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Report to the Committees on Armed Services, U.S. Senate and House of Representatives

July 1999

DEFENSE HEALTH CARE

Improvements Needed to Reduce Vulnerability to Fraud and Abuse

GAO/HEHS-99-142

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Health, Education, and
Human Services Division

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July 30, 1999

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

The Honorable Floyd D. Spence
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

In fiscal year 1998, the Department of Defense (DOD) spent about $2.5 billion through contracts to provide health care in civilian settings to about 1.5 million beneficiaries, including dependents of active duty personnel, military retirees, and their dependents. As with other health care systems, fraud and abuse threaten DOD with significant financial loss and may adversely affect the quality of care delivered if beneficiaries are exposed to unnecessary care or not treated at all.

The military health care system is administered by the military services in partnership with civilian contractors (see app. I). TRICARE, DOD's managed health care program, was established to improve beneficiaries' access to health care while maintaining quality and controlling costs in a time of military downsizing and budgetary concerns. DOD, including its Office of Inspector General, and its civilian contractors work together to prevent and detect TRICARE fraud and abuse.

Senate Report 105-189, accompanying the National Defense Authorization Act for fiscal year 1999, expressed congressional concerns regarding the impact of fraud on military health care and directed that we evaluate DOD efforts to combat it. In response, we (1) analyzed DOD estimates of the extent of health care fraud and abuse, (2) evaluated DOD efforts to reduce health care fraud and abuse in civilian settings, and (3) identified initiatives and incentives that could improve DOD's antifraud efforts. We conducted our work between August 1998 and June 1999 in accordance with generally accepted government auditing standards (see app. II for details on our scope and methodology).

Results in Brief

It is impossible to precisely quantify the amount lost to health care fraud and abuse given the nature of such activities, but there is general consensus in DOD and the health care industry that fraud and abuse could account for 10 to 20 percent of all health care costs. Given TRICARE managed care contract expenditures of $5.7 billion between 1996 and 1998, DOD could have lost over $1 billion to fraud and abuse during this period. In addition to the financial loss, health care fraud and abuse can also adversely affect the quality of care provided and may cause serious harm to patients' health. For instance, when a provider fabricates test results instead of actually conducting the tests for which it bills DOD, patients can receive incorrect diagnoses and inadequate medical treatment.

DOD and its contractors have had limited success in identifying TRICARE fraud and abuse. For example, contractors have identified a negligible number of potential fraud cases: of the approximately 50 million claims that contractors processed between 1996 and 1998, they referred only about 100 potential fraud cases to DOD for further investigation. This low level of fraud identification has occurred, in part, because DOD contracts do not require contractors to aggressively identify and prevent fraud and abuse. During this same period, DOD recovered about $14 million in fraudulent payments out of the $5.7 billion spent.

To its credit, DOD recognizes the need to reduce its vulnerability to fraud and abuse and has identified a number of revisions it could make to its antifraud policies and requirements. However, it has been slow to implement these policy revisions, which collectively would require contractors to put into place a more aggressive fraud and abuse identification program. Once these revisions are implemented, existing contracts can be modified to include specific results-oriented goals and performance measures, thus putting DOD in a better position to evaluate contractors' progress in identifying and reducing fraud and abuse. Given the magnitude of potential financial loss and harm to patients' health, it is important that DOD place a high priority on, and establish a concerted strategy for, reining in health care fraud. DOD's strategic plan for the military health system, prepared in response to the Government Performance and Results Act of 1993, provides an appropriate vehicle for articulating DOD's strategy and establishing how the agency will identify and prevent TRICARE fraud and abuse. This report makes recommendations to the Secretary of Defense for reducing TRICARE's vulnerability to fraud and abuse.

Background

The mission of the military health care system is to maintain the health of active duty service personnel and provide health care during military operations. The system also offers health care to non-active duty beneficiaries, including dependents of active duty personnel and military retirees and their dependents, through various military-operated hospitals and clinics worldwide; the system is supplemented through contracts with civilian health care providers. TRICARE, the name given to the program providing this care, is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization, a preferred provider organization, and a fee-for-service benefit. Five managed care support contractors create networks of civilian health care providers. These providers submit claims, either individually or as part of a group practice, to contractors for payment of medical care they have provided to DOD beneficiaries. Fraud occurs when health care providers knowingly submit claims containing false information. Common types of provider fraud and abuse include billing for services not rendered, misrepresentation of services, and conducting unwarranted medical procedures.

Multiple players support DOD's health care fraud identification and prevention efforts. DOD's TRICARE Management Activity's (TMA) Program Integrity Branch serves as the centralized administrative hub for TRICARE fraud and abuse activity worldwide. Its primary responsibilities include (1) developing policies and procedures for the prevention, detection, investigation, and control of TRICARE fraud and abuse; (2) educating beneficiaries, health care providers, and others about various health care fraud and abuse issues; (3) initiating administrative remedies, such as sanctioning fraudulent providers; and (4) coordinating with other DOD and external investigative agencies, such as the Federal Bureau of Investigation, to assist in investigations of health care fraud and abuse. TMA staff are also responsible for overseeing and ensuring that the five contractors comply with contractual antifraud requirements.

Each DOD TRICARE contractor is responsible for establishing a program for identifying and reporting potential health care fraud and abuse to DOD. To help with this effort, the contractors have subcontracted with one of two companies to process TRICARE claims. In conjunction with their claims processing duties, the subcontractors provide various prepayment controls and perform postpayment reviews that are designed, among other things, to identify erroneous billings, duplicate claims, and unusual or excessive patterns of care.

DOD's health care fraud identification and prevention efforts are further supported by investigators from the Defense Criminal Investigative Service (DCIS), the investigative unit of DOD's Office of Inspector General. While DCIS is involved in some efforts to identify fraudulent activity through undercover operations, the vast majority of cases it investigates are referred from other sources, such as TMA and whistleblowers.

DOD Could Be Losing Hundreds of Millions of Dollars to Fraud and Abuse

While the exact extent of health care fraud and abuse can never be precisely quantified, the general consensus, based on the experience of public and private sector organizations such as DOD, the Health Care Financing Administration (HCFA), the U.S. Chamber of Commerce, the Health Insurance Association of America, and the National Health Care Anti-Fraud Association, is that fraud and abuse could account for 10 to 20 percent of all health care costs. Applying this percentage to TRICARE contract expenditures of about $5.7 billion between 1996 and 1998, DOD could have lost between $570 million and $1.14 billion to fraud and abuse over the last 3 years. As health care costs increase over time, fraud and abuse can be expected to increase proportionally.

Health care fraud and abuse also affect the quality of care provided and may cause serious harm to patients' health. For example, illegal practices such as "sink testing," which involves throwing out patients' blood and urine specimens and fabricating test results, rather than actually performing the necessary tests, can result in improper diagnoses and either no medical treatment or unnecessary treatment. Another health care fraud scheme that may affect patients' health involves individuals who provide unauthorized care by falsely representing themselves as licensed medical providers.

DOD Has Had Limited Success in Identifying Fraud and Abuse

DOD and its contractors have had limited success in identifying TRICARE fraud and abuse. To date, contractors have referred relatively few cases to TMA for further investigation and development, in part, because DOD's contracts do not require contractors to establish a focused, aggressive antifraud program. Furthermore, DOD has recovered only a relatively small portion of its estimated losses to fraud and abuse.

DOD Contractors Have Referred Few Fraud Cases to TMA

DOD depends on its contractors to help it combat fraud and abuse. Up to this point, however, contractors have identified and referred relatively few potential fraud cases to TMA. Table 1 shows that, of approximately

50 million claims processed between 1996 and 1998, contractors referred only about 100 potential fraud cases to TMA for further investigation, 92 of which were referred by the contractor with the most TRICARE experience. Although DOD has not established a specific number of cases its contractors should refer, DOD officials acknowledge that its contractors could be more aggressive in their efforts to identify potentially fraudulent activity. According to DOD officials, this lack of aggressiveness is due, in part, to the fact that DOD contracts do not specify to what extent contractors should be identifying and referring potential fraud cases. Moreover, some contractor program integrity staff told us that they were unclear about the types of potential fraud cases to refer to TMA and that they were not adequately trained to identify fraud and abuse. In addition, DOD officials told us that, because two of the five contractors were relatively new to the TRICARE program, they had not yet compiled sufficient data to identify fraudulent behavior.

Table 1: Claims Processed and Potentially Fraudulent Cases Referred by TRICARE Contractors, 1996-98

Contractor	Claims processed	Referrals of potential fraud cases[a]
Foundation Health Federal Services, Inc.	25,700,000	92
Humana Military Healthcare Services, Inc.	14,500,000	4
TriWest Healthcare Alliance, Inc.	6,100,000	3
Anthem Alliance for Health, Inc.	2,700,000	2
Sierra Military Health Services	1,000,000	0
Total	**50,000,000**	**101**

[a]Potential fraud cases may involve multiple claims.

Source: TMA.

In addition to their modest efforts specifically associated with identifying and referring potential fraud cases, contractors use claims editing software and other approaches to ensure that accurate payments are made to authorized providers and eligible beneficiaries. Such software and prepayment screens could also serve to deter fraudulent and abusive behavior. While TRICARE contractors prevented various types of erroneous payments totaling about $73 million in 1998 through the use of claims editing software and other prepayment screens and edits, neither TMA nor contractors could quantify what portion of this amount might be associated with fraud and abuse. TMA officials acknowledged that while some of this amount could have been related to fraud and abuse, they believe the vast majority represented payments generated by clerical and

other types of errors. They told us, however, that prepayment screens and edits are likely to deter fraudulent and abusive behavior on the part of some health care providers.

DOD Has Recovered a Small Amount of Its Estimated Losses to Fraud and Abuse

DOD and its contractors' antifraud efforts have resulted in the recovery of a tiny fraction of DOD's estimated losses from fraud and abuse. For example, as table 2 shows, between 1996 and 1998, DOD recovered only about $14 million in fraudulent payments. This amount is negligible when compared with estimated losses of between $570 million and $1.14 billion during the same period. Even though the exact extent of TRICARE fraud and abuse is unknown, the small amount of recoveries indicates that DOD efforts have considerable room for improvement and that DOD's vulnerability to fraud and abuse is still high.

Table 2: Results of TMA Antifraud Efforts, 1996-98

Year	DOD estimates of fraud and abuse (in millions)	Fraudulent payments recovered[a] (in millions)
1996	$130-260	$1.2
1997	190-380	7.1
1998	250-500	6.1
Total	**$570-1,140**	**$14.4**

[a]These figures may be related to cases identified in previous years.

In addition to recovering fraudulent payments, between 1996 and 1998 DOD participated with other organizations in investigations of TRICARE and other government health care programs, such as Medicare and Medicaid, which resulted in penalties, fines, and other assessments totaling approximately $804 million, 199 criminal charges, and 150 civil settlements. TMA officials told us, however, that they could not identify the portion of these penalties, fines, and other assessments associated with the TRICARE program or its funds.

Opportunities Exist to Improve TRICARE's Antifraud Efforts

While DOD recognizes that it needs to reduce its vulnerability to fraud and abuse, it has been slow to implement revised policies and requirements directing its contractors to put into place a much more aggressive fraud and abuse identification program. Once these revisions are implemented, DOD's efforts could also be strengthened by establishing results-oriented goals and performance measures in its managed care contracts and by overseeing contractors to assess their performance against these goals and

measures. In addition, given the potential magnitude of fraud and abuse within TRICARE, DOD top management could better focus and otherwise improve DOD's antifraud efforts by committing itself to, and developing a concerted strategy for, addressing the problem in its military health system strategic plan. Such plans are mandated by the Government Performance and Results Act of 1993 (also known as the Results Act).[1] These steps should improve DOD's antifraud activities and help reduce the adverse impact fraud and abuse currently have on TRICARE and its beneficiaries.

TMA Is in the Process of Implementing Revised Antifraud Requirements

According to the Chief of TMA's Program Integrity Branch, DOD's antifraud policies and procedures are vague concerning contractors' responsibilities. She told us that DOD policies do not direct contractors to provide their antifraud staff with training in fraud detection and prevention methods, nor do the policies guide contractors as to the level of emphasis they should place on such activities. In an effort to improve the effectiveness of its antifraud efforts, TMA is in the process of implementing revised program integrity policies and procedures to require more aggressive fraud identification activities by its contractors. Although TMA originally intended that its contractors implement these revisions by October 1, 1998, TMA and the contractors have been negotiating for over 8 months to formally implement these changes. As of June 1, 1999, DOD and its contractors had not yet agreed to contract terms. If and when implemented, these changes would include the following requirements of TRICARE contractors:

- Develop and publish a corporate antifraud strategy. This strategy, developed and endorsed by corporate management to underscore its commitment to health care fraud detection and prevention, includes plans for (1) maintaining a focus on increased health care fraud awareness, (2) developing processes that identify fraud, (3) aggressively referring health care fraud cases to TMA, (4) assisting in the prosecution of cases, and (5) developing deterrents to health care fraud. TMA officials told us that having a published corporate antifraud strategy would better enable its contractors to focus their fraud prevention and detection activities, as well as generate companywide support for these efforts.
- Use new antifraud software. Antifraud software will be used to analyze health care data associated with the type, frequency, duration, and extent of services to identify patterns of probable fraudulent or abusive practices

[1]The Results Act (P.L. 103-62) requires agencies to clearly define their missions, set goals, measure performance, and report on their accomplishments.

by providers and beneficiaries. TMA officials told us that using artificial intelligence software would allow contractors to be more effective in identifying fraud and would likely increase the number of fraud cases they referred to TMA.

- Establish and maintain an antifraud training program. Specifically, contractors will train their staff to identify abnormal patterns of care, over- or underutilization of services, and other practices that may indicate fraudulent or abusive behavior. According to TMA officials, with new developments in information technology and frequent contractor staff turnover, structured training would help institutionalize contractors' antifraud activities. Some contractor and subcontractor staff told us they were not adequately trained to effectively identify fraud and abuse and would benefit from a structured, continuously updated antifraud education program.

In addition, in an effort to increase beneficiary awareness of health care fraud and abuse, TMA has directed its contractors to include a fraud hot line telephone number and mailing address on beneficiaries' "explanation of benefits" statement. This information provides beneficiaries with a contact in the event fraudulent activity is suspected or observed. As of April 1999, all five contractors had included an antifraud contact on their explanation of benefits statements.

Although TRICARE policy requires that claims be denied when submitted under a clinic or group practice subidentifier, TMA waived this requirement in 1996 in an effort to improve claims processing timeliness. However, our March 1999 testimony raised a concern that TRICARE claims did not always identify the individual provider rendering care, potentially masking fraudulent or abusive activity. In response, as of June 1, 1999, TMA directed all of its contractors to pay only those claims that identify providers individually, rather than their group or clinic affiliation.[2] TMA officials told us that information on individual providers is also needed to monitor quality of care.

TMA has not established results-oriented goals or performance measures for its managed care contracts, although doing so would help it assess contractors' performance as well as enable contractors to track their own progress in combating fraud and abuse.[3] Comparing contractor

[2]Defense Health Care: Management Attention Needed to Make TRICARE More Effective and User-Friendly (GAO/T-HEHS-99-81, Mar. 11, 1999).

[3]In 1994, DOD's Office of Inspector General recommended that DOD establish performance measures related to its health care fraud detection activities.

performance with established goals and measures would enable TMA to identify program deficiencies and help contractors focus their efforts on needed improvements.

DOD's Military Health System Strategic Plan Does Not Address TRICARE Fraud and Abuse

As required by the Results Act, agencies must articulate, in a strategic plan, how they will address issues that significantly affect their ability to manage program operations. Given the potential magnitude of health care fraud and abuse within TRICARE, it is important for DOD to address this concern in such a plan. DOD's current military health system strategic plan, however, does not specify how the agency will combat TRICARE fraud and abuse. A more complete plan would provide better direction and guidance by including an antifraud mission statement, identifying long-term antifraud objectives and describing how DOD would achieve them, and explaining key external factors that could affect achievement of those objectives.

In addition, taking a more strategic approach would help TMA establish annual performance goals and measures related to its long-term objectives and determine how it will assess its progress in achieving them. Specific performance measures could include calculating the cost-effectiveness of TMA's antifraud efforts. By benchmarking and periodically assessing its progress in combating TRICARE fraud and abuse, TMA would be in a better position to measure its vulnerability to such activity, focus its antifraud efforts on the most prevalent types of fraud and abuse, and allocate an appropriate level of resources to combat this problem.

Conclusions

Health care fraud and abuse within TRICARE potentially result in the loss of hundreds of millions of dollars and adversely affect the health of untold numbers of beneficiaries. Despite TRICARE's known vulnerability, DOD's activities thus far have not been very successful in identifying fraud and abuse. Furthermore, as health care costs increase over time, fraud and abuse can be expected to increase proportionally. While DOD recognizes the importance of its contractors' role in combating fraud and abuse and has been negotiating with them to implement new antifraud requirements, it has been slow in doing so. If effectively implemented, these requirements would help DOD and its contractors increase the effectiveness of their antifraud efforts; in our view, immediate attention should be focused on getting these requirements in place. In addition, by establishing results-oriented goals and performance measures for its contractors, TMA would be in a better position to identify program

deficiencies and help its contractors more effectively target their efforts to reduce fraud and abuse. Given the relatively few dollars DOD has recovered and the magnitude of potential fraudulent activity, DOD would also benefit from adopting a more strategic approach. We believe DOD's military health system strategic plan provides an appropriate mechanism for articulating this approach and for setting forth the specific goals, objectives, and strategies for reducing DOD's vulnerability to TRICARE fraud and abuse. Ultimately, the success of DOD's antifraud efforts will depend on the priority it places on fraud prevention and detection and how effectively it oversees its contractors' antifraud activities.

Recommendations

To reduce TRICARE's vulnerability to fraud and abuse, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to

- expedite implementation of TMA's revised antifraud requirements, including the requirements that contractors develop a corporate antifraud strategy, utilize new antifraud software, and develop an antifraud training program;
- modify current contracts to establish specific results-oriented goals and performance measures for contractors; and
- include in DOD's military health system strategic plan how DOD will combat health care fraud and abuse and an assessment of DOD's performance in combating such activity.

Agency Comments and Our Evaluation

In commenting on a draft of this report, the Assistant Secretary of Defense (Health Affairs) stated that the report will provide DOD with invaluable assistance as it begins to do more in the area of reducing fraud and abuse in its health care program. In response to our recommendations, DOD agreed to expedite implementation of revised antifraud requirements by requiring contractors to develop a corporate antifraud strategy, utilize antifraud software, and develop an antifraud training program. In addition, DOD agreed to include in the TMA strategic plan how DOD will combat health care fraud and abuse.

However, DOD is concerned about establishing specific results-oriented goals and performance measures for its contractors. While DOD agrees that establishing goals and measures is desirable, it states it is unaware of a methodology that would enable it to do so. We recognize that finding the right methodology is challenging, but establishing program-specific goals

and performance measures for key program activities is a fundamental responsibility placed on all agencies by the Results Act. In our view, combating fraud and abuse is a key management activity; therefore, DOD needs to establish goals and measures to assess contractors' performance, identify program deficiencies, and enable contractors to track their own progress in combating fraud and abuse.

DOD also raised concerns about data presentation in two areas. First, it was concerned that a comparison between the number of claims processed and the number of fraud cases identified presupposes a correlation between the two sets of data. DOD stated that no industry standard based on such a correlation exists. We do not dispute that there is no industry standard. However, by virtually any standard, DOD contractor referrals of 101 potential fraud cases out of about 50,000,000 processed claims represent a minimal level of activity. In this context, it seems clear that there is room for the contractors to be more aggressive in their efforts to identify fraudulent activity. Further, DOD concurred with our recommendation to expedite the implementation of revised antifraud policies and requirements that place greater demands on contractors to identify and prevent fraud.

Second, DOD raised a concern that the report compares gross estimates of potential amounts lost to fraud and abuse with only the amounts recovered in fraud cases. Our report clearly states that DOD was unable to estimate recoveries for abuse but reported that contractors prevented erroneous payments totaling about $73 million. Moreover, most of this $73 million was not attributable to abuse but rather to payments resulting from clerical and other types of errors.

DOD's comments are included as appendix III.

We are sending copies of this report to the Honorable William S. Cohen, Secretary of Defense, and other interested parties. We will also make copies available to others upon request.

If you or your staffs have any questions about this report, please contact me at (202) 512-7101 or Michael T. Blair, Jr., Assistant Director, at (404) 679-1944. Jeffrey L. Pounds, Steve D. Morris, and Michael Tropauer also made key contributions to this report.

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Contents

Tables

Abbreviations

DCIS	Defense Criminal Investigative Service
DOD	Department of Defense
HCFA	Health Care Financing Administration
TMA	TRICARE Management Activity

TRICARE Contractors and Subcontractors Responsible for Antifraud Efforts

TRICARE regions	TRICARE contractors	Subcontractors
Northwest	Foundation Health Federal Services, Inc.	Wisconsin Physicians Service
Southwest	Foundation Health Federal Services, Inc.	Wisconsin Physicians Service
Southern California, Golden Gate, and Hawaii-Pacific	Foundation Health Federal Services, Inc.	Palmetto Government Benefits Administrators
Southeast and Gulf South	Humana Military Healthcare Services, Inc.	Palmetto Government Benefits Administrators
Central	TriWest Healthcare Alliance, Inc.	Palmetto Government Benefits Administrators
Northeast	Sierra Military Health Services	Palmetto Government Benefits Administrators
Mid-Atlantic and Heartland	Anthem Alliance for Health, Inc.	Palmetto Government Benefits Administrators

Scope and Methodology

To evaluate DOD's antifraud efforts, we met with DOD officials responsible for planning, managing, and implementing TRICARE's antifraud program. We reviewed DOD regulations, policies, and requirements pertaining to its program integrity functions, as well as strategic plans developed by DOD. We also reviewed antifraud requirements outlined in contracts with managed care support contractors hired by DOD to administer the TRICARE program regionally. In addition, we visited DOD's five contractors and their two subcontractors to obtain information on their antifraud efforts. We also interviewed representatives of public and private sector organizations involved in health care fraud issues, including the Health Care Financing Administration; the Federal Bureau of Investigation; and the National Health Care Anti-Fraud Association, whose mission is to improve the private and public sectors' detection, investigation, and prevention of health care fraud.

Comments From the Department of Defense

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

6 JUL 1999

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military Health Care Issues
Health, Education and Human Services Division
U. S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) DRAFT REPORT, "DEFENSE HEALTH CARE: Improvements Needed to Reduce Vulnerability to Fraud and Abuse," dated June 17, 1999 (GAO Code 101621/OSD Case 1846).

The Department welcomes this opportunity to do more in the area of reducing fraud and abuse in our health care program and believes your report will provide us with invaluable assistance. Our partial concurrence with your recommendations is attached.

I am concerned that the presentation of data in the report is misleading. For example, where the report compares the number of claims processed with the number of fraud cases, it presupposes a correlation between the two data sets. In fact, no industry standard exists based on such a correlation. In a similar fashion, the report compares gross estimates of potential amounts lost to fraud ***and*** abuse only with amounts recovered in prosecuted/settled fraud cases.

TRICARE Management Activity (TMA) participates in the quarterly Department of Justice (DOJ) Task Force Meetings, the Managed Care Fraud Working Group, the National Health Care Anti-Fraud Association and, on a continuous, on-going basis, looks for and incorporates new approaches to maximize identification and referral of fraud cases. Your focus on this important area is appreciated.

Please feel free to address any questions to my project officer on this matter, Ms. Rose Sabo, (functional) at (303) 676-3478 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Dr. Sue Bailey

Attachment:
As stated

Now on p. 10.

GAO DRAFT REPORT – DATED JUNE 17, 199
GAO CODE 101621/OSD CASE 1846

"DEFENSE HEALTH CARE: IMPROVEMENTS NEEDED TO REDUCE VULNERABILITY TO FRAUD AND ABUSE"

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATIONS

RECOMENDATION 1: To reduce TRICARE's vulnerability to fraud and abuse, the GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to:

1. Expedite implementation of TMA's revised antifraud requirements, to include the requirement that contractors develop a corporate antifraud strategy, utilize new antifraud software, develop an antifraud training program, and modify current contracts to establish specific results-oriented goals and Performance measures for contractors, and

2. Include in its Military Health System strategic plan how DoD will combat health care fraud and abuse and assess its performance in combating such activity.
(P.13/GAO Draft Report)

DoD Response:

DoD partially concurs with the recommendations made by the GAO.

We concur in expediting implementation of current contract requirements and are taking a variety of steps to do so. However, we are concerned with that portion of the recommendation that calls on DoD "to establish specific results-oriented goals and performance measurements for contractors." We agree that such is desirable; however, we are not aware of any methodology that would allow us to establish such goals without also creating perverse incentives. We will continue to look for a way to increase appropriate efforts by our contractors to reduce the incidence of fraud and abuse, and we welcome specific suggestions in this regard. TMA participates in the quarterly Department of Justice (DoJ) Task Force Meetings, the DoJ Managed Care Fraud Working Group, various fraud task forces and the National Health Care Anti-Fraud Association and, on a continuous, on-going basis, looks for and incorporates new approaches to maximize identification and referral of fraud cases. DoD does have controls in place for reimbursement such as DRGs and mental health per diem and extensive preauthorization requirements for certain types of care (e.g., inpatient mental health) that are not generally found in the private sector. Also, health care fraud is generally viewed as a provider caused problem and not a massive patient caused problem.

We completely concur in including in the TMA strategic plan a section on fraud and abuse and have already done so in the draft plan that is now getting final approval. A copy of the language is attached.

Now on pp. 5-6.

TECHNICAL CHANGES:

The use of claims editing software and other prepay screens, which identified $73 million of savings in 1998, identified not just "clerical errors and other types of erroneous payment" but also abusive, aberrant payments. For accuracy, we recommend the last paragraph on page 6 be moved under the subheading on page 7, "DoD Has Recovered a Small Amount of Its Estimated Losses to Fraud and Abuse."

TRICARE MANAGEMENT ACTIVITY (TMA) STRATEGIC PLAN

TMA GOAL 4. BUILD THE WORLD'S LEADING INTEGRATED HEALTH SYSTEM

Health Affairs, the TRICARE Management Activity, the Uniformed Services, Managed Care Support Contractors, host-nation providers, and key federal agencies are members of the TRICARE enterprise. Working together, we will create a uniform, integrated system for delivering health services. We will recognize that designing and building a quality health care system for military families requires an effective abuse and fraud control program that promotes patient safety and protects financial resources. We will optimize Military Treatment Facility capacity, recapture care where prudent, and obtain additional health services through civilian networks. We will move smartly to "best business practices" and lead the TRICARE enterprise towards an effective and efficient world-class health system.

STRATEGY:

4.5 Promote the prevention and early detection of any activities which clinically or financially abuse the TRICARE program, its beneficiaries, or the taxpayers.

OBJECTIVES:

a. Emphasize priority of abuse or fraud cases involving patient harm.

b. Develop an aggressive oversight plan of the Managed Care Support Contractors, emphasizing fraud detection and prevention and referral of cases with investigative merit.

c. Train appropriate government and contractor staff involved in the Military Health System to recognize and report any activities which might involve abuse or fraud.

d. Develop an effective abuse and fraud prevention and education program.

e. Facilitate information sharing and coordination of fraud cases.

f. Review claims and clinical data regularly reported to find patterns which may indicate abuse or fraud and warrant further investigation.

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