



April 2014

DEFENSE HEALTH CARE

More-Specific Guidance Needed for Assessing Nonenrolled TRICARE Beneficiaries' Access to Care

Why GAO Did This Study

DOD provides health care through TRICARE, its regionally structured health care program. In each of its regions (North, South, West), DOD has a TRO that oversees health care delivery. Beneficiaries who choose the TRICARE Prime option must enroll. Beneficiaries who do not enroll may obtain care under the TRICARE Standard, Extra, or Reserve Select options—referred to as nonenrolled beneficiaries. Since TRICARE's inception in 1995, nonenrolled beneficiaries have complained about difficulties finding civilian providers who will accept them as patients.

The National Defense Authorization Act for Fiscal Year 2008 mandated that GAO evaluate the processes, procedures, and analyses used by DOD to determine the adequacy of access to care for these beneficiaries. This report addresses the extent to which the TROs have assessed nonenrolled beneficiaries' access to care. To conduct this work, GAO reviewed and analyzed relevant documentation and interviewed DOD officials, including officials in each of the TROs. In addition, GAO reviewed federal internal control standards for monitoring performance. GAO also interviewed officials from organizations representing military beneficiaries to discuss their perspectives on the TROs' efforts.

What GAO Recommends

GAO recommends that DOD enhance existing guidance for the TROs to include more specificity on assessing nonenrolled beneficiaries' access to care. DOD concurred with GAO's recommendation.

View [GAO-14-384](#). For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.

DEFENSE HEALTH CARE

More-Specific Guidance Needed for Assessing Nonenrolled TRICARE Beneficiaries' Access to Care

What GAO Found

The Department of Defense (DOD) has devoted significant resources over the past decade—largely through national surveys of beneficiaries and civilian providers—in determining whether nonenrolled beneficiaries (those not enrolled in TRICARE Prime) have adequate access to health care. However, the lack of access standards for this population has significantly limited the department's ability to make these determinations. In 2010, the Deputy Chief of TRICARE Policy and Operations issued an action memo that outlined a series of recommendations for how the TRICARE Regional Offices (TRO) should gauge nonenrolled beneficiaries' access to care. Two of the memo's recommendations—analyzing the results of DOD's national surveys and using beneficiary-to-provider population models—provide a strategy for monitoring and assessing nonenrolled beneficiaries' access to care. However, GAO found that these recommendations do not include sufficient guidance that specifies what process to follow in determining whether nonenrolled beneficiaries' access to care is adequate. According to federal internal control standards, having a monitoring strategy that includes specific guidance is important for leadership to ensure that ongoing monitoring is effective and will trigger separate evaluations when problems are identified.

In the absence of more-specific guidance, GAO found that the TROs' efforts to implement the action memo's recommendations have resulted in limited and inconsistent methods for identifying and addressing areas with potential access problems, which in some instances have included the use of judgment in place of clear criteria for making these determinations. For example:

- One recommendation advises the TROs to report on the results of the access questions from the nonenrolled beneficiary survey for their region, and to include any subsequent action plans to address the potential access problems they identify. GAO found that the TROs varied in the extent to which they used the survey data to identify potential problem areas, and none of them had a clearly documented methodology for how they used these data, including a rationale for when further actions should be taken.
- Another recommendation advises the TROs to establish a working group to adapt and standardize a beneficiary population-to-provider model to determine whether there are sufficient numbers of civilian providers to provide reasonable access to care. However, GAO found that only one of the TROs applied criteria to its population-to-provider ratios, and while this TRO identified areas with potential access problems, officials told GAO that they ultimately used their judgment to determine that no access problems existed because they had not received beneficiary complaints from these areas.

Without more-specific guidance, DOD does not have reasonable assurance that the TROs' efforts to assess access to care for nonenrolled beneficiaries are effective or that its own efforts to field and analyze large, costly, national surveys are providing useful data.

Contents

Letter		1
	Background	5
	The TROs' Efforts to Assess Nonenrolled Beneficiaries' Access to Care Have Been Limited and Inconsistent due to Insufficient Guidance	11
	Conclusions	17
	Recommendation for Executive Action	18
	Agency Comments	18
Appendix I	Benchmarks for TRICARE Management Activity's 2008 through 2011 Surveys	20
Appendix II	Comments from the Department of Defense	23
Appendix III	GAO Contact and Staff Acknowledgments	25
Tables		
	Table 1: Summary of TRICARE Benefit Options	6
	Table 2: TRICARE Management Activity (TMA) Benchmarks for Its 2008 through 2011 Nonenrolled Beneficiary Surveys	20
	Table 3: TRICARE Management Activity (TMA) Benchmarks for Its 2008 through 2011 Civilian Provider Surveys	22
Figures		
	Figure 1: Types and Percentages of Nonenrolled TRICARE Beneficiaries	7
	Figure 2: Location of TRICARE Regions in the United States	8

Abbreviations

BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
DHA	Defense Health Agency
DOD	Department of Defense
HHS	Department of Health and Human Services
NDA 2008	National Defense Authorization Act for Fiscal Year 2008
non-PSA	non-Prime Service Area
PSA	Prime Service Area
TMA	TRICARE Management Activity
TRO	TRICARE Regional Office

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April 28, 2014

The Honorable Carl Levin
Chairman
The Honorable James Inhofe
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Howard P. “Buck” McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

In fiscal year 2013, the Department of Defense (DOD) offered health care services to almost 9.6 million eligible beneficiaries in the United States and abroad through TRICARE, its regionally structured health care program.¹ Under TRICARE, beneficiaries may obtain health care either from military hospitals and clinics, referred to as military treatment facilities, or from civilian providers. DOD’s Defense Health Agency (DHA),² which oversees the program, uses managed care support contractors (contractors) to develop networks of civilian providers—referred to as network providers—to serve all TRICARE beneficiaries in

¹Generally, eligible beneficiaries include active duty personnel and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and retirees and their dependents and survivors. Active duty personnel include Reserve component members on active duty for at least 30 days. The TRICARE program provides health care services in overseas regions called “areas” in Eurasia-Africa, Latin America and Canada, and the Pacific. These areas are beyond the scope of this report.

²Prior to October 1, 2013, the TRICARE Management Activity (TMA) oversaw the TRICARE program. In response to increasing pressure on its budgetary resources, DOD established the DHA on October 1, 2013, to assume management responsibility of numerous functions of its medical health system, including the former TMA, which was terminated on that date. For additional information about the establishment of DHA, see GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD’s Plans and Enhance Accountability*, [GAO-14-49](#) (Washington, D.C.: November 2013).

geographic areas called Prime Service Areas (PSA).³ The contractors also perform other customer service functions, such as processing claims and assisting beneficiaries with finding providers. Each TRICARE region (North, South, and West) within the United States has a contractor, as well as a TRICARE Regional Office (TRO) that oversees health care delivery within its respective region. Each TRO monitors the regional contractor's performance, including its ability to achieve and maintain an adequate civilian provider network.

The number and type of civilian providers available to serve TRICARE beneficiaries can vary depending on a beneficiary's location and choice of coverage among TRICARE's three basic options—TRICARE Prime, TRICARE Standard, and TRICARE Extra.⁴ Beneficiaries who live in a PSA may choose to enroll in TRICARE Prime, a managed care option;⁵ however, this option is not typically available to beneficiaries living outside of a PSA. Beneficiaries do not need to enroll in TRICARE Standard (a fee-for-service option) or TRICARE Extra (a preferred provider organization option) and can choose to receive care either through TRICARE Standard when they are seeing nonnetwork civilian providers or through TRICARE Extra when they are seeing network civilian providers.⁶ We use the term “nonenrolled beneficiaries” in this report to refer to beneficiaries who are not enrolled in TRICARE Prime and who use TRICARE's Standard or Extra options and to beneficiaries who are

³PSAs are geographic areas determined by the Assistant Secretary of Defense for Health Affairs and are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of a military treatment facility. In addition to developing networks of civilian providers in PSAs around these facilities, the managed care support contracts also require the contractors to develop these networks at all Base Realignment and Closure (BRAC) sites, which are military installations that have been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure. Contractors are not required to develop networks in areas outside of PSAs—called non-PSAs—but have done so in some locations.

⁴TRICARE has several other plans, including TRICARE Young Adult-Standard Option (for beneficiaries' dependents up to age 26) and TRICARE Reserve Select (for certain National Guard and Reserve servicemembers), which are similar to TRICARE Standard and Extra in terms of benefits to the beneficiary.

⁵Active duty servicemembers are required to use TRICARE Prime.

⁶Nonnetwork civilian providers are those providers that are not in the TRICARE network, but are certified to see TRICARE patients.

enrolled in TRICARE Reserve Select.⁷ At the end of fiscal year 2013, there were about 2.2 million nonenrolled beneficiaries, about 67 percent of which were retirees and their dependents or survivors.

Since TRICARE's inception in 1995, nonenrolled beneficiaries have complained about difficulties finding civilian providers who will accept them as patients. However, it has been difficult for DOD to determine the type and extent of access problems for this population because unlike TRICARE Prime, there are no established access standards for the TRICARE Standard and Extra options.⁸ To determine the adequacy of access to civilian health care providers for nonenrolled beneficiaries under TRICARE, the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) directed DOD to conduct annual surveys over 4 years of both nonenrolled beneficiaries and civilian providers.⁹ It also mandated GAO to review these surveys, along with the processes, procedures, and analyses used by DOD to determine the adequacy of the number of health care providers that currently accept nonenrolled TRICARE beneficiaries as patients. We have issued several reports in response to this mandate,¹⁰ including a 2011 report that addressed the department's preliminary efforts to establish an approach to routinely monitor nonenrolled beneficiaries' access to care, among other issues.¹¹ More

⁷We include TRICARE Reserve Select beneficiaries in our definition of nonenrolled beneficiaries because, although they must enroll in the plan, they receive the same benefits as beneficiaries of TRICARE's Standard and Extra options.

⁸The TRICARE Prime option has five access standards that set requirements for the following: (1) travel time, (2) appointment wait time, (3) availability and accessibility of emergency services, (4) composition of network specialists, and (5) office wait time. See 32 C.F.R. § 199.17(p)(5) (2013).

⁹The mandate directed DOD to conduct these annual surveys for 4 years, beginning in fiscal year 2008. See Pub. L. No. 110-181, § 711(a), 122 Stat. 3, 190-91 (2008), H.R. Conf. Rep. No. 110-477, at 189-91, 940 (2007), and S. Rep. No. 110-77, at 359-60 (2007).

¹⁰GAO, *Defense Health Care: TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries*, [GAO-13-364](#) (Washington, D.C.: April 2, 2013); *Defense Health Care: DOD Lacks Assurance That Selected Reserve Members Are Informed About TRICARE Reserve Select*, [GAO-11-551](#) (Washington, D.C.: June 3, 2011); *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, [GAO-11-500](#) (Washington, D.C.: June 2, 2011); *Defense Health Care: 2008 Access to Care Surveys Indicate Some Problems, but Beneficiary Satisfaction Is Similar to Other Health Plans*, [GAO-10-402](#) (Washington, D.C.: March 31, 2010).

¹¹See [GAO-11-500](#).

recently, in 2013 we reported on the cumulative results of the department's 2008 through 2011 nonenrolled beneficiary and civilian provider surveys, and we found that these surveys indicated potential problems with access to care for nonenrolled beneficiaries in certain locations in all three TRICARE regions.¹² This report addresses the extent to which the TROs have assessed nonenrolled beneficiaries' access to care.

To determine the extent to which the TROs have assessed nonenrolled beneficiaries' access to care, we obtained relevant documentation and interviewed officials from the TRICARE Management Activity's (TMA) Policy and Operations Directorate, the three TROs, and the three contractors. Specifically, we obtained information on how the TROs have responded to a DOD 2010 action memo that contained recommendations to the TROs on how they should assess nonenrolled beneficiaries' access to civilian providers, including how to analyze and use the results from DOD's surveys of nonenrolled beneficiaries. We also compared this memo to the standards described in the *Standards for Internal Controls in the Federal Government* and the related *Internal Control Management and Evaluation Tool*,¹³ specifically the internal control activities that establish performance measures for evaluating and monitoring performance. In addition, we reviewed and analyzed data collected by the contractors and TMA's Beneficiary Education & Support Division on nonenrolled beneficiaries' inquiries and complaints. We interviewed Beneficiary Education & Support officials and obtained information from the contractors about the reliability of the data on beneficiaries' inquiries, and we determined that these data were sufficiently reliable for the purposes of our report. Finally, we spoke with representatives from military beneficiary organizations to discuss their perspectives on the TROs' efforts to monitor access to care for nonenrolled beneficiaries.

¹²See [GAO-13-364](#).

¹³See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives. The *Internal Control Management and Evaluation Tool* is based on the *Standards for Internal Control in the Federal Government*, and it is intended to provide a systematic approach to assessing an agency's internal control structure. It is one in a series of related documents we have issued to assist agencies in improving or maintaining effective operations. See GAO, *Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: August 2001).

Because the majority of our data collection occurred prior to the establishment of DHA on October 1, 2013, we refer to TMA throughout most of this report. When relevant, we refer to DHA for activities that occurred after that time.

We conducted this performance audit from June 2013 to April 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Background

TRICARE's Benefit Options

TRICARE provides benefits through several basic options for its non-Medicare-eligible beneficiary population. These options vary by the beneficiaries' locations, enrollment requirements, choices in civilian and military treatment facility providers, and required contribution toward the cost of their care. For example, beneficiaries living in PSAs can choose between TRICARE's Prime, Standard, and Extra options. In most instances, beneficiaries living in non-Prime Service Areas (non-PSA) can choose only between TRICARE Standard and TRICARE Extra. Table 1 provides a summary of some of these benefit options.

Table 1: Summary of TRICARE Benefit Options

TRICARE option	Description
TRICARE Prime	This managed care option requires enrollment, and all active duty servicemembers are required to use this option, while other TRICARE beneficiaries have a choice of benefit options. TRICARE Prime enrollees receive most of their care from providers at military treatment facilities, and also may receive care from network civilian providers. This option has the lowest out-of-pocket costs for beneficiaries.
TRICARE Standard and TRICARE Extra	TRICARE beneficiaries who choose not to enroll in TRICARE Prime may obtain health care from nonnetwork providers (TRICARE Standard) or network civilian providers (TRICARE Extra). The TRICARE Standard option is designed to provide beneficiaries with maximum flexibility in selecting providers; beneficiaries who obtain care from a network provider through TRICARE Extra pay lower copayments than they would under the TRICARE Standard option. TRICARE Standard and Extra beneficiaries also may receive care from military treatment facilities, though they have a lower priority for receiving care at these facilities than do TRICARE Prime enrollees.
TRICARE Reserve Select	TRICARE Reserve Select is a premium-based health plan that certain National Guard and Reserve members may purchase. ^a TRICARE Reserve Select beneficiaries may obtain health care from either nonnetwork or network providers, similar to beneficiaries using TRICARE Standard or Extra, respectively.

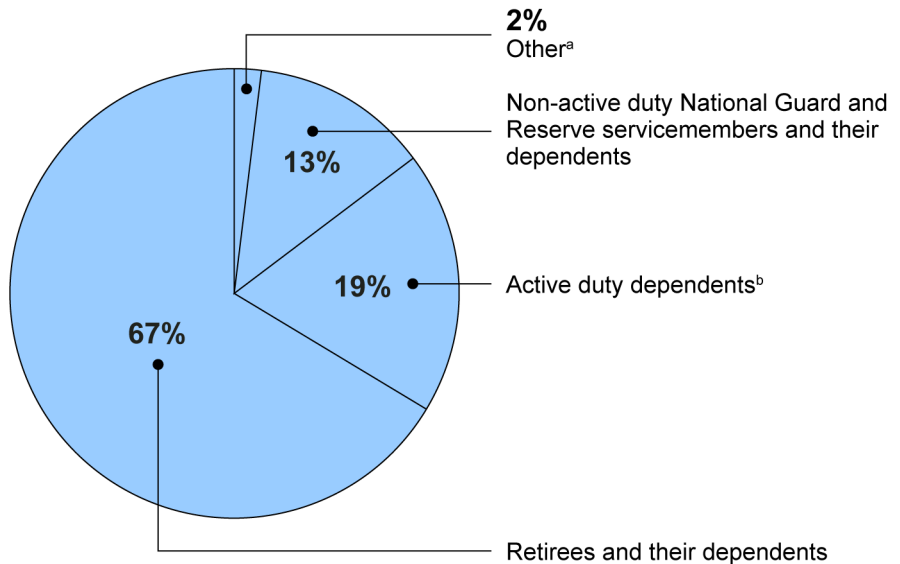
Source: GAO analysis of documentation from the Department of Defense.

^aTo be eligible for TRICARE Reserve Select, the beneficiary must be a member of the Selected Reserve or the Ready Reserve, and not eligible for or enrolled in the Federal Employees Health Benefits program, either under their own eligibility or through a family member who is enrolled in a family plan.

Composition of TRICARE's Nonenrolled Beneficiary Population

At the end of fiscal year 2013, TMA identified about 2.2 million nonenrolled beneficiaries (approximately 22 percent of the total eligible TRICARE population), who fell into three main categories: (1) retirees and their dependents, (2) active duty dependents, and (3) non-active duty National Guard and Reserve servicemembers and their dependents. (See fig. 1.)

Figure 1: Types and Percentages of Nonenrolled TRICARE Beneficiaries



Source: GAO analysis of data from the Department of Defense.

Notes: Nonenrolled beneficiaries are beneficiaries not enrolled in TRICARE Prime who are eligible for TRICARE's Standard or Extra options, as well as TRICARE Reserve Select enrollees. Data are for nonenrolled beneficiaries as of September 30, 2013, and percentages do not add up to 100 due to rounding.

^aOther nonenrolled beneficiaries include inactive Guard and Reserve sponsors who are not enrolled in TRICARE Prime, but have a transitional benefit following deactivation.

^bActive duty dependents include dependents of activated National Guard or Reserve servicemembers.

Most nonenrolled beneficiaries (81 percent) lived in PSAs at the end of fiscal year 2013. However, due to a recent policy change that eliminated some PSAs, the percentage of nonenrolled beneficiaries that lived in PSAs decreased to 67 percent on October 1, 2013.¹⁴

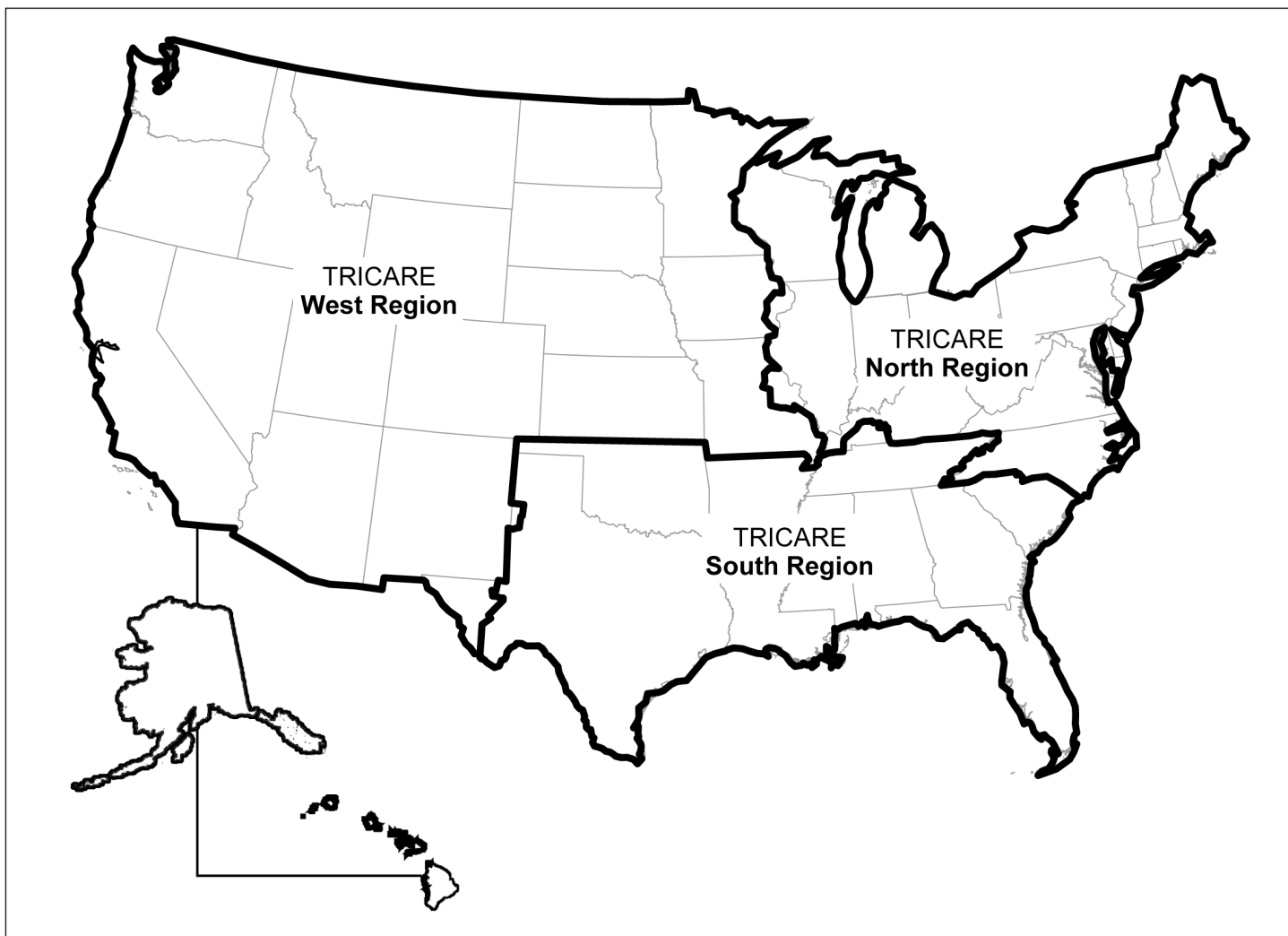
TRICARE Regional Structure and Contracts

Within the United States, TRICARE is organized into three main regions—North, South, and West. (See fig. 2 for a map of the three regions.) DHA (formerly TMA) and the TROs are responsible for

¹⁴Prior to October 1, 2013, the contractors had the option of developing additional PSAs, called Transitional PSAs, which were not located near military treatment facilities or Base Realignment and Closure (BRAC) sites. DOD directed the contractors to eliminate the Transitional PSAs as of October 1, 2013.

managing civilian health care through contractors in each of these regions. The TROs, in particular, are responsible for monitoring the quality and adequacy of contractors' provider networks and customer-satisfaction outcomes. The TROs also provide customer service to all TRICARE beneficiaries who request assistance, regardless of their enrollment status.

Figure 2: Location of TRICARE Regions in the United States



Sources: GAO analysis of data from the Department of Defense; Map Resources (map).

Note: Alaska and Hawaii are in TRICARE's West region.

Within their respective PSAs, the contractors in each region are required to establish and maintain adequate networks of civilian providers that must meet specific access standards for TRICARE Prime beneficiaries in five categories—travel time, appointment wait time, availability and accessibility of emergency services, composition of network specialists, and office wait time.¹⁵ However these access standards do not apply to nonenrolled beneficiaries. Nonetheless, the contractors are responsible for helping all TRICARE beneficiaries locate providers and for informing and educating TRICARE beneficiaries and providers on all aspects of the TRICARE program. In addition, they provide customer service to any TRICARE beneficiary who requests assistance, regardless of their enrollment status.

Under the current iteration of TRICARE managed care support contracts—referred to as TRICARE’s third generation managed care support contracts—health care delivery was scheduled to begin nationwide on April 1, 2010.¹⁶ However, due to sustained bid protests for each of the contracts and TMA’s implementation of related corrective actions, health care delivery started at different times in each of the TRICARE regions. TRICARE’s West region was the last of the three regions to transition to the third generation of contracts, with a health care delivery start date of April 1, 2013.¹⁷

¹⁵See 32 C.F.R. § 199.17(p)(5) (2013).

¹⁶TRICARE’s first and second generation managed care contracts were awarded in 1996/1997 and 2003, respectively.

¹⁷The managed care support contract’s health care delivery date in the North region was on April 1, 2011, and in the South region on April 1, 2012. For additional information on the third generation of TRICARE’s managed care support contracts and the associated bid protests, see GAO, *Defense Health Care: Acquisition Process for TRICARE’s Third Generation of Managed Care Support Contracts*, [GAO-14-195](#) (Washington, D.C.: March 7, 2014). As described in that report, an offeror—a competitor for a government contract—who was not awarded a contract may challenge a federal agency’s award or proposed award of a contract based on an alleged violation of statute or regulation. Such a challenge, known as a “post award bid protest,” may be filed with the contracting agency (referred to as an agency-level protest), the U.S. Court of Federal Claims, or GAO. GAO’s bid protest function—in contrast to its audit function—is an adjudicative process that is carried out by attorneys in GAO’s Procurement Law group, who prepare bid protest decisions resolving disputes concerning the awards of federal contracts.

TMA's Implementation of the NDAA 2008 Nonenrolled Beneficiary and Civilian Provider Surveys

In response to requirements contained in the NDAA 2008, TMA separately surveyed nonenrolled beneficiaries and civilian providers in each of four fiscal years, 2008 through 2011.¹⁸ In addition, to conduct the required surveys, TMA consulted with representatives of TRICARE beneficiaries and health care providers to identify locations where nonenrolled beneficiaries have experienced significant access problems, and then it oversampled nonenrolled beneficiaries and civilian health care providers in these areas. TMA also included specific questions in each survey to obtain certain information required by the act. For example, the beneficiary survey included questions to determine whether nonenrolled beneficiaries have difficulties finding a provider who will accept TRICARE, and the civilian provider survey included questions to determine whether civilian providers are aware of TRICARE. TMA was allocated nearly \$5.3 million to administer and analyze the 2008 through 2011 nonenrolled beneficiary and civilian provider surveys.

In accordance with the NDAA 2008, TMA identified benchmarks for analyzing the results of these surveys. For the 2008 through 2011 nonenrolled beneficiary survey, TMA used the results of the Department of Health and Human Services' (HHS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey to create eight benchmarks for nonenrolled beneficiaries' satisfaction with, and access to care under, the TRICARE program.¹⁹ For the 2008 through 2011 civilian provider surveys, TMA used the results of its 2005 through 2007 civilian physician surveys to create seven benchmarks for civilian

¹⁸The National Defense Authorization Act for Fiscal Year 2012 extended annual nonenrolled beneficiary and civilian provider surveys for another 4 years beyond the NDAA 2008 requirement, from fiscal years 2012 through 2015. See Pub. L. No. 112-81, § 721(a), 125 Stat. 1298, 1478 (2011).

¹⁹The CAHPS health plan survey is administered to beneficiaries of commercial health insurance, Medicare, Medicaid, and the Children's Health Insurance Program, by the health plans themselves. Results are voluntarily submitted each year to the National CAHPS Benchmarking Database, which is maintained by HHS's Agency for Healthcare Research and Quality.

physicians' awareness and acceptance of TRICARE beneficiaries.²⁰ (See app. I for the list of benchmarks for the nonenrolled beneficiary and civilian provider surveys.) TMA's Defense Health Cost Assessment and Program Evaluation Division administered the surveys, conducted the initial analyses on their results, and presented the results annually to relevant internal stakeholders, including the TROs. The TROs were responsible for sharing this information with their respective contractors and for determining what actions, if any, they and the contractors should take in response.

The TROs' Efforts to Assess Nonenrolled Beneficiaries' Access to Care Have Been Limited and Inconsistent due to Insufficient Guidance

In 2010, the Deputy Chief of TRICARE Policy and Operations issued an action memo to the Deputy Director of TMA that outlined four recommendations related to nonenrolled beneficiaries' access to care, including the utilization of specific methods for gauging the availability of providers for this population. The TROs concurred with the memo's recommendations, and the Deputy Director of TMA approved all but one of them. However, we found two of the memo's approved recommendations—which provide the strategy for monitoring and assessing nonenrolled beneficiaries' access to care—do not include sufficient guidance that specifies what process to follow or the type of criteria to use in determining whether nonenrolled beneficiaries' access to care is adequate. According to federal standards for internal controls, having a monitoring strategy that includes specific guidance is important for leadership to ensure that ongoing monitoring is effective and will trigger separate evaluations when problems are identified.²¹ In the absence of such guidance, we found that the TROs' efforts to implement the recommendations have resulted in limited and inconsistent methods for identifying and addressing areas with potential access problems, which in some instances have included the use of judgment in place of clear criteria for making these determinations. Consequently, DHA has no

²⁰The National Defense Authorization Act for Fiscal Year 2004 directed DOD to conduct surveys of civilian providers, which DOD did in 2005, 2006, and 2007. See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532 (2003), H.R. Conf. Rep. No. 108-354, at 719 (2003), and S. Rep. No. 108-46, at 330 (2003). TMA's 2005 through 2007 civilian physician surveys were sent to physicians (civilian primary care and specialty care physicians, including psychiatrists). TMA's 2008 through 2011 civilian provider surveys were sent to both physicians and nonphysician mental health care providers (including clinical social workers and psychologists).

²¹See [GAO/AIMD-00-21.3.1](#).

assurance that all potential problem areas are being consistently identified and managed across the TRICARE regions.

Each of the action memo's recommendations and the TROs' efforts to implement them are as follows:

First recommendation: The first recommendation advises the TROs to report to the Deputy Director of TMA on the results of the access questions from the nonenrolled beneficiary survey for their region, and to include any subsequent action plans to address the potential access problems they identify. However, this recommendation is silent on the type of methodology the TROs should use for analyzing the surveys' data or the specific criteria they should use for determining when their analyses should lead to subsequent action.

Without sufficient guidance for implementing this recommendation, we found that while the TROs all initially relied on TMA's analyses of the surveys' data, they varied in the extent to which they used these data to identify potential problem areas. Additionally, none of the TROs had a clearly documented methodology for how they used these data, including a rationale for when further actions should be taken.

- TRO-North officials told us that since 2010 they have used both the nonenrolled beneficiary and the civilian provider survey results to identify specific locations needing further analysis. Officials explained that they initially selected locations in their region that TMA's analysis identified as being below the national average for each of the surveys' benchmarks. According to TRO-North officials, their next step was to determine which of these selected locations had more than 500 nonenrolled beneficiaries, and these locations would be further analyzed with the beneficiary population sizing model—an analytical approach based on another recommendation in the memo and discussed in further detail later in this report.
- TRO-South officials told us that since 2009 they have used TMA's analysis of the nonenrolled beneficiary and civilian provider survey results as a basis to identify locations that may need additional action, such as outreach to providers. Specifically, using the nonenrolled beneficiary surveys' results, officials told us that they selected the locations in their region that TMA's analysis identified as being below the national average for the surveys' benchmarks. They also selected the locations in their region that they identified as being below the PSA average on the satisfaction-related questions. Using the results of the civilian provider surveys, TRO-South officials explained that

they selected the locations in their region that TMA's analysis identified as having lower percentages of civilian providers' awareness and acceptance of TRICARE than the national average for those benchmarks. For example, in 2012, after the completion of the 2008 through 2011 civilian provider surveys, TRO-South officials told us that they identified four PSAs in their region that fell below the national average for those provider benchmarks, and they asked the contractor to determine how to increase civilian provider awareness and acceptance in these four PSAs. In response to this request, the contractor faxed educational materials about TRICARE to providers in those areas to increase their awareness of the program.

- We found that TRO-West officials relied entirely on TMA's analyses of the surveys' data and did not take steps to further examine these data. Specifically, TRO-West officials told us that in 2010 and 2011, they asked the contractor to conduct outreach and education to providers in any areas in their region that TMA's analyses had identified as falling below the national average for either survey's benchmarks, which the contractor completed. TRO-West officials told us that they also asked the contractor to conduct similar education and outreach efforts in late 2012. According to a TRO-West official, however, the region was transitioning to a new contractor in 2012, and the outgoing contractor no longer provided reports of these education and outreach efforts; as a result, the TRO was unable to provide documentation that these efforts were completed.²²

Second recommendation: The second recommendation advises the TROs to establish a working group to adapt and standardize, to the extent possible, a beneficiary population-to-provider model to determine whether there are sufficient numbers of civilian providers to provide reasonable access to care. This model was to be based on the beneficiary population sizing model that had been independently developed by TRO-West to assess access to care for nonenrolled beneficiaries in the West region. The TRO-West model was designed to analyze locations with 500 or more nonenrolled beneficiaries and evaluate access to care using the Graduate Medical Education National Advisory Committee standards to estimate the appropriate number of required civilian providers based on a

²²The West region began transitioning to a new contractor in July 2012 and completed the transition in April 2013.

population-to-provider ratio.²³ Each TRO is to report to the Deputy Director of TMA on the results of its analysis, as well as provide action plans to address specific areas where the model identified potential access issues. In 2011, we found that each TRO had developed a model that generally followed the same methodology and included similar data as the TRO-West model with some regional variation. At that time, we reported that the TROs' models seemed reasonable, but that because they had only begun their implementation, it was too early to determine their effectiveness.²⁴

In this review, we found that the TROs' models have evolved, and that only TRO-West continues to use the original approach of applying criteria to population-to-provider ratios. The other two TROs mapped beneficiary-to-provider population densities in selected locations, but were not applying criteria to these data to identify potential problem areas. Instead, these TROs have used the mapping results along with additional information, such as beneficiary complaints and their contractor's reports on network adequacy as a basis for determining areas with potential access problems. Officials from these TROs told us that their approach was more multifaceted than the original model. However, in the absence of criteria, we found that they ultimately relied on their judgment to determine that no access problems existed in their regions. Additionally, TRO-West officials told us that even when their model's criteria identified areas with potential access problems for certain medical specialties, they used their judgment to determine that no access problems existed. Without clear criteria for identifying areas with potential access problems and determining whether additional action is needed, there is no assurance that the TROs' models are useful or consistent in gauging and addressing nonenrolled beneficiaries' access to care.

- TRO-North officials applied their model to the counties they identified through their analyses of the 2008 through 2011 nonenrolled beneficiary and civilian provider surveys' results, which consisted of 16 counties in 2012. For each identified location, TRO-North officials explained that they analyzed TRICARE claims over the previous

²³The Graduate Medical Education National Advisory Committee projected the need for and supply of physicians and other providers and developed guidelines for the geographic distribution of physicians. A key assumption in the model is that the providers will agree to treat the next nonenrolled beneficiary seeking treatment.

²⁴See [GAO-11-500](#).

12 months to determine the number of network and nonnetwork civilian providers in more than 25 specialty categories. Officials then mapped each location with nonenrolled beneficiary and civilian provider densities and used their judgment to determine whether the area had potential access problems. Specifically, they made this determination by correlating the model's results with other relevant information, including results from other beneficiary surveys, nonenrolled beneficiaries' correspondence to the TRO, and input from military treatment facility commanders. Based on this approach, TRO-North officials told us that they had not identified any locations of concern since they began using the model in 2010. However, these officials could not clearly describe the criteria for what constitutes an adequate number of providers in each area, or what information from the additional sources would indicate a potential access problem, triggering the need to develop and implement a plan of action for a particular location.

- TRO-South officials applied their model to the top 25 counties in their region that they identified as having at least 500 nonenrolled beneficiaries. For each county, TRO-South officials analyzed TRICARE claims submitted over the previous 12 months to determine the number of network and nonnetwork civilian providers by four broad specialty categories.²⁵ Officials then mapped each location with nonenrolled beneficiary and civilian provider densities to determine if all counties with high beneficiary concentrations also had a high provider density. For example, the map uses incremental shading to depict the number of beneficiaries in four categories (500 to 999 beneficiaries, 1,000 to 4,999, 5,000 to 9,999, and 10,000 to 22,000) and the number of providers from 1 to 3,000. Based on the results of the mapping, along with a review of beneficiary complaints, officials told us that they used their judgment to determine whether any of the locations had potential access problems. Officials stated that based on the mapping results and the small number of beneficiary complaints they have received, they have not identified any locations with potential access problems since they began using the model in 2011. However, TRO-South officials could not clearly describe what criteria they used in making this determination, including what concentration of beneficiaries should have what density of providers in each area, or what defined a "small number" of complaints.

²⁵These four categories (primary care, orthopedics, obstetrics and gynecology, and mental health) included many of the same specialties analyzed in TRO-North's model.

-
- TRO-West officials applied their model to zip codes that they identified as having more than 500 nonenrolled beneficiaries, which consisted of 68 groups of zip codes in 2013. For each of these groups, TRO-West officials analyzed TRICARE claims submitted over the previous 13 months to determine the number of network and nonnetwork civilian providers by 27 specialty categories. TRO-West officials explained that they use this information to calculate a ratio of nonenrolled beneficiaries to civilian providers, by specialty category, in each of the groups of zip codes included in the analysis. Using the Graduate Medical Education National Advisory Committee model's ratios, TRO-West officials found that each of the 68 groups of zip codes had at least one specialty group that fell below the ratio, meaning that these areas may not have an adequate number of civilian provider specialties to meet the needs of the areas' nonenrolled beneficiary population. However, TRO-West officials told us that they used their judgment to determine that they did not need to take any actions because they had not received any inquiries or complaints from nonenrolled beneficiaries, military treatment facility commanders, or congressional staff about access problems in these locations.²⁶

Third recommendation: The third recommendation involved a modification to the managed care support contracts that would require the contractors to provide the TROs with standardized reports about access inquiries and complaints received from nonenrolled beneficiaries. It also recommended that the TROs report to the Deputy Director of TMA on the results of these reports, including the TROs' development of action plans to address any access issues identified in the reports. The Deputy Director of TMA did not approve this recommendation and cited a lack of evidence that it would provide a result that had a return on investment.

Nonetheless, as we have previously reported, TMA and the contractors already collect data on complaints and inquiries for all beneficiaries, including nonenrolled beneficiaries.²⁷ However, TMA has cautioned us that these data are not representative because not all beneficiaries will communicate when they have a question or complaint. Our analysis of

²⁶In addition, TRO-West officials also use the model to compile a list of network and nonnetwork providers in these areas that can be used as a provider directory when nonenrolled beneficiaries inquire about finding a civilian provider in these locations.

²⁷See [GAO-11-500](#).

the Beneficiary Education & Support Division's and the contractors' data found that of those nonenrolled beneficiaries who made a complaint or inquiry, access to care was a relatively minor issue for fiscal years 2011 through 2013.²⁸ For example, about 6 percent of inquiries and complaints documented in the Beneficiary Education & Support Division's database during this time were from nonenrolled beneficiaries, and of those, less than 1 percent were related to access to care. Additionally, of the access complaints received by contractors in fiscal year 2013, about 2 percent in the South region and about 5 percent in the North region were from nonenrolled beneficiaries.²⁹

Fourth recommendation: The fourth recommendation advises TMA to establish the capability for beneficiaries to search online for nonnetwork civilian providers within the continental United States. However, when we previously reported on this effort in 2011, we noted that TMA did not have sufficient data to develop this online search tool.³⁰ Instead, TMA officials decided that under the current generation of TRICARE contracts, each contractor would be responsible for creating an online provider directory for its region that would include information for beneficiaries on TRICARE-authorized providers, both network and nonnetwork. Officials told us that by early 2013, each of the three region's contractors had produced an online nonnetwork civilian provider directory.

Conclusions

TMA has devoted significant resources over the past decade—largely through national surveys of beneficiaries and civilian providers—in determining whether nonenrolled beneficiaries have adequate access to health care. However, the lack of access standards for this population has significantly limited the department's ability to make these determinations. While identifying access problems and taking action are largely the responsibility of the TROs, TMA's guidance to them lacked the level of specificity needed for conducting the recommended analyses of the available data, including from the beneficiary and provider surveys and

²⁸DOD's Beneficiary Education and Support division was a part of TMA prior to October 1, 2013.

²⁹The West region's contractor began health care delivery on April 1, 2013, and the inquiries and complaints from this contractor could not yet be separated by beneficiary type.

³⁰[GAO-11-500](#).

the beneficiary population sizing model. Furthermore, TMA's guidance for these analyses also lacked criteria for clearly identifying areas with potential access problems. Not only did this result in inconsistent and limited efforts across the regions, but TRO officials relied predominantly on their own judgment to determine whether access problems existed. In many instances, officials cited the number of beneficiary complaints—an admittedly unreliable measure—as a key factor in determining that there were no access problems even when the data indicated otherwise. Although TMA established a framework for the TROs to assess nonenrolled beneficiaries' access to care, more-specific guidance for conducting these analyses and interpreting their results would provide a more rigorous and consistent approach across the regions for identifying areas with potential access problems and determining whether actions should be taken, in accordance with internal control standards for effective monitoring. Without such guidance, DHA—which assumed oversight responsibility for TRICARE in 2013—cannot provide reasonable assurance that the TROs' efforts to assess access to care for nonenrolled beneficiaries are effective or that its own efforts to field and analyze large, costly surveys are providing useful data.

Recommendation for Executive Action

We recommend that the Secretary of Defense require the Director of DHA to enhance existing guidance for the TROs to include more specificity on assessing nonenrolled beneficiaries' access to care. Specifically, the guidance should contain criteria for analyzing and interpreting the nonenrolled beneficiary and civilian provider surveys' results and the beneficiary population sizing model to facilitate a more rigorous and consistent approach across regions for identifying locations with potential access problems and determining whether actions should be taken.

Agency Comments

We provided a draft of this report to DOD for comment. DOD concurred with our finding, conclusions, and recommendation. DOD stated that the Director of DHA will enhance guidance to the TROs to include more specificity on assessing nonenrolled beneficiaries' access to care. However, DOD did not provide a time frame for when this guidance would be developed.

DOD's comments are reprinted in appendix II. DOD did not provide any technical comments.

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

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



Debra A. Draper
Director, Health Care

Appendix I: Benchmarks for TRICARE Management Activity's 2008 through 2011 Surveys

In accordance with the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008), the Department of Defense's TRICARE Management Activity (TMA) identified benchmarks for analyzing the results of the nonenrolled beneficiary and civilian provider surveys.¹ Because TMA based some of its nonenrolled beneficiary survey questions on those included in the Department of Health and Human Services' (HHS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey, it was able to compare the results of those questions with its 2008 through 2011 nonenrolled beneficiary survey results.² This resulted in eight benchmarks for nonenrolled beneficiaries' satisfaction with, and access to care under, the TRICARE program. Table 2 lists the eight benchmarks.

Table 2: TRICARE Management Activity (TMA) Benchmarks for Its 2008 through 2011 Nonenrolled Beneficiary Surveys

Benchmark categories	Benchmark (percentage)
Global ratings (rating of 8 or higher on a 0-10 scale)	
1. Rating of health plan	64 ^a
2. Rating of health care	77 ^a
3. Rating of personal doctor	76 ^a
4. Rating of specialist doctor	77 ^a
Access ratings	
5. Access to personal doctor	69 ^b
6. Access to specialist doctor	77 ^b
7. Getting needed care	79 ^c
8. Getting care quickly	79 ^d

Source: GAO analysis of data from TMA.

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

²The CAHPS health plan survey is administered to beneficiaries of commercial health insurance, Medicare, Medicaid, and the Children's Health Insurance Program, by the health plans themselves. Results are voluntarily submitted each year to the National CAHPS Benchmarking Database, which is maintained by HHS's Agency for Healthcare Research and Quality.

**Appendix I: Benchmarks for TRICARE
Management Activity's 2008 through 2011
Surveys**

Notes: Information in this table is based on interviews with TMA officials, and we did not verify that the methods for determining the benchmarks were accurate. TMA used the results of the Department of Health and Human Services' (HHS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan surveys as its benchmarks. The CAHPS health plan survey is administered to beneficiaries of commercial health insurance, Medicare, Medicaid, and the Children's Health Insurance Program, by the health plans themselves. Results are voluntarily submitted each year to the National CAHPS Benchmarking Database, which is maintained by HHS's Agency for Healthcare Research and Quality.

^aThis percentage is based on the national average for commercial beneficiaries, adjusted to match the age and health status of TRICARE Standard respondents, who answered with a rating of 8 or higher in the 2006 version of the CAHPS health plan survey. For rating of health plan: "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?" For rating of health care: "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all of your health care in the last 12 months?" For rating of personal doctor: "Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible and 10 is the best personal doctor or nurse possible, what number would you use to rate your personal doctor or nurse?" For rating of specialist doctor: "Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist? (For the specialist you saw most often in the last 12 months)."

^bThis percentage is based on the national average for commercial beneficiaries, adjusted to match the age and health status of TRICARE Standard respondents, who answered "not a problem" in the 2006 version of the CAHPS health plan survey. For access to personal doctor: "Since you joined your health plan, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?" For access to specialist doctor: "In the last 12 months, how much of a problem, if any, was it to see a specialist that you needed to see?"

^cThis percentage is based on the average of the adjusted national averages for access to personal doctor, access to specialist doctor, and two other averages about access or delays: (1) beneficiaries who answered "not a problem" to the question that asked "In the last 12 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?" (2) beneficiaries who either answered "no" to the question that asked "In the last 12 months, did you need approval from your health plan for any care, tests, or treatment?" or "no problem" to the question that asked "In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?"

^dThis percentage is based on the national average for commercial beneficiaries, adjusted to match the age and health status of TRICARE Standard respondents, who answered "usually" or "always" to the question "In the last 12 months, when you needed care right away for an illness, injury, or condition, how often did you get care as soon as you wanted?" in the 2006 version of the CAHPS health plan survey.

To establish benchmarks for its civilian provider survey, TMA compared the results of its 2008 through 2011 civilian provider surveys with the results of its 2005 through 2007 civilian physician surveys.³ This resulted

³The National Defense Authorization Act for Fiscal Year 2004 directed DOD to conduct surveys of civilian providers, which DOD did in 2005, 2006, and 2007. See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532 (2003), H.R. Conf. Rep. No. 108-354, at 719 (2003), and S. Rep. No. 108-46, at 330 (2003). TMA's 2005 through 2007 civilian physician surveys were sent to physicians (civilian primary care and specialty care physicians, including psychiatrists). TMA's 2008 through 2011 civilian provider surveys were sent to both physicians and nonphysician mental health care providers (including clinical social workers and psychologists).

Appendix I: Benchmarks for TRICARE Management Activity's 2008 through 2011 Surveys

in seven benchmarks for civilian providers' awareness and acceptance of TRICARE beneficiaries. Table 3 lists these seven benchmarks.

Table 3: TRICARE Management Activity (TMA) Benchmarks for Its 2008 through 2011 Civilian Provider Surveys

Benchmark category	Benchmark (percentage)
1. Civilian physicians' awareness	87 ^a
2. Civilian physicians' acceptance of new patients	92 ^b
3. Civilian physicians' acceptance of new TRICARE Standard patients (for all claims or on a claim-by-claim basis only)	76 ^c
4. Civilian physicians' acceptance of new TRICARE Standard patients (for all claims), if they are accepting new TRICARE Standard patients	91 ^d
5. Civilian physicians' acceptance of new TRICARE Standard patients, if they are accepting any new patients	81 ^e
6. Civilian physicians' acceptance of new Medicare patients	88 ^f
7. Civilian physicians' acceptance of new TRICARE Standard patients, if they are accepting new Medicare patients	87 ^g

Source: GAO analysis of data from TMA.

Notes: Information in this table is based on interviews with TMA officials, and we did not verify that the methods for determining the benchmarks were accurate. TMA used the results of its 2005 through 2007 surveys of civilian physicians, which were sent to physicians only (civilian primary care and specialty care physicians, including psychiatrists), and did not include nonphysician mental health providers, such as clinical social workers and psychologists. TMA's 2008 through 2011 civilian provider surveys were sent to both physicians and nonphysician mental health care providers.

^aThis percentage is based on the national average of respondents that answered yes to the following question: "Is the provider aware of the TRICARE health care program?"

^bThis percentage is based on the national average of respondents that answered yes to the following question: "As of today, is the provider accepting any new patients?"

^cThis percentage is based on the national average of respondents that answered "for all claims" or on a "claim-by-claim basis" to the following question: "As of today, is the provider accepting new TRICARE Standard patients?"

^dThis percentage is based on the national average of respondents that answered "Yes, for all claims" to the following question: "As of today, is the provider accepting new TRICARE Standard patients?" and yes to the following question: "As of today, is the provider accepting new TRICARE Standard patients?"

^eThis percentage is based on the national average of respondents that answered yes to the following questions: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents providers' indications that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

^fThis percentage is based on the national average of respondents that answered yes to the following question: "As of today, is the provider accepting new Medicare patients?"

^gThis percentage is based on the national average of respondents that answered yes to the following questions: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents providers' indications that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR - 8 2014

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

Dear Ms. Draper:

Attached is the Department of Defense's response to the Government Accountability Office (GAO) Draft Report GAO-14-384, "DEFENSE HEALTH CARE: More Specific Guidance Needed for Assessing Non-Enrolled TRICARE Beneficiaries' Access to Care," dated March 10, 2014 (GAO Code 291141). Thank you for the opportunity to review and comment on the draft report.

I concur with the report's conclusion and findings. The Director, Defense Health Agency, will enhance guidance to the TRICARE Regional Offices to include more specificity on assessing non-enrolled beneficiaries' access to care.

Please direct any questions to the points of contact on this matter, Mr. Mark Ellis, Functional and Mr. Gunther Zimmerman, Audit Liaison. Mr. Ellis may be reached at (703) 681-0039, or Mark.Ellis@dha.mil. Mr. Zimmerman may be reached at (703) 681-4360, or Gunther.Zimmerman@dha.mil.

Sincerely,

Jonathan Woodson, M.D.

Attachment:
As stated

GOVERNMENT ACCOUNTABILITY OFFICE
DRAFT REPORT – DATED MARCH 10, 2014
(GAO-14-384)

“DEFENSE HEALTH CARE: More Specific Guidance Needed for Assessing Non-
Enrolled TRICARE Beneficiaries’ Access to Care”

DEPARTMENT OF DEFENSE COMMENTS

RECOMMENDATION: We recommend that the Secretary of Defense require the Director, Defense Health Agency, to enhance existing guidance for the TRICARE Regional Offices to include more specificity on assessing non-enrolled beneficiaries’ access to care. Specifically, the guidance should contain criteria for analyzing and interpreting the non-enrolled beneficiary and civilian provider surveys’ results and the beneficiary application sizing model to facilitate a more rigorous and consistent approach across regions for identifying locations with potential access problems and determining whether actions should be taken.

DOD RESPONSE: Concur.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

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

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