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United States
Department of Defense

Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia

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Acronyms

ASD(HA)	Assistant Secretary of Defense (Health Affairs)
DBA	Defense Base Act of 1941
DFAS	Defense Finance and Accounting Service
DoD CFO	Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer
MTF	Military Treatment Facility
QMAD	Quantitative Methods and Analysis Division
USCENTCOM	U.S. Central Command
USD(AT&L)	Under Secretary of Defense (Acquisition, Technology, and Logistics)

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-4704

May 4, 2009

MEMORANDUM FOR DISTRIBUTION

SUBJECT: Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Report No. D-2009-078)

We are providing this report for your information and use. We performed this audit in response to the requirements in Public Law 110-181, the FY 2008 National Defense Authorization Act, Section 842, which requires the DoD Inspector General to audit DoD logistics contracts supporting coalition forces in Iraq and Afghanistan.

We considered management comments on a draft of the report when preparing the final report. All management comments conformed to the requirements of DoD Directive 7650.3; therefore, additional comments are not required.

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 604-8905.

Paul J. Granetto
Assistant Inspector General
Readiness, Operations, and Support

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Results in Brief: Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia

What We Did

Our objectives were to determine whether (1) contract terms for health care provided by military treatment facilities to contractors in Southwest Asia were adequately addressed, and (2) controls for billing and collecting payment from contractors for health care provided by military treatment facilities in Southwest Asia were adequate.

What We Found

- Contract terms for health care provided by military treatment facilities to contractors in Southwest Asia were not adequately addressed. Based on a statistical sample of 2,561 DoD contracts, we projected that 1,383, or 54 percent of the contracts had health care terms that were vague and subject to interpretation, or were silent on health care terms.
- Military treatment facilities were not billing and collecting payment from contractors for health care provided. DoD internal controls were inadequate. We identified a material internal control weakness in billing and collecting payments from contractors that receive health care from military treatment facilities in Southwest Asia.
- Military treatment facilities in Southwest Asia may have provided health care billable in the millions without seeking reimbursement. We did not project a potential monetary benefit. See page 20, "Use of Computer-Processed Data" for more details.

During the audit, DoD officials from various organizations established a working group to discuss how to implement a billing and collection process in contingency operations. Implementing Recommendation 2 should improve internal controls for billing contractors.

What We Recommend

We recommend that the Under Secretary of Defense (Acquisition, Technology, and Logistics) ensure that contracts for contractor personnel that are deployed outside the United States include terms that adequately address health care coverage and reimbursement.

We recommend that the Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer continue to chair the working group with officials from Components listed on the back of this page to implement a billing system that is practical for U.S. Central Command.

Management Comments and Our Response

Management comments were responsive or satisfied the intent of the recommendations and no additional comments are required. The Under Secretary of Defense (Acquisition, Technology, and Logistics) agreed to adequately address health care contract terms and stated that a pilot program is to be implemented at military treatment facilities using scanning devices to track contractor personnel usage in U.S. Central Command area of responsibility. The Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer agreed to continue to chair the working group seeking a common solution to the billing challenge. All other Components, including U.S. Central Command, the Assistant Secretary of Defense (Health Affairs), and the Joint Staff were responsive.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Under Secretary of Defense (Acquisition, Technology, and Logistics)		1., 2.
Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer		2.
U.S. Central Command		2.
Assistant Secretary of Defense (Health Affairs)		2.
Defense Finance and Accounting Service		2.
The Joint Staff		2.
Assistant Secretary of the Army (Financial Management and Comptroller)		2.
Assistant Secretary of the Navy (Financial Management and Comptroller)		2.
Assistant Secretary of the Air Force (Financial Management and Comptroller)		2.
Surgeon General of the Army		2.
Surgeon General of the Navy		2.
Surgeon General of the Air Force		2.

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Introduction

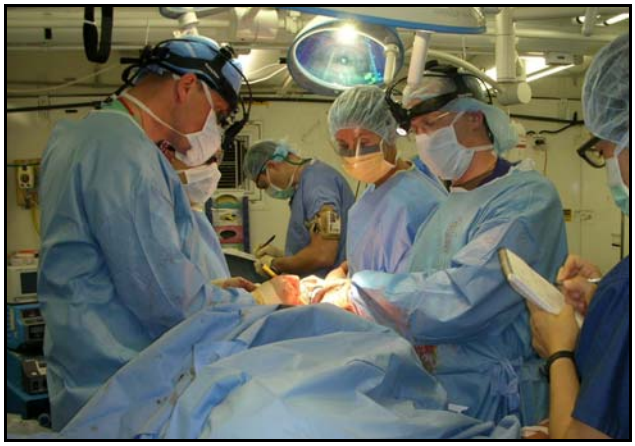
Objectives

Our audit objectives were to determine whether (1) contract terms for health care provided by military treatment facilities (MTFs) to contractors in Southwest Asia were adequately addressed, and (2) controls for billing and collecting payment from contractors for health care provided by MTFs in Southwest Asia were adequate. See Appendix A for the scope and methodology.

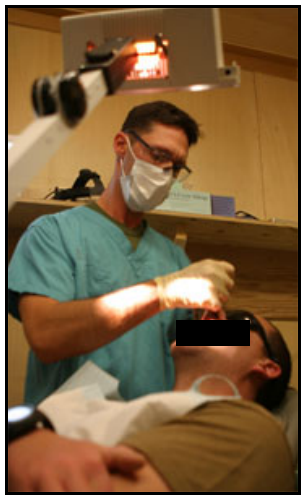
Background

Public Law 110-181, the FY 2008 National Defense Authorization Act, Section 842, requires that the DoD Inspector General audit DoD logistics contracts supporting coalition forces in Iraq and Afghanistan. This audit responds to that requirement.

U.S. Central Command (USCENTCOM) census data for the first quarter of FY 2008 stated that there were about 223,200 contractor personnel in USCENTCOM's area of responsibility. The contractor personnel were to perform a variety of contracted services such as construction, security, vehicle maintenance and storage, and the removal of hazardous material. Contractor personnel require support, which may include the use of military billeting facilities, military post offices, military banking facilities, and medical and dental services.



Air Force surgeons working at Joint Base Balad, Iraq
Photo courtesy of the U.S. Air Force



A Navy dental officer extracting a tooth from a DoD contractor in the Kandahar Province, Afghanistan
Photo courtesy of the U.S. Marine Corps

Title 10, United States Code §1079b, "Procedures for charging fees for care provided to civilians; retention and use of fees collected," requires the Secretary of Defense to implement procedures under which an MTF may charge civilians who are not covered beneficiaries (or their insurers) fees representing the costs of trauma and other medical care provided. An MTF may retain and use the fees collected.

DoD Instruction (DoDI) 3020.41, "Contractor Personnel Authorized to Accompany the U.S. Armed Forces," October 3, 2005, states that DoD may provide resuscitative care, stabilization, hospitalization, and assistance with patient movement in emergencies where loss of life, limb, or eyesight could occur. Primary medical or dental care[1] is not authorized and will not be provided by MTFs to contingency contractor personnel unless specifically authorized under the terms of the contract and the corresponding letter of authorization. All costs associated with both emergency and primary medical care are reimbursable to the Government and are the responsibility of the contingency contractor personnel, their employer, or their health insurance provider. Also, the Defense Federal Acquisition Regulation Supplement 225.7402-4(a) states to use the clause 225.52-7040, "Contractors Authorized to Accompany U.S. Armed Forces Deployed Outside the United States," in solicitations and contracts that authorize contractor personnel to accompany U.S. Armed Forces deployed outside the United States. The clause mirrors DoDI 3020.41 regarding contractor health care terms.

In July 2006, USCENTCOM issued Fragmentary Order 09-1038, "Contractor Care in the USCENTCOM [Area of Responsibility]," which establishes guidance in accordance with DoDI 3020.41. Furthermore, the fragmentary order states that USCENTCOM "…will work with the Joint Staff and [Office of the Secretary of Defense] to establish a billing mechanism utilizing the [Office of the Secretary of Defense] established outpatient and inpatient rates for contingency operations as a basis for billing."

On January 4, 2007, the Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer (DoD CFO) issued a memorandum establishing medical billing rates for contractors deployed with U.S. Armed Forces. The established inpatient rate was $1,910 per day, and the outpatient rate was $184 per visit.[2] The memorandum required the contractor to provide a letter of authorization from the contracting officer that stated the level of health care authorized and the entity responsible for payment of the bill. In addition, the memorandum required the Military Departments to establish policies for eligibility, billing, and collections for deployed or nonfixed medical facilities. On June 4, 2008, DoD CFO revised the medical billing rates for inpatients and outpatients to $2,041 per day and $195 per visit, respectively.

The Defense Base Act (DBA) of 1941 required contractors to purchase workers' compensation insurance for workers on overseas military bases. The law was expanded to require coverage of contractors and subcontractors under almost any overseas contract with any government agency. According to a memorandum, dated May 15, 2008, from

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[1] Primary care includes inpatient and outpatient services, nonemergency evacuation, pharmaceutical support, dental services, and other medical support as determined by appropriate military authorities based on recommendations from the joint force command surgeon and existing capabilities of the forward-deployed MTFs.

[2] A visit is an encounter with a privileged provider, which includes diagnostic imaging, laboratory/pathology, and pharmacy provided at the medical facility. It does not include costs of services or supplies ordered by the provider but furnished by an entity other than the deployed medical facility; for example, a pharmacy order purchased by the patient in the open economy.

the House Committee on Oversight and Government Reform, for 90 percent of the DBA insurance required in Iraq and Afghanistan, the premiums and other terms were negotiated between the private contractors and the insurance companies while the costs were paid by the Federal Government. DBA workers' compensation benefits include disability, medical, and death benefits for injury or death in the course of employment. Injured contractor personnel are entitled to receive coverage for medical costs. Under the DBA program, insurance companies and Federal taxpayers share the risks of contractor injuries and deaths that occur overseas. Insurers pay the costs of injuries or deaths that occur in the normal course of employment. The War Hazards Compensation Act of 1942 addresses possible compensation by the United States in the case of injury or death resulting from injury that "proximately results from a war-risk hazard."

Review of Internal Controls

We determined that DoD had a material internal control weakness as defined by DoD Instruction 5010.40, "Managers' Internal Control (MIC) Program Procedures," January 4, 2006. DoD did not have clearly defined roles and responsibilities for implementing and overseeing a billing and collection process for health care provided to contractors by MTFs in Southwest Asia. Also, no DoD Component had accepted responsibility as the proponent for this issue. Until roles and responsibilities are defined and a proponent is designated, we cannot determine who is responsible for this material internal control weakness. Implementing Recommendation 2. should improve internal controls for billing contractors for health care provided by MTFs in Southwest Asia.

Finding. Adequacy of the Contract Terms and Controls Over Billing for Health Care Provided to Contractors in Southwest Asia

Contract terms for health care provided by MTFs to contractors in Southwest Asia were not adequately addressed. Based on a statistical sample of 2,561 DoD contracts, we projected that 1,383, or 54 percent of the contracts had health care terms that were vague and subject to interpretation, or were silent on health care terms. DoD controls over billing and collections for health care provided to contractors by MTFs in Southwest Asia were inadequate. Specifically, no DoD Component had responsibility for billing and collecting payment, and DoD did not have clearly defined roles and responsibilities for implementing and overseeing a billing and collection process. MTFs in Southwest Asia may have provided health care billable in the millions without seeking reimbursement.[3] Two medical units at Baghdad and Bagram, which are responsible for the largest total number of contractor patient visits, reported that contractor health care was a burden on their staff. For example, the medical unit in Baghdad stated that at least 33 percent of its outpatient visits were contractors and that the unit was not staffed to support this workload.

Contract Terms for Health Care Provided to Contractors in Southwest Asia Were Vague and Subject to Interpretation

Contract terms for health care provided by MTFs to contractors in Southwest Asia were not adequately addressed. USCENTCOM provided us with spreadsheets that listed each DoD contract in Iraq and Afghanistan for second quarter FY 2008 with the number of contractor personnel assigned to that contract. The spreadsheet showed 2,561 prime contracts with about 137,200 contractor personnel estimated to be working in Iraq and Afghanistan. The spreadsheet did not include contracts from other Federal entities, such as the Department of State, Department of Justice, U.S. Agency for International Development, or Department of Agriculture. To determine whether health care terms were adequately addressed, we statistically sampled 88 contracts estimated by USCENTCOM to have about 52,200 contractor personnel working in Iraq and Afghanistan. We used the Electronic Document Access Web site to obtain the contracts or requested the contracts from the responsible contracting officials.

We examined the 88 contracts to determine whether health care terms clearly addressed the level of care the contractor personnel were authorized to receive at an MTF. We also examined the contracts to determine whether they stated that the health care costs incurred by the contractor personnel were reimbursable to DoD.

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[3]We did not project a monetary benefit. See p. 20, "Use of Computer-Processed Data" for more details.

Based on the sample, we projected the number of contracts that:

- clearly addressed health care authorized as emergency care only and costs reimbursable to DoD (adequately addressed health care terms), and

- were vague and subject to interpretation on health care authorized or silent on health care (did not adequately address health care terms).

See Table 1 for the statistical sample projections over the universe of 2,561 contracts. See Appendix B for more details on our statistical sample projections. See Appendix C for specific health care terms listed in the contracts.

Table 1. Projection of Clear and Vague Contracts[a]

Health Care Terms	Contracts	
	Number	**Percentage**
Emergency care authorized; reimbursement required	1,178	46
Vague and subject to interpretation, or silent on health care	1,383	54
Total	**2,561**	**100**

[a] 2nd quarter, FY 2008.

Of the 88 contracts sampled, we identified 46 contracts that stated only emergency care was authorized and all costs were reimbursable to DoD; these contracts adequately addressed health care terms. We identified 19 contracts that had health care terms that were vague and subject to interpretation. We identified 23 contracts that were silent on health care terms.

Contracts that do not clearly address health care coverage and reimbursement may leave the Government at risk of an incorrect interpretation. The following are examples of vague contract terms.

- Contract Number W91B4N-08-M-0565 has three inconsistent clauses that address contractor health care. One states that: "The government will provide any and all medical services required as a result of injuries incurred in the performance of this contract. If injured on duty, personnel shall receive emergency treatment." Another clause states: "Lodging, meals and basic services will be provided as will basic medical, optical and dental services on a space available basis." Lastly, the "Clauses Incorporated by Full Text" section of the contract states: "Contract performance may require work in dangerous or austere conditions. Except as otherwise provided in the contract, the Contractor accepts the risks associated with required contract performance in such operations." The contract did not address cost reimbursement. USCENTCOM informed us that there was only one contractor performing under this contract.

- Contract Number W91B4L-08-C-0026 states, "The contractor will provide emergent medical treatment in order to prevent undue suffering or loss of life." The contract does not address health care coverage and reimbursement to DoD. USCENTCOM informed us that there were 75 contractor personnel performing under this contract.

- Contract Number W91GFC-08-M-0467 states, "Life Support: IAW AR 600-700 the government will not provide life support services to U.S. contractor personnel equivalent to those provided to military personnel. Specific services provided: NONE." The clause referred to U.S. contractor personnel, yet USCENTCOM informed us that there were 10 host nation personnel performing under this contract. Care to be provided to host nation personnel is not addressed.

Because we did not visit MTFs in Southwest Asia, we could not trace the letters of authorization to the contracts to compare health care terms.[4] However, on August 13, 2007, the Commanding General, Joint Contracting Command-Iraq/Afghanistan issued a memorandum stating, "…Vague contract language has resulted in Letters of Authorization that have obligated the DoD to provide primary health care for numerous contractors, who contractually are not authorized routine health care services at MTFs."

The Under Secretary of Defense for Acquisition, Technology, and Logistics (USD[AT&L]) should require DoD Components to include controls in the standard operating procedures to ensure that new and existing contracts and letters of authorization include terms that adequately address health care coverage and reimbursement. USD(AT&L) should also perform a review to verify that contracts for contractor personnel that are deployed outside the United States include terms that adequately address health care coverage and reimbursement to DoD. Also, the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) officials suggested the contractor personnel's letter of authorization include DBA insurance billing information, health insurance billing information (if applicable), or both. USD(AT&L) should consider coordinating with other Federal entities writing contracts in support of Southwest Asia operations to emphasize the importance of adequately addressing health care coverage and reimbursement to DoD.

Absence of Controls for Billing and Collecting Payment From Contractors for Health Care Provided in Southwest Asia

The MTFs in Southwest Asia did not bill contractor organizations, DBA insurance companies, health insurance companies, or contractor personnel for health care provided at the MTFs. These MTFs did not have a billing and collection process for the contractor to reimburse DoD.

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[4] See Appendix A, "Scope Limitations," p. 19 for more details on why we did not visit MTFs in Southwest Asia.

In September 2008, we sent questionnaires to medical units that command MTFs in the following locations:

- Baghdad, Iraq
- Bagram Air Base, Afghanistan
- Joint Base Balad, Iraq
- Mosul, Iraq
- Tikrit, Iraq
- Al Asad, Iraq
- Camp Bucca, Iraq
- Camp Cropper, Iraq
- Camp Arifjan, Kuwait

The questionnaires requested responses about the (1) number of contractor personnel treated by the medical units, (2) additional burden contractor personnel placed on the medical unit staff, (3) commercial clinics available to provide care, and (4) billing and reimbursement for health care provided to contractors.

Health Care Provided to Contractors by Medical Units in Southwest Asia

We requested medical units in Southwest Asia to provide us with average contractor personnel visits per month by inpatient visits and outpatient visits. See Table 2.

Table 2. Average Monthly Contractor Health Care Visits by MTF Location

MTF Location	Inpatient Visits	Outpatient Visits
Baghdad	54	998
Bagram Air Base	18	359
Joint Base Balad	45	134
Mosul	9	75
Tikrit and Al Asad[a]	14	51
Camp Bucca and Camp Cropper[a]	4	100
Camp Arifjan[b]	3	46
Total	**147**	**1,763**

Note: See "Reporting of Health Care Provided to Contractors" for specifics on the accuracy of the data. When we received contractor visit data for more than one month from a medical unit, we calculated the monthly average.

[a] These medical units reported inpatient and outpatient statistics together.

[b] Camp Arifjan inpatient and outpatient contractor statistics include some U.S. Government civilians.

According to responses, the MTFs in Baghdad and Bagram were the two busiest medical units for outpatient visits by contractor personnel. In response to the question about whether contractor workload was a burden to the medical units, both Baghdad and Bagram considered it a burden to provide health care to contractor personnel. Specifically, the medical unit in Baghdad stated that at least 33 percent of its outpatient

visits were contractors and that the unit was not staffed to support this workload. The medical unit in Bagram stated that its unit was staffed for surgical and trauma resuscitations and that contractor personnel tended to have more chronic medical conditions, which became a burden when specialty care had to be arranged.

The MTFs provide treatment to the wounded as well as patients with illnesses. The following are examples of inpatient care provided by MTFs to contractor personnel in Iraq and Afghanistan.

- A patient was admitted for 2 billable days with chest pain and diagnosed with a heart attack. The patient had a history of high blood pressure and coronary artery disease with stent placement. The patient was stabilized and evacuated to Landstuhl Regional Medical Center, Germany.

- A patient accidentally shot own foot and was hospitalized for 16 billable days.

- A patient suffered a blast injury and was hospitalized for 29 billable days.

- A patient suffered a clot in the leg after an airplane flight and was hospitalized for 17 billable days.

- A patient suffered from pneumonia and was hospitalized for 10 billable days.

Medics carry a U.S. civilian contractor onto a C-130 Hercules in Balad, Iraq
Photo courtesy of the U.S. Air Force

The MTFs could have billed $141,340 for the contractor patient visits above; however, nothing was billed.

On May 5, 2007, the Commander, Multi-National Forces-Iraq issued a memorandum to the ASD(HA) about the extent of contractor health care services in Iraq and the impact on the MTFs. The Multi-National Forces-Iraq Commander stated that the MTFs have limited capability to provide primary care services in-theater, and when health care is provided to contractor personnel, it places increased demands on the MTFs and consumes precious resources that should be used in providing care to coalition military forces. On August 28, 2007, the ASD(HA) replied that the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness would explore options for both long-term and short-term solutions. As of April 22, 2009, ASD(HA) had not responded to the Multi-National Forces Iraq Commander.

Commercial Health Care in Southwest Asia

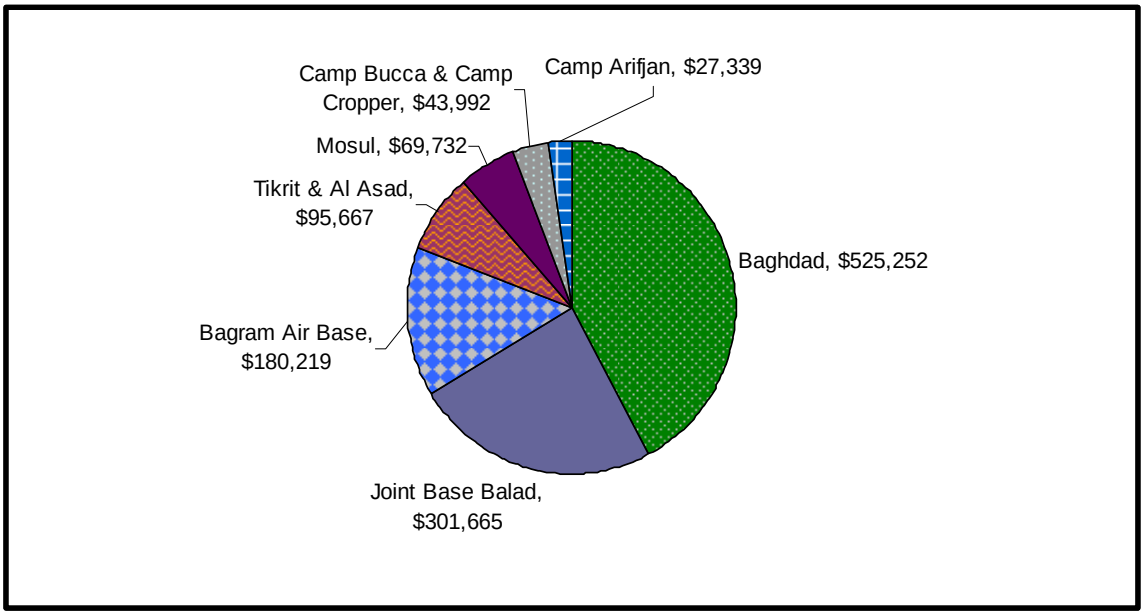
According to medical unit responses, contractor personnel were able to seek health care at contractor clinics, except at Balad and Bagram. For example, Baghdad's International Zone has clinics operated by contractors, some of which may provide care to other contractors' personnel. Xe (formerly called Blackwater Worldwide) had a clinic that provides health care to contractors regardless of affiliation, charging $150 per visit. In addition, a medical unit stated that KBR Inc. had two clinics that provide routine and emergency care to its contractor personnel and emergency care to non-KBR contractor personnel. We requested the costs billed to DoD for the operation of KBR's clinics from the U.S. Army Sustainment Command. The Army informed us that KBR's clinic costs are not tracked because they are not a specific contract line item. In summary, some of the larger contractors have primary care facilities in Iraq, while employees of smaller contractors do not have primary care available unless they are able to obtain it, for a fee, at one of the larger contractor organization's clinics.

Contractor Reimbursement

Based on survey responses, none of the medical units in Southwest Asia billed and collected from contractors for health care services provided. MTF personnel stated that they did not have a billing and collection process in place, nor the proper staff to perform billing and collections for health care provided to contractors. One of the medical units stated that a process to account for contractors needs to be in place before billing can occur. Another medical unit responded that it was not in the best interest of the mission to handle billing for contractor employee health care. Nevertheless, during the audit, USCENTCOM Surgeon officials informed us that they want to bill contractors for health care provided, but they need specific guidance on how to implement a billing and collection process in Southwest Asia.

To determine the potential monthly billings for contractor inpatient and outpatient visits by MTF location, we multiplied the visit data from Table 2 by the current inpatient and outpatient rates of $2,041 per day and $195 per visit, respectively. We determined the average inpatient stay was about 3 days. Our calculations resulted in potential inpatient monthly billings of $900,081 and potential outpatient monthly billings of $343,785, which results in total potential monthly billings of $1,243,866. See Figure 1 for potential billing details by MTF location. See Appendix D for more details on potential average monthly billings for contractor health care.

Figure 1. Potential Average Monthly Inpatient and Outpatient Billings for Contractors by MTF Location



Note: See "Reporting of Health Care Provided to Contractors" for specifics on the accuracy of the data.

Reporting of Health Care Provided to Contractors

To determine the extent of health care provided by MTFs to contractors in Southwest Asia, we requested that ASD(HA) provide data from the Theater Medical Data Store on inpatient stays and outpatient visits from January 4, 2007, through July 31, 2008. We tested the database by comparing it to inpatient hard copy records. Specifically, we reviewed 211 patients who had 237 inpatient stays stored on 297 database entry lines in the Theater Medical Data Store. Some of the patients had more than one admission on one database entry line. We identified the following discrepancies:

- Patients incorrectly identified as contractors - 13% (27/211)
- Duplicate entries in database - 22% (65/297)
- Admission and/or discharge date discrepancy between database and hard copy record - 25% (60/237)

Officials responding to our questionnaire told us that contractors were frequently categorized as "other" rather than contractors. If so, the database for contractors receiving health care in Southwest Asia could be significantly understated. For these reasons, we did not rely on the database. Further, we questioned the accuracy of the MTF responses to our questionnaire because many of them were based on data from this database. We did not use the MTF estimates of inpatient and outpatient visits for projecting potential monetary benefits because they were not reliable.

Roles and Responsibilities for Implementation and Oversight

No DoD Component had accepted responsibility as the proponent for billing and collecting for health care provided to contractors by MTFs in Southwest Asia, and DoD

did not have clearly defined roles and responsibilities. During the audit, we discussed who should be the proponent for implementation and oversight with the following DoD Components:

- DoD CFO
- ASD(HA)
- USCENTCOM
- Army, Navy, and Air Force Comptroller Offices
- Joint Staff, J-4 Logistics
- U.S. Army Medical Command
- U.S. Air Force Medical Operations Agency
- U.S. Navy, Bureau of Medicine and Surgery

Each of these DoD Components stated that from their interpretation of existing guidance, they were not the proponent for this initiative. For instance, several officials from the DoD medical community stated that this was a Comptroller issue because the ASD(HA) and Service Surgeons General do not manage medical resources that are deployed in a contingency operation. For that reason, according to an ASD(HA) official, the Uniform Business Office in the ASD(HA) developed the billing rates for deployed medical facilities and requested the DoD CFO to approve the billing rates and to task the Service Comptrollers with developing implementing guidance within 90 days. The DoD CFO issued a memorandum to that effect on January 4, 2007, and then again on June 4, 2008, with revised billing rates.

As of December 2008, the Service Comptrollers had not developed implementing guidance for billing contractors receiving health care at deployed MTFs. According to Army and Air Force Comptroller officials, they do not have oversight of this issue. According to a Navy Comptroller official, the Navy delegated the responsibility to the Fleets; however, it had not received implementing guidance from the Fleets.

On November 3, 2008, we held a meeting with Defense Finance and Accounting Service (DFAS) and DoD CFO officials, in which a DFAS official requested that the involved DoD Components meet to discuss a solution for implementing a system for billing contractors for health care provided by MTFs in contingency operations. Subsequently, DoD CFO officials organized a working group that has met several times with officials from USD(AT&L), USCENTCOM, ASD(HA), Joint Staff, DFAS, and the Military Departments.

We believe that the DoD CFO should continue to chair this working group to determine roles and responsibilities and to develop specific policy for implementing and overseeing a billing process in Southwest Asia. The group should include officials from USD(AT&L), USCENTCOM, ASD(HA), DFAS, Joint Staff, and Military Departments.

The working group should, at a minimum:

- Establish clearly defined roles and responsibilities for implementing and overseeing a process for billing and collecting from contractors receiving health care at MTFs in Southwest Asia, including the assignment of a DoD functional proponent.
- Establish procedures for identifying eligibility for care, level of care to be provided, and reimbursement requirements based on information obtained in the letter of authorization.
- Establish procedures for accurately capturing information needed to bill and collect payment, including, at a minimum, contractor organization, contract number, patient category, treatment dates, and health care provided.
- Determine which DoD Component will do the billing and collection. Consider a centralized billing function.
- Ensure the billing system provides the capability to bill the contractor personnel, their employer, their health insurance provider, and their DBA insurance provider. Consider initial billing to the contractor organization.
- Establish a process to bill for health care provided in prior years to contractors.
- Determine which DoD Components may retain and use any of the collected funds from billing for health care provided by MTFs to contractors.
- Establish procedures and frequency for financial reporting of billing and collecting from contractors in Southwest Asia.
- Consult with DBA insurance providers to ensure claims are processed properly.
- Determine how often the billing rates will be reevaluated.
- Consider a solution that will work in other contingency operations.
- Include policy, procedures, and standards in the Uniform Business Office Manual 6010.15-M or other appropriate formal guidance.
- Develop a timeline to implement the billing and collection system in Southwest Asia.

Our audit revealed a material internal control weakness because DoD did not have clear roles and responsibilities for implementing and overseeing a billing and collection process for health care provided to contractors by MTFs in Southwest Asia, and no DoD Component had accepted responsibility as the proponent for this issue.

Conclusions

Contracts that do not clearly address health care coverage and reimbursement may leave the Government at risk of an incorrect interpretation. As a result, MTFs may have provided unauthorized health care. MTFs in Southwest Asia may have provided health care billable in the millions, without seeking reimbursement.[5] DoD needs to clearly define roles and responsibilities for implementing and overseeing a billing and collection process. Lastly, many contractors have DBA insurance, through which the government

[5] We did not project a monetary benefit. See p. 20, "Use of Computer-Processed Data" for more details.

reimburses the contractor for the premiums, which may pay for health care procedures in Southwest Asia. We believe that billing for health care provided by MTFs to contractors would provide additional resources to be used to support the troops.

Management Actions

During the audit, officials from DoD CFO, USD(AT&L), ASD(HA), USCENTCOM, DFAS, Joint Staff, and Military Departments established a working group to discuss how to implement a billing and collection process in contingency operations. The working group is trying to determine who will manage and fund the billing and collection process, and it is developing a draft conceptual plan. DoD CFO has agreed to chair the working group.

Recommendations, Management Comments, and Our Response

1. We recommend that the Under Secretary of Defense for Acquisition, Technology, and Logistics:

a. Require DoD Components to include controls in their standard operating procedures to ensure that new and existing contracts and letters of authorization include terms that adequately address health care coverage and reimbursement.

b. Add the requirement that letters of authorization include the individual's Defense Base Act insurance billing information, other health insurance billing information, or both.

c. Perform a review to verify that contracts for contractor personnel that are deployed outside the United States include terms that adequately address health care coverage and reimbursement to DoD.

d. **Coordinate with other Federal entities writing contracts in support of Southwest Asia operations to emphasize the importance of adequately addressing health care coverage and reimbursement to DoD.**

Under Secretary of Defense (Acquisition, Technology, and Logistics) Comments

The Deputy Under Secretary of Defense for Logistics and Materiel Readiness provided comments for USD(AT&L). The Deputy Under Secretary agreed and stated that contingency contracting policy and procedures have been developed to address concerns in our report. Every contracting activity must comply with Joint Contracting Command-Iraq/Afghanistan acquisition instruction to ensure unity of effort and rapid support to the warfighter. Also, a pilot program has been established to provide point of service scanning capability at four MTFs in USCENTCOM's area of responsibility to capture contractor personnel usage at the MTFs.

Chief of Staff, U.S. Central Command Comments

Although not required to comment, U.S. Forces-Afghanistan agreed with comment, stating that letters of authorization need to be specific about authorized health care entitlements.

Assistant Secretary of Defense (Health Affairs) Comments

Although not required to comment, ASD(HA) agreed and stated that the need for insurance information in the letters of authorization is critical for effective billing and collections for health care provided to contractor personnel.

Our Response

The Deputy Under Secretary for Logistics and Materiel Readiness; Chief of Staff, USCENTCOM; and ASD(HA) comments are responsive and no additional comments are required.

2. We recommend that the Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer chair the working group with officials from the Under Secretary of Defense for Acquisition, Technology, and Logistics; U.S. Central Command; Assistant Secretary of Defense (Health Affairs); Defense Finance and Accounting Service; Joint Staff; Assistant Secretary of the Army (Financial Management and Comptroller); Assistant Secretary of the Navy (Financial Management and Comptroller); Assistant Secretary of the Air Force (Financial Management and Comptroller); Surgeon General of the Army; Surgeon General of the Navy; and Surgeon General of the Air Force to implement a billing system that is practical for U.S. Central Command. The working group should, at a minimum:

- **a. Establish clearly defined roles and responsibilities for implementing and overseeing a process for billing and collecting from contractors receiving health care at military treatment facilities in Southwest Asia, including the assignment of a DoD functional proponent.**
- **b. Establish procedures for identifying eligibility for care, level of care to be provided, and reimbursement requirements based on information obtained in the letter of authorization.**
- **c. Establish procedures for accurately capturing information needed to bill and collect payment, including, at a minimum, contractor organization, contract number, patient category, treatment dates, and health care provided.**
- **d. Determine which DoD Component will do the billing and collection. Consider a centralized billing function.**
- **e. Ensure the billing system provides the capability to bill the contractor, their employer, their health insurance provider, and their Defense Base Act insurance provider. Consider initial billing to the contractor organization.**
- **f. Establish a process to bill for health care provided in prior years to contractors.**

g. Determine which DoD Components may retain and use any of the collected funds from billing for health care provided by military treatment facilities to contractors.
h. Establish procedures and frequency for financial reporting of billing and collecting from contractors in Southwest Asia.
i. Consult with Defense Base Act insurance providers to ensure claims are processed properly.
j. Determine how often the billing rates will be reevaluated.
k. Consider a solution that will work in other contingency operations.
l. Include policy, procedures, and standards in the Uniform Business Office Manual 6010.15-M or other appropriate formal guidance.
m. Develop a timeline to implement the billing and collection system in Southwest Asia.

Managements Comments on the Draft Report

We requested management comments from 12 DoD Components; however, three DoD Components did not provide comments: DFAS; the Assistant Secretary of the Army (Financial Management and Comptroller); and the Assistant Secretary of the Air Force (Financial Management and Comptroller). Additionally, USD(AT&L) did not specifically comment on this recommendation. We are not requesting comments from USD(AT&L), DFAS, the Army Comptroller Office, or the Air Force Comptroller Office because officials from these offices are participating in the medical billing working group.

Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer Comments

The DoD CFO agreed and stated that staff will continue to chair the technical working group seeking a common solution to the billing challenge. Also, the Under Secretary stated that once the details of the new billing process are finalized, implementing directions will be issued and codified in the DoD Financial Management Regulation.

Our Response

The DoD CFO comments are responsive and no additional comments are required.

Chief of Staff, U.S. Central Command Comments

The Chief of Staff, USCENTCOM partially agreed and recommended that contractor employees be required to have health insurance for the entire time that they will be in USCENTCOM's area of responsibility and that bills be sent to the contractor employee's health insurance provider. USCENTCOM believes that billing the contractor organization and the individual will increase the overall costs to the Government.

The Multi-National Forces-Iraq stated that the working group should consider using any DoD best practices from other theaters before developing a billing process for Iraq. Multi-National Forces-Iraq provided additional recommendations for the working group

to consider, including the use of military veterinarians providing care to contractor organizations' animals and absorbing the cost of this care.

U.S. Forces-Afghanistan agreed with comments, stating that it had no issues at the macro level; however, it would need additional personnel with the skills to perform the billing function if it is implemented in theater. U.S. Forces-Afghanistan also stated that although collected funds could be retained by the MTF, it believed these funds should go back to the "line" component and be under the purview of the Comptroller.

Our Response

The Chief of Staff, USCENTCOM comments are responsive. The decision to bill the health insurance, individual or company should be decided by the working group. We note that there are differing opinions as to which DoD Component should receive collected funds, and Recommendation 2.g. allows the working group to determine where any collected funds should be retained. We also agree that existing best practices should be considered by the working group when determining the solution. We did not perform audit work on the provision of care to animals in Southwest Asia by military veterinarians. However, we have contacted ASD(HA) and the Chair of the working group and asked that they explore this issue. The actions planned and taken by USCENTCOM satisfy the intent of the recommendation.

Assistant Secretary of Defense (Health Affairs) Comments

ASD(HA) agreed with comment, stating that representatives from the TRICARE Management Activity Uniform Business Office have actively participated in a working group chaired by the DoD CFO since its inception and would continue to do so. ASD(HA) did not believe that policy for deployed medical units should be part of the Military Treatment Facility Uniform Business Office Manual, DoD 6010.15-M, as the focus of this regulation is exclusively on fixed medical and dental facilities funded by the Defense Health Program appropriation.

Our Response

The ASD(HA) comments are responsive. Recommendation 2.l. allowed the Components to consider Uniform Business Office Manual or other guidance to disseminate the new policy. We believe the working group should select the most appropriate guidance to use. No additional comments are required.

Vice Director, Joint Staff Comments

The Vice Director, Joint Staff agreed and stated that a medical billing process for contractors has not yet been established in theater operations. The Vice Director stated that the Joint Staff, the Office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, and USCENTCOM had been collecting information on the contractor health care issue since September 2008 and joined a working group led by DoD CFO in December 2008. The "group has made huge steps toward achieving a viable method for billing contractors" for health care provided by MTFs in theater.

The Vice Director stated that any solution would be a learning experience, and would likely create personnel and workload issues. Additionally, the Vice Director informed us that electronic devices are being installed in Southwest Asia to monitor contractor use at MTFs. Lastly; the Vice Director recommended that DoD conduct a review of current policies regarding contractor health care in overseas contingency operations.

Our Response

The Vice Director, Joint Staff, comments are responsive and no additional comments are required.

Department of the Army Comments

The Chief of Staff, U.S. Army Medical Command agreed with comment, stating that a centralized billing function should be considered rather than make this the responsibility of MTFs, which do not have the resources for a billing and collecting function. Also, the amounts collected should reimburse the deployed/contingency medical unit that provides the care; however, if there is centralized billing, that entity may need to recover its costs.

The Chief of Staff recommended the billing rates continue to be revaluated annually. Additionally, the Chief of Staff recommended that the new contractor health care billing guidance not be included in the Uniform Business Office Manual as the policy in this manual does not apply to deployed/contingency medical units.

Our Response

The Chief of Staff, U.S. Army Medical Command, comments are responsive. We agree that a centralized billing function should be considered and Recommendation 2.d. states this. We note that there are differing opinions as to which DoD Component should receive collected funds, and Recommendation 2.g. allows the working group to determine where any collected funds should be retained. Recommendation 2.l. allows the working group to select the most appropriate guidance to use to include contractor health care billing policy. No additional comments are required.

Department of the Navy Comments

The Acting Assistant Secretary of the Navy (Financial Management and Comptroller) agreed with comment, providing a joint response for the Assistant Secretary of the Navy (Financial Management and Comptroller) and the Surgeon General of the Navy. The Acting Assistant Secretary stated the process for billing and collecting for health care provided to contractors by deployed/nonfixed MTFs in contingency operations should be standardized across the DoD, rather than have each component implement the process independently.

Our Response

The Acting Assistant Secretary of the Navy (Financial Management and Comptroller) comments are responsive and no additional comments are required.

Department of the Air Force Comments

The Air Force Surgeon General agreed and stated that its staff is actively participating in the working group as recommended in the draft report.

Our Response

The Air Force Surgeon General comments are responsive and no additional comments are required.

Appendix A. Scope and Methodology

We conducted this performance audit from July 2008 through April 2009 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 finding and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

We contacted officials from the Department of Labor, USD(AT&L), DoD CFO, ASD(HA), Military Department Assistant Secretaries for Financial Management and Comptroller, U.S. Central Command, Joint Staff, and Military Department Surgeons General, Defense Contracting Audit Agency, Defense Finance and Accounting Service, U.S. Army Materiel Command, Defense Manpower Data Center, U.S. Army Corps of Engineers, Air Force Center for Engineering and the Environment, U.S. Special Operations Command, and U.S. Southern Command.

We reviewed public laws, DoD policy, DoD memoranda, and a USCENTCOM fragmentary order to identify requirements for contract health care terms and billing contractors for health care provided by MTFs in Southwest Asia. Specifically, we reviewed DoDI 3020.41, "Contractor Personnel Authorized to Accompany the U.S. Armed Forces"; DoD CFO memos from January 7, 2007, and June 4, 2008, "Medical Billing Rates for Other Than Foreign Military Personnel Utilizing DoD Deployed/Non-Fixed Facilities"; and USCENTCOM Fragmentary Order 09-1038, "Contractor Care In the USCENTCOM [Area of Responsibility]." We also reviewed USD(AT&L) memorandum, "Contractor Healthcare Services-Defense Contractors Outside the United States," September 17, 2007; MNF-I correspondence to ASD(HA), "Status of and Recommendations for Contractor Healthcare Services in the Iraqi Theater of Operations"; 42 United States Code §1651, "Compensation for Disability or Death to Persons Employed at Military, Air, and Naval Bases Outside United States"; and Defense Federal Acquisition Regulation Supplement 252.225-7040, "Contractor Personnel Authorized to Accompany U.S. Armed Forces Deployed Outside the United States."

Scope Limitations

We submitted questionnaires to medical units that command MTFs in Southwest Asia in September 2008 to gather information on contractor workload, additional burden contractor personnel placed on the medical staff, availability of commercial clinics, and billing and reimbursement for health care provided to contractors. To verify the medical officials' responses, we requested permission to perform site visits to MTFs in Southwest Asia during November 2008. USCENTCOM stated that it could not accommodate another DoDIG visit to Iraq in November. As a result, we were unable to visit and physically verify the responses from the medical officials at MTFs in Southwest Asia.

USCENTCOM provided us with spreadsheets that listed contracts in Iraq and Afghanistan for the second quarter of FY 2008. The spreadsheets included the number of

contractor personnel performing work in Southwest Asia. We did not verify the accuracy of the spreadsheets because of time constraints and our inability to visit Southwest Asia in a timely fashion. Therefore, the spreadsheets upon which we relied might be inaccurate. However, our conclusion would be the same based on the results of the contracts we reviewed.

Because medical records available to us did not have the contract number for contractor personnel treated, we were unable to trace contracts from our statistical sample to contractor patient visits. Therefore, we were unable to determine whether contractor personnel were receiving unauthorized health care.

Use of Computer-Processed Data

We used computer-processed data obtained from the Theater Medical Data Store, a database managed by ASD(HA). We tested the reliability of the inpatient data entries to scanned hard-copy records obtained from the U.S. Army Medical Command, Patient Administration Systems and Biostatistics Activity. We encountered duplicate entries on inpatient stays, discharge dates that occurred before admission dates, and numerous instances of incorrect admission and discharge dates. We also identified numerous duplicate entries for outpatient visits in the database and were told by officials responding to our questionnaire that contractors were frequently categorized as "other" rather than as contractors in the database. Further, we questioned the accuracy of the MTF responses to our questionnaire because many of them were based on data pulled from this database. We concluded that we could not rely on these data to project a potential monetary benefit for billing for health care provided to contractors at the MTFs in Southwest Asia. However, we used the MTF responses to the questionnaire to provide an estimate of the magnitude of the problem because their responses were the best data available. Monetary benefits will be quantified after a billing and collection process has been implemented worldwide. We plan to track monetary benefits during the audit follow-up process.

Use of Technical Assistance

The DoD OIG Quantitative Methods and Analysis Division (QMAD) assisted with the audit. See Appendix B for detailed information about the work the Division performed. In addition, we received legal opinions from the DoDIG Office of General Counsel dealing with contract health care terms and the roles and responsibilities of DoD Components.

Prior Coverage

We found no coverage on the billing and collections for health care provided to contractors in Southwest Asia during the last 5 years.

Appendix B. Statistical Sample

With the assistance of the QMAD, we used a statistical sample to project whether contract terms for health care provided by MTFs to contractors in Southwest Asia were adequately addressed.

Sample Plan

The original database provided by USCENTCOM had 2,782 contracts from Iraq and Afghanistan. From the 2,782 unique contracts, QMAD developed a stratified sample design based on the number of employees assigned to each contract. QMAD drew a sample of 107 contracts.

After we reviewed the 107 contracts, we found that the population of 2,782 contracts from which the sample was drawn was a mixture of prime contracts, subcontracts, and other type actions. Because we intended to report the results based only on prime contracts, we identified the 2,561 prime contracts out of the total 2,782 contracts. QMAD used the new population of 2,561 prime contracts for all projection purposes.

Of the original sample of 107 contracts, 88 corresponded to the new population of 2,561 prime contracts. QMAD used the sample of 88 prime contracts as a basis for the projections over the population of 2,561 prime contracts. Table B.1 provides details of the stratified design and sample data used in the analysis.

Table. B.1. Details of Stratified Design

Number of Employees	Stratum Population	Sample
More than 1,000	15	15
100 to 1,000	222	30
10 to 99	1,281	29
1 to 9	999	9
Zero	44	5
Total	**2,561**	**88**

Statistical Projection

We reviewed the contracts from the sample and assigned them to the applicable categories defined below:

- emergency care authorized; reimbursement required;
- vague and subject to interpretation; and
- silent on health care terms.

QMAD calculated two sets of statistical projections using a 90-percent confidence level.

1. For the positive results, the contracts that adequately addressed the health care terms; and

2. For the negative results, the contracts that did not adequately address health care terms.

The contracts that adequately addressed contract terms (46) are those classified as "emergency care authorized; reimbursement required," and those that did not adequately address contract terms (42) as "vague and subject to interpretation" or "silent on health care terms." QMAD calculated the following projections based on the audit results. See Table B.2.

Table B.2. Sample Projection Details

Positive Results			
Contract terms adequately addressed	**Lower Bound**	**Point Estimate**	**Upper Bound**
Number of contracts	736	1,178	1,620
Success rate	28.7%	46.0%	63.2%

Negative Results			
Contract terms not adequately addressed	**Lower Bound**	**Point Estimate**	**Upper Bound**
Number of contracts	941	1,383	1,825
Error rate	36.8%	54.0%	71.3%

Interpretation of Results

The positive results can be interpreted as follows. From the population of 2,561 prime contracts, we are 90-percent confident that the number of contracts that adequately address health care terms is between 736 and 1,620 contracts, and the success rate is between 28.7 percent and 63.2 percent. The point estimate is 1,178 contracts that adequately address health care terms, or 46 percent.

The negative results can be interpreted as follows. From the population of 2,561 prime contracts, we are 90-percent confident that the number of contracts that do not adequately address health care terms is between 941 and 1,825 contracts, and the error rate is between 36.8 percent and 71.3 percent. The point estimate is 1,383 contracts that do not adequately address health care terms, or 54 percent.

Appendix C. Health Care Contract Terms by Specific Contract

Command[a]	Contract Number[b]	Country[c]	Health Care Terms Listed in the Contract[d]
AFCEE	FA8903-04-D-8677/0083	Iraq	Emergency care authorized; reimbursement required
AFCEE	FA8903-06-D-8510/0004	Iraq	Emergency care authorized; reimbursement required
AFCEE	FA8903-06-D-8511/0013	Iraq	Emergency care authorized; reimbursement required
AFCEE	FA8903-06-D-8511/0026	Iraq	Emergency care authorized; reimbursement required
AFCEE	FA8903-06-D-8511/0039	Iraq	Emergency care authorized; reimbursement required
AFCEE	FA8903-06-D-8513/0022	Iraq	Emergency care authorized; reimbursement required
AFCEE	FA8903-06-D-8515/0011	Iraq	Emergency care authorized; reimbursement required
AMC	DAAA09-02-D-0007	Iraq	Emergency care authorized; reimbursement required
AMC	W52P1J-07-D-0009	Iraq	Emergency care authorized; reimbursement required
AMC	W56HZV-05-G-0005	Iraq	Emergency care authorized; reimbursement required
AMC	W56HZV-07-C-0295	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91B4K08C0003P00002	Afghanistan	Vague and subject to interpretation
JCC-I/A	W91B4K08C0029	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4L06A0039	Afghanistan	Silent on health care terms
JCC-I/A	W91B4L07M0022	Afghanistan	Silent on health care terms
JCC-I/A	W91B4L08C0026	Afghanistan	Vague and subject to interpretation
JCC-I/A	W91B4L08C0030	Afghanistan	Vague and subject to interpretation
JCC-I/A	W91B4M05P3548	Afghanistan	Silent on health care terms
JCC-I/A	W91B4M07C4026	Afghanistan	Vague and subject to interpretation
JCC-I/A	W91B4M07C4155	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4M07C7116	Afghanistan	Vague and subject to interpretation

[a] Commands listed: Air Force Center for Engineering and the Environment (AFCEE); U.S. Army Materiel Command (AMC); Joint Contracting Command-Iraq/Afghanistan (JCC-I/A); U.S. Special Operations Command (USSOCOM); and U.S. Army Corps of Engineers (USACE)
[b] This list of contracts is per a spreadsheet provided by USCENTCOM on August 11, 2008.
[c] Documents the country where the contractor personnel are assigned.
[d] As of July 14, 2008.

Command[a]	Contract Number[b]	Country[c]	Health Care Terms Listed in the Contract[d]
JCC-I/A	W91B4M07D0002	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4M07P1007P00004	Afghanistan	Silent on health care terms
JCC-I/A	W91B4M07P4501P2	Afghanistan	Silent on health care terms
JCC-I/A	W91B4M07P7173	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4M07P7322	Afghanistan	Silent on health care terms
JCC-I/A	W91B4M08C0010	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4M08C7078	Afghanistan	Vague and subject to interpretation
JCC-I/A	W91B4M08P0184	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4N06A0068	Afghanistan	Silent on health care terms
JCC-I/A	W91B4N07M0828	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4N07M1676	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4N08A0001	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4N08M0565	Afghanistan	Vague and subject to interpretation
JCC-I/A	W91B4N08M0594	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4N08M0621	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P06C0090	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P06C0169P00005	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P07C0263	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P07C0313	Afghanistan	Silent on health care terms
JCC-I/A	W91B4P07C0362	Afghanistan	Silent on health care terms
JCC-I/A	W91B4P07C6015P00003	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P07C6018P00003	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P08C0012	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P08C0074	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4P08C0173	Afghanistan	Vague and subject to interpretation
JCC-I/A	W91B4P08C6004	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91B4M07P7240	Afghanistan	Emergency care authorized; reimbursement required
JCC-I/A	W91GDW07A4004	Iraq	Emergency care authorized; reimbursement required

Command[a]	Contract Number[b]	Country[c]	Health Care Terms Listed in the Contract[d]
JCC-I/A	W91GDW07C4042	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GDW07D4020	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GDW07D4021	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GDW07D4031	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GDW-08-M-0053	Iraq	Silent on health care terms
JCC-I/A	W91GER07A0009	Iraq	Silent on health care terms
JCC-I/A	W91GET06A5004	Iraq	Silent on health care terms
JCC-I/A	W91GET08M0261	Iraq	Vague and subject to interpretation
JCC-I/A	W91GET08M0405	Iraq	Vague and subject to interpretation
JCC-I/A	W91GEU07MS026	Iraq	Silent on health care terms
JCC-I/A	W91GEU07P1590	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GEU07P1910	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GEY08M0382	Iraq	Vague and subject to interpretation
JCC-I/A	W91GF507A7063	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GF908D0001	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GF908M0224	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GFB07C2085	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GFB07M9079	Iraq	Silent on health care terms
JCC-I/A	W91GFB08M9014	Iraq	Vague and subject to interpretation
JCC-I/A	W91GFC08M0467	Iraq	Vague and subject to interpretation
JCC-I/A	W91GFP07M0334	Iraq	Silent on health care terms
JCC-I/A	W91GXE07M0282	Iraq	Silent on health care terms
JCC-I/A	W91GXE08M0143	Iraq	Vague and subject to interpretation
JCC-I/A	W91GY006D0009	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GY007C0053	Iraq	Vague and subject to interpretation
JCC-I/A	W91GY007D0013	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GY007D0018	Iraq	Vague and subject to interpretation
JCC-I/A	W91GY008C0015	Iraq	Emergency care authorized; reimbursement required
JCC-I/A	W91GY308C0012	Iraq	Vague and subject to interpretation
JCC-I/A	W91GY308C0020	Iraq	Vague and subject to interpretation
USACE	W912DY-04-D-0011 TO 0005	Iraq	Emergency care authorized; reimbursement required
USACE	W912ER-04-D-0004-0017	Iraq	Vague and subject to interpretation

Command[a]	Contract Number[b]	Country[c]	Health Care Terms Listed in the Contract[d]
USACE	W912ER-04-D-0005	Iraq	Emergency care authorized; reimbursement required
USACE	W917BE-07-C-0021	Iraq	Silent on health care terms
USACE	W917BG-07-C-0033	Iraq	Silent on health care terms
USACE	W917BG-07-C-0161	Iraq	Silent on health care terms
USACE	W917BG-07-C-0166	Iraq	Silent on health care terms
USACE	W917BK-06-P-0133	Iraq	Silent on health care terms
USACE	W917BK-07-C-0085	Iraq	Silent on health care terms
USSOCOM	H92237-07-A-0601	Iraq	Silent on health care terms

Appendix D. Potential Average Monthly Billings for Contractor Visits by Military Treatment Facility Location

To determine the potential monthly billings for contractor inpatient and outpatient visits by MTF location, we multiplied the visit data from Table 2 by the current inpatient and outpatient rates of $2,041 per day and $195 per visit, respectively. We determined the average inpatient stay was about 3 days. See Tables D.1, D.2, and D.3 for our billing calculations.

Table D.1. Average Monthly Contractor Inpatient Billings by MTF Location

MTF Location	Contractor Visits		Current Rate		Total Inpatient Billings
Baghdad	54	X	$2,041	X 3 Days =	$330,642
Bagram Air Base	18	X	2,041	X 3 Days =	110,214
Joint Base Balad	45	X	2,041	X 3 Days =	275,535
Camp Bucca & Camp Cropper	4	X	2,041	X 3 Days =	24,492
Mosul	9	X	2,041	X 3 Days =	55,107
Tikrit & Al Asad	14	X	2,041	X 3 Days =	85,722
Camp Arifjan	3	X	2,041	X 3 Days =	18,369
Total	**147**				**$900,081**

Table D.2. Average Monthly Contractor Outpatient Billings by MTF Location

MTF Location	Contractor Visits		Current Rate		Total Outpatient Billings
Baghdad	998	X	$195	=	$194,610
Bagram Air Base	359	X	195	=	70,005
Joint Base Balad	134	X	195	=	26,130
Camp Bucca & Camp Cropper	100	X	195	=	19,500
Mosul	75	X	195	=	14,625
Tikrit & Al Asad	51	X	195	=	9,945
Camp Arifjan	46	X	195	=	8,970
Total	**1,763**				**$343,785**

Table D.3. Total Potential Average Monthly Contractor Inpatient and Outpatient Billings by MTF Location

MTF Location	Inpatient Billings		Outpatient Billings		Inpatient & Outpatient Billings
Baghdad	$330,642	+	$194,610	=	$525,252
Bagram Air Base	110,214	+	70,005	=	180,219
Joint Base Balad	275,535	+	26,130	=	301,665
Camp Bucca & Camp Cropper	24,492	+	19,500	=	43,992
Mosul	55,107	+	14,625	=	69,732
Tikrit & Al Asad	85,722	+	9,945	=	95,667
Camp Arifjan	18,369	+	8,970	=	27,339
Total	**$900,081**		**$343,785**		**$1,243,866**

Under Secretary of Defense (Acquisition, Technology, and Logistics) Comments

DEPUTY UNDER SECRETARY OF DEFENSE FOR
LOGISTICS AND MATERIEL READINESS
3500 DEFENSE PENTAGON
WASHINGTON, DC 20301-3500

April 15, 2009

MEMORANDUM FOR PROGRAM DIRECTOR, MILITARY HEALTH SYSTEM,
INSPECTOR GENERAL, DEPARTMENT OF DEFENSE,
DoDIG

THROUGH: DIRECTOR, ACQUISITION RESOURCES AND ANALYSIS 4/16/09

SUBJECT: USD(AT&L) response to DoDIG Draft Report on Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Project No. D-2008-0241)

As requested, I am providing a response to the general content and recommendation 1.~~c~~, in the subject report which is the only recommendation USD(AT&L) can address. JST Concur w/ Recommendation 1

Recommendation 1.~~c~~: JST Based on phone con w/ DODIG 4/17/09
We recommend that the Under Secretary of Defense for Acquisition, Technology, and Logistics ensure that contracts for contractor personnel that are deployed outside the United States include terms that adequately address health care coverage and reimbursement.

Response: Concur. DUSD(L&MR) and DPAP in coordination with The Deputy Assistant Secretary of the Army (Procurement)(DASA(P)), Commander, USCENTOM (J4), and Commander, Joint Contracting Command-Iraq/Afghanistan (JCC-I/A), have developed and implemented the following Contingency Contracting Policy and procedures addressing the concerns found in the first recommendation. The second issue, (reimbursement) must be addressed by OASD – Health Affairs.

1. DFAR 252.225 – 7040 **Contractor Personnel Authorized to Accompany U.S. Armed Forces Deployed Outside the United States** provides the contractual guidance for medical care provide to contractor personnel when deployed to a contingency operations.

> "(2)(i) Generally, all Contractor personnel authorized to accompany the U.S. Armed Forces in the designated operational area are authorized to receive resuscitative care, stabilization, hospitalization at level III military treatment facilities, and assistance with patient movement in emergencies where loss of life, limb, or eyesight could occur. Hospitalization will be limited to stabilization and short-term medical treatment with an emphasis on return to duty or placement in the patient movement system.

(ii) When the Government provides medical treatment or transportation of Contractor personnel to a selected civilian facility, the Contractor shall ensure that the Government is reimbursed for any costs associated with such treatment or transportation.

(iii) Medical or dental care beyond this standard is not authorized unless specified elsewhere in this contract."

To ensure medical is addressed contractually, the Theater Business Clearance (TBC) - TBC is applied to all contracts (Theater Support, External Support, and Systems Support) worldwide, (except DLA, which has a MOU with JCC-I/A to conduct their own review and clearance of contract actions prior to award), prior to award and prior to entering the I/A theater of operations. Every contracting activity preparing contract actions with performance in theater must comply with the Joint Contracting Command-I/A Acquisition Instructions for unity of effort and rapid support to the warfighter. JCC-I/A will review, approve, and clear contracts insuring theater requirements are fully met. TBC helps enforce the JCC-I/A requirements for compliance with the Synchronized Predeployment and Operational Tracker (SPOT), which provides accountability and visibility of contractor and contractor personnel on the battlefield. The following are notable actions and elements of TBC are:

- On 17 Oct 2007, OSD issued a memo with procedures for contracting, contract concurrence and contract oversight for Iraq and Afghanistan.
- This memo and subsequent policy, procedures, and guidance, issued by DPAP, instructed contracting officers on how to have the Joint Contracting Command - Iraq and Afghanistan (JCC-I/A) review and clear SOWs and terms and conditions of all contracts requiring performance in Iraq or Afghanistan, prior to award.
- Upon contract award, contract administration of that portion of the contract that relates to performance in Iraq and Afghanistan is delegated to JCC-I/A. Depending on complexity, availability of resources, etc., JCC-I/A may delegate contract administration to DCMA or back to the originating contracting officer.
- See USCENTCOM J4 Contracting at http://www2.centcom.mil/sites/contracts/Pages/Default.aspx for more details regarding specific elements of TBC. (note: emailed version of this link may need to be re-connected in order to work properly; link must be accessed from a DoD computer system)

2. To minimize the use of Medical Treatment Facilities by contractor personnel, DODI 3020.41 (Oct 2005) requires contractor personnel to medically and physically qualifited to deploy.

2

DODI 3020.41:

"4.8. Require defense contractors provide medically and physically qualified contingency contractor personnel to perform duties in contingency operations. Medical support procedures shall be consistent with the following:

> 4.8.1. All external support and systems support contracts contain or incorporate by reference: minimum medical and dental standards for CDF; a requirement to make available CDF medical and dental records (including current panograph) for deployment center validation; a requirement to submit a specimen sample suitable for deoxyribonucleic acid (DNA) analysis for CDF; and immunization requirements for the relevant joint operations area (JOA). Selected theater support contracts (e.g., for food handlers) should, as appropriate, contain minimum medical and dental standards and immunization requirements.
>
> 4.8.2. Generally, all contingency contractor personnel who support U.S. forces in contingency operations or other military operations may be provided resuscitative care, stabilization, hospitalization at level III military treatment facilities (MTF), and assistance with patient movement in emergencies where loss of life, limb, or eyesight could occur. Hospitalization will be limited to stabilization and short-term medical treatment with an emphasis on return to duty or placement in the patient movement system. The contract and the appropriate medical authorities must specifically authorize medical or dental care beyond this standard.
>
> 4.8.3. All costs associated with treatment and transportation of contingency contractor personnel to a selected civilian facility will be the responsibility of the contingency contractor personnel, their employer, or their health insurance provider. "

3. OSD-ATL does recognize that access to "primary" medical care is not always available to contractors operating under DoD contracts in remote areas. Because there is a high probability contractors will continue to utilize military medical treatment facilities (MTF), OSD-ATL has recommended the Synchronized Predeployment and Operational Tracker (SPOT) be used to date stamp when a contractor personnel enters a MTF. As a proof of concept, OASD (HA) along with the CENTCOM surgeon general have agreed to a pilot program using 4 Military Treatment Facilities (MTF) in the CENTCOM area of operation. The pilot program will employ the Joint Asset Movement Management Systems (JAMMS) to provide point of service (POS) scanning capability at the MTF throughout the CENTCOM AOR. As an interim measure, once a contractor enters the MTF, a contractor would scan their ID card (CAC) or their letter of authorization (LOA) as a part of their check in process. These scan transactions would be loaded into the Synchronized Predeployment and Operational Tracker (SPOT) and applied as a movement activity to a contractors' record. The SPOT team would then conduct a comparison of contractually authorized services registered by the contracting

officer (KO) to the contractors' services consumed. The KO and medical community would then receive a report showing a recap of all activity where contractors consumed services not authorized by the contract and therefore adjust from their final invoice. This is also being applied to dining facilities and in the future central issue facilities.

Please contact [redacted], if additional information is required.

/s/ Jack Bell

Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer Comments

UNDER SECRETARY OF DEFENSE
1100 DEFENSE PENTAGON
WASHINGTON, DC 20301-1100

COMPTROLLER

APR 2 2009

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Draft Report, "Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia" (Project No. D2008-D000LF-0241.000)

Thank you for the opportunity to review and provide comments on the subject draft report, dated February 25, 2009. We concur with the draft report's conclusions and second recommendation. As recommended in the draft report, my staff will continue to chair the technical working group seeking a common solution to the billing challenge. Once the details of the new billing process are finalized, implementing directions will be issued and codified in the DoD Financial Management Regulation.

My point of contact for this issue is [redacted], who may be reached at [redacted].

Robert F. Hale

Robert F. Hale

U.S. Central Command Comments

UNITED STATES CENTRAL COMMAND
OFFICE OF THE CHIEF OF STAFF
7115 SOUTH BOUNDARY BOULEVARD
MACDILL AIR FORCE BASE, FLORIDA 33621-5101

23 March 2009

FOR: DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Review of DODIG Draft Report "“Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia” Project No. D2008-D000LF-0241.000.

1. Thank you for the opportunity to respond to the recommendations presented in the DODIG draft report.

2. Attached is the consolidated CENTCOM, MNF-I and USFOR-A response to the recommendations and comments on the report.

3. The Point of Contact is [redacted], USCENTCOM Inspector General, [redacted]

JAY W. HOOD
Major General, U.S. Army

Enclosure
Combined CENTCOM Response

DODIG DRAFT REPORT – DATED February 25, 2009
DODIG CODE D2008-D000LF-0241.000

"Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia"

CENTCOM COMMENTS
TO THE FINAL REPORT

CENTCOM STAFF COMMENTS

RECOMMENDATION 2. DODIG recommends that the Under Secretary of Defense (Comptroller), DoD Chief Financial Officer chair the working group with officials from the Under Secretary of Defense for Acquisition, Technology, and Logistics; U.S. Central Command; Assistant Secretary of Defense (Health Affairs); Defense Finance and Accounting Service; Joint Staff; Assistant Secretary of the Army (Financial Management and Comptroller); Assistant Secretary of the Navy (Financial Management and Comptroller); Assistant Secretary of the Air Force (Financial Management and Comptroller); Surgeon General of the Army; Surgeon General of the Navy; and Surgeon General of the Air Force to implement a billing system that is practical for U.S. Central Command. The working group should, at a minimum:

a. Establish clearly defined roles and responsibilities for implementing and overseeing a process for billing and collecting from contractors receiving health care at military treatment facilities in Southwest Asia, including the assignment of a 000 functional proponent.

b. Establish procedures for identifying eligibility for care, level of care to be provided, and reimbursement requirements based on information obtained in the letter of authorization.

c. Establish procedures for accurately capturing information needed to bill and collect payment, including, at a minimum, contractor organization, contract number, patient category, treatment dates, and health care provided.

d. Determine which 000 Component will do the billing and collection. Consider a centralized billing function.

e. Ensure the billing system provides the capability to bill the contractor, their employer, their health insurance provider, and their Defense Base Act insurance provider. Consider initial billing to the contractor organization.

f. Establish a process to bill for health care provided in prior years to contractors.

g. Determine which 000 Components may retain and use any of the collected funds from billing for health care provided by military treatment facilities to contractors.

h. Establish procedures and frequency for financial reporting of billing and collecting from contractors in Southwest Asia.

i. Consult with Defense Base Act insurance providers to ensure claims are processed properly.

j. Determine how often the billing rates will be reevaluated.

k. Consider a solution that will work in other contingency operations.

l. Include policy, procedures, and standards in the Uniform Business Office ManuaI6010.15-M or other appropriate formal guidance.

m. Develop a timeline to implement the billing and collection system in Southwest Asia.

(DODIG report page 14)

CENTCOM RESPONSE: CENTCOM partially concurs with Recommendation 2, above. Recommend that contractors be required to have health insurance for the entire time that they will be in the AOR and that bills will be sent to their health insurance company. Per the previous recommendation, the DODIG added the capability to bill their health insurance provider but did not delete the individual and contractor from being billed as previously recommended.

Billing the insurance company will have no negative impact and all contractors can be required to have medical insurance; however, billing the contractor and the individual will increase the overall costs to the government. The contractor will bill the government directly for medical costs in cost type contracts and will indirectly bill the government for medical costs via overhead rates in fixed priced contracts. The overall costs to the government will be increased because the contractor will add on G&A and profit to the direct medical costs that they bill to the government.

There are also issues related to having an insufficient number of contracting personnel to adequately administer this program for medical billing. Contracts will not be able to be closed out until all medical billings have been completed. This will cause an increase in workload for the contracting workforce to track medical billing and contract funding related to medical expenses. This will place additional strain on the contracting workforce which already has major shortages in completing the current work load.

There are numerous other contractual and legal impacts that must be taken into consideration particularly if bills are not sent out in an expeditious manner. This could cause illegal activity related to funding such as funding may not be available for the FY in which medical services were rendered. Anti-Deficiency Act violations may occur if the contracting officer does not include enough funding in the contract to cover medical billings.

MNF-I COMMENTS
TO THE FINAL REPORT

RECOMMENDATION 2. DODIG recommends that the Under Secretary of Defense (Comptroller), DoD Chief Financial Officer chair the working group with officials from the Under Secretary of Defense for Acquisition, Technology, and Logistics; U.S. Central Command; Assistant Secretary of Defense (Health Affairs); Defense Finance and Accounting Service; Joint Staff; Assistant Secretary of the Army (Financial Management and Comptroller); Assistant Secretary of the Navy (Financial Management and Comptroller); Assistant Secretary of the Air Force (Financial Management and Comptroller); Surgeon General of the Army; Surgeon General of the Navy; and Surgeon General of the Air Force to implement a billing system that is practical for U.S. Central Command. The working group should, at a minimum:
a. Establish clearly defined roles and responsibilities for implementing and overseeing a process for billing and collecting from contractors receiving health care at military treatment facilities in Southwest Asia, including the assignment of a 000 functional proponent.
b. Establish procedures for identifying eligibility for care, level of care to be provided, and reimbursement requirements based on information obtained in the letter of authorization.

c. Establish procedures for accurately capturing information needed to bill and collect payment, including, at a minimum, contractor organization, contract number, patient category, treatment dates, and health care provided.
d. Determine which 000 Component will do the billing and collection. Consider a centralized billing function.
e. Ensure the billing system provides the capability to bill the contractor, their employer, their health insurance provider, and their Defense Base Act insurance provider. Consider initial billing to the contractor organization.
f. Establish a process to bill for health care provided in prior years to contractors.
g. Determine which 000 Components may retain and use any of the collected funds from billing for health care provided by military treatment facilities to contractors.
h. Establish procedures and frequency for financial reporting of billing and collecting from contractors in Southwest Asia.
i. Consult with Defense Base Act insurance providers to ensure claims are processed properly.
j. Determine how often the billing rates will be reevaluated.
k. Consider a solution that will work in other contingency operations.
l. Include policy, procedures, and standards in the Uniform Business Office Manual6010.15-M or other appropriate formal guidance.
m. Develop a timeline to implement the billing and collection system in Southwest Asia.
(DODIG report page 14)

MNF-I RESPONSE: MNF-I partially concurs with information provided in this DODIG Report. The committee/work group should consider exporting any DOD best practice from other theaters before recreating a billing process for the ITO

1. Example: Check with Balkans comptroller/RM and see if the Multi-National Support Cell (MNSC) can export their process (item 2 below) to the ITO
2. Balkans Process: Each contract FTE carries a KFOR (yellow badge). When they go to the MTF, they present it, complete a data worksheet, scan the badge, and attach it to the documentation. The MTF staff is then done with the processing as the contract liaison office picks up the forms on a weekly basis and prepares a DD 1151 who then take it to the local finance office for payment. Finance adds the DOV number to the DD 1151 and provides a copy to the Resource Management office. The RM office adds the CCV to a tracking ledger, validates the credit disbursement has been posted to our Class VIII account, and the process ends. There has been success in the Balkans with this system and it should be considered for export to other theaters of operation.

GENERAL MNF-I COMMENTS ON THE REPORT:

A. Other considerations beyond those listed on recommendation 2 for the committee:

1. Require third party collection of care provided to retired military members that are in theater as contractors.

2. Consider a mechanism for collecting reimbursement for high cost pharmaceuticals that are otherwise not available through normal ITO formulary

3. Require contracting office in ITO have all contracts reviewed by a medical authority prior to final signature to ensure that all contract language appropriately articulates healthcare coverage. No contractor should arrive in theater without having been medically screened to

avoid burden on healthcare delivery system or bring infectious disease to the theater that could jeopardize mission effectiveness.

4. Wherever and whenever possible, contractor organizations should establish primary care and dental clinics in areas of high concentration of contract staff in the ITO. All contractors should take advantage of some form of mail-order pharmaceuticals whenever possible. There is no system currently in use in the ITO that adequately stores contractor data and subsequently charges them appropriately for the care rendered in DOD facilities. (CDA does not have a separate contractor field so their data gets lost and is makes tracking impossible).

5. Require a billing processes to reflect outpatient care charges and a separate pharmaceutical process to recapture the huge uncaptured cost that exists today in the ITO (there are a large number of contractors requiring high cost pharmaceuticals in the ITO).

6. Require optometry care provided to contractors in the ITO be appropriately charged. The large amount of optometry care/glasses fabrication is largely uncaptured at present time. Contractor organizations should consider again a mail order service for glasses replacement similar to g-eye services.

7. Require contractor organizations to establish and maintain care provided to working dogs. This is currently uncaptured workload and the cost is absorbed by CF vets, who contend with a shortage of availability.

B. General comments/feedback on DODIG Draft Report CFC FRAGO 09-1038, Contractor Care Data Collection (page 6, para 3.a.4.) – review and advise to the feasibility of execution

1. Joint patient tracking application is no longer in use. Current business practice within the ITO requires the MTF to enter patient registration data into AHLTA. The data is then transferred into TMDS once the providers digitally signs/dispositions the encounter.

2. Recommend the FRAGO reference AHLTA as the minimum registration system for outpatient (AHLTA-T) and inpatient (TC2) encounters. Registration demographic data will include correct patient category and the contractors/patients letter of authorization (LOA) id number. TF MED MRO strongly recommends that all end of day processing/disposition status be completed in both AHLTA and TMDS systems to ensure compliance and accuracy of the information collected.

USFOR-A COMMENTS
TO THE FINAL REPORT

USFOR-A has reviewed CENTCOM RFI 20090226-030 DODIG DRAFT Report, Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia, S: 16 MAR 2009 and CONCURS with comments from CJTF-101 and Task Force Medical below.

Recommendation #1: The accuracy of the LOA's needs to be enforc ed; Experience in Baghdad is that many LOA's are written author izing "Medical Care" a nd are no more specific than that; the DCCS of a CSH in Baghdad, required contractors to present a copy of the contract to support the LOA; upon reviewing the contracts, >95% were only authorized

"emergency c are"; eliminating ineligible contractors this way greatly reduced outpatient clinic workload. Bottom line: LOA's need to be spec ific to authorized entitlements.

Recommendation #2: Add the following – "Identify additio nal Joint Service, DoD civilian, or contract personnel requirements to source this function at Role 3 Medical Treatment Facilities (MTF) in theater." None of the services' Role 3 MTFs have the expertise or the ability to perform this function without additional staff.

The commanders have reviewed the draft report and find no issues at the macro level with the report as written. However, local implementation will be challenging due to the line funding stream and embedded subject matter experts (SME) in the different units at Bagram Airfield (BAF) and throughout Afghanistan. If the expectation is to centralize all billing under Task Force Medical (TF MED) for the entire area of operation, then well defined business rules for use at the local level are critical as well as a mature information system and adequate resources to implement and manage. Whether this is done at the TF MED or Medical Brigade level, the implementation and management issues/concerns remain the same.

Finally, USFOR-A concurs with recommendation that this topic be placed under a Comptroller purview as Defense Health Program (DHP) funding is not the funding source in a deployment environment. While the language indicates funds collected may be retained by the MTF, any funds collected should go back to the "Line" component and not medical (DHP); hence why it should be under one a Comptroller purview.

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 27 2009

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL,
PROGRAM DIRECTOR, MILITARY HEALTH SYSTEM

SUBJECT: Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Project No. D2008-D000LF-0241.000)

Thank you for the opportunity to review and provide comments (see attached) on the referenced Department of Defense Inspector General Draft Report for D2008-D000LF-0241.000.

Overall, I concur, and provide comments regarding the draft reports' findings, conclusions, and recommendations. I note that the responsibility for Recommendation 2 has been reassigned from the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) to the Office of the Under Secretary of Defense (Comptroller). I appreciate your incorporation of our comments and suggestions submitted on the Discussion Draft of the Proposed Report.

As has been stated previously by ASD (HA) representatives, the deployed medical units in Southwest Asia are not Defense Health Program funded facilities. As such, they are not under the control of ASD (HA), but rather fall under the Military Departments and the Combatant Commands.

My points of contact on this issue are [redacted] (Functional) at [redacted] and [redacted] (Audit Liaison) at [redacted].

S. Ward Casscells, MD

Attachments:
As stated

DEPARTMENT OF DEFENSE INSPECTOR GENERAL
DRAFT REPORT
D2008-D2000LF-0241.000

"Audit of Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia"

RECOMMENDATION #1: We recommend that the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD(AT&L)):

a. Require Department of Defense (DoD) Components to include controls in their standard operating procedures to ensure that new and existing contracts and letters of authorization include terms that adequately address health care coverage and reimbursement.

b. Add the requirement that letters of authorization include the individual's Defense Base Act insurance billing information, other health insurance billing information, or both.

c. Perform a review to verify that contracts for contractor personnel that are deployed outside the United States include terms that adequately address health care coverage and reimbursement to DoD.

d. Coordinate with other Federal entities writing contracts in support of Southwest Asia operations to emphasize the importance of adequately addressing health care coverage and reimbursement to DoD.

HEALTH AFFAIRS RESPONSE: Concur. The need to include insurance information in the letters of authorization for contractor personnel is critical for effective billing and collection for health care provided to contractor personnel by deployed medical units in the Area of Responsibility (AOR).

RECOMMENDATION #2: We recommend that the Under Secretary of Defense (Comptroller) (USD(C))/DoD Chief Financial Officer chair the working group with officials from the USD(AT&L); U.S. Central Command; Assistant Secretary of Defense (Health Affairs (ASD (HA)); Defense Finance and Accounting Service; Joint Staff; Assistant Secretary of the Army (Financial Management and Comptroller); Assistant Secretary of the Navy (Financial Management and Comptroller); Assistant Secretary of the Air Force (Financial Management and Comptroller); Surgeon General of the Army; Surgeon General of the Navy; and Surgeon General of the Air Force to implement a billing system that is practical for U.S. Central Command. The working group should, at a minimum:

a. Establish clearly defined roles and responsibilities for implementing and overseeing a process for billing and collecting from contractors receiving health care at military

treatment facilities in Southwest Asia, including the assignment of a DoD functional proponent.

b. Establish procedures for identifying eligibility for care, level of care to be provided, and reimbursement requirements based on information obtained in the letter of authorization.

c. Establish procedures for accurately capturing information needed to bill and collect payment, including, at a minimum, contractor organization, contract number, patient category, treatment dates, and health care provided.

d. Determine which DoD Component will do the billing and collection. Consider a centralized billing function.

e. Ensure the billing system provides the capability to bill contractors, their employers, their health insurance providers, and their Defense Base Act insurance provider. Consider initial billing to the contractor organization.

f. Establish a process to bill for health care provided in prior years to contractors.

g. Determine which DoD Components may retain and use any of the collected funds from billing for health care provided by military treatment facilities to contractors.

h. Establish procedures and frequency for financial reporting of billing and collecting from contractors in Southwest Asia.

i. Consult with Defense Base Act insurance providers to ensure claims are processed properly.

j. Determine how often the billing rates will be reevaluated.

k. Consider a solution that will work in other contingency operations.

l. Include policy, procedures, and standards in the Uniform Business Office Manual 6010.15-M or other appropriate formal guidance.

m. Develop a timeline to implement the billing and collection system in Southwest Asia.

HEALTH AFFAIRS RESPONSE: Concur with comment. Representatives from the TRICARE Management Activity Uniform Business Office (UBO) have actively participated working group chaired by the USD(C) since its inception and will continue to do so. We do not believe policy for deployed medical units should be part of the Military Treatment Facility Uniform Business Office Manual, DoD 6010.15-M, as the focus of this regulation is exclusively on fixed medical and dental facilities funded by the Defense Health Program appropriation.

DEPARTMENT OF DEFENSE INSPECTOR GENERAL
DRAFT REPORT
D2008-D2000LF-0241.000

"Audit of Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia"

General Comments:

- The deployed medical units in Southwest Asia are not Defense Health Program (DHP) funded facilities. As such, they are not under the control of ASD (HA) but rather fall under the Military Departments and the Combatant Commands.

DEPARTMENT OF DEFENSE INSPECTOR GENERAL
DRAFT REPORT
D2008-D2000LF-0241.000

"Audit of Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia"

Technical Comments:

- Concur with Recommendation 2(l). The need for appropriate formal guidance for use by deployed medical units in the Area of Responsibility (AOR) is definitely needed. However, the Military Treatment Facility UBO Manual 6010.15-M has been developed to provide guidance and procedures for DHP funded military treatment facilities. Many of the provisions of the UBO Manual would not be applicable to deployed medical units in the AOR. To eliminate any confusion as to which provisions of the UBO Manual apply to deployed medical units and which do not, our suggestion is that separate formal guidance be developed that is applicable specifically to deployed medical units.

The Joint Staff Comments

THE JOINT STAFF
WASHINGTON, DC

Reply ZIP Code:
20318-4000

01-Apr-09

MEMORANDUM FOR THE INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

Subject: Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Project No. D2008-D000LF-0241.000)

1. Thank you for the opportunity to review and comment on the subject report.[1] The Joint Staff concurs with the findings and recommendations in the draft, and provides the following comments.

2. The Joint Staff, the Office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, and USCENTCOM have collected information on this issue since September 2008. They joined a larger working group led by the OSD Comptroller in December 2008. This working group has made huge steps toward developing a viable method for billing contractors for medical care received in military treatment facilities.

3. A medical billing process for contractors has not yet been accomplished in a theater of operations. As a result, any solution will be a learning experience. There will likely be manpower and workload issues to resolve. Any billing process must be transparent to the combatant command. Additionally, this is not a USCENTCOM unique issue; the solution must be easily transferable to other combatant commands.

4. Any solution will require medical information and billing systems. The working group has developed draft billing and reimbursement procedures to ensure contractors receive appropriate levels of health care while allowing the Department of Defense to seek reimbursement.

5. As a result of the working group's efforts, electronic devices are being installed at medical treatment facilities in Southwest Asia to monitor contractor use and provide a direct link to the contractor for billing purposes. We anticipate the devices will be installed within the next 60 to 90 days. This is a first step toward ensuring the various systems are functioning and capable of delivering the appropriate information needed to actually complete billing transactions. Finally, after the billing process is approved, it will need to be

codified in policy and implementation guidance and then provided to the affected combatant commands.

6. We are confident that the working group is already addressing the recommendations within your report and are on the appropriate course to identify a billing and reimbursement system that will work in a contingency environment. In addition to this effort, we recommend that the Department of Defense conduct a review to critically examine the current policies regarding contractor health care in overseas contingency operations.

7. The Joint Staff point of contact is [redacted] USAF; J-4/HSSD; [redacted]

W. E. GASKIN
Major General, USMC
Vice Director, Joint Staff

Reference:
1 DOD(IG) e-mail, 25 February 2009, "Draft Report – Health Care Provided by MTFs to Contractors in SWA (D2008-D000LF-0241.000), 2-25-2009.pdf"

2

Department of the Army Comments

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TX 78234-6000

REPLY TO
ATTENTION OF

23 MAR 2009

MCIR

MEMORANDUM THRU Deputy Assistant Secretary of the Army (Procurement), ATTN: SAAL-ZP, 103 Army Pentagon Room 2E533, Washington, DC 20310-0103

FOR Department of Defense Inspector General, Readiness and Operations Support, Military Health System Division, ATTN: [redacted]

SUBJECT: Reply to Draft Report on Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Project No. D2008-D000LF-0241.000)

1. Thank for you the opportunity to review this report. Our comments are enclosed for your consideration.

2. Our point of contact is [redacted] Internal Review and Audit Compliance Office, [redacted], or email: [redacted]

FOR THE COMMANDER:

Herbert A. Coley
HERBERT A. COLEY
Chief of Staff

Encl

US Army Medical Command (MEDCOM) and
Office of the Surgeon General (OTSG)

Comments on DODIG Draft Report: Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Project No. D2008-D000LF-0241.000)

RECOMMENDATION 2.d.: Determine which DoD Component will do the billing and collection. Consider a centralized billing function.

RESPONSE: Concur with comment. A centralized billing function should be considered, rather than—as implied throughout the report—being made the responsibility of military treatment facilities (MTF) (for example, page i, second bullet). A centralized billing function should be considered for the following reasons:

- Capability. Units in theater do not have the resources to bill and collect for services rendered. The deployed/contingency medical units should be capable of correctly categorizing beneficiary status and entering encounter information in AHLTA-T or the Theater Medical Data Store (TMDS) to allow for billing from a central location.

- Feasibility. A draft plan for a centralized billing function was developed by the Medical Billing for Contractor Medical Care in Contingency Operations Working Group. (Oversight responsibility for the billing and collection function, however, is labeled as "TBD" in the draft.)

RECOMMENDATION 2.g.: Determine which DoD Components may retain and use any of the collected funds from billing for health care provided by military treatment facilities to contractors.

RESPONSE: Concur with comment. As provided by 10 USC 1079b (and as referenced in the draft report on page 1, "An MTF may retain and use the fees collected,") the amounts collected should be used to reimburse the deployed/contingency medical unit that provides the care to deployed contractors. It may be appropriate to pay the central billing entity their cost of billing/collections out of the amount collected.

RECOMMENDATION 2.j.: Determine how often the billing rates will be reevaluated.

RESPONSE: Concur with comment. Recommend the billing rates continue to be reevaluated/reset on an annual basis, as this is currently done. The TRICARE Management Activity Uniform Business Office (UBO) establishes the rates for approval by the DoD Comptroller.

RECOMMENDATION 2.l.: Include policy, procedures, and standards in the UBO Manual 6010.15-M or other appropriate formal guidance.

Encl

RESPONSE: Concur with comment. Policy, procedures, and standards for billing and collections should be included in other appropriate guidance rather than UBO Manual 6010.15-M. UBO policies and procedures do not apply to deployed/contingency medical units. UBO policy applies to MTFs funded by the Defense Health Program (DHP). Coordination with MEDCOM Resource Management and the Army member of the Medical Billing for Contractor Medical Care in Contingency Operations Working Group indicates that DHP funds are specifically appropriated for the provision of fixed-facility, peacetime healthcare. Contingency/wartime operations are specifically appropriated under supplemental GWOT funding bills which, for Army, are OMA appropriations. Responsibility for this billing has not yet been determined, but for the reasons above, it should not be a DHP-funded organization, and the policy/procedures should be published in other (non-UBO) appropriate formal guidance.

Department of the Navy Comments

THE ASSISTANT SECRETARY OF THE NAVY
(FINANCIAL MANAGEMENT AND COMPTROLLER)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

MAR 27 2009

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Review of DODIG Draft Report "Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia" (Project No. D2008-D000LF-0241.000)

We appreciate the opportunity to review and comment on this draft DoD-IG report. The accompanying attachment provides a combined response for ASN(FM&C) and the Surgeon General of the Navy on recommendations 2.a. through 2.m.

John W. McNair
Acting

Attachment:
1. DON Response to DODIG Draft Report "Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia"

DoD-IG Draft Report, Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Project No. D2008-D000LF-0241.000)

Recommendation #2a-2m (p. 14): We recommend that the Under Secretary of Defense (Comptroller)/DoD Chief Financial Officer chair the working group with officials from the Under Secretary of Defense for Acquisition, Technology, and Logistics; U.S. Central Command; Assistance Secretary of Defense (Health Affairs); Defense Finance and Accounting Service; Joint Staff; Assistant Secretary of the Army (Financial Management and Comptroller); Assistant Secretary of the Navy (Financial Management and Comptroller); Assistant Secretary of the Air Force (Financial Management and Comptroller); Surgeon General of the Army; Surgeon General of the Navy; and Surgeon General of the Air Force to implement a billing system that is practical for U.S. Central Command. The working group should, at a minimum:

a. Establish clearly defined roles and responsibilities for implementing and overseeing a process for billing and collecting from contractors receiving health care at military treatment facilities in Southwest Asia, including the assignment of a DoD functional proponent.
b. Establish procedures for identifying eligibility for care, level of care to be provided, and reimbursement requirements based on information obtained in the letter of authorization.
c. Establish procedures for accurately capturing information needed to bill and collect payment, including, at a minimum, contractor organization, contract number, patient category, treatment dates, and health care provided.
d. Determine which DoD Component will do the billing and collection. Consider a centralized billing function.
e. Ensure the billing system provides the capability to bill the contractor, their employer, their health insurance provider, and their Defense Base Act insurance provider. Consider initial billing to the contractor organization.
f. Establish a process to bill for health care provided in prior years to contractors.
g. Determine which DoD Components may retain and use any of the collected funds from billing for health care provided by military treatment facilities to contractors.
h. Establish procedures and frequency for financial reporting of billing and collecting from contractors in Southwest Asia.
i. Consult with Defense Base Act insurance providers to ensure claims are processed properly.
j. Determine how often the billing rates will be reevaluated.
k. Consider a solution that will work in other contingency operations.
l. Include policy, procedures, and standards in the Uniform Business Office Manual 6010.15-M or other appropriate formal guidance.
m. Develop a timeline to implement the billing and collection system in Southwest Asia.

Assistant Secretary of the Navy (Financial Management and Comptroller) and the Surgeon General of the Navy position: Concur with comment. ASN (FM&C) staff has been participating in meetings with the OUSD (Comptroller) working group formed to address the issues and challenges raised in recommendation #2. As a part of the working group, we have coordinated input from our Fleet Medical Office and Fleet Comptroller and provided feedback on the proposed processes and courses of action.

We believe the process of billing and collecting for health care provided to contractors by deployed/non-fixed MTFs in contingency operations should be standardized across the Department of Defense, rather than each component implementing the process independently. The commonalities between the military departments far exceed their differences and would appear to make consistent implementation not just a possibility but a necessity. A joint approach would also allow for potential efficiencies associated with the billing and collection process.

It should be further noted that in-theater or deployed medical treatment facilities operate under the command of a Unified Combatant Commander; therefore, the Surgeon General of the Navy does not have the authority to issue policy and procedures that govern the operation of such facilities.

We continue to participate in the OUSD(C) working group and will remain engaged in this process through implementation of the final decisions.

Department of the Air Force Comments

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

27 March 2009

MEMORANDUM FOR SAF/AG

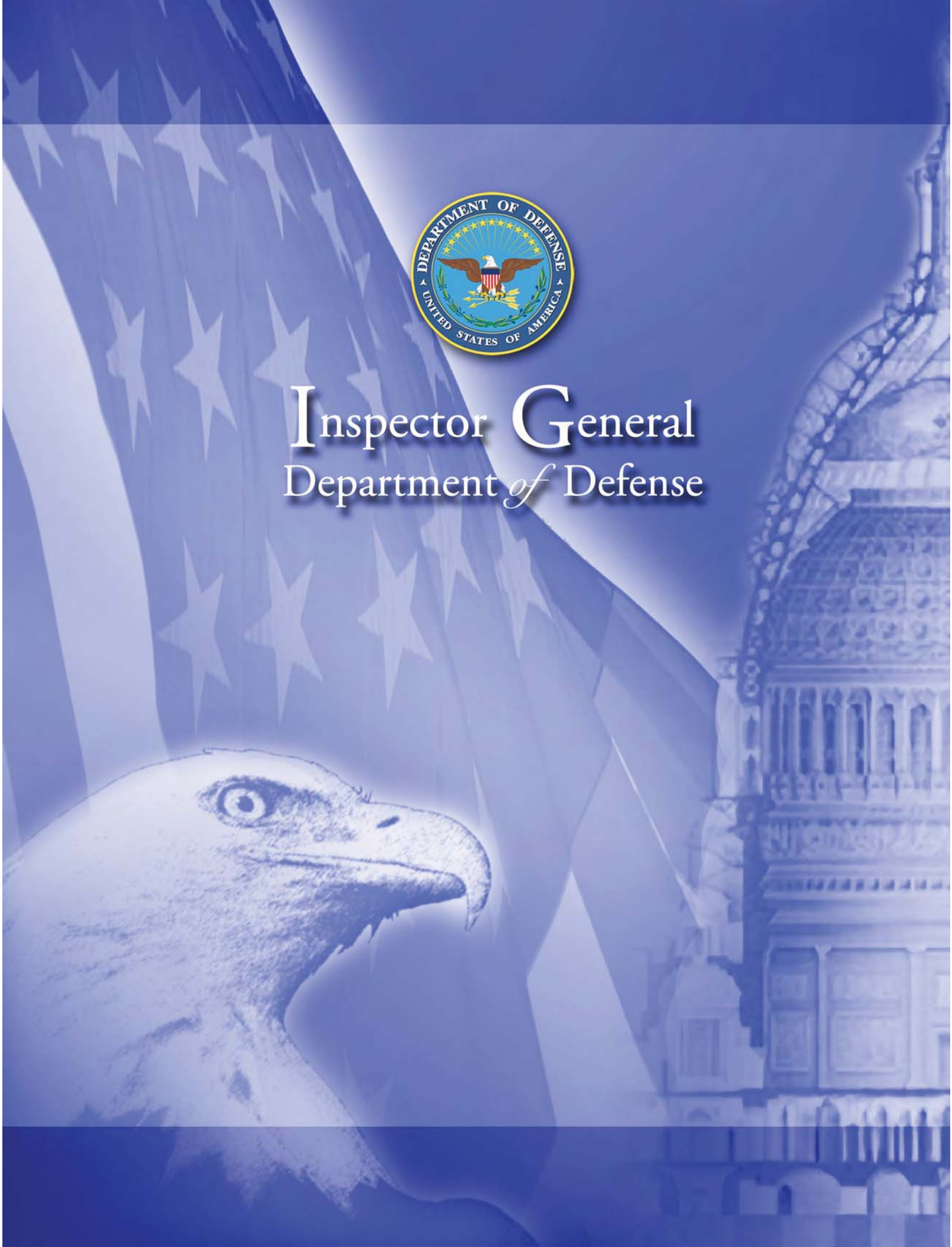
FROM: AF/SG

SUBJECT: AFAA Draft Report of Audit, Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (Project F2008-D000LF-0241.000)

Thank you for the opportunity to respond to the AFAA Draft Report of Audit, Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia. I concur with Recommendation 2 and our staff is actively participating in the working group as recommended in the draft report. We will work to expeditiously address the recommendations and follow the lead of the working group chair as to the timeline for completion.

My point of contact for this issue is [redacted], AFMSA/SGY, [redacted], or [redacted].

JAMES G. ROUDEBUSH
Lieutenant General, USAF, MC, CFS
Surgeon General



Inspector General
Department of Defense