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DEFENSE HEALTH CARE

Implementation Issues for New TRICARE Contracts and Regional Structure

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Implementation Issues for New TRICARE Contracts and Regional Structure

Why GAO Did This Study

The Department of Defense (DOD) provides health care through TRICARE—a regionally structured program that uses civilian contractors to maintain provider networks to complement health care provided at military treatment facilities (MTF). In 2004, DOD implemented extensive changes to its TRICARE contracts and regional structure. A committee report accompanying the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 directed GAO to provide information on implementation issues for (1) the new TRICARE contracts and (2) the new regional structure. This report also provides information on the new management tools used to assess (3) contractors' performance and (4) program performance at the MTF and regional levels.

What GAO Recommends

GAO is making recommendations to DOD that are aimed at determining the costs associated with its automated system for referrals and authorizations to decide what future investments are warranted as well as clarifying responsibilities for contract oversight and establishing protocols for regional offices to collaborate with MTFs to facilitate regional oversight.

DOD concurred with each of GAO's recommendations and stated that it was actively working to manage these issues.

www.gao.gov/cgi-bin/getrpt?GAO-05-773.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marcia Crosse at (202) 512-7119 or crossem@gao.gov.

What GAO Found

During implementation of the new health care delivery contracts, issues arose that affected the administration of the TRICARE program. These issues increased program costs and impacted operations but had a minimal impact on the delivery of health care to beneficiaries. In particular, DOD's automated referral and authorization system was not available for contractors and MTFs at the start of health care delivery, resulting in the need for labor-intensive manual processes. DOD could not provide comprehensive costs associated with the system's development and subsequent nonavailability, but contractors' initial estimates for implementing manual processes in response to the system's nonavailability exceed $250 million over the 5-year contract period. DOD continues to incur costs to identify and develop solutions for managing referrals and authorizations and could not yet provide a time frame for when an automated system would be implemented.

Implementation of the new regional structure, called the governance structure, highlighted ambiguities about the roles and responsibilities of the newly established TRICARE regional offices (TRO) with respect to both contract oversight and coordination with the military services' MTFs. DOD offices, which traditionally oversee the contracts, and the TROs, which were assigned contract oversight responsibilities under the plan for the new governance structure, have had difficulties coordinating their responsibilities. In addition, while the governance plan states that TRO directors are to work with MTFs on issues such as maximizing the use of the direct care system, it does not provide the TROs with a protocol for these interactions. TRO directors do not have authority over MTFs and must rely on a collaborative approach to obtain cooperation. In some instances, military service officials have expressed concern that TROs have overstepped their authority by directly providing MTFs with guidance.

DOD has two new management tools for assessing the performance of contractors—performance guarantees and award fees. While performance guarantees serve as the basis for financial penalties, DOD's process for assessing penalties is still evolving. Nonetheless, for the first quarter of the contract year, DOD assessed all contractors with performance guarantee penalties, including penalties related to telephone wait times and the timely submission of referral reports for specialty care. In addition to penalties, DOD uses award fees to provide contractors with financial bonuses based on customer service. All contractors received an award fee for their performance during the first quarter of their contract year.

Although business plans were intended to be the management tools used to assess program performance at the MTF and regional levels, the fiscal year 2005 business plans for MTFs and TROs could not be used as intended for program oversight. Lacking clear guidance, each military service used its own approach to develop MTF business plans. The resulting inconsistencies in content and form impeded development of regional business plans, which are intended to incorporate the regions' MTF business plans. The three military services have collaborated to develop a standard MTF business planning approach—an effort that should improve both the MTF and regional plans for fiscal year 2006.

Contents

Abbreviations

DEERS	Defense Enrollment Eligibility Reporting System
DOD	Department of Defense
EWRAS	Enterprise Wide Referral and Authorization System
MCSC	managed care support contractor
MTF	military treatment facility
RFP	request for proposal
TED	TRICARE Encounter Data
TMA	TRICARE Management Activity
TOL	TRICARE On Line
TRO	TRICARE regional office

United States Government Accountability Office
Washington, DC 20548

July 27, 2005

The Honorable John Warner
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Duncan Hunter
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Department of Defense (DOD) provides health care to over 9 million beneficiaries, including active duty personnel, retirees, and their dependents, through its TRICARE program, which is expected to cost $36 billion in 2005. TRICARE beneficiaries can obtain health care through DOD's direct care system of military hospitals and clinics, commonly referred to as military treatment facilities (MTF), and through DOD's purchased care system of civilian providers. DOD uses managed care support contractors (MCSC) to develop networks of providers to complement care available in MTFs and to perform other customer service functions, such as claims processing. DOD's TRICARE Management Activity (TMA), under the Assistant Secretary of Defense for Health Affairs, is responsible for procuring, administering, and overseeing the health care delivery contracts for purchased care. Beginning in 1995, TMA implemented the TRICARE purchased care system through 7 health care delivery contracts that covered 11 geographic health care regions nationwide. We previously reported that the contracts' size, complexity, and prescriptive requirements limited innovation and competition among contractors.[1]

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[1]GAO, *Defense Health Care: Lessons Learned From TRICARE Contracts and Implications or the Future,* GAO-01-742T (Washington, D.C.: May 17, 2001).

In August 2002, TMA announced extensive changes to the next generation of TRICARE contracts that included consolidating the number of health care regions from 11 to 3 and correspondingly reducing the number of health care delivery contracts to 3. Additionally, some of the health care functions that had been included in the previous TRICARE contracts, such as retail pharmacy services and MTF appointments, were removed from the new health care delivery contracts. These functions were either separately awarded as national contracts or were given to the military services to manage. In designing the new contracts, TMA used a performance-based contracting approach that focuses on outcomes and gives the MCSCs latitude on how to achieve them—unlike the previous contracts that more specifically prescribed how MCSCs were to meet contract standards. To oversee MCSCs' performance under the new contracting approach, TMA developed management tools to ensure that specific program outcomes are achieved and to monitor MTF commanders' and beneficiaries' satisfaction with customer service.

TMA and the military services also made substantial changes to the management and oversight of TRICARE's purchased and direct care systems through the joint development of a governance plan. This plan established a new, regional governance structure, including the creation of TRICARE regional offices (TRO) to manage each of the three TRICARE regions (North, South, and West).[2] The TROs are each led by a director, who reports to the Deputy Director of TMA. According to the governance plan, TRO directors are considered the health plan managers for the regions and are responsible for managing the new contracts, including ensuring network quality and adequacy, monitoring customer satisfaction outcomes, and coordinating appointment and referral management policies. TRO directors are also responsible for supporting MTF commanders in their efforts to maximize the use of MTFs and for providing other assistance as needed.

Through the governance plan, TMA and the military services established annual business plans as the primary management tools for overseeing the delivery of health care at the MTF and regional levels. MTFs are responsible for developing business plans that establish their capabilities and capacity and that provide financial and workload information. After each military service approves the MTF business plans, MTF commanders

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[2]The governance plan also designated selected locations with more than one MTF as Multiple Service Markets. We did not include these markets in the scope of our review.

submit them to the TROs for inclusion in a single, regional business plan that also contains information about health care delivery in areas without MTFs. To oversee the delivery of health care and achieve optimal use of the direct care system, senior officials can use business plans to make informed decisions on what health care should be provided through the MTFs versus the purchased care system of civilian providers.

The implementation of the new contracts and governance structure involved numerous transition activities that required careful planning and execution to ensure that the delivery of health care to beneficiaries was not disrupted. The Senate Committee on Armed Services, in a report accompanying the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, directed GAO to monitor the transition to the new contracts and governance structure supporting the TRICARE program and to provide an assessment of initial transition activities.[3] In response, we examined

1. issues that arose during implementation of the new TRICARE contracts and how they are being addressed,

2. issues that arose during implementation of the new TRICARE governance structure and how they are being addressed,

3. management tools established to assess MCSCs' performance and how these tools are being used, and

4. management tools established to assess TRICARE program performance at the MTF and regional levels and how these tools are being used.

To conduct our evaluation, we interviewed officials at the offices responsible for administering the TRICARE program, including TMA; the Offices of the Surgeons General for the Army, Navy, and Air Force; TROs and MCSCs for the North, South, and West regions; and beneficiary group representatives. We also reviewed TMA directives, organizational charts, guidance, manuals, and contract requirements. We evaluated the governance plan and organizational structure and reviewed the timelines and plans for the transition to the new contracts and governance structure. We analyzed business planning documents for each of the TROs and for selected MTFs for fiscal year 2005. We also reviewed the reports

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[3]S. Rep. No. 108-260, at 351 (2004).

and tools that are being used to monitor MCSC performance, including customer satisfaction surveys that are administered to beneficiaries and to MTF commanders. We assessed the reliability of the data used in this report and determined that they were sufficiently reliable for our purpose. To assess the reliability of the data, we (1) confirmed with TMA and MCSCs that the data they provided included the elements that we requested and that these data elements were consistent with provided documentation and (2) conducted detailed interviews with TMA and MCSC officials to identify any limitations in the data. We conducted our work from December 2004 through July 2005 in accordance with generally accepted government auditing standards.

On May 2, 2005, we provided your staff with a briefing on the preliminary results of this review. The purpose of this letter is to provide the published briefing slides to you, which appear as appendix I. The information in these slides has been updated to provide more current data.

Results in Brief

A range of issues arose during implementation of the new health care delivery contracts that affected the administration of the TRICARE program. These issues increased program costs and impacted operations but had a minimal impact on the delivery of health care to beneficiaries. For example, the transition to new contracts prompted a higher-than-expected volume of beneficiary calls, requiring MCSCs to use additional resources to reduce telephone hold times and minimize beneficiary inconvenience. In addition, other problems, including difficulties with computer systems, strained program operations. The most significant and costly issue was the nonavailability of the Enterprise Wide Referral and Authorization System (EWRAS) that TMA and the military services had been developing since 2001. EWRAS was expected to provide automated referrals and authorizations for specialty care, and both MTFs and MCSCs had developed business processes based on the assumption that EWRAS would be available at the start of health care delivery. In its absence, both entities expeditiously developed and implemented labor-intensive manual processes. MCSCs' initial estimates of the costs involved with addressing the absence of EWRAS exceed $250 million over the 5-year contract period, but they have not yet negotiated this cost with TMA for reimbursement. MTFs had to absorb the costs associated with addressing the additional workload resulting from the need to manually process referrals and authorizations, and the military services could not provide the costs of these efforts. TMA officials also could not provide comprehensive costs incurred to develop EWRAS but estimated $9 million in contract costs—an estimate that does not include the staff resources

expended to develop specifications for the system. Further, additional resources are being expended as TMA has established multiple teams to develop solutions for managing referrals and authorizations. Depending on what these teams recommend, TMA officials will decide whether EWRAS will be used or whether another automated system will need to be developed even though TMA lacks critical cost information needed to facilitate decision making on the optimal approach for managing referrals and authorizations. Additionally, although TMA continues to incur costs related to identifying and developing solutions, TMA officials could not provide an estimate of when an automated system would be available.

Issues arose during the implementation of the new TRICARE regional governance structure that highlighted ambiguities about the roles and responsibilities of the TROs with respect to both contract oversight and collaboration with the military services' MTFs. Although the governance plan gives TRO directors responsibility for overseeing contract functions, it does not specifically delineate how this responsibility is to be coordinated with the TMA offices traditionally responsible for contract oversight. As a result, there have been coordination difficulties between the TROs and these TMA offices, resulting in conflicting communications on issues such as financial penalties and policy related to authorizations for care to an MCSC. In light of these difficulties, TMA officials have acknowledged the need to reassess and clarify the responsibilities and coordination requirements for contract oversight functions. In addition, while the governance plan states that TRO directors are to work with MTFs on issues such as maximizing the use of the direct care system, it does not provide the TROs with a protocol for these interactions. Because MTFs belong to the military services, TRO directors do not have authority over them and must rely on a collaborative approach to obtain cooperation. In the absence of clear protocols, military service officials have expressed concern about TROs' efforts to exert influence on MTFs stating that TROs have overstepped their authority in some instances by directly providing guidance to MTFs on issues such as referral management procedures and the movement of staff among MTFs.

TMA has two new management tools for assessing the performance of the MCSCs—performance guarantees and award fees—which are used to financially penalize and reward MCSCs. Performance guarantees establish a minimum baseline for performance against 10 specific standards and serve as the basis for financial penalties. Although TMA has assessed performance guarantee penalties for each of the MCSCs, the process for assessing these penalties is still evolving. Because the new health care delivery contracts are performance based and focus on outcomes instead

of processes, each MCSC measures and reports performance data differently. As of April 2005, TMA was still working with two MCSCs to understand their reported data and was still working to complete the validation of MCSCs' systems that generate reported performance data. Furthermore, TMA and MCSC officials acknowledge that administering the performance guarantees is difficult because not all of these standards reflect common industry practices and, therefore, they have no precedent on how to measure them. Separately, TMA uses award fees to provide MCSCs with financial bonuses based on customer satisfaction surveys administered to beneficiaries and MTF commanders as well as the TRO directors' firsthand knowledge of MCSCs' performance. All MCSCs received an award fee for their performance during the first quarter of their contract year.

Business plans—the management tools established for overseeing TRICARE performance at the MTF and regional levels—could not be used as intended during fiscal year 2005. TMA provided the military services with only minimal guidance on developing MTF business plans and, consequently, each of the services developed its own guidance, resulting in variations among the fiscal year 2005 MTF business plans in both content and format. These inconsistencies subsequently impeded the development of the regional business plans, which were intended to incorporate the regions' MTF business plans. As a result, regional business plans for fiscal year 2005 focused primarily on regional operations and health care delivery in areas without MTFs and could not be used to ensure optimal use of the direct care system. To improve upon the business planning process for fiscal year 2006, the three military services collaborated to develop an automated tool to standardize the content and format of MTF business plans and to ensure that the plans are aligned with the military health system's overarching strategic plan. The automated tool also includes metrics that can be used to assess direct care system performance. TMA officials expect that the automated tool for MTF business plans will subsequently improve the quality of information to be incorporated in the regional plans, allowing regional plans to be used as intended to monitor both the direct and purchased care systems.

Conclusions

The overall implementation of the new contracts and governance structure was an enormous undertaking for all stakeholders in the TRICARE system that proceeded with few issues affecting beneficiaries due to the close collaboration of TMA, MCSCs, and the military services. Most of the contract implementation issues were related to program administration and affected costs and operations with little impact on health care

delivery. The most significant implementation issue—the nonavailability of EWRAS—required extensive and costly process changes under short time frames. However, TMA has not clearly identified all of the costs associated with EWRAS development and nonavailability although MCSCs' have estimated costs of over $250 million for their efforts in addressing this problem over the 5-year contract period. Additionally, TMA continues to incur costs related to developing solutions for managing referrals and authorizations—a process that may take years to complete. Without a complete understanding of past and ongoing costs associated with EWRAS and the development of solutions, TMA will have difficulty determining what further investments are warranted in developing the optimal approach for managing referrals and authorizations.

The implementation of the new regional governance structure has not been flawless, largely because the role of the newly created TROs was not always clearly defined in the governance plan. Confusion about the TROs' role in contract oversight has created coordination problems with the TMA offices that have traditionally conducted contract oversight functions, resulting in conflicting directions on certain issues. Further, despite the TROs' lack of authority over the direct care system, the governance plan did not provide clear protocols for how TROs are expected to collaborate with the military services' MTFs in order to obtain their cooperation and maximize regional use of the direct care system. In some instances, military service officials have expressed concerns about the TROs overstepping their authority in working with MTFs, potentially straining the collaborative relationships. Without clearly defined roles and responsibilities for overseeing the contracts and collaborating with MTFs, TRO's oversight of regional health care delivery as envisioned by the governance plan could be compromised.

Finally, the management tools used in assessing program performance continue to evolve. TMA is working with the MCSCs to hone its approach for measuring and administering performance guarantees, an effort that should help improve contract oversight. Furthermore, the new automated business planning tool appears promising and could result in improvements in the consistency and content of the fiscal year 2006 MTF business plans, subsequently improving the quality of the regional plans. If effective, TROs and MTF commanders should be able to use the business plans as intended to assess program performance at the MTF and regional levels and to ensure optimal use of the direct care system.

Recommendations for Executive Action

As DOD considers what further investments are warranted for managing referrals and authorizations, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to determine comprehensive costs for the development and nonavailability of EWRAS as well as the costs being incurred to develop a solution.

To facilitate the TROs' oversight of regional health care delivery, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to take the following two actions:

1. clearly define the TROs' contract oversight roles and responsibilities as they relate to other TMA offices and

2. establish protocols for how TROs are to collaborate with the military services' MTFs.

Agency Comments and Our Evaluation

In commenting on a draft of this report, DOD concurred with each of our recommendations and said that it was actively working to manage the issues we noted. DOD's written response is reprinted in appendix II. DOD also provided several technical comments that we incorporated where appropriate.

DOD specifically stated that as the search for an automated solution to referrals and authorizations continues, the process of cost development and containment is ongoing. Once all costs associated with the nonavailability of EWRAS have been fully examined, DOD plans to negotiate a final cost for manual referral processing with the MCSCs. In addition, DOD stated that as it develops and implements an automated solution for processing referrals and authorizations, program oversight will be maintained to ensure that an automated solution satisfies the needs of all end users.

To more clearly define contract oversight responsibilities, DOD said that it is in the process of reexamining business functions for the TROs and other TMA offices. DOD acknowledged that TMA's existing business practices and processes were established before the TROs were created and that business functions need to be reexamined in light of the new regional structure. The Assistant Secretary of Defense for Health Affairs has directed TMA to evaluate certain business functions and to develop written guidance to clearly define how the related business practices are performed. In conducting this evaluation, it will be important for DOD to specifically examine the administration of MCSCs' performance

guarantees and the associated financial penalties—a critical aspect of contract oversight where coordination has been problematic. Further, to ensure continuous communication and coordination of critical issues affecting all contracts, DOD has recently established a Program Oversight Council, whose members include the TRO Directors, the Deputy Chief for Acquisitions, the Deputy Chief for Resource Management and Procurement, and the Chief of Health Plan Operations.

In addition, DOD stated that it intends to establish protocols and specific management mechanisms for the TROs to coordinate with MTFs. In particular, the Assistant Secretary of Defense for Health Affairs has directed the development of agreed-upon protocols and mechanisms for the TROs to coordinate regional business plans with MTFs in their regions. While we agree that the business planning process is the primary method of collaboration between TROs and MTFs, it is not the only area for which protocols are needed. Because TROs serve as the health plan managers for the regions, they will sometimes need to collaborate with MTFs on issues that are not directly related to business plans, such as the communication of referral management procedures. We believe that established protocols could facilitate such communication and alleviate the military services' concerns about how TROs are interacting with the MTFs.
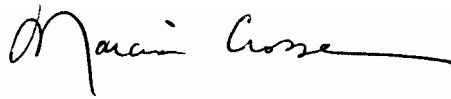
Despite concurring with our recommendations, DOD stated that the report did not emphasize what it viewed as the positive aspects of the implementation—primarily that DOD achieved its paramount goal of assuring a minimal impact on beneficiaries. However, the objectives of our review were to identify the issues that were encountered during the implementation of the new contracts and governance structure, and our report appropriately focuses on these issues. Nonetheless, our overarching assessment of DOD's implementation activities clearly states that the impact on beneficiaries was minimal and attributes this to the close collaboration of TMA, MCSCs, and the military services.

We are sending copies of this report to the Secretary of Defense and other interested parties. We will also make copies available upon request. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7119. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. In addition to the contacts named above, Bonnie Anderson, Assistant Director, Lois Shoemaker, Rob Suls, and Cathy Hamann made key contributions to this report.

Marcia Crosse
Director, Health Care

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Implementation of New TRICARE Contracts and Governance Structure

Briefing for Congressional Staff

Senate Committee on Armed Services
House Committee on Armed Services

Updated

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Introduction

- The Department of Defense (DOD) provides health care for over 9 million beneficiaries through its military health system, called TRICARE, which is expected to cost $36 billion in 2005.
  - Beneficiaries include active duty servicemembers, their families, military retirees and their eligible family members, and survivors.
- Under TRICARE, beneficiaries can receive health care through
  - military hospitals and clinics, commonly referred to as military treatment facilities (MTF), and
  - civilian providers.

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Introduction (continued)

- MTFs comprise DOD's direct care system for providing health care to beneficiaries.
  - Within the direct care system, each military service, under its Surgeon General, is responsible for managing its MTFs.
- Networks of civilian providers comprise DOD's purchased care system, which is intended to complement the direct care system of MTFs.
  - Through its health care delivery contracts, DOD uses civilian managed care support contractors (MCSC) to develop networks of primary and specialty care providers and to provide other customer service functions, such as claims processing.
    - The TRICARE Management Activity (TMA), under the Assistant Secretary of Defense for Health Affairs, is responsible for awarding, administering, and overseeing these contracts.

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Introduction (continued)

- Beginning in 1995, TMA implemented its TRICARE program through 7 health care delivery contracts that covered 11 geographic health care regions nationwide.
- We previously reported that the size, complexity, and prescriptive requirements of these contracts limited innovation and competition among contractors.[1]
- In August 2002, TMA announced major changes to the next generation of TRICARE health care delivery contracts.
    - These contracts consolidated the number of health care regions from 11 to 3—North, South, and West. (See fig. 1.)
        - Each region contains about one-third of the beneficiary population.
    - TMA used a performance-based contracting approach that focused on outcomes and gave MCSCs latitude on how to achieve them, unlike the previous contracts that more specifically prescribed how MCSCs were to meet contract standards.
        - For these contracts, TMA developed new management tools to ensure that specific program outcomes were achieved and to monitor customer satisfaction.

[1]GAO, *Defense Health Care: Lessons Learned From TRICARE Contracts and Implications for the Future,* GAO-01-742T (Washington, D.C.: May 17, 2001).

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Figure 1: Comparison of Previous and Current TRICARE Regions

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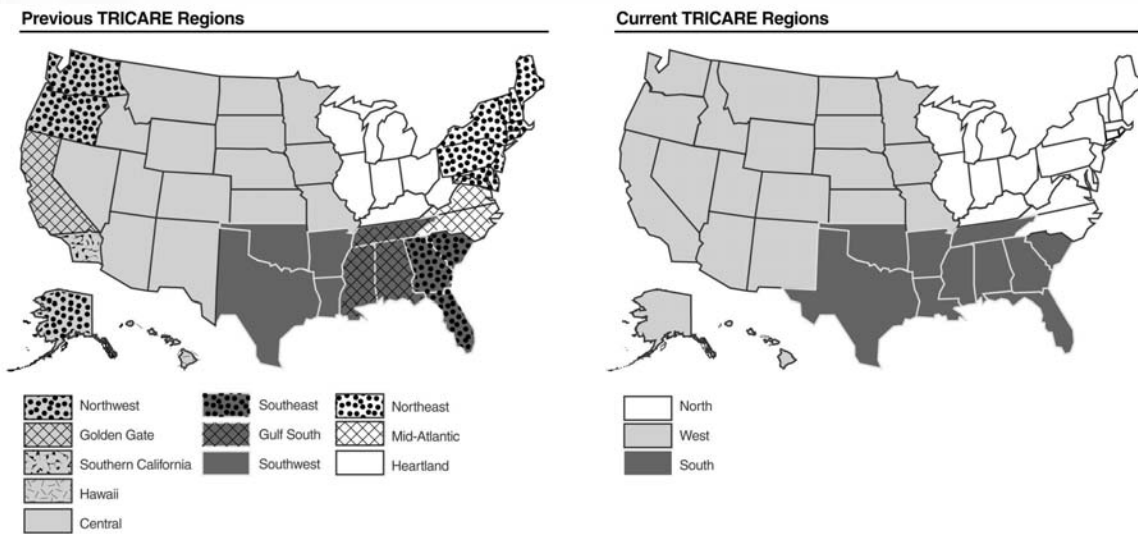
Introduction (continued)

- TMA and the military services also created a governance plan to help manage and oversee the TRICARE program.
- The governance plan established a new regional infrastructure, called the governance structure, to manage and oversee both the direct care and purchased care systems of the TRICARE program.
    - Each of the three regions has a TRICARE regional office (TRO) that is led by a regional director who reports to TMA.
    - The TROs are considered part of TMA's organization.
    - The plan designated selected locations with more than one MTF as Multiple Service Markets.[2]
    - The governance plan established annual business plans as the primary management tools for overseeing the delivery of health care at the MTF and regional levels.

[2]We did not include these markets in the scope of our review.

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Purpose & Key Questions

- The Senate Committee on Armed Services, in a report accompanying the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, directed GAO to monitor the transition to the new contracts and governance structure supporting the TRICARE program and to provide an assessment of initial transition activities by May 2005.[3]

- In response, we addressed the following key questions:

  1. What issues arose during implementation of the new TRICARE contracts, and how are they being addressed?

  2. What issues arose during implementation of the new TRICARE governance structure, and how are they being addressed?

  3. What management tools were established to assess MCSCs' performance, and how are these tools being used?

  4. What management tools were established to assess TRICARE program performance at the MTF and regional levels, and how are these tools being used?

[3]S. Rep. No. 108-260, at 351 (2004).

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Scope and Methodology

- To do our work, we interviewed officials from offices with responsibilities for developing, implementing, and monitoring the TRICARE program, including
  - TMA;
  - Offices of the Surgeons General for the Army, Navy, and Air Force;
  - TROs for the North, South, and West regions;
  - MCSCs for the North, South, and West regions; and
  - beneficiary group representatives.

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Scope and Methodology (continued)

- We also reviewed
  - TMA directives, organizational charts, guidance, manuals, and contract requirements;
  - the governance plan and organizational structure;
  - timelines and plans for the transition to the new contracts and governance structure;
  - copies of all TRO business planning documents and selected MTF business planning documents for fiscal year 2005;
  - reports and tools used to monitor MCSCs' performance; and
  - customer satisfaction surveys that are administered to beneficiaries and to MTF commanders.
- We did not evaluate information related to Multiple Service Markets.

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Scope and Methodology (continued)

- We did not independently validate data on provider network changes, telephone hold times, electronic claims processing, or costs provided by TMA and MCSC officials.
- However, we determined that these data were sufficiently reliable for the purpose of our work by
  - confirming with TMA and MCSCs that the data they provided included the elements that we requested and that these data were consistent with provided documentation and
  - conducting detailed interviews with DOD and MCSC officials to understand the limitations of the data.

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Background

- Functions Included in the Previous TRICARE Health Care Delivery Contracts
- Design of the Previous TRICARE Contracts
- Changes to the TRICARE Contracts
- Functions Included in the Current TRICARE Health Care Delivery Contracts
- Design of the Current TRICARE Health Care Delivery Contracts
- TMA's Approach to Monitoring the Current TRICARE Health Care Delivery Contracts
- New TRICARE Health Care Delivery Contract Implementation
- Previous Regional Oversight Structure
- Current Regional Oversight Structure
- Responsibilities of TRO Directors
- Business Planning
- MTF Business Plans
- Regional Business Plans
- Magnitude of the Transition

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Background (continued)
Functions Included in the Previous TRICARE Health Care Delivery Contracts

- The main functions covered in the previous TRICARE health care delivery contracts included
  - developing civilian provider networks,
  - referring and authorizing beneficiaries for health care,
  - processing health care claims,
  - conducting utilization management and quality management programs, and
  - educating providers and beneficiaries.

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Background (continued)
Design of the Previous TRICARE Contracts

- The design of the previous TRICARE contracts was based on prescriptive requirements.
  - For example, the adequacy of the provider network was measured through the requirement that MCSCs maintain a specific provider-to-beneficiary ratio: 1 provider to every 1,200 TRICARE enrollees.[4]
- TMA was responsible for monitoring the MCSCs' performance to ensure compliance with these requirements.

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[4]Beneficiary enrollment is required for participation in TRICARE's health maintenance organization option.

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Background (continued)
Changes to the TRICARE Contracts

- Previously, TMA solicited proposals for TRICARE's seven health care delivery contracts that covered 11 regions through separate requests for proposals (RFP)—each of which contained unique regional requirements.

- To ensure program uniformity among the regions and to simplify administration of the program, new health care delivery contracts were awarded separately for each of the three regions from a single RFP.

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Background (continued)
Functions Included in the Current TRICARE Health Care Delivery Contracts

- TMA collaborated extensively with each of the military services to design the next generation of TRICARE contracts.
- Some of the health care functions that had been included in the previous TRICARE contracts were carved out from the new health care delivery contracts and were either separately awarded as national contracts or were given to the military services to manage.
  - Carve-out contracts: retail pharmacy services, marketing and education services, and the adjudication of Medicare-eligible retiree claims.
  - Military services' responsibilities: MTF appointment setting, resource-sharing agreements, health care information line, and medical necessity reviews, among others.

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Background (continued)
Design of Current TRICARE Health Care Delivery Contracts

- The current TRICARE health care delivery contracts are designed to be performance based.
  - Performance-based contracts focus on desired outcomes—usually based on common industry practices—and give the contractor latitude on how to achieve them.
  - For example, provider network adequacy is now ensured through an outcome that requires MCSCs to establish a sufficient network of providers so that beneficiaries can make appointments for care within TRICARE's access standards[5] rather than through a specific provider-to-beneficiary ratio.
  - However, some prescriptive requirements remain in these contracts when results are mandated by law or regulations.

[5]The wait time for a well-patient visit or a specialty care referral may not exceed 4 weeks; for a routine visit, the wait time may not exceed 1 week; for urgent care, the wait time may not exceed 24 hours.

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Background (continued)
Design of Current TRICARE Health Care Delivery Contracts

- The current health care delivery contracts are based on five overarching objectives to
  - ensure optimal use of MTFs,
  - attain the highest possible level of beneficiary satisfaction,
  - attain best-value health care by utilizing commercial practices when possible,
  - have fully operational services and systems at the start of health care delivery so there is minimal disruption to beneficiaries and MTFs, and
  - ensure that TMA has ready access to contractor-maintained data.
- The contract contains more than 130 outcomes, which are linked to these objectives.

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Background (continued)
TMA's Approach to Monitoring the Current TRICARE Health Care Delivery Contracts

- Under the new health care delivery contracts, TMA requires MCSCs to have internal quality management programs that it uses to assess MCSC performance.

- In addition, the contracts specify weekly, monthly, quarterly, and annual reporting requirements.

- TMA is responsible for validating the systems that MCSCs use to generate the data for their performance reports to ensure that the information provided is reliable and accurate.

- In addition, TMA obtains data to monitor performance through other sources, such as its own claims records database and claims accuracy audits.

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Background (continued)
New TRICARE Health Care Delivery Contract Implementation

- TMA awarded its current TRICARE health care delivery contracts on August 21, 2003.
- TMA and the MCSCs collaborated extensively in planning and conducting the transition to the new contracts.
  - Each MCSC had to submit a transition plan to TMA.
  - TMA designated transition managers for each region and had routine meetings with MCSCs to monitor transition activities.
- Each of the three health care delivery contracts had multiple start dates to accommodate the transition from each of the former seven contracts.
  - The first health care delivery start date was June 1, 2004.
  - The last health care delivery start date was November 1, 2004.

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Background (continued)
Previous Regional Oversight Structure

- Previously, each of the 11 health care regions had been managed by a designated MTF commander, called a lead agent, who also functioned as the focal point for coordinating regional health care services.
- Lead agents collaborated with other MTF commanders in the region to facilitate health care delivery in the direct care system.
- Lead agents also monitored selected contract requirements, such as the adequacy of the civilian provider networks.
- Each lead agent had his or her own office and staff.
  - Staffing and organizational structures of each office varied.
  - Lead agents reported to their respective military services.

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Background (continued)
Current Regional Oversight Structure

- The TRICARE governance plan established a new regional structure for overseeing the purchased care and direct care systems.
- The governance plan establishes three TROs—one for each region and contract.
  - Each TRO is led by a director and can have up to 60 staff, including some staff from the military services.
  - Each TRO has the same organizational structure.
- TRO locations:
  - TRO North—Falls Church, Virginia
  - TRO South—San Antonio, Texas
  - TRO West—San Diego, California

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Background (continued)
Responsibilities of TRO Directors

- TRO directors are considered the health plan managers for the regions and report to the Deputy Director of TMA.
- TRO directors are responsible for managing the new contracts including
  - ensuring network quality and adequacy,
  - monitoring customer satisfaction outcomes, and
  - coordinating appointment and referral management policies.
- TRO directors are also responsible for supporting MTF commanders in their efforts to maximize the use of the MTFs and providing other assistance as needed.

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Background (continued)
Business Planning

- According to the governance plan, business planning will be the key management tool for integrating the direct and purchased care systems in order to achieve optimal utilization of direct care resources and provide management accountability at every level of the military health system.

- The governance plan established requirements for annual business plans at the MTF and regional levels.

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Background (continued)
MTF Business Plans

- MTF commanders are responsible for developing business plans to
  - help establish the direct care system capabilities and capacity,
  - analyze local market demands and identify opportunities to maximize the use of the MTFs, and
  - provide complete financial and workload information.
- Once they are finalized and approved, MTF business plans are provided to the TROs for incorporation into the regional business plans.

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Background (continued)
Regional Business Plans

- The TRO directors are responsible for the development and implementation of the regional business plans.
  - TRO directors are responsible for developing business plans for non-MTF areas where beneficiaries would need to rely primarily on civilian providers to obtain health care.
  - The business plans for non-MTF areas are integrated with the MTF business plans to create a single, regional business plan that is intended to provide TRO directors with information about all regional assets, costs, and expenditures.
- TRO directors can use the regional business plans as management tools to make recommendations to the military services regarding direct care system resources.
- In addition, the TRO directors are supposed to monitor regional performance against the business plans.

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Background (continued)
Magnitude of Transition

- The overall transition to the new contracts and governance structure was an enormous undertaking for all stakeholders in the TRICARE system.

- Multiple transitions were required.
  - 7 health care contracts had to be phased out and transitioned to 3 new health care delivery contracts.
  - 11 lead agent offices had to be phased out with their work transitioned to the 3 TROs.
  - Selected functions had to be transitioned from the previous health care delivery contracts to either the separate, national contracts or to the military services for local administration.

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Background (continued)
Magnitude of Transition

- In addition, TMA had to plan for the transition of new information systems, including
  - a new version of the Defense Enrollment Eligibility Reporting System (DEERS);
  - a new records system for health care claims, called the TRICARE Encounter Data (TED) System; and
  - TRICARE On Line (TOL), an all-inclusive Web portal that provides access to military health system resources.
    - Enterprise Wide Referral and Authorization System (EWRAS), a component of TOL, is designed to provide automated referrals and authorizations for specialty care.

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Key Question 1: Contract Implementation Issues

- What issues arose during implementation of the new TRICARE contracts, and how are they being addressed?
  - Issues Impacting Beneficiaries
  - EWRAS
  - Difficulties Implementing the TED System
  - Difficulties Meeting Electronic Claims Submission Standard
  - Challenges with Carve-out Contracts
  - Military Services' Challenges with New Contract Responsibilities

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Key Question 1: Contract Implementation Issues
Issues Impacting Beneficiaries

- Overall, TMA, MCSC, and military service officials stated that most issues encountered during implementation appeared to have little impact on beneficiaries because complaints have been minimal.
- To ensure a seamless transition for beneficiaries,TMA, MCSC, and military service officials cited a high level of collaboration prior to and during the implementation.
  - For example, TMA officials identified the transition to new DEERS as a high-risk area because DEERS is used to determine eligibility for health care services. Problems with its implementation would have negatively impacted beneficiaries' access to care.
  - Therefore, officials within TMA, the military services, and the MCSCs collaborated in the development and testing of new DEERS, which was implemented with minimal disruption.

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Key Question 1: Contract Implementation Issues
Issues Impacting Beneficiaries (continued)

- Beneficiary group representatives told us that the transition was relatively seamless, and the issues that existed are being resolved. The issues most often noted included the following:
  - Some beneficiaries had to change their primary care provider when the contracts transitioned.
  - Long telephone wait times for customer service occurred in some places.
  - Access to care was sometimes delayed due to implementation of new procedures for specialty care referrals.

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Key Question 1: Contract Implementation Issues
Issues Impacting Beneficiaries (continued)

- According to the MCSCs, about 5 percent (34,392 of 659,814) of beneficiaries enrolled with civilian primary care providers had to change their primary care provider.
- Percentage of beneficiaries by region who had to change providers:
  - West region: 11 percent (28,336 of 247,379)
  - North region: 2 percent (4,656 of 266,435)
  - South region: 1 percent (1,400 of 146,000)
- In most regions where the contracts changed, the incoming MCSC was able to either purchase the incumbents' civilian provider networks or recruit previously participating providers into the new networks.

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Key Question 1: Contract Implementation Issues
Issues Impacting Beneficiaries (continued)

- MCSCs experienced a higher-than-expected customer-service call volume during early contract implementation.
  - MCSC and TMA officials stated that the main reasons for calls included questions about changes in TRICARE and the status of referrals and authorizations for specialty care.
- As a result, all of the MCSCs experienced difficulties meeting TMA's telephone wait-time standard that "95 percent of all calls shall not be on hold for a period of more than 30 seconds during the entire call."
  - One MCSC told us that in July 2004—its highest volume month for phone calls—it had average hold times of over 10 minutes with a peak of 29 minutes.

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Key Question 1: Contract Implementation Issues
Issues Impacting Beneficiaries (continued)

- In response, MCSCs told us that they took the following steps:
  - One MCSC added almost 200 additional staff.
  - Another MCSC added 100 additional staff.
  - A third MCSC established and staffed a new phone center.
- As of March 2005, only one MCSC was meeting the telephone wait-time standard. The other two MCSCs were meeting the hold-time standard for about 81 and 93 percent of calls instead of the required 95 percent.
- The previous TRICARE contracts did not have hold-time standards. TMA officials told us that there was no comparable industry standard and that they included this requirement in the new contracts because of beneficiary dissatisfaction with hold times under the old contracts.

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Key Question 1: Contract Implementation Issues
EWRAS Nonavailability

- The most significant and costly issue was that EWRAS was not available for MCSCs and MTFs at the start of health care delivery and continues to be unavailable despite years of effort in designing the system.

- EWRAS, intended to be a component of TOL, was designed to be an automated tool for accepting and sending referrals and authorizations for specialty care between MTFs and MCSCs' network providers while complying with privacy standards.

- MCSC officials told us they based their proposals in 2002 on the assumption that EWRAS would be available. However, EWRAS was only a concept at that time.

- Correspondingly, MTFs developed business processes with the expectation that EWRAS would be available when the new TRICARE health care delivery contracts were implemented.

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Key Question 1: Contract Implementation Issues
EWRAS Timeline

- TMA began conceptualizing and designing EWRAS in 2001.
  - A triservice working group was established in June 2001 to define referrals and authorizations and to develop business processes to support an automated system.
    - However, TMA did not involve MCSCs in EWRAS' development as it did for the new version of DEERS.
  - TMA's contractor for developing TOL was given the added responsibility of developing the referral and authorization system.
    - A modification to the TOL contract, dated March 2003, called for a fully functioning system prototype to be available in May 2003.
  - However, this prototype was not delivered, and in November 2003, a separate contract for developing EWRAS was awarded to the TOL contractor.
    - The planned completion date stated in the contract's project management plan was March 31, 2004.

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Key Question 1: Contract Implementation Issues
EWRAS Timeline (continued)

- According to TMA officials, the EWRAS prototype was tested in March 2004. At that time, TMA officials recognized that EWRAS might not be ready by the start of health care delivery.
- According to TMA officials, the prototype did not adequately address the business processes that MTFs and MCSCs needed.
  - MTFs were focused on clinical information.
  - MCSCs were focused on information needed to process claims.
- On March 5, 2004, TMA issued a contract change order to the MCSCs directing them to work with MTF commanders to develop a contingency plan for transmitting referrals and authorizations in the event that EWRAS would not be available.

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Key Question 1: Contract Implementation Issues
EWRAS Contingency Plans

- On May 20, 2004, TMA issued a contract change order to MCSCs directing them to implement the contingency plans.

- MCSCs had to respond quickly in light of the first health care delivery start date of June 1, 2004. Within a short time frame, MCSCs told us that they had to
  - implement new business processes,
  - realign existing staff,
  - hire and train additional staff, and
  - obtain additional office space and technology.

- Correspondingly, MTFs had to modify their business processes for transmitting referrals and authorizations because they had developed processes based on the assumption that EWRAS would be available.

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Key Question 1: Contract Implementation Issues
EWRAS Costs

- EWRAS's development and its subsequent nonavailability have increased the costs associated with implementing the new TRICARE contracts.
- The cost of EWRAS's development is difficult to quantify.
  - According to TMA, approximately $9 million was spent on EWRAS's development.
    - TMA officials could not specify how much of the TOL contract's costs were related to EWRAS's development, but they estimate a cost of $3 million.
    - TMA subsequently spent about $6 million on EWRAS's development under a separate contract.
  - In addition to contract costs, TMA and the military services expended staffing resources for several years developing specifications for the system.

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Key Question 1: Contract Implementation Issues
EWRAS Costs (continued)

- Unexpected costs associated with the nonavailability of EWRAS are also difficult to quantify.
  - In March 2004, the three MCSCs estimated that the manual process could cost the government over $250 million over 5 years. However, the costs of these contract changes have not been negotiated with TMA.
  - The military services told us that MTFs had to absorb the additional workload created by the need for manual referrals. The military services have not estimated the costs associated with these changes for the direct care system.
    - To help alleviate the additional workload, two of the military services procured electronic fax systems for the exchange of referral information.

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Key Question 1: Contract Implementation Issues
EWRAS Customer Service Impact

- EWRAS's nonavailability also had a customer service impact.
- According to MCSCs,
  - implementing the manual process in a short time frame caused confusion for beneficiaries and resulted in many phone calls asking for clarification that contributed to longer telephone wait times, and
  - questions about referrals and authorizations continue to be one of the main reasons for phone calls.

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Key Question 1: Contract Implementation Issues
EWRAS Solutions

- TMA has established multiple teams to develop solutions to EWRAS's nonavailability.
  - Similar to the 2001 tri-service working group, these teams started by developing definitions and business processes related to referrals and authorizations.
  - The teams have developed recommendations for short-term remedies and continue to work on midrange and long-term solutions.
- Depending on what these teams conclude, TMA officials will decide whether EWRAS will be used or whether another automated system will need to be developed.
  - As a result, TMA officials do not know when an automated referral and authorization system will be available even though TMA continues to incur costs seeking a solution.

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Key Question 1: Contract Implementation Issues
Difficulties Implementing the TED System

- TMA experienced problems with its new TED system at the start of health care delivery under the new contracts.

  - After a claim is processed and paid, a claim record is submitted to TMA's TED system. This system uses the claim records to monitor claims processing timeliness and accuracy and to reimburse MCSCs for the care of MTF enrollees that is provided by civilian providers.

  - Although initial processing of beneficiary and provider claims have not been impacted by problems with the TED system's implementation, MCSCs have been impacted by these problems.

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Key Question 1: Contract Implementation Issues
Difficulties Implementing the TED System (continued)

- MCSC officials told us they did not get to test the TED system to identify any potential problems prior to the start of health care delivery as they had with the new version of DEERS.

  - As a result, some claim records were rejected by the TED system because of errors made by MCSCs as they learned how the system functioned.

- Additionally, some claim records were erroneously rejected due to errors with TMA's TED system. As a result, TMA made a temporary adjustment to the TED system.

- In some cases, MCSCs had to use additional staff or resources to correct and resubmit rejected claim records.

  - One MCSC planned for a claim record reject rate of about 6 percent but actually experienced a much higher reject rate of about 30 percent.

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Key Question 1: Contract Implementation Issues
Difficulties Implementing the TED System (continued)

- Due to MCSC submission errors and TED system problems, TMA had large accounts payable with the MCSCs because of the backlog of claim records that needed to be cleared so that MCSCs could be reimbursed.

  - As of May 2005, one MCSC official told us that it still had large accounts receivable with TMA largely due to submission errors.

- TMA implemented an update to the TED system in April 2005 that is expected to resolve problems related to errors in the system.

- According to TMA, some TED errors have been reduced as a result of the update, but as of May 2005, the full impact of the update had not been assessed.

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Key Question 1: Contract Implementation Issues
Difficulties Meeting Electronic Claims Submission Standard

- MCSCs stated that they experienced difficulties meeting the contract standard that 100 percent of network providers submit claims electronically.
  - In March 2005, MCSCs received about 50-70 percent of network claims electronically.[6]
  - MCSCs stated that some providers do not submit any of their health care claims electronically.
  - MCSCs have little leverage to encourage electronic submission because TRICARE patients are generally a low percentage of most providers' business.
- According to one MCSC, this standard is not realistic and is costly to the government because MCSCs must expend additional resources in attempting to meet it.
- TMA officials are reexamining this standard.

[6]Under the previous TRICARE contracts, TMA received about 30-35 percent of claims for health care electronically.

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Key Question 1: Contract Implementation Issues
Challenges with Carve-Out Contracts

- Carving certain functions out of the new health care delivery contracts appears to have created some confusion for beneficiaries.
  - According to MCSCs, some beneficiaries are uncertain about whom to call when they have questions about issues such as retail pharmacy claims or Medicare-eligible retiree claims, which are managed by other contractors.
    - TMA has worked with MCSCs to establish phone procedures to assist beneficiaries who contact them about issues related to the carve-out contracts.

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Key Question 1: Contract Implementation Issues
Challenges with Carve-Out Contracts (continued)

- MCSC officials told us that assigning responsibility for retail pharmacy services to a separate contractor impeded their ability to adequately monitor beneficiaries' drug use because they no longer have this information.
  - One MCSC told us that under the previous health care delivery contracts, they mined pharmacy data in order to direct individualized mailings to providers and beneficiaries to ensure that medical best practices related to pharmaceuticals were followed.
- In addition, one MCSC told us that the pharmacy carve-out contract eliminates any financial incentives for the MCSCs to manage beneficiaries' drug use.
- According to TMA officials, MCSCs can currently obtain beneficiary pharmacy data on a case-by-case basis from TMA's centralized pharmacy database.

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Key Question 1: Contract Implementation Issues
Military Services' Challenges with New Contract Responsibilities—National Appointment Contract

- At the start of health care delivery under the new contracts, the national contract for MTF appointments had not been awarded.
    - The appointment contract was intended to provide appointment-making services for MTFs that did not have the capability to perform this task internally.
    - The military services were responsible for awarding this contract under the auspices of the U.S. Army Medical Command Center for Health Care Contracting.
    - Military service officials told us that the contract award was delayed for many reasons, including the need for coordination among the services and the fact that the initial proposals did not meet requirements.

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Key Question 1: Contract Implementation Issues
Military Services' Challenges with New Contract Responsibilities—National Appointment Contract (continued)

- To provide for appointments until the national contract was awarded, the military services temporarily extended existing MTF appointment contracts.
- On March 29, 2005, the U.S. Army Medical Command Center for Health Care Contracting awarded three national appointment contracts to the three MCSCs that are managing the health care delivery contracts.
  - MTF commanders who need appointment services can request contract support through their local contracting support agencies.
  - Each contractor will then have the opportunity to bid on each request for appointing services.
  - MTFs will have to pay the MCSCs for the services they request under these contracts.
- The new contracts were effective April 2005.

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Key Question 1: Contract Implementation Issues
Military Services' Challenges with New Contract Responsibilities—Medical Necessity Reviews

- TMA initially gave the military services responsibility for medical necessity reviews related to referrals and authorizations for specialty care.

  - According to military service officials, TMA did not provide sufficient information about executing this responsibility. Additionally, some MTFs did not have the manpower or clinical expertise to conduct the reviews.

  - As a result, TMA gave this responsibility to MCSCs through a contract change order.

  - The MCSCs currently estimate that this change could cost more than $80 million over 5 years, but the cost of this change has not yet been negotiated with TMA.

  - According to TMA officials, if this function had been initially included as a requirement of the health care delivery contracts, its cost would likely have been less than that of the contract change order.

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Key Question 2: Governance Implementation Issues

- What issues arose during implementation of the new TRICARE governance structure, and how are they being addressed?
  - TRO Contract Oversight Responsibilities
  - TRO Collaboration with MTFs

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Key Question 2: Governance Implementation Issues
TRO Contract Oversight Responsibilities

- Although the governance plan gives TRO directors responsibility to oversee contract functions, it did not specifically delineate how this responsibility would be coordinated with central TMA offices that have traditionally conducted oversight of the TRICARE contracts.

  - Each of the three TROs has an on-site contract operations office whose responsibilities include contract oversight.

  - TRO directors are responsible for awarding financial bonuses to MCSCs on the basis of customer satisfaction.

- TMA's centrally located offices also conduct contract oversight.

  - Among other duties, these staff are responsible for determining and communicating financial penalties to MCSCs.

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Key Question 2: Governance Implementation Issues
TRO Contract Oversight Responsibilities (continued)

- The TROs' contract staff and TMA's centralized contract staff have not always coordinated on issues involving oversight of MCSCs.
  - For example, according to TMA officials,
    - a TRO director had TRO contract staff communicate a financial penalty reduction to an MCSC without the consensus of TMA's centrally located contract staff, who did not agree with this decision, and
    - TRO contract staff approved mailings from an MCSC to beneficiaries related to authorization requirements. However, TMA's centrally located contract staff determined that these mailings conflicted with TMA regulations.
  - While these TRO decisions were ultimately rescinded, they resulted in conflicting messages to an MCSC.

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Key Question 2: Governance Implementation Issues
TRO Contract Oversight Responsibilities (continued)

- TMA officials acknowledged the need to reassess
  - what contract oversight functions should reside in the TROs and what functions should remain centralized and
  - existing business practices and processes that need to be modified to clearly define
    - how TMA offices will coordinate and perform certain functions with TROs and
    - how the TROs will coordinate with each other.

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Key Question 2: Governance Implementation Issues
TRO Collaboration with MTFs

- According to the governance plan, TRO directors are to have information about the assets and capacity of the MTFs in their regions so they can make recommendations to the military services about maximizing the use of the direct care system.

- However, the governance plan did not establish protocols for TRO collaborations with MTFs.

- TRO directors do not have authority over the direct care system of MTFs in their regions.
  - MTF commanders report to their respective military service and are not accountable to the TRO directors.
  - To obtain cooperation, TRO directors must work collaboratively with the military services.

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Key Question 2: Governance Implementation Issues
TRO Collaboration with MTFs (continued)

- The Surgeons General and their representatives stated that TRO directors should view the MTFs as "customers" and should focus on managing the contracts. They also expressed concern about TRO directors' efforts to exert influence on the MTFs.

  - For example, they stated that the TROs have sometimes overstepped their authorities by providing individual MTFs with guidance—especially related to referral management and movement of staff among MTFs.

- One Surgeon General pointed out that it is difficult for TROs to provide MTFs with individual assistance because the new regions are large and contain many MTFs.

  - In contrast, lead agents managed smaller regions and could provide MTFs with more individual attention.

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Key Question 3: Tools to Oversee MCSCs

- What management tools are in place to assess MCSCs' performance, and how are these tools being used?
  - MCSC Performance Guarantees
  - MCSC Award Fees

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees

- One management tool that TMA uses to oversee the health care delivery contracts is performance guarantees.
- TMA's RFP included 10 performance standards that were designated as performance guarantees. (See app. I for a list of the performance guarantees.)
  - Each organization that submitted a proposal had to guarantee that it would meet or exceed these standards.
- On a quarterly basis, TMA assesses the MCSCs' performance in meeting these standards and notifies them of financial penalties when their performance does not meet the standards.
  - Upon receipt of notification, MCSCs have 10 days to respond to TMA's assessment. TMA evaluates the responses and makes a final determination.

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees (continued)

- According to TMA officials, performance guarantees are focused on customer service but do not always rely on common industry practices.
  - Some performance guarantees are prescriptive and identical to requirements in the previous contracts, such as
    - claims processing timeliness and
    - claims processing accuracy.
  - In addition, some performance guarantees were created for the new contracts.

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees (continued)

- One newly created performance guarantee requires network specialty providers to submit clear and legible reports to the referring provider within 10 working days of the specialty encounter 98 percent of the time.
  - TMA officials acknowledged that there was no precedent upon which to base this standard.
  - According to TMA and MCSCs, this process inserts a health care plan in the middle of the relationship between the referring and consulting physician—something that is never done in the civilian market.
    - When a network specialty referral is required, the MCSC is provided with a referral letter that recommends one or more specialty providers to the beneficiary.

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees (continued)

- TMA and MCSC officials acknowledge that one problem with measuring the performance guarantee related to network specialty reports is that not all beneficiaries follow through with their referral appointments.

  - For example, if more than 2 percent of the beneficiaries do not follow through with their appointments, the standard cannot be met regardless of the MCSCs' efficiency.

- MCSC and TMA officials acknowledged that this standard, among others, needs to be reassessed.

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees (continued)

- All MCSCs were assessed performance guarantee penalties during their first quarter of health care delivery.
  - Generally, penalties were assessed for not meeting standards for referral reports, telephone wait times, and network adequacy.
  - One claims processing standard was waived because of TMA's problems with specific edits in the TED system.
- Because the new health care delivery contracts are performance-based and focus on outcomes, there is some variation in how MCSCs are measuring and reporting performance data.
  - For example, one MCSC incorrectly reported compliance with the telephone hold-time standard using an alternative definition of hold time that resulted in inaccurate but more favorable measurements for the MCSC.

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees (continued)

- The penalties for not meeting the performance guarantee related to network specialty provider referral reports are
  - $100 for each report not submitted within 10 days and
  - an additional $100 for each report not submitted within 30 days.
- TMA officials told us that they established the penalty amount based on the approximate cost of a specialty care office visit.
- For the first quarter of performance guarantees, TMA initially assessed MCSCs almost $9 million for not meeting this standard.[7]
- TMA did not modify the standard for referral reports even though EWRAS was not available.

[7]The amount of this assessment may change after TMA and MCSCs negotiate a final settlement.

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees (continued)

- In December 2004—6 months after the first health care delivery start date–TMA officials established an approach for consistently assessing performance guarantee penalties when not all data were available from the MCSCs or when TMA had not validated the MCSCs' systems used to generate the data.[8]

  - For one MCSC, TMA officials told us that they had to use this approach for all but one of the performance guarantees because the MCSC's reports did not provide clear measures against the standards.

- As of April 2005, TMA was still working with two of the MCSCs to understand the data that were being reported. In addition, TMA was still working to complete validation of MCSCs' systems for generating performance data to ensure that they are accurate and reliable.

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[8]In these instances, TMA will withhold an amount necessary to protect the government. If the data have not been validated, TMA will subsequently coordinate with the MCSC to correct or reaffirm the penalty.

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Key Question 3: Tools to Oversee MCSCs
Performance Guarantees (continued)

- The health care delivery contract requires quarterly round table meetings with TMA, MCSCs, and others to review current policies and procedures and determine where best practices can be implemented.
  - The first of these meetings was convened in April 2005. According to a TMA official, participants agreed to reconvene in May 2005 to discuss selected contractual performance standards, including
    - common definitions of the standards,
    - common measurements of the standards, and
    - whether the standards comply with common industry practices.

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Key Question 3: Tools to Oversee MCSCs
Award Fees

- Another management tool that TMA is using to oversee the new health care delivery contracts is the award fee, which is a financial bonus based on customer satisfaction.
  - Award fees are assessed quarterly with a structured but subjective process using the results of satisfaction surveys of beneficiaries and MTF commanders as well as the TRO directors' firsthand knowledge of the MCSCs' performance.
    - MCSCs provide input on their performance.
    - TRO directors determine the award amount.
- All three MCSCs have received an award fee for the first quarter of performance for which they were assessed.
- MCSCs stated that adding quantifiable goals to the award fee determination process would help increase incentives for improving performance.

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Key Question 4: Tools for MTFs and Regions

- What management tools are in place to assess program performance at the MTF and regional levels, and how are these tools being used?
  - MTF Business Plans
  - Regional Business Plans

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Key Question 4: Tools for MTFs and Regions
MTF Business Plans

- The MTF business plan is the key management tool that MTF commanders are expected to develop and use to manage the delivery of health care in the direct care system and to make decisions on what health care should be provided through the purchased care system.

- TMA did not provide the military services with comprehensive guidance on how to prepare and use business plans for fiscal year 2005 even though TMA has been developing its business planning approach since fiscal year 2003.

  - According to the TMA official involved in developing the business planning process, TMA initially conceived business plans as budgeting spreadsheets, not as management tools.

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Key Question 4: Tools for MTFs and Regions (continued)
MTF Business Plans

- MTF commanders are expected to submit their completed business plans to TRO directors for inclusion in the regional business plan.

- For fiscal year 2005, each military service developed its own business planning guidance. As a result, business plan formats and content lacked consistent metrics for monitoring MTF performance and varied among the services.

  - For example, some business plans were spreadsheets while others contained some narrative.

- TMA officials told us that MTF business plans for fiscal year 2005 could not be used as management tools.

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Key Question 4: Tools for MTFs and Regions (continued)
MTF Business Plans

- The military services are working together to improve and standardize the business planning process.
- Representatives of the three military services developed an automated tool for creating standardized MTF business plans beginning in fiscal year 2006.
    - The business plan tool aligns with the military health system's overarching strategic plan.
    - The tool contains metrics for monitoring MTF performance in areas such as enrollment levels and beneficiary satisfaction with telephone access.
    - TMA officials endorsed this tool but were not involved in its initial development.
- TMA officials also told us they were planning to establish a triservice work group to develop uniform business planning guidance that would also establish the relationship between the military services' business plans and the military health system budget.

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Key Question 4: Tools for MTFs and Regions (continued)
Regional Business Plans

- The regional business plan is the key management tool for TRO directors because it is intended to provide information about the regional health care assets of both the direct and purchased care systems.

- In fiscal year 2005, TRO directors were unable to develop and use regional business plans as envisioned by the governance plan.

    - The MTF business plans they received, which were to be incorporated into the regional plan, did not provide comparable or complete information for MTFs in the regions.

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Key Question 4: Tools for MTFs and Regions (continued)
Regional Business Plans

- Reasons that TRO directors had difficulty incorporating MTF business plans into the regional plans include the following:
  - The military services' MTF business plans varied in content.
  - Two TRO directors stated that not all MTFs in the region submitted their business plans prior to the development of the regional plan.
  - One of the TRO directors stated that some plans that were submitted had not been approved by their respective Surgeons General and could not be considered final. As a result, these MTF plans could not be incorporated into the regional plan.

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Key Question 4: Tools for MTFs and Regions (continued)
Regional Business Plans

- Due to limited MTF information, the fiscal year 2005 regional business plans are currently focused on issues such as
  - TRO operations and
  - health care delivery in areas without MTFs.
- Because the fiscal year 2005 regional business plans are lacking information about the direct care system, TRO directors cannot use them as intended to monitor and make suggestions to the military services on maximizing the use of the direct care system.
- TMA officials stated that improvements in the MTF business plans for fiscal year 2006 should correspondingly improve the regional business plans and allow them to be used as intended to monitor both the direct and purchased care systems.

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Appendix I: Performance Guarantees

The 10 performance guarantees are as follows:

1. Telephone service (busy signals)—Not less than 95 percent of calls shall be received without the caller encountering a busy signal.
2. Telephone service (hold time)—95 percent of all calls shall not be on hold for a period of more than 30 seconds during the entire telephone call.
3. Claims processing—Not less than 95 percent of retained claims and adjustment claims processed shall be completed within 30 calendar days from the date of receipt.
4. Claims processing—100 percent of retained claims shall be processed to completion within 60 calendar days.
5. Claims processing—100 percent of all claims shall be processed to completion within 120 calendar days.

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Appendix I: Performance Guarantees (continued)

6. Payment errors—The absolute value of the payment errors for sampled TEDS (initial submissions, resubmissions, and adjustments/cancellation submissions) shall not exceed 2 percent.

7. TED validity edits—The accuracy rate for TED validity edits shall not be less than

- 93 percent after 6 months of performance and
- 98 percent after 9 months and thereafter during the entire term of the contract.

8. TED provisional edits—The accuracy rate for TED provisional edits shall not be less than

- 88 percent after 6 months of performance and
- 94 percent after 9 months and thereafter during the entire term of the contract.[1]

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[1]Validity edits check for the presence of an expected value in a data field, such as a number in an age field. Provisional edits check for the accuracy of an expected data value relative to another known value, such as relating "female" to "hysterectomy."

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Appendix I: Performance Guarantees (continued)

9. Network adequacy—Not less than 96 percent of contractor referrals of beneficiaries residing within selected geographic areas shall be to an MTF or network provider with an appointment available within the access standards.

10. Specialty care referral/consultation/operative reports—The MCSC shall ensure that network specialty providers provide clearly legible specialty care consultation of referral reports, operative reports, and discharge summaries to the beneficiary's initiating provider within 10 working days of the specialty encounter 98 percent of the time.

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THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

JUN 2 9 2005

Ms. Marcia Crosse
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Crosse:

This is the Department of Defense (DoD) response to the GAO draft report,
'DEFENSE HEALTH CARE: Implementation Issues for New TRICARE Contracts and
Regional Structure,' dated June 13, 2005, (GAO Code 290419/GAO-05-773).

Thank you for the opportunity to review the draft report. We do not concur with the
draft report as written. The report is a very one-sided assessment of a very complex and
multifaceted transition/transformation of DoD's purchased health care system. The
report does not offer comments on the many positive aspects of this endeavor.
In your notice of review for this audit, it was stated that the audit would focus, in part, on
what impacts the new TRICARE contracts are having on beneficiaries and civilian
providers. The letter portion of your report addressed to the Chairmen and Ranking
Members of the Committees on Armed Services for the Senate and House of
Representatives states that, "issues increased program costs and impacted operations but
had a minimal impact on the delivery of health care to beneficiaries." Our paramount
goal during the transition was to assure a minimal impact on beneficiaries. We believe
there is clear and ample evidence to show that the transition had an overall positive
impact, such as the seamless transfer of management responsibility for provider networks
in Region North that allowed many beneficiaries to enjoy uninterrupted continuity of
care. While no program is implemented 100% without flaw, given the magnitude of this
effort, the complexity of the actions, and the scope the endeavor called for, we believe
DoD has achieved, and continues to achieve, its goals for a successful transition. This
should be reflected in the report.

The report makes three recommendations for action by the TRICARE Management
Activity. We concur with comments on these recommendations and are actively working
to manage the issues noted in the recommendations. Our comments are included in the
enclosure along with responses to the recommendations. We have also included specific
technical corrections for your consideration to help strengthen the report.

My points of contact are Mr. Ron Richards (functional) at (703) 681-1133 and
Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-3492.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

GAO DRAFT REPORT – DATED June 13, 2005
GAO CODE 290419/GAO-05-773

**"DEFENSE HEALTH CARE: Implementation Issues for New TRICARE Contracts and
Regional Structure"**

DEPARTMENT OF DEFENSE COMMENTS

     The draft report provides a review of the Department's implementation of the new
TRICARE contracts and regional structure recently implemented for the Military Health System
(MHS).

<u>Overall Comments:</u>

<u>ENTERPRISE-WIDE REFERRAL AND AUTHORIZATION SYSTEM (EWRAS):</u>

1. Executive Summary Highlights, paragraph 1, lines 7-10: with regard to EWRAS costs, the
   report reads: "DOD could not provide comprehensive costs associated with the system's
   development, but contractors' initial estimates for implementing manual processes in
   response to system nonavailability exceed $250 million over the five year contract period."

   It is recommended that the report should read: "DOD estimates that $9M has been spent on
   concept exploration, initial business process and requirement definition and the development
   of EWRAS. DOD is in the process of negotiating the costs for the current manual referral
   and authorization process. Contractors' initial estimates for implementing manual processes
   in response to system nonavailability exceed $250 million over the five year contract period"

   > **Rationale:** The replacement wording and revised sentence structure more accurately
   > depicts the history and status of the enterprise wide referral and authorization and
   > progress to date.

2. Executive Summary Highlights, paragraph 1, lines 10-13: with regard to DoD cost estimates,
   the report reads: "DOD continues to incur costs to identify and develop solutions for
   managing referrals and authorizations and could not yet provide a timeframe for when an
   automated system would be implemented."

   It is recommended that the report should read: "The Enterprise Wide Referral and
   Authorization (EWRA) IPT has clearly delineated the enterprise wide referral and
   authorization business process. Functional requirements are being defined and technical
   solutions analyzed. Development of the referral and authorization automated technical
   solution is expected to be complete within 24 months."

   > **Rationale:** The DODI 5000.2 defines the incremental steps required for development and
   > implementation of Information Technology related acquisitions.
   > Clear definition of business processes and functional requirements must be completed
   > prior to development of a technical solution and timeline for implementation.

See comment 1.

See comment 2.

Now on pp. 4 and 5.

See comment 3.

3. Page 5, paragraph 1, lines 2-23: with regard to the EWRAS development history, the report reads: "EWRAS was expected to provide automated referrals......TMA officials could not provide an estimate of when an automated system would be available"

It is recommended that the report should read: "EWRAS was expected to provide automated referrals and authorizations for specialty care, however both MTFs and MCSCs had developed unique processes which could not be uniformly automated. In the absence of EWRAS, both entities expeditiously developed and implemented manual processes. TMA is currently negotiating the cost for the manual referral and authorization process with the MCSCs. TMA officials estimate that $9M has been spent on concept exploration, initial business process and requirement definition, and development of EWRAS to date. A EWRA IPT has clearly delineated the enterprise wide referral and authorization business process. Development of the referral and authorization automated technical solution is expected to be complete within 24 months."

   Rationale: The replacement wording more accurately depicts the history and status of the enterprise wide referral and authorization and progress to date.

Now on pp. 6 and 7.

See comment 4.

4. Pages 7-8, Conclusions, paragraph 1, lines 6-16: with regard to EWRAS implementation, the report reads: "The most significant implementation issue ... warranted in developing the optimal approach for managing referrals and authorizations."

It is recommended that the report should read: "The most significant implementation issue was the lack of standardization of the referral and authorization process across the MHS which prevented the fielding of EWRAS. TMA has estimated the costs associated with concept exploration, initial business process and requirement definition, and development of EWRAS to be $9M. The cost of the manual process is not yet available as it is currently being negotiated between TMA and the MCSCs. The EWRA IPT has clearly delineated the enterprise wide referral and authorization business process. The Senior Military Medical Advisory Council (SMMAC) has indicated that the fielding of the automated technical referral and authorization solution is a top priority. High level program oversight by the SMMAC will ensure that the automated solution is developed based on the end users needs as defined by the enterprise wide referral and authorization business process."

   Rationale: The replacement wording more accurately depicts the history and status of the enterprise wide referral and authorization and progress to date.

**GAO DRAFT REPORT – DATED June 13, 2005
GAO CODE 290419/GAO-05-773**

**"DEFENSE HEALTH CARE: Implementation Issues for New TRICARE Contracts and
Regional Structure"**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATIONS**

<u>RECOMMENDATION 1</u>: The GAO recommended that the Secretary of Defense direct the
Assistant Secretary of Defense (Health Affairs) to determine comprehensive costs for the
development and nonavailability of the Enterprise Wide Referral and Authorization System as
well as costs being incurred to develop a solution." (Pages 8 and 9/GAO Draft Report)

<u>DOD RESPONSE:</u> Concur. The process of cost development and containment is ongoing. The
Enterprise Wide Referral and Authorization System (EWRAS) is designed to support the
business processes involved in managing the referral and authorization process for specialty care.
The goal is to field an automated information system, <u>EWRAS</u>, whose measure of effectiveness
is to effectively support the Enterprise Wide Referral and Authorization Processes (EWRAP) as
defined by the users. The end result is EWRAP optimization. The Enterprise Wide Referral and
Authorization (EWRA) Integrated Project Team (IPT) has clearly delineated EWRAP. The
ERWA IPT, chaired by a Flag Officer, is defining the functional requirements and analyzing the
technical solutions. Development of the referral and authorization automated technical solution,
ERWAS, is expected to be complete within 24 months." As this process continues to unfold, the
development and implementation costs of the EWRAP and EWRAS remain an important
consideration. TMA issued a contract change order to implement contingency plans in the
absence of an automated EWRAS solution. Although the Managed Care Support Contractors
(MCSCs) estimate the cost of the manual process at $250M over five years, this figure is only
their rough order of magnitude (ROM). Historically, once all costs have been fully examined,
TMA has negotiated the cost of unilateral change orders at substantially less than the contractors'
ROM estimates, and is confident of achieving the same result in this instance. The $9M cost to
date to develop the EWRAS capability was not a wasted investment for the Government. The
capability developed was an electronic solution to referrals and authorizations, but lacked
adequately approved business processes to accomplish the function. The EWRA IPT developed,
refined, and achieved approval of the business process requirements for performing referrals and
authorizations by the MTFs and the MCSCs, and is now performing a map-and-gap analysis of
the relationship between the electronic EWRAS platform and the functional requirement to
determine what, if any, adjustments are required to field the EWRAS system. As DOD
implements the automated solution, program oversight will be maintained to ensure that the
automated solution is developed based on the end users needs. The DODI 5000.2 defines the
incremental steps required for development and implementation of Information Technology
related acquisitions, and is the model being employed to develop, track and control program
costs.

<u>RECOMMENDATION 2:</u> The GAO recommended that the "Secretary of Defense direct the
Assistant Secretary of Defense (Health Affairs) to clearly define the TRICARE regional offices'
contract oversight roles and responsibilities as they relate to other TRICARE Management
Activity offices." (Page 9/GAO Draft Report)

DOD RESPONSE: Concur. In January 2005, as part of the continuing TRICARE Management Activity (TMA) transformation process, the ASD(HA) appointed an SES-level committee to look at what appropriate additional steps were required to assure that the organization had the optimal balance to effectively support the TRICARE governance structure. In April, the committee provided several recommendations designed to support the appropriate balance to enhance TMA's effective management of both the global and regional aspects of the TRICARE Program. The committee noted that the major business practices and processes had all been established, either in writing or practice, before the TRICARE Regional Office (TRO) structure was put in place and have remained unchanged. Because new guidance had not been issued to the staff, confusion occurred in what is expected of them and how they were to perform various functions. The committee recommended that TMA re-examine its business functions and clearly define how it wanted its business practices to be performed.

The Assistant Secretary of Defense (Health Affairs) has embraced this recommendation and in May 2005 he directed a re-look of the following TMA business functions: policy development and coordination; issue development and coordination; requirements management; change order management; pre-negotiation/award review and approval; coordination among the TRICARE Regional Offices; financial management [contract financial execution visibility and purchase care requirements determination]; program integrity; program management decision process; and marketing and education. The ASD(HA) directed that the review process of these business functions and the development of written guidance be completed in 60 days to clearly define how business practices are performed. This will provide a clear picture to the staff of what is expected of them and how they are to perform various functions.

In addition, a Program Oversight Council whose members include the TRO Directors, the Deputy Chiefs for Acquisitions and Resource Management and Procurement, and the Chief, Health Plan Operations (Chair), has been formed and meets weekly. This forum links the field (TROs) with the operations, policy and resource functions of TMA, and ensures continuous communication and coordination of critical issues affecting all contracts. It also allows for prioritization of issues to be worked and vetted through the TMA leadership.

RECOMMENDATION 3: The GAO recommended that the "Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to establish protocols for how TRICARE regional offices are to collaborate with the military services' military treatment facilities." (Page 9/GAO Draft Report)

DOD RESPONSE: Concur. The Regional Directors are the health plan managers for their respective regions, and are charged with developing a regional business plan that optimizes the capabilities of the direct care Military Treatment Facilities (MTFs). In the first year of the new governance structure, Fiscal Year 2005, the business planning process was in its initial stages. The Assistant Secretary of Defense (Health Affairs) has issued Military Health System Business Planning Guidance to the Service Surgeons General and the TRICARE Regional Directors for the Fiscal Year 2006-2008 budget cycle. The guidance:
- Directs use of the Tri-Service Business Planning Tool for Military Treatment Facility, Multi-Service Market and TRICARE Regional Office business plans
- Establishes 8 critical initiatives as the focus of the plans.

- Assigns responsibility to the TRICARE Regional Offices for optimizing the direct care and purchased care resources and for determining the purchased care requirements of the "white spaces" (the areas in a region outside the Prime Service Area of any Military Treatment Facility); and
- Includes a timeline to make the Fiscal Year 2006 business plan the basis for the Fiscal Year 2008-FY 2013 Defense Health Program Budget Estimate Submission.

To assure that the business planning process is optimized, the Assistant Secretary of Defense (Health Affairs) has directed that the Military Health System Strategic Management process be used as the vehicle to establish agreed upon protocols and specific management and coordination mechanisms for the TRICARE Regional Offices to coordinate effective regional business plans with the Military Treatment Facilities and multi-service market managers in their regions.

The following are GAO's comments on the DOD June 29, 2005, letter.

GAO's Comments

1. The TRICARE Management Activity (TMA) estimated that $9 million in contract costs had been spent for the development of EWRAS through June 2004. In addition, as a result of EWRAS nonavailability, the managed care support contractors (MCSC) estimated $250 million for implementing a manual referral and authorization process over five years. However, TMA did not provide us with complete data related to EWRAS costs. TMA could only verify that $6 million had been spent on a contract to develop the system and estimated that an additional $3 million had been spent on EWRAS development through another information system contract. Therefore, TMA's estimate of EWRAS expenditures are associated only with system development contracts and do not include the separate costs incurred by TMA or the military services for staffing resources expended in conceptualizing the system and developing system specifications.

2. TMA has established multiple teams to develop solutions for managing referrals and authorizations. In July 2005, we confirmed with TMA officials that the most recent team has established a business process that will serve as the framework for the automated management of referrals and authorization. DOD's response acknowledges that efforts to develop an automated system are ongoing as functional requirements for a system are being defined and technical solutions analyzed. Therefore, as we reported, TMA continues to incur costs to identify and develop solutions for managing referrals and authorizations. Additionally, DOD's response asserts that an automated system is expected to be complete within 24 months. However, in further discussions, TMA officials told us that implementation would not be initiated until the concept of operations is approved and funding is provided—activities that had not occurred and would likely stretch the timeline past 24 months. Additionally, in its rationale, DOD confirms that until definitions for both business processes and functional requirements are completed, a technical solution and implementation timeline cannot be developed.

3. We believe that our report paragraph accurately depicts the history and status of the referral and authorization process. Further, as previously stated, TMA officials told us that implementation would not be initiated until the concept of operations is approved and funding is provided—activities that had not occurred and would likely stretch the timeline past 24 months. In addition, DOD confirmed that a technical solution and implementation timeline cannot be developed until

definitions for both business processes and functional requirements are completed.

4. We agree that the lack of standardization of the referral and authorization process prohibited TMA from deploying its EWRAS automated system. This was a critical issue that TMA should have recognized and addressed during EWRAS development. Because this was not done, EWRAS could not be deployed, and, as we concluded, EWRAS nonavailability became the most significant implementation issue.