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

HEALTH AFFAIRS

AUG - 4 2008

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report responds to the request in House Report 110-146, National Defense Authorization Act for Fiscal Year (FY) 2008 on H.R. 1585, to submit a report to the Congressional Defense committees on the prevalence and scope of billing fraud being committed by covered beneficiaries against the Military Health System (MHS) TRICARE Program.

The enclosed report provides background on the history of this problem, its scope, and various measures put into place, along with several planned to help combat the fraud problem. Each year health care fraud committed against the TRICARE Program and the direct care system of military treatment facilities costs the Department of Defense and taxpayers millions of dollars. These are funds that could have been spent on the health care needs of Service members who are proudly defending our country or have served, their family members, and their survivors.

By working together with the Congress, the Department can take significant steps to help control and reduce the level of beneficiary fraud being committed against the MHS. Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2008

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

Dear Mr. Chairman:

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Ted Stevens
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Robert C. Byrd
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

This report responds to the request in House Report 110-146, National Defense Authorization Act for Fiscal Year (FY) 2008 on H.R. 1585, to submit a report to the Congressional Defense committees on the prevalence and scope of billing fraud being committed by covered beneficiaries against the Military Health System (MHS) TRICARE Program.

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John M. McHugh
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2008

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Duncan Hunter
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2008

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

Dear Mr. Chairman:

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As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2008

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

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S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

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

HEALTH AFFAIRS

AUG - 4 2008

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable C.W. Bill Young
Ranking Member

Report to Congress

Report to Congress on Prevalence and Scope of Billing Fraud Being Committed by Covered Beneficiaries Against the Military Health System (MHS)

REPORT TO CONGRESS ON THE PREVALENCE AND SCOPE OF BILLING FRAUD BEING COMMITTED BY COVERED BENEFICIARIES AGAINST THE MILITARY HEALTH SYSTEM

Introduction

As a major component of the Military Health System (MHS), TRICARE brings together the health care resources of the Uniformed Services and supplements them with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide access to high-quality health care services, while maintaining the capability to support military operations.

The submission of fraudulent claims to TRICARE is a misuse of taxpayer dollars and trust. With 9.2 million beneficiaries and 170 million claims per year, TRICARE must ensure prompt adjudication of claims to prevent financial hardship to honest providers and beneficiaries.

Private industry experts estimate that health care fraud costs approximately 3 – 7% of program expenditures, therefore, a $40 billion program such as TRICARE could expect to suffer conservatively, approximately $1.2 billion in health care fraud, at a 3% fraud rate. It is further estimated that of that $1.2 billion loss, 25% is attributed to beneficiary fraud, equating to approximately $300,000,000.

TRICARE Management Activity needs the authority to temporarily exclude beneficiaries form the Program who engage in fraud. This authority already exists with providers who commit fraud against the Program. The availability of this proactive measure would be highly publicized in an effort to significantly curtail beneficiary and beneficiary/provider fraud scams, contributing to a major cost avoidance through the "sentinel effect."

Combating Beneficiary Fraud

Beneficiary fraud and abuse is growing each year and impacts the care and cost of the MHS. In those cases where providers submit fraudulent billings, multiple options are available, to include the False Claims Act, fines and penalties, sanctions, and suspensions. However, all those options do not all exist when dealing with fraudulent claims from beneficiaries. Although providers can be sanctioned and suspended from billing government programs, there is no such recourse for beneficiaries involved in fraudulent billing activities. Beneficiary fraud and abuse is growing each year and impacts the care and cost of the MHS.

Health care fraud has resulted in TRICARE having to pay millions of dollars to the contractors every year in administrative cost to combat health care fraud. In addition, millions of dollars are lost every year to the fraud itself. Beneficiary health care fraud is not a victimless crime. It takes millions of dollars

away from the delivery of health care to Service members, retirees, and dependent beneficiaries. Below is a table representing total identified beneficiary fraud cases, beneficiaries who have been placed on pre-pay review, and dollar harm to the Program 2004 thru 2007. According to expert statistical estimates of beneficiary fraud, the identified dollars are only a small portion of the actual dollars attributed to beneficiary fraud.

* Dollar losses for identified beneficiary fraud

FY 2004-2007	TOTAL
BENEFICIARY FRAUD CASES	1968
BENEFICIARIES ON PRE-PAY REVIEW	6028
TRICARE DOLLAR LOSS*	$4,294,015

Types of Beneficiary Fraud

Following are a few cases case vignettes providing examples of beneficiary fraud from 2001 to present:

Forging of Provider Invoices for Noncovered Services'

A spouse of an active duty member submitted claims for non-covered services for their minor son. The services had been rendered by a provider that was not credentialed, not authorized by TRICARE, and would have been rejected. The spouse forged invoices she had obtained from an authorized provider and submitted the claims as if the services were actually provided by the authorized

provider. An investigation by the Military Criminal Investigative Office established that the spouse had knowingly and purposefully attempted to commit fraud against TRICARE. The case was submitted to the U.S. Attorney's Office (USAO) for prosecution. Initially the USAO accepted the case, but after further review and due to a high administrative workload, the USAO elected not to pursue the case and recommended TRICARE recoup the funds. The active duty member's spouse still continues to be eligible for TRICARE and has not repaid the $4,757 of fraudulent monies paid directly to her by TRICARE.

Fraudulent Claims for Fabricated Services

A retired military member submitted false claims to TRICARE for all members of his family for allergy testing and allergy shots. The retiree obtained the tax identification number (TIN) of a retired physician with a current medical license and submitted claims under this TIN. To further the fraud, the retiree opened a P.O. Box under the retired physician's name to receive the checks. This resulted in over $101,506 being paid by TRICARE for services that were fabricated. The retiree pled guilty to one criminal count of health care fraud and two counts of mail fraud. He was sentenced to one day incarceration, three years supervised release, and home detention. The retiree continues to be eligible for TRICARE despite his conviction. The terms of his sentencing did not require him to repay the fraudulently obtained monies from TRICARE.

Beneficiary-Provider Fraud Ring

Retired beneficiaries entered into a scam with a provider in the Philippines to allow their beneficiary information to be used to submit claims to TRICARE that were fabricated—no actual medical services were rendered. When the checks were issued, the provider divided the monies between himself and the beneficiaries. The provider received $2,708,713, and the beneficiaries received between 40 and 80 percent of the paid amount in kickbacks for allowing their beneficiary information to be used. The beneficiaries involved in this fraudulent scam continue to receive TRICARE benefits.

Beneficiary Fraud-Fraudulent Claims for Service Not Rendered

Two TRICARE beneficiaries (sponsor and spouse) living in Guatemala routinely submitted claims for services never rendered or received. The beneficiaries were the subject of an investigation in 1999 and had submitted fraudulent claims in the amount of $29,165.80; however, the USAO declined prosecution due to the low dollar value and difficulties in prosecuting someone who lived outside of the United States. The two beneficiaries continued their submission of fabricated claims. They forged medical and prescription receipts and then, submitted claims for services from the same Guatemalan doctor. The beneficiaries both claimed to have diabetes and heart conditions. Attempts to get records directly from the doctor went unanswered. TRICARE records showed that

the only beneficiaries the doctor apparently saw were these two individuals. Once the beneficiaries were required to submit medical documentation, the claims submitted decreased to two or three a month and the beneficiaries informed TRICARE that, due to their improving health, their doctor had informed them that they would not need as much medical and drug treatment in the future. TRICARE monetary harm was determined to be $261,632. Although these beneficiaries have been placed on pre-pay review, they are entitled to continuing health care benefits.

Brick and Mortar Provider Certification-Philippines

Several hundred beneficiaries were placed on pre-pay review due to fraudulent claims submission for facilities that did not exist. Following an on-site visit to the Philippines in 2001, TRICARE Management Activity (TMA) found 79 facilities that did not exist to which over $3,000,000 had been paid. In an effort to ensure government dollars were going to pay for medically necessary care, TMA established a contractual requirement for the certification of "brick and mortar" existence prior to claims being submitted to the program for payment.

Summary

TMA participates in investigations regarding all beneficiaries involved in health care fraud activities, whether at the local, state, or federal level. When the military sponsor is involved in fraudulently submitting claims, TMA also supports those cases which generally involve court martial. Additional remedies are needed to prevent fraudulent expenditures of TRICARE dollars.

Because there is no strong disincentive in place to discourage beneficiaries from submitting fraudulent claims, TRICARE has burdened beneficiaries with additional documentation requests, thus slowing down reimbursement, in an effort to ensure the beneficiary submitted claims are for legitimate care. This occurs not only in the United States but also in the Philippines, Mexico, Panama, Costa Rica, Guatemala, and Ghana.

Not all fraud cases are accepted by law enforcement because of limitations with investigative resources, prosecutorial support, and crowded court dockets. That is why it is so important to have multiple fraud control remedies available.

While TMA currently has several administrative options to return dollars obtained fraudulently by providers, recoupment is the only option available when dealing with the fraudulent acts of TRICARE beneficiaries when prosecutorial support is not available. As demonstrated in the examples above, the recoupment option alone is inadequate. Even if TMA is successful in getting its dollars back, only having to pay back if and when a beneficiary gets caught, sends the message that "crime pays." There is no fine or other penalty.

Effect of New Program Safeguards

Direct Savings

Direct savings will be generated from the actual cost avoidance achieved by sanctioning the beneficiary, who has acted fraudulently in the submission of claims, for a period of five to seven years, and the cost avoidance of not having financial responsibility for either that person's health care costs or for expenses related to closely monitoring that beneficiary's billings to ensure claims are legitimate. Sanctions for beneficiaries (similar to those for providers) will be reserved for the most egregious cases, which may involve fewer than five cases a year with a focus on the higher dollar cases.

Aligns TRICARE with Other Federal Programs

Veterans Administration

The Department of Veterans Affairs has authority to terminate eligibility for benefits under 38 U.S.C.6103 (forfeiture of all rights, claims, and benefits under the laws administered by the Veteran's Administration) for beneficiaries who make or present a false or fraudulent claim for benefits.

Social Security Act

Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b) provides criminal penalties for persons convicted of fraud (as defined in the statute), and

authorizes the administrator of federal health care programs to restrict or suspend the eligibility of such person.