UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

FEB 23 2011

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is submitted in response to section 732 of the John Warner National Defense Authorization Act for Fiscal Year (FY) 2007, P.L. 109-364, which requires an annual report on the support of Military Treatment Facilities by civilian contractors under the TRICARE program during the preceding fiscal year. The Department regrets the delay in submitting this report.

During FY10, there were 3,851 contracts and 99 clinical support agreements in place throughout the three TRICARE regions. The total expenditure for these clinical support agreements and direct contracts was $1,374,701,078 in FY10, which represents a 12 percent decrease compared to FY09.

Since 2004, the three TRICARE Regional Directors have coordinated with the Military Departments to develop an integrated regional business plan through which the requirements for support to be provided by contractors are identified. Excellent processes are in place to ensure that Military Treatment Facilities are well supported by civilian health care contracts and that consistent standards of quality are well-established throughout the Military Health System.

Thank you for your interest in the health and well-being of Service members, veterans, and their families.

Sincerely,

Clifford L. Stanley

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

[illegible] 2011

The Honorable Jim Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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cc:
The Honorable Lindsey Graham
Ranking Member

UNDER SECRETARY OF DEFENSE
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WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Howard P. "Buck" McKeon
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

The Honorable Joe Wilson
Chairman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Clifford L. Stanley

Enclosure:
As stated

cc:
Susan A. Davis
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

FEB 25 2011

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is submitted in response to section 732 of the John Warner National Defense Authorization Act for Fiscal Year (FY) 2007, P.L. 109-364, which requires an annual report on the support of Military Treatment Facilities by civilian contractors under the TRICARE program during the preceding fiscal year. The Department regrets the delay in submitting this report.

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Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman

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PERSONNEL AND
READINESS

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Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

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PERSONNEL AND
READINESS

The Honorable Harold Rogers
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Norman D. Dicks
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable C. W. Bill Young
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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The Honorable Norman D. Dicks
Ranking Member

Report to Congress

Requirements for Support

of

Military Treatment Facilities

by

Civilian Contractors under TRICARE

Preparation of this study cost the Department of Defense a total of approximately $14,000 in FY2010-2011.

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Report to Congress
on
Requirements for Support of Military Treatment Facilities
by
Civilian Contractors under TRICARE

Introduction

The National Defense Authorization Act (NDAA) for Fiscal Year 2007 required the Secretary of Defense to submit an annual report on the support of military treatment facilities (MTF) by civilian contractors under the TRICARE program during the preceding fiscal year. The report is to set forth, for the fiscal year covered by such report, the following elements:

(A) The level of support of military treatment facilities that is provided by contract civilian health care personnel under the TRICARE program in each region of the TRICARE program.

(B) Assessment of the compliance of such contract support with regional requirements.

(C) The number and type of agreements for the support of military treatment facilities by contract civilian health care personnel.

(D) The standards of quality in effect for TRICARE support contract requirements.

(E) The savings anticipated, and any savings achieved, as a result of the implementation of the requirements developed each year.

(F) Assessment of the compliance of contracts for health care staffing services for Department of Defense facilities with the requirements for consistent standards of quality.

This report provides the requested information for Fiscal Year 2010.

Background

The Deputy Secretary of Defense, under the auspices of the TRICARE Governance Plan of January 20, 2004, established the overall organizational construct, regional office responsibilities and staffing plan, market manager responsibilities, and the business planning requirements and process for delivery of the TRICARE benefit. The former TRICARE regions in the United States were consolidated into three TRICARE regions, three TRICARE Regional Offices (TRO) were established, and the TRICARE

regional managed care support contracts were aligned with the three TRICARE regions. Regional Directors are to maintain knowledge of all regional assets, costs, and expenditures. They can make recommendations to the Military Departments regarding the flow of dollars and staffing in their respective regions.

However, per Department of Defense Directive 5136.12 and the TRICARE Governance Plan, the TRICARE Regional Directors are not in the chain of command of the MTF commanders. Under provisions of title 10 of the United States Code, it is the Military Departments, not the TRICARE Regional Directors, that have command authority over and accountability for operations of the MTFs. By law, each Military Department is responsible for organizing, training and equipping its own medical force to provide high quality care and to meet its mission needs.

The MTFs satisfy their medical and administrative staffing requirements through a combination of uniformed medical personnel, government civilian employees, and contracted personnel. The mix of providers and administrative staff from these three staffing sources varies from MTF to MTF. The MTF commander determines the amount and provider-types of contracted personnel to acquire for staff augmentation purposes. However, by regulation, within each region, the TRICARE Regional Director is the health plan manager. The Regional Director has visibility of both contract and direct care assets, coordinates with the Military Departments to develop an integrated health plan, and monitors MTF performance in accordance with the business plan. When deviations from the plan are noted, the Regional Director communicates with the MTF commander and Service headquarters. The Military Departments retain the authority to direct and validate the MTF/Services health care delivery process.

The vast majority of the contracted providers in the MTFs work under personal services contracts in accordance with the provisions outlined in Department of Defense Instruction 6025.5. This type of contract enables the MTF commanders to oversee assignment and performance of the contracted personnel in an employer-employee manner, much like the supervisory relationship the MTF commander has over the performance of the military and government civilian providers on the MTF staff. This type of contractual relationship is consistent with the MTF commander's authority over and accountability for all operations of the MTF. In particular, the contractual relationship enhances the MTF commander's ability to ensure that the quality of care provided by contracted providers meets the standards that other providers on the MTF staff must meet.

Required Report Elements

(A) The level of support of military treatment facilities that is provided by contract civilian health care personnel under the TRICARE program in each region of the TRICARE program:

The following table displays the estimated level of support in the MTFs provided by civilian health care personnel under the TRICARE program during FY 2010, by region. Current business systems and methodology do not allow all the Services to accurately capture and report a clear distinction between clinical support agreements (CSAs) and direct contracting (DC) cost. Below are estimated expenditures for both CSAs and DC across the MHS:

TRICARE Region ($000)			
North	**South**	**West**	**Total**
$523,990	$402,528	$448,183	$1,374,701

(B) An assessment of the compliance of contract support with requirements that the Regional Director of each region under the TRICARE program has established:

Within each region, the Regional Director is the health plan manager who has visibility of both contracted private sector assets and MTF care assets. The Regional Director coordinates with the Services annually to develop an integrated, regional business plan through which the requirements for support to be provided by contractors are identified. The requirements are assessed and reestablished annually, but can be adjusted throughout the year, as necessary.

A compliance assessment is done at least annually to evaluate the support contracts. Throughout the Contract Option Year, or other period of performance as determined by the contracting officer, assessments of contractor performance are documented in the Performance Assessment Tracking (PAT) system. The results of assessments are shared with the contractors in a spirit of partnering to continually improve the purchased care system and its support of the direct care system.

Additionally, the Contractor Performance Assessment Reporting System (CPARS) houses, routes and dispositions the annual assessment of contractor performance. CPARS is used throughout the Military Health System (MHS). It is intended to support the needs of future contract selections when evaluating contractor past performance. The annual CPARS assessment is an excellent tool for motivating improved performance and/or documenting exceptional performance to effect the continual improvement of services. The CPARS is external to the PAT and there is no automated interface between the two systems.

(C) The number and type of agreements for the support of military treatment facilities by contract civilian health care personnel:

The MTFs acquire contracted health care and administrative services primarily through direct contracting or less frequently for health care and administrative support personnel through clinical support agreements. Direct contracts are those that a Military Service itself establishes with one or more other parties. With a clinical support agreement, the MTF applies its resources to fund a task order placed against one of the three TRICARE managed care support contracts. The following table presents the estimated number of each of these two types of vehicles the MTFs used during FY 2010 to acquire support services:

Direct Contracts	Clinical Support Agreements
3,851	99

(D) The standards of quality in effect for the TRICARE support contract requirements:

Currently, the National Quality Monitoring Contract (NQMC) assists TMA, the TRICARE Regional Offices, and the Services by monitoring the quality of care provided to ensure health care delivery quality standards are met and the care provided is medically necessary. On May 28, 2010, the TRICARE Quality Monitoring Contract (TQMC), as a follow-on to the NQMC, was awarded to Keystone Peer Review Organization (KePRO). The contract is due to start delivery of services on April 1, 2011. TQMC will provide the Government with an independent, impartial evaluation of the care provided to MHS beneficiaries.

Communication to support quality management in the MHS is accomplished through the inclusion of quality management in key leadership committees and the development of a select number of quality-focused committees. These committees successfully connect information flow from policy development to implementation and evaluation. The lead committees include the Senior Military Medicine Advisory Council (SMMAC), the Clinical Proponency Steering Committee (CPSC), and the MHS Clinical Quality Forum. The MHS Clinical Quality Forum gathers clinical quality subject matter experts from the Services, TRICARE Management Activity, and the purchased care civilian contractors together on a monthly basis to present and discuss quality management in the MHS. Quality initiatives, performance assessment, and policy changes are presented and discussed at the Forum. A summary of the Forum meetings is presented to MHS Leadership on a quarterly basis.

The management of quality in the MHS is interdependent on continuous and multi-directional communication across various direct and purchased care components. Structures and processes have been established to support clinical quality management and facilitate consistent communication for opportunities to enhance the care provided throughout the system. The assessment of the quality of health care provided by DoD is accomplished at the facility, Service, regional and system levels.

(E) The savings anticipated, and any savings achieved, as a result of the implementation of the regional requirements for the support of military treatment facilities by contract civilian health care and administrative personnel under the TRICARE program:

The MHS has not specifically documented savings achieved as a result of implementing the regional requirements for the support of military treatment facilities by contract civilian health care and administrative personnel under the TRICARE program. The MTFs gain the potential for cost avoidance at an undetermined level by conducting full and open competitions for most of their direct contracting for medical and administrative services. When the purpose of the contract is to obtain the services of medical personnel who will provide health care to TRICARE beneficiaries, "best value" is usually the appropriate source selection criterion to use. That criterion promotes selection of the lowest cost offeror who can be expected to meet MHS quality standards for the provision of health care.

The MHS, however, has begun looking more holistically at the management of costs by focusing on per capita costs, rather than simply the unit costs of health care services. In health care, savings are generated both by the management of unit costs and the management of utilization of services. As part of its strategic imperatives, the senior leadership is now assessing trends in Prime enrollees' Per Member Per Month (PMPM) costs. This metric calculates the costs of both Direct Care and Purchase Care enrollees on a per capita basis no matter which system provides the care. The MHS is analyzing the significant drivers of growth in this metric looking at beneficiary category, enrollment location, diagnoses and venue of care (inpatient, outpatient, emergency room, pharmacy, etc). We anticipate these analyses will help focus efforts to control overall MHS costs and may even allow for an eventual savings via contract negotiations.

(F) Assessment of the compliance of contracts for health care staffing services for Department of Defense facilities with the requirements for consistent standards of quality

Assessment of compliance to quality standards by contracts which provide direct MTF support is done in a variety of ways layering the opportunities for evaluation and

improvement. The following structures and processes have been established to support clinical quality management and facilitate consistent communication for opportunities to enhance the care provided throughout the system.

Credentialing: DoD policy, in DoD 6013.25-R, establishes credentialing standards for all personnel providing health care in the MTFs. The standards are consistent for uniformed medical providers, government civilian employees, and contracted providers. As long as they remain in compliance with DoD policy, the Military Departments may, to meet their own needs, adjust credentialing processes used in the MTFs. The Military Departments all use the Centralized Credentials Quality Assurance System (CCQAS), the Department's on-line credentials record system, for recording the training and qualifications, as well as the scope of practice granted a provider, including a contracted provider.

Joint Commission Accreditation: The Services do not consistently require, when issuing requests for proposals for performance of health care services in the MTFs, that offerors must have a Joint Commission Health Care Staffing Services certification. However, DoD policy requires that MTFs comply with current Joint Commission patient safety goals, and contracted personnel, when working in the MTFs, must meet these standards.

Financial stability: The procuring contracting officers of each Military Department comply with the Federal Acquisition Regulation (FAR) requirements for determining the financial responsibility of companies before making awards to them.

Medical management: Military treatment facilities are responsible for granting privileges to providers operating under non-personal services contracts. In that case, the MTF retains responsibility for clinical oversight while the contractor is responsible for the administrative clinical supervision of the health care professionals serving as non-personal service contractors. All non-personal services contracts used by the MTFs require health care workers to have and maintain a license in the state where the work is performed and to carry medical malpractice insurance commensurate with the local market. However, the vast majority of contracts awarded during FY 2010 were for personal services. Under this arrangement, the Military Departments are responsible for medical management of direct health care providers and assume liability, clinical supervision, and peer review responsibilities.

Continuity of operations: Contractors recruit, qualify, and retain contracted professional medical and administrative workers. To assure continuity of operations, contracts to acquire medical and administrative staffing for the MTFs include the Federal Acquisition Regulation (FAR) continuity of services clause to allow for transition from one contract to another and prevent a lapse in service.

Training: Contractors providing services to the MTFs are responsible for recruiting health care workers with required training and education. Position descriptions matching or exceeding minimum service requirements for training, experience, and advanced education are defined by the Military Departments. Payment and management of ongoing education and training are the responsibility of the contractor. The Military Departments monitor the status of contractor employees' education, training, and licensing just as they do for uniformed medical providers and government civilian employees working in the MTFs. Any health care worker — military, civilian, or contractor — can have their privileges suspended at the MTF until all training and licensing requirements are up to date.

Employee retention: In their requests for proposals for providing services in the MTFs, all of the Military Departments address requirements for contractors to minimize employee turnover. Thus, employee retention standards become part of the contracts when signed.

Access to contractor data: The Military Departments' contracts to satisfy MTF medical and administrative staffing needs require delivery of contractor data. Management data is shared between the MTFs and the contractors in periodic performance status reports. Data is validated by Contracting Officer Representatives (CORs). All of the Military Departments utilize the Contractor Performance Assessment Report System (CPARS) as a standard means of assessing a contractor's performance and providing a record, both positive and negative, on a given contract during a specific period of time. Each assessment is based on objective facts and supported by program and contract management data, such as cost performance reports, customer comments, quality reviews, technical interchange meetings, financial solvency assessments, management reviews, contractor operations reviews, functional performance evaluations, and earned contract incentives.

Fraud prevention: Contracts of all the Military Departments for medical and administrative staffing contain fraud prevention standards. The qualifications of contracted health care workers are independently validated by the Services during the credentialing and privileging process using multiple databases and primary source verification of education, training, experience, and malpractice events.

National Quality Monitoring Contract (NQMC)/TRICARE Quality Monitoring Contract (TQMC): In situations where the Services have reviewed a case in which a malpractice claim has been paid and have made a determination that the standard of care was met, the NQMC until April, 2011 and then the TQMC will provide board certified specialty matched physicians and other providers to conduct peer review on these MTF standard-of-care cases. TQMC also has a provision for this level of peer review for cases involving active duty Service members who were prevented from filing a malpractice suit

by the Feres Doctrine. In addition, cases of Command interest can also be sent for review.

Conclusion

The integrated regional business plans through which the requirements for MTF contract support is identified have proved essential for meeting the Department's mission to provide health care for TRICARE beneficiaries. Augmentation of MTF staffs with contracted personnel is especially important while the Military Departments deploy many of their uniformed medical providers out of the MTFs to the combat theater. Excellent processes are in place to ensure that MTFs are well supported by civilian health care contracts and consistent standards of quality are well established and working throughout the Military Health System (MHS).

SEC. 732. REQUIREMENTS FOR SUPPORT OF MILITARY TREATMENT FACILITIES BY CIVILIAN CONTRACTORS UNDER TRICARE.

(a) ANNUAL INTEGRATED REGIONAL REQUIREMENTS ON SUPPORT.--The Regional Director of each region under the TRICARE program shall develop each year integrated, comprehensive requirements for the support of military treatment facilities in such region that is provided by contract civilian health care and administrative personnel under the TRICARE program.

(b) PURPOSES.--The purposes of the requirements established under subsection (a) shall be as follows:

(1) To ensure consistent standards of quality in the support of military treatment facilities by contract civilian health care personnel under the TRICARE program.

(2) To identify targeted, actionable opportunities throughout each region of the TRICARE program for the most efficient and cost effective delivery of health care and support of military treatment facilities.

(3) To ensure the most effective use of various available contracting methods in securing support of military treatment facilities by civilian health care personnel under the TRICARE program, including resource-sharing and clinical support agreements, direct contracting, and venture capital investments.

(c) FACILITATION AND ENHANCEMENT OF CONTRACTOR SUPPORT.--

(1) IN GENERAL.--The Secretary of Defense shall take appropriate actions to facilitate and enhance the support of military treatment facilities under the TRICARE program in order to assure maximum quality and productivity.

(2) ACTIONS.--In taking actions under paragraph (1), the Secretary shall--

(A) require consistent standards of quality for contract civilian health care personnel providing support of military treatment facilities under the TRICARE program, including--

(i) consistent credentialing requirements among military treatment facilities;

(ii) consistent performance standards for private sector companies providing health care staffing services

to military treatment facilities and clinics, including, at a minimum, those standards established for accreditation of health care staffing firms by the Joint Commission on the Accreditation of Health Care Organizations Health Care Staffing Standards; and

(iii) additional standards covering--

(I) financial stability;

(II) medical management;

(III) continuity of operations;

(IV) training;

(V) employee retention;

(VI) access to contractor data; and

(VII) fraud prevention;

(B) ensure the availability of adequate and sustainable funding support for projects which produce a return on investment to the military treatment facilities;

(C) ensure that a portion of any return on investment is returned to the military treatment facility to which such savings are attributable;

(D) remove financial disincentives for military treatment facilities and civilian contractors to initiate and
sustain agreements for the support of military treatment facilities by such contractors under the TRICARE program;

(E) provide for a consistent methodology across all regions of the TRICARE program for developing cost benefit analyses of agreements for the support of military treatment facilities by civilian contractors under the TRICARE program based on actual cost and utilization data within each region of the TRICARE program; and

(F) provide for a system for monitoring the performance of significant projects for support of military treatment facilities by a civilian contractor under the TRICARE program.

(d) REPORTS TO CONGRESS.--

(1) ANNUAL REPORTS REQUIRED.--Not later than February 1, 2008, and each year thereafter, the Secretary, in coordination with the military departments, shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the support of military treatment facilities by civilian contractors under the TRICARE program during the preceding fiscal year.

(2) ELEMENTS.--Each report shall set forth, for the fiscal year covered by such report, the following:

(A) The level of support of military health treatment facilities that is provided by contract civilian health care personnel under the TRICARE program in each region of the TRICARE program.

(B) An assessment of the compliance of such support with regional requirements under subsection (a).

(C) The number and type of agreements for the support of military treatment facilities by contract civilian health care personnel.

(D) The standards of quality in effect under the requirements
under subsection (a).

(E) The savings anticipated, and any savings achieved, as a result of the implementation of the requirements under subsection (a).

(F) An assessment of the compliance of contracts for health care staffing services for Department of Defense facilities with the requirements of subsection (c)(2)(A).

(e) EFFECTIVE DATE.--This section shall take effect on October 1, 2006.