



April 2018

DEFENSE HEALTH CARE

TRICARE Select Implementation Plan Included Mandated Elements, but Access Standards Should Be Clarified

GAO Highlights

Highlights of [GAO-18-358](#), a report to congressional committees.

Why GAO Did This Study

DOD offers health care services to approximately 9.4 million eligible beneficiaries through TRICARE, DOD's regionally structured health care program. In each of its regions, DOD uses contractors to manage health care delivery through civilian provider networks, among other tasks.

The NDAA 2017 made several changes to the TRICARE program, including the establishment of a new preferred provider network health plan option called TRICARE Select. The NDAA 2017 also required DOD to develop an implementation plan for TRICARE Select that addresses seven specific mandated elements on access to care, beneficiary complaints, and quality metrics for network providers.

The NDAA 2017 included a provision for GAO to review the implementation plan. This report examines the extent to which DOD's implementation plan addressed the mandated elements. GAO evaluated DOD's implementation plan using leading planning practices identified in GAO's prior work and standards for internal control. GAO examined program policies, procedures, and contracts and interviewed DOD officials and TRICARE regional contractors.

What GAO Recommends

GAO recommends that DOD provide written documentation of its approach for developing and approving the TRICARE Select access standards, as well as the final access standards, to Congress. DOD agreed with GAO's recommendation.

View [GAO-18-358](#). For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.

April 2018

DEFENSE HEALTH CARE

TRICARE Select Implementation Plan Included Mandated Elements, but Access Standards Should Be Clarified

What GAO Found

The Department of Defense's (DOD) TRICARE Select Implementation Plan addressed the seven specific elements mandated by the National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017). These elements are

- Element A: ensuring that at least 85 percent of the TRICARE Select beneficiary population is covered by the network by January 1, 2018;
- Element B: ensuring access standards for health care appointments;
- Element C: establishing mechanisms for monitoring compliance with standards for access to care;
- Element D: establishing health care provider-to-beneficiary ratios;
- Element E: monitoring complaints by beneficiaries with respect to network adequacy and health care provider availability;
- Element F: establishing requirements for mechanisms to monitor the responses to complaints by beneficiaries; and
- Element G: establishing mechanisms to evaluate the quality metrics of the network providers.

GAO also assessed the implementation plan against leading practices for sound strategic management planning and found that it incorporated many of the practices, such as establishing goals, strategies to achieve goals, and plans to assess progress. However, a few of the leading practices were only partially incorporated or not incorporated at all. For example, the implementation plan did not always fully address the leading practice that planning documents include strategies to achieve goals and plans to assess progress. DOD officials explained that some of the details of their approach to the elements had not been finalized when they were completing the implementation plan. These officials added that their approach to the implementation plan was to create a strategic overview, and that some of the details are contained in contract documents and monitored through their oversight responsibilities.

Furthermore, GAO's assessment of the plan's elements found that the approach outlined in the implementation plan for ensuring access standards for health care appointments (Element B) is different from the approach DOD intends to use. The plan noted that DOD will use the access standards for TRICARE Prime—a managed care option—for TRICARE Select. However, DOD officials told GAO that the contractors are responsible for developing their own access standards, which DOD must approve. These officials added that DOD did not include information about the contractors proposing their own access standards because DOD was still developing its approach to this element when the plan was submitted. Because the implementation plan does not reflect DOD's current approach, Congress may not have the information it needs about the contractors' responsibilities for providing access to care, impeding its ability to provide oversight.

Contents

Letter		1
	Background	3
	DOD's TRICARE Select Implementation Plan Included the Mandated Elements and Addressed Most Leading Planning Practices, but Does Not Reflect Current Approach for Access Standards	7
	Conclusions	12
	Recommendation for Executive Action	13
	Agency Comments	13
Appendix I	Leading Practices for Strategic Management Planning as Identified by GAO's Prior Work	14
Appendix II	Comments from the Department of Defense	15
Appendix III	GAO Contact and Staff Acknowledgments	16
Tables		
	Table 1: Summary of Selected Past and Current TRICARE Options	4
	Table 2: Extent to Which the Department of Defense's (DOD) August 2017 TRICARE Select Implementation Plan Addressed Select Leading Practices for Sound Strategic Management Planning	8
	Table 3: Six Leading Practices for Strategic Management Planning Identified by GAO's Prior Work	14

Abbreviations

DHA	Defense Health Agency
DOD	Department of Defense
MTF	military treatment facility
NDAAs 2017	National Defense Authorization Act for Fiscal Year 2017

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



April 13, 2018

The Honorable John McCain
Chairman
The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

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

In fiscal year 2017, the Department of Defense (DOD) offered health care services to over 9 million beneficiaries in the United States and abroad through TRICARE, DOD's regionally structured health care program.¹ In the past, beneficiaries had their choice of coverage among TRICARE's three basic health plan options—TRICARE Prime, a managed care option; TRICARE Standard, a fee-for service option; and TRICARE Extra, a preferred provider organization option.² The National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017) required DOD to terminate two of these options, TRICARE Standard and Extra, and establish a new self-managed preferred provider option called TRICARE Select no later than January 1, 2018.³ According to DOD, this change will modernize the TRICARE benefit—specifically by introducing a

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

²Active duty servicemembers are required to use TRICARE Prime. TRICARE offers several other plans, including TRICARE Reserve Select (for certain Reserve servicemembers and their dependents), TRICARE Retired Reserve (for certain retired Reserve servicemembers and their families), and TRICARE Young Adult (Prime and Select options, for servicemembers' dependents who are at least age 21 but not yet 26 years old). TRICARE also offers TRICARE for Life to TRICARE beneficiaries who are eligible for Medicare and enroll in Part B. Under TRICARE for Life, TRICARE processes claims after they have been adjudicated by Medicare.

³Pub. L. No 114-328, §§ 701(a)(1) and (c), 130 Stat. 2000, 2180, 2187 (2016).

progressive health plan model with enrollment requirements for beneficiaries. It is also intended to improve beneficiaries' access to care—an issue we have previously reported on for beneficiaries who used the TRICARE Standard and Extra options.⁴

The NDAA 2017 also required DOD to develop an implementation plan for TRICARE Select that includes seven specifically defined elements on access to care, including elements related to TRICARE Select's network coverage, access standards for health care appointments, beneficiary complaints about network coverage and access, and quality metrics for providers.⁵ DOD submitted this plan to Congress on August 7, 2017. The NDAA 2017 included a provision for us to review the adequacy of the plan in addressing the mandated elements.⁶ In this report, we examine the extent to which DOD's implementation plan for TRICARE Select addressed these elements.

To conduct this assessment, we reviewed DOD's implementation plan, TRICARE program policies and procedures, and contract documents that require specific access-related plans and data reports from the contractors. We compared this information with the plan elements mandated by the NDAA 2017, leading practices for strategic management planning identified by our prior work, and standards for internal controls in the federal government.⁷ (See app. I.) We also interviewed DOD officials,

⁴For example, see GAO, *Defense Health Care: More-Specific Guidance Needed for Assessing Nonenrolled TRICARE Beneficiaries' Access to Care*, [GAO-14-384](#) (Washington, D.C.: Apr. 28, 2014); *Defense Health Care: TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries*, [GAO-13-364](#) (Washington, D.C.: Apr. 2, 2013); and *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, [GAO-11-500](#) (Washington, D.C.: June 2, 2011).

⁵Pub. L. No. 114-328, § 701(c), 130 Stat. at 2187-2188. The NDAA 2017 also included two additional implementation plan elements that were to be included if necessary or appropriate: (1) making recommendations for legislative action to carry out the plan, as necessary, and (2) any other element determined to be appropriate. Because these two elements were not addressed in DOD's implementation plan, we did not include them in the scope of our review.

⁶ Pub. L. No 114-328, § 701(c), 130 Stat. at 2188.

⁷For an example of our prior work, see GAO, *Military Readiness: DOD Needs to Incorporate Elements of a Strategic Management Planning Framework into Retrograde and Reset Guidance*, [GAO-16-414](#) (Washington, D.C.: May 13, 2016). Also, see GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

including officials from the Defense Health Agency (DHA), which oversees the TRICARE program, and the TRICARE Regional Offices, which oversee health care delivery in each TRICARE region, to understand the development and function of the plan, as well as the planned approach to addressing each element. We also interviewed representatives of the managed care support contractors, which manage health care delivery through civilian provider networks in each region, among other tasks, to understand any challenges related to implementation of the mandated elements.

We conducted this performance audit from July 2017 to April 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

TRICARE Regional Structure and Contracts

Under TRICARE, beneficiaries may obtain health care through DOD's system of military hospitals and clinics, referred to as military treatment facilities (MTF), or from civilian providers. DHA uses managed care support contractors to develop networks of civilian providers, referred to as network providers, to serve all TRICARE beneficiaries in geographic areas called Prime Service Areas.⁸ The contractors also perform other customer service functions, such as processing claims and assisting beneficiaries with finding providers. Each TRICARE region within the United States has a managed care support contractor. In July 2016, DOD awarded its fourth generation of TRICARE managed care support contracts. The new contracts reduced the number of TRICARE regions from three (North, South, and West) to two (East and West).⁹ On January

⁸Prime Service Areas are geographic areas determined by the Assistant Secretary of Defense for Health Affairs and are usually within an approximate 40-mile radius of an MTF and at all Base Realignment and Closure 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.

⁹The East region resulted from the merger of the North and South regions.

1, 2018, the TRICARE program began health care delivery under these contracts.

TRICARE’s Health Plan Options

Prior to January 1, 2018, TRICARE’s non-Medicare-eligible beneficiary population could obtain care through three basic health plan options—TRICARE Prime (managed care), TRICARE Standard (fee-for-service), and TRICARE Extra (preferred provider organization)—that varied by enrollment requirements, choices in civilian providers, and whether there were established access standards.¹⁰ Beginning January 1, 2018, the TRICARE Standard and Extra options were terminated and TRICARE Select, a self-managed, preferred provider option, was established. (See table 1.)

Table 1: Summary of Selected Past and Current TRICARE Options

TRICARE option	Description of option
TRICARE Prime	<ul style="list-style-type: none"> This managed care option requires enrollment.^a There is no enrollment fee for active duty servicemembers and their families, but most other beneficiaries must pay an annual enrollment fee. Active duty servicemembers are required to use TRICARE Prime, while other beneficiaries have a choice. Enrollees obtain most of their care from providers at military treatment facilities (MTF) but also may obtain care from TRICARE’s network of civilian providers (network providers). There are established access standards for this option.^b
TRICARE Standard and TRICARE Extra (Terminated on January 1, 2018)	<ul style="list-style-type: none"> These options did not require enrollment. Beneficiaries could obtain health care from nonnetwork providers under TRICARE Standard, the fee-for-service option. Beneficiaries could also choose to obtain care from network civilian providers under TRICARE Extra, the preferred provider option. Beneficiaries were also able to receive care from MTFs, though they had a lower priority for receiving care than TRICARE Prime beneficiaries. There were no established access standards for these options.

¹⁰The TRICARE non-Medicare-eligible beneficiary population includes all beneficiaries—such as active duty personnel and their dependents, National Guard and Reserve servicemembers and their dependents, and retired servicemembers and their dependents or survivors—who do not meet the requirements for obtaining health care coverage under Medicare. Medicare is available, generally, to people age 65 or older, younger people with disabilities, and people with end-stage renal disease.

TRICARE option	Description of option
TRICARE Select (Established on January 1, 2018)	<ul style="list-style-type: none"> • This self-managed, preferred provider option requires enrollment.^a • There is no enrollment fee for active duty servicemembers and their families, but most other beneficiaries must pay an annual enrollment fee.^c • Beneficiaries are able to obtain health care from network and nonnetwork providers.^d • Beneficiaries are also able to receive care from MTFs, though they have a lower priority for receiving care than TRICARE Prime beneficiaries. • Access standards are required for this option.

Source: GAO summary of TRICARE program information. | GAO-18-358

^aPrior to January 1, 2019, beneficiaries are able to change plans at any time. On or after January 1, 2019, beneficiaries will only be able to change plans during an annual open enrollment season or within a certain time period following a qualifying life event. Qualifying life events include military changes—such as activating or deactivating, deploying, separating from active duty, or retiring—and family events—such as getting married or divorced, having or adopting a baby, becoming Medicare-eligible, or experiencing a death in the family. In general, beneficiaries are able to make enrollment changes within 90 days of such an event.

^bThe TRICARE Prime option has five access standards that set requirements for the following: (1) travel time to provider sites, (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) (2017).

^cThe amount of this enrollment fee is based upon a sponsor's initial enlistment date, among other factors.

^dNonnetwork providers are those providers that are not in the TRICARE network, but are certified to see TRICARE patients.

Beneficiaries using the TRICARE Standard and Extra options as of December 31, 2017, were automatically enrolled in TRICARE Select on January 1, 2018. Beneficiaries are allowed to change their plan at any time prior to January 1, 2019, after which they will only be able to change plans during an annual open enrollment season or within a certain time period following a qualifying life event.¹¹ In August 2017, DOD estimated that over 2 million beneficiaries will be enrolled in TRICARE Select, which is approximately the same number of beneficiaries who used the TRICARE Standard option. According to DOD, approximately 66 percent of these beneficiaries resided in a Prime Service Area—where networks of civilian providers have been established.

¹¹Qualifying life events include military changes—such as activating or deactivating, deploying, separating from active duty, or retiring—and family events, such as getting married or divorced, having or adopting a baby, becoming Medicare-eligible, or experiencing a death in the family. In general, beneficiaries are able to make enrollment changes within 90 days of such an event.

TRICARE Select Implementation Plan

In addition to establishing the TRICARE Select option and making other TRICARE program changes, the NDAA 2017 required DOD to develop an implementation plan for TRICARE Select that includes seven specific elements. These elements are, in part, intended to ensure beneficiaries' access to care under the TRICARE Select option, and they require DOD to

- ensure that at least 85 percent of the beneficiary population under TRICARE Select is covered by the network by January 1, 2018 (Element A);
- ensure access standards for appointments for health care that meet or exceed those of high-performing health care systems in the United States, as determined by the Secretary (Element B);
- establish mechanisms for monitoring compliance with access standards (Element C);
- establish health care provider-to-beneficiary ratios (Element D);
- monitor on a monthly basis complaints by beneficiaries with respect to network adequacy and the availability of health care providers (Element E);
- establish requirements for mechanisms to monitor the responses to complaints by beneficiaries (Element F); and
- establish mechanisms to evaluate the quality metrics of the network providers established under section 728 (of the NDAA 2017) (Element G).¹²

¹²Section 728 of the NDAA 2017 requires that DOD, to the extent appropriate, adopt the core quality performance metrics agreed upon by the Core Quality Measures Collaborative, which comprises officials from the Centers for Medicare & Medicaid Services and representatives of health care organizations such as America's Health Insurance Plans, for use by the military health system and in contracts awarded to carry out the TRICARE program. Pub. L. No. 114-328, § 728(a)(1), 130 Stat. at 2233.

DOD's TRICARE Select Implementation Plan Included the Mandated Elements and Addressed Most Leading Planning Practices, but Does Not Reflect Current Approach for Access Standards

DOD's Implementation Plan Included the Mandated Elements and Addressed Most Leading Practices for Strategic Management Planning

The TRICARE Select implementation plan DOD submitted to Congress included the seven specific elements mandated by the NDAA 2017. Specifically, the implementation plan described the upcoming changes to the TRICARE benefit and included individual sections outlining DOD's approach for implementing each of the required elements. For example, for element A—ensure that at least 85 percent of the beneficiary population under TRICARE Select is covered by the network by January 1, 2018—DOD described, among other things, how the regional contractors will identify geographic areas with concentrations of TRICARE Select beneficiaries and how they will establish a sufficient provider network to serve that population.

We also found that the implementation plan reflected most of the leading practices for sound strategic management planning as identified by our prior work.¹³ (See table 2.) These leading practices suggest that strategic planning documents include the following: (1) a mission statement, (2)

¹³GAO, *Military Readiness: DOD Needs to Incorporate Elements of a Strategic Management Planning Framework into Retrograde and Reset Guidance*, [GAO-16-414](#) (Washington, D.C.: May 13, 2016). See app. I for a listing of GAO's leading practices for strategic management planning. For the purposes of this report, we combined the practices "use of metrics to gauge progress" and "evaluations of the plan to monitor goals and objectives" into a single category, referred to as "plans to assess progress" and renamed the practice "external factors that could affect goals" to "challenges and risks."

goals, (3) strategies to achieve goals, (4) plans to assess progress, and (5) identification of challenges and risks. For example, DOD’s implementation plan clearly articulated a mission statement, which is “to ensure beneficiaries receive the right level of care, at the right time, delivered by the right provider.”¹⁴ Additionally, for six of the mandated elements, DOD’s implementation plan outlined the goal, strategies to achieve the goal, and how DOD will assess progress. (See elements A, B, C, D, E, and F in table 2.) This information is supplemented by contract documents that require specific plans and data reports from the managed care support contractors. For example, for element A—ensure that at least 85 percent of the beneficiary population is covered by the network—each managed care support contractor is required to submit monthly performance reports that show that a sufficient number of providers in primary and specialty care are available to meet access requirements. While DOD’s implementation plan addressed many of our leading practices, there were instances where some of the leading practices were only partially addressed or not addressed at all. For example, none of the mandated elements incorporated the leading practice related to identifying the challenges and risks that could affect the success of the element.

Table 2: Extent to Which the Department of Defense’s (DOD) August 2017 TRICARE Select Implementation Plan Addressed Select Leading Practices for Sound Strategic Management Planning

National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017) mandated elements	Select leading practices for planning			
	Goals	Strategies to achieve goals	Plans to assess progress	Challenges and risks
Element A: Ensure that at least 85 percent of the beneficiary population under TRICARE Select is covered by the network by January 1, 2018	●	●	●	○
Element B: Ensure access standards for appointments for health care that meet or exceed those of high-performing health care systems in the United States, as determined by the Secretary	●	●	●	○
Element C: Establish mechanisms for monitoring compliance with access standards	●	●	●	○
Element D: Establish health care provider-to-beneficiary ratios	●	●	●	○

¹⁴For the purposes of this report, we evaluated whether a mission statement existed for the entire implementation plan rather than for each element.

National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017) mandated elements

	Select leading practices for planning			
	Goals	Strategies to achieve goals	Plans to assess progress	Challenges and risks
Element E: Monitor on a monthly basis complaints by beneficiaries with respect to network adequacy and the availability of health care providers	●	●	●	○
Element F: Establish requirements for mechanisms to monitor the responses to complaints by beneficiaries	●	●	●	○
Element G: Establish mechanisms to evaluate the quality metrics of the network providers established under section 728 ^a	●	◐	○	○

Legend: ● Fully addressed practice ◐ Partially addressed practice ○ Did not address practice

Source: GAO analysis of DOD's TRICARE Select implementation plan and supporting documentation. | GAO-18-358

^aSection 728 of the NDAA 2017 requires that DOD, to the extent appropriate, adopt the core quality performance metrics agreed upon by the Core Quality Measures Collaborative, which comprises officials from the Centers for Medicare & Medicaid Services and representatives of health care organizations such as America's Health Insurance Plans, for use by the military health system and in contracts awarded to carry out the TRICARE program.

Element G, Evaluation of Quality Metrics, Remains under Development

We also found that the implementation plan partially addressed or did not address the leading practices related to strategies or plans to assess progress for element G—establish mechanisms to evaluate the quality metrics of the network providers. The plan stated that DOD is reviewing the required set of core quality performance metrics and will implement a subset of these performance measures that can be used in future contracts. However, the plan did not include several strategic details such as (1) the process that DOD will use to determine the metrics, (2) the criteria and resources that are needed to select the subset of these performance measures, and (3) how DOD will assess progress and evaluate future metrics. DOD officials told us that a workgroup of departmental officials—including those from DHA and the TRICARE Regional Offices and representatives of the military service branches—with expertise in health care quality are

- evaluating the metrics for inclusion in the subset of measures based on criteria such as availability of data, the size of the population affected, and resources needed;
- developing a work plan and time frames to analyze the metrics that are (1) already being reported, (2) not being reported but data are available, and (3) not being reported and require data solutions in order to track information; and

-
- making preliminary recommendations on which measures to adopt and which to consider for future adoption.

DOD officials explained that some of the details of their approach to the mandated elements had not been finalized when they were completing the implementation plan, including some of the details for element G, which continues to be a work in progress. They added that they were under tight time constraints with competing priorities. They explained that they had to plan for the implementation of TRICARE Select while concurrently transitioning to new managed care support contracts, which had to be modified to incorporate this new health plan option.¹⁵ Therefore, while DOD officials were developing the TRICARE Select implementation plan, they had to determine the specific program requirements for this option and modify the contracts to account for these changes.

Leading Practice on Challenges and Risks May Be Captured through Contract Oversight Mechanisms

We also found that DOD's implementation plan did not address the leading practice related to recognizing the challenges or risks to success for any of the seven elements. This practice ensures that an organization considers any external factors that could significantly affect the achievement of its goal. For example, for element A—ensure that at least 85 percent of the beneficiary population is covered by the network—the implementation plan did not address what challenges and risks the contractors might experience in establishing this network. For example, one of the two managed care support contractors stated that it did not have data on the beneficiaries who had sought coverage under TRICARE Standard and Extra as these beneficiaries did not have to enroll in these health plan options. Thus, the contractor explained that it was difficult to establish a baseline for calculating the 85 percent network coverage required for TRICARE Select. The other managed care support contractor told us that specific challenges included negotiating provider discounts in certain areas, identifying which providers participated in the past, and balancing the composition of the network between primary and specialty

¹⁵The NDAA 2017 was enacted in December 2016—after the contracts were awarded and the same month that DOD commenced the contractor transition period, according to DOD officials. DOD officials noted that the establishment of the TRICARE Select option had not been accounted for in DOD's original contract requirements or transition timeline. DOD moved the health care delivery start date under the new contracts from October 1, 2017, to January 1, 2018, to allow time for these changes to be made and to coincide with the TRICARE Select implementation date.

care. However, DOD officials told us that they considered and planned for the challenges and risks associated with certain elements—including establishing a monitoring and remediation process to help ensure contractors meet the 85 percent network coverage requirement—even though this was not described in the plan.

DOD officials explained that their approach to the implementation plan was to create a strategic overview rather than a detailed work plan. These officials also told us that details and time frames related to the mandated elements are captured in contract documents, such as those that establish the managed care support contractors' reporting and planning requirements. Although these contract documents do not specifically address challenges and risks for each element, officials stated that they have oversight mechanisms in place that allow them to address any challenges faced by these contractors, thereby mitigating any potential risks. For example, DHA officials told us that the managed care support contractors provide status updates on their network expansion progress at weekly transition meetings with DHA and at biweekly meetings with the TRICARE Regional Offices. DHA officials told us that the TRICARE contracts have specific expansion goals and deadlines, such as requiring that 50 percent of network providers are in the system 120 days prior to the start of health care delivery. Given that both TRICARE Select and the new TRICARE contracts were implemented on January 1, 2018, it is too early to determine whether this approach will be sufficient to deal with any upcoming challenges and risks.

Implementation Plan Does Not Reflect Current Approach for Establishing Access Standards

Our review of element B—ensure access standards for appointments for health care that meet or exceed those of high-performing health care systems in the United States, as determined by the Secretary—noted that the approach described in the implementation plan differs from the approach that DOD intends to use. The implementation plan states that the access standards for TRICARE Select will mirror those of TRICARE Prime, DOD's managed care option, and that DOD will continue to compare these standards with those of high-performing U.S. health care systems. However, DOD officials told us in interviews that the access standards for TRICARE Select will be developed by each managed care support contractor and approved by DOD. This approach is outlined in contract documents, which state that the contractors are required to develop access-to-care plans that detail how they will ensure access standards that meet or exceed those of high-performing health care systems in the United States.

DOD officials told us that they did not intend to suggest in the plan that the TRICARE Prime access standards would be applied to TRICARE Select. Instead, these officials explained that they meant that the access standards for TRICARE Select would be evaluated with the same tools as the access standards for TRICARE Prime. DOD officials further stated that they did not include information about the managed care support contractors proposing their own access standards because they were still developing the approach to this element when the implementation plan was submitted. DOD officials told us they decided on this approach because there is no national model for preferred provider organization access standards, and therefore they did not want to be prescriptive about the access standards for this option. However, as a result of this approach, there is the potential that the managed care support contractors for the East and West regions could be using two different sets of access standards for TRICARE Select.

Standards for internal control in the federal government state that management should externally communicate the necessary information to achieve the entity's objectives.¹⁶ Because the implementation plan does not reflect DOD's current approach, Congress may be lacking important information, including what responsibilities the contractors have in terms of providing access to care, impeding its ability to provide oversight.

Conclusions

On January 1, 2018, DOD implemented significant changes to the TRICARE program, which provides health care to millions of beneficiaries worldwide. One of these changes is the establishment of a new preferred provider option—TRICARE Select—intended to modernize the TRICARE benefit and improve beneficiaries' access to care. While DOD's implementation plan for this new option addressed all of the elements that were required, time constraints along with competing priorities impeded DOD's ability to fully develop its approach for some elements, which are being addressed through other oversight efforts. Furthermore, although one of TRICARE Select's primary goals is to improve access to care, DOD's implementation plan does not reflect how access standards will be established. Without the most current information, it will be difficult for Congress to determine whether the department is achieving its mission of ensuring that beneficiaries receive the right level of care, at the right time, delivered by the right provider.

¹⁶[GAO-14-704G](#).

Recommendation for Executive Action

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to provide written documentation of DOD's approach to developing and approving the TRICARE Select access standards, as well as the final access standards, to Congress. (Recommendation 1)

Agency Comments

We provided a draft of this report to DOD for comment. In its written comments, which are reproduced in Appendix II, DOD concurred with our recommendation. DOD stated that it will provide written documentation about the TRICARE Select access standards to Congress by June 30, 2018. DOD did not provide technical comments.

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

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



Debra A. Draper
Director, Health Care

Appendix I: Leading Practices for Strategic Management Planning as Identified by GAO's Prior Work

This appendix provides additional information regarding six elements identified by our prior work as leading practices for strategic management planning to establish a comprehensive, results-oriented framework. (See table 3.)

Table 3: Six Leading Practices for Strategic Management Planning Identified by GAO's Prior Work

Key leading practice	Description of leading practice components
Mission statement	A statement that concisely summarizes what the organization does, presenting the main purposes for all its major functions and operations.
Long-term goals	A specific set of policy, programmatic, and management goals for the programs and operations covered in the plan. The long-term goals should correspond to the purposes set forth in the mission statement and develop with greater specificity how an organization will carry out its mission.
Strategies to achieve goals	A description of how goals contained in the plan are to be achieved, including the operational processes, skills and technology, and other resources required to meet these goals.
Use of metrics to gauge progress	A set of metrics that will be applied to gauge progress toward attainment of the plan's long-term goals.
Evaluations of the plan to monitor goals and objectives	Assessments, through objective measurement and systematic analysis, of the manner and extent to which programs associated with the plan achieve their intended goals.
External factors that could affect goals	Key factors external to the organization and beyond its control that could significantly affect the achievement of the long-term goals contained in the plan. These external factors can include economic, demographic, social, technological, or environmental factors, as well as conditions or events that would affect the organization's ability to achieve its strategic goals.

Source: GAO. | GAO-18-358

Note: Source is *Military Readiness: DOD Needs to Incorporate Elements of a Strategic Management Planning Framework into Retrograde and Reset Guidance*, [GAO-16-414](#) (Washington, D.C.: May 13, 2016), 28.

Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR - 3 2018

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

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-18-358, "TRICARE Select Implementation Plan Included Mandated Elements, but Access Standard Should Be Clarified," dated February 22, 2018. Thank you for the opportunity to review and comment on the draft report.

I concur with your sole recommendation that the Secretary of Defense provide written documentation of its approach for developing and approving the TRICARE Select access standards, as well as the final access standards to Congress. We will provide written documentation to Congress by June 30, 2018.

Thank you for your detailed review of our TRICARE Select Implementation Plan and its execution. My points of contact for this matter are Mr. Mark Ellis (functional) and Ms. Joyce Forrest (audit liaison). Mr. Ellis may be reached at (703) 681-0063 or via email at mark.a.ellis14.civ@mail.mil, and Ms. Forrest may be reached at (703) 681-6741 or via email at joyce.forrest2.civ@mail.mil.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom McCaffery", is written over a horizontal line.

Tom McCaffery
Acting

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson (Assistant Director), Daniel Klabunde (Analyst-in-Charge), and Karen Belli made key contributions to this report. Also contributing were Jacquelyn Hamilton and Elizabeth T. Morrison.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<https://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <https://www.gao.gov> and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <https://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).
Subscribe to our [RSS Feeds](#) or [E-mail Updates](#). Listen to our [Podcasts](#).
Visit GAO on the web at <https://www.gao.gov>.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <https://www.gao.gov/fraudnet/fraudnet.htm>

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room 7149 Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707 U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548



Please Print on Recycled Paper.