table 2: Defense Health Agency (DHA) Actions to Address Problems Experienced by the Fourth Generation TRICARE Managed Care Support Contractors after January 1, 2018, by TRICARE Region

	Critical area	Problem contractor experienced after start of health care delivery	Formal DHA remediation action ^a	Status as of June 2019 ^b
West Region	Provider directory^c	Inaccurate online directory	<ul style="list-style-type: none"> • Corrective action request – September 2017 (during transition) • Subsequent corrective action requests in January 2018 and November 2018 to request additional corrective action detail 	Open
	Provider network^c	Problem loading network providers to relevant systems	<ul style="list-style-type: none"> • Corrective action request – September 2017 (during transition) • Assessed transition performance guarantee – September 2017^d • Subsequent corrective action request in January 2018 to request additional corrective action detail 	Closed September 2018
	Customer service	Call center calls not responded to within timeliness standards	<ul style="list-style-type: none"> • Corrective action request – January 2018 	Closed November 2018
	Enrollment	Backlog of beneficiary enrollments to process	<ul style="list-style-type: none"> • None^e 	Backlog processed by April 2018
	Referral management	Referrals and authorizations not processed within timeliness standard	<ul style="list-style-type: none"> • Corrective action request – January 2018 • Referral waiver^f 	Closed September 2018
	Medical management	Problems meeting requirements for having a user friendly web-based interface for Medical Management and Utilization Management programs	<ul style="list-style-type: none"> • Corrective action request – January 2018 	Closed March 2018
East Region	Provider directory^c	Inaccurate online directory	<ul style="list-style-type: none"> • Corrective action request – January 2018 	Open
	Customer service	Written correspondence not responded to within timeliness standards	<ul style="list-style-type: none"> • Corrective action request – June 2018 	Closed March 2019
	Enrollment	Backlog of beneficiary enrollments to process	<ul style="list-style-type: none"> • None^e 	Backlog processed by the end of February 2018
	Claims processing	Claims not processed accurately or within timeliness standards	<ul style="list-style-type: none"> • Letter of concern – January 2018 • Corrective action request – April 2018 • Subsequent corrective action request May 2018 to request additional corrective action detail 	Open

Source: GAO analysis of DHA information | GAO-20-39

^aIf DHA identifies deficiencies (based on transition PRV/PRAV activities or other contract deliverables), the DHA contracting officer may take formal action by informing the contractor in writing of the performance issues via a corrective action request. The corrective action request describes the

deficiency and requires the contractor to submit, within a specified timeframe, a corrective action plan with milestones and completion date.

^bCorrective action requests remain open until contractors demonstrate marked improvement in addressing the problem and meeting contract standards and DHA sends a letter indicating that they consider the corrective action request closed.

^cProvider directory is part of the provider network critical area. We separated the provider directory from the provider network critical area for purposes of this report because DHA issued a corrective action request for only the subset provider directory requirement in the East region. Further, in the West region, DHA partially closed the corrective action request for provider network in September 2018, but the provider directory requirement remained open as of June 2019.

^dThe T-2017 contracts included financial penalties—transition performance guarantees—for problems meeting certain contract requirements during transition.

^eDHA did not issue a corrective action request for the enrollment backlog in each region because additional time was needed to process enrollments due to an extended TRICARE Select enrollment freeze.

^fIn February 2018, DHA issued a temporary waiver of the requirement for TRICARE Prime beneficiaries to obtain a referral authorization for specialty care through April 15, 2018 to minimize the referral backlog.

Although most of the problems have been resolved, some problems have persisted into the second year of health care delivery, which DHA and contractors reported they are continuing to address.

- **Provider directory accuracy.** Both contractors have continued to fall short of the requirement for 95 percent accuracy of their online provider directories—problems they also experienced during the transition.³⁰ As of June 2019, the West region contractor’s directory was 76 percent accurate and the East region’s was 64 percent accurate, according to DHA officials. Both contractors expressed concern about the methodology used to assess their performance against this requirement and stated that the 95 percent standard is too high. DHA officials acknowledged that the 95 percent standard is high and that the provider directory corrective action requests may remain open indefinitely because of the high standard, though they continue to monitor the corrective action requests.
- **Claims processing timeliness and accuracy.** The East region contractor has struggled to meet timeliness and accuracy standards for processing claims. The contract requires contractors to process 98 percent of claims within 30 calendar days of receipt and 100 percent of claims within 90 days with a 98 percent accuracy rate. As of June

³⁰For the purposes of the PRV/PRAV, contractor’s online provider directories needed to be 95 percent accurate based on each data field (e.g., name, fax number) for each provider. After the start of health care delivery, accuracy calculations changed to be measured at the record-level for each provider, where an inaccuracy with any element of the record rendered the whole record inaccurate.

2019, the contractor was meeting the 30 day timeliness requirement and was close to meeting the 90 day timeliness requirement (99.99 percent within 90 days). However, the contractor continued to miss the performance standard for claims processing accuracy, according to DHA officials.³¹ DHA officials told us that the department had completed multiple on-site reviews and continues to monitor this issue to ensure the contractor improves its ability to meet claims processing standards. Contractor officials acknowledged that they needed to improve their oversight of claims functions and improve training and job aids with their claims processing subcontractor, which was a new partner for their T-2017 contract.

Conclusions

A smooth transition of health care delivery between outgoing and incoming managed care support contractors helps ensure continuity of care for TRICARE beneficiaries. In the most recent transition, the need to concurrently implement a new benefit option—TRICARE Select—presented some unique challenges that delayed the transition timeline and limited DHA’s ability to ensure contractors’ readiness in certain areas. While the implementation of a new benefit option during the T-2017 contract transition was a one-time occurrence, our review highlighted weaknesses in DHA’s transition guidance and oversight that could pose challenges to future contract transitions. By improving the specificity of its transition guidance, revising its process for resolving contractors’ issues, and ensuring review of PRV/PRAV requirements for feasibility and effectiveness, DOD could mitigate these challenges and thus improve future transitions.

Recommendations for Executive Action

We are making the following three recommendations to DHA:

- The Director of DHA should define data sharing requirements with more specificity in its transition guidance for outgoing and incoming

³¹DHA subjectively evaluates contractors’ claims accuracy performance. DHA officials reported that the East region contractor’s accuracy was not satisfactory relative to the 98 percent standard as of June 2019. Based on the most recently finalized review in 2018, the contractor reported that it is close to meeting the standard.

contractors, including the time period covered and the types of data that must be shared. (Recommendation 1)

- The Director of DHA should revise the process the agency has in place for resolving issues raised between contractors during transition to ensure such issues are resolved within time frames that will not adversely affect the transition schedule. (Recommendation 2)
- The Director of DHA should incorporate lessons learned from this transition and ensure that subject matter experts review PRV/PRAV requirements and performance guarantees prior to the issuance of the request for proposal for the next transition. These requirements should be reviewed to ensure their feasibility and effectiveness for assessing contractor readiness. (Recommendation 3)

Agency Comments

We provided a draft of this report to DOD for comment. In its written comments, reproduced in appendix I, DOD generally agreed with our findings and concurred with our recommendations. DOD outlined steps the department will take to improve the next TRICARE contract transition, including revising the TRICARE Operations Manual to better define data sharing requirements, developing a process to ensure that all contractor questions are answered appropriately and in a timely manner, and ensuring SMEs are involved in writing the PRV/PRAV requirements. DOD also provided technical comments, which we incorporated as appropriate

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix II.



James Cosgrove
Director, Health Care

Appendix I: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

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HEALTH AFFAIRS

James Cosgrove, PhD
Director, Health Care
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

NOV - 8 2019

Dear Mr. Cosgrove:

Thank you for the opportunity for the Department of Defense (DoD) to review and respond to the recommendations contained in the Government Accountability Office (GAO) Draft Report, DEFENSE HEALTH CARE: Opportunities to Improve Future TRICARE Managed Care Support Contract Transitions (GAO-20-39).

The Department concurs with all three recommendations contained in the report. Specific responses to each of the three GAO recommendations can be found in the attached.

Again, thank you for the opportunity to review and respond to the recommendations. My point of contact for this issue is our GAO/DoD IG Liaison, Mr. Richard Legg-Benavides. Mr. Legg-Benavides can be reached at (703) 681-5922 or via email at richard.w.leggbenavides.civ@mail.mil.

A handwritten signature in blue ink, appearing to read "Tom McCaffery".

Thomas P. McCaffery

Attachment:
As stated

Department of Defense (DoD) Response to Government Accountability Office (GAO) Recommendations

DEFENSE HEALTH CARE: Opportunities to Improve Future TRICARE Managed Care Support Contract Transitions (GAO-20-39; Code 103188)

RECOMMENDATION 1: The Director of the Defense Health Agency (DHA) should define data sharing requirements with more specificity in its transition guidance for outgoing and incoming contractors, including the time period covered and the types of data that must be shared.

DoD RESPONSE: Concur.

DoD ACTIONS ALREADY TAKEN: DHA Subject Matter Experts (SMEs) are currently revising language in the TRICARE Operations Manual to better define sharing requirements regarding data transfers between incoming and outgoing contractors.

Areas to be addressed in the contract/manuals:

- 1) Specific types of data required during transition (e.g. enrollment, referral, claims, medical management, and contractor management data specific to TRICARE beneficiaries).
- 2) The number of years of historical data that must be transferred.
- 3) Instructions on handling of information considered proprietary.

RECOMMENDATION 2: The Director of DHA should revise the process the Agency has in place for resolving issues between contractors during transition to ensure such issues are resolved within timeframes that will not adversely affect the transition schedule.

DoD RESPONSE: Concur.

DoD ACTIONS PROPOSED: When the fifth generation TRICARE contract (T-5) is awarded, the contractors will begin working on transition, and historically, the DHA will begin receiving questions from the contractors. For T-5, a formal process will be developed to ensure that all questions are answered appropriately and timely. The process will include:

- 1) Instruction to the contractors to send questions to a central location (e.g., mailbox) and to label each question as either routine or urgent.
- 2) All questions be entered into a database for tracking. All questions will be tracked and assigned a due date based on urgency.
- 3) Establishment of T-5 governance committees which will provide transition guidance and review and assessment of open issues so appropriate responses are furnished in a timely manner.

RECOMMENDATION 3: The Director of DHA should incorporate lessons learned from this transition and ensure that SMEs review performance readiness validation and performance readiness assessment and verification (PRV/PRAV) requirements and performance guarantees

prior to the issuance of the request for proposal for the next transition. These requirements should be reviewed to ensure their feasibility and effectiveness for assessing contractor readiness.

DoD RESPONSE: Concur.

DoD ACTIONS ALREADY TAKEN: All DHA SMEs have had the opportunity to read the T2017 After Action Report and will also have the opportunity to read this GAO report for lessons learned. The DHA SMEs have been very involved with writing the requirements for T-5 and have attended various requirements writing and risk management workshops. SMEs have also been given the opportunity to review, edit, and provide input to all PRV/PRAV and performance guarantee standards to ensure their feasibility and effectiveness.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

James Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Rebecca Abela, Analyst-in-Charge; Cathleen Hamann; Jacquelyn Hamilton; Rianna Jansen; and Vikki Porter made contributions to this report.

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