Program Integrity Division

Operational Report

Calendar Year 2021

"Guarding the Health Care of Those Who Guard Us"

Vision

DHA Program Integrity serves as a model of excellence for the industry ensuring high quality health care for beneficiaries balanced with the protection of benefit dollars.

Mission

Safeguarding beneficiaries and protecting benefit dollars through the management of healthcare anti-fraud and abuse activities within the DHA.

1.0 Defense Health Agency, Program Integrity Division – General

As a joint, integrated Combat Support Agency, DHA leads the MHS integration of readiness and health to deliver the Quadruple Aim: improved readiness, better health, better care, and lower cost. DHA supports the delivery of integrated, affordable, and high quality health services to MHS beneficiaries and is responsible for integration of clinical and business processes across the MHS. DHA supports the medical care of 9.6 million Department of Defense (DoD) beneficiaries comprised of Uniformed Service members, retirees and their families. The TRICARE benefit brings together the worldwide health care resources of the Uniformed Services through Military Medical Treatment Facilities (often referred to as "direct care") and supplements this capability with network and non-network civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "private sector care").

The DHA Program Integrity Division (DHA PID) is responsible for healthcare anti-fraud activities to protect benefit dollars and safeguard beneficiaries. This includes both the private sector care and direct care settings. DHA PID develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, supports and coordinates investigative activities, develops cases for criminal prosecution and civil litigation, initiates administrative measures, and identifies areas for cost containment and internal controls.

DHA PID is part of the DHA Special Staff and reports directly to the DHA Chief of Staff. This reporting structure facilitates DHA PID's anti-fraud activities without interference from competing agency priorities. Due to the nature and scope of the work performed by DHA PID, its reporting line is separate and distinct organizationally from the day-to-day operational activities of other departments to avoid the appearance or potential of undue influence or conflict of interest.

The DHA PID staff collectively has over 185 years of fraud fighting experience and 150 years of experience specific to TRICARE. DHA PID team members hold credentials from the American Health Information Management Association (AHIMA), American Association of Professional Coders (AAPC), Association of Certified Fraud Examiners (ACFE), Health Care Compliance Association (HCCA), and National Health Care Anti-Fraud Association (NHCAA).

1.1 PID Vision 2025

In 2020, DHA PID launched a strategic plan focused on modernizing Program Integrity and cost containment over the next 5 years. This strategy, identified as PID Vision 2025 includes: rebalancing agency and beneficiary focus on fraud, waste and abuse; strengthening internal partnerships to enhance cost containment across the agency; and engaging with MTFs to enhance fraud, waste and abuse education, reporting and training. These strategic areas also align with the DHA priorities of Great Outcomes, Satisfied Patients, and Fulfilled Staff.

The PID Vision 2025 focus contrasts the current environment which focuses on pay-and-chase, looking primarily for fraud while placing limited focus on areas of waste and abuse. DHA PID Vision 2025 focuses on updating program requirements to fully realize pre-payment controls to detect and deter negative provider or

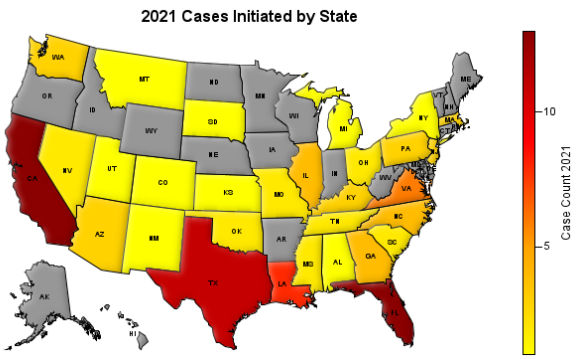
beneficiary behavior before it reaches the level of fraud. Pre-payment controls include education, pre-payment review, and peer comparison audit. Looking to the future of TRICARE private sector care contracts, revisions to the T5 contract provide a wider scope of focus, including both pre-payment review and detection as well as post-payment recoveries to provide a robust Program Integrity function addressing all areas of fraud, waste and abuse.

Many issues of waste and abuse are due to program vulnerabilities in both policy and operational application. The current process is to share findings of program vulnerabilities with staff of Healthcare Operations (HCO), the DHA directorate responsible for the direct oversight and policy making within the TRICARE program. Additionally, DHA PID is often omitted when new policies and benefits are determined. This introduces risk into the process by lacking a cohesive "anti-fraud" review of benefits before they are rolled out. DHA PID Vision 2025 seeks to develop formal lines of communication between DHA PID and HCO to identify and mitigate issues early in the process, and deter fraud, waste and abuse before it gets out of control. Additionally, it allows for integrated process teams to address cross-departmental concerns prior to policy implementation.

The third area of focus in PID Vision 2025 is enhanced focus and partnership with the Military Medical Treatment Facilities and Direct Care system in developing an enterprise approach to identifying and reporting fraud, waste and abuse. Working within the Market transition, DHA PID has partnered with the Functional Champions to work towards an integrated anti-fraud, waste and abuse program. This includes partnering with the Risk Management Internal Controls (RMIC) team working on enterprise-wide compliance requirements and requiring attestations from the Markets, SSOs and individual MTFs that they have anti-fraud controls in place. DHA PID also continues to solidify these efforts through the revision of the DoD Instruction (DoDI) 5505.12 and DHA Procedural Instruction which address anti-fraud, waste and abuse activities in the MTFs. The revision to the DoDI has been in process since its proposed deletion in 2016; however, it is currently being coordinated through the DHA and DoD Health Affairs for publication. It addresses fraud, waste and abuse in a holistic manner, and drives home the point that detecting and deterring fraud, waste and abuse throughout the program is everyone's responsibility.

2.0 Fraud and Abuse Cases

Many operational and worldwide challenges related to the COVID-19 pandemic continued into 2021, impacting an already stressed national healthcare system. With these challenges, new fraud schemes emerged, often pairing existing vulnerabilities with the nuances of COVID-19 testing and treatment. As the pandemic moves towards endemic, the indicators of potential fraud, waste and abuse in healthcare continue to grow. During calendar year 2021, 693 investigative cases were actively managed by the team. A total of 110 new cases were opened, and the team responded to over 600 lead requests and fraud allegation inquiries. As documented in the maps below, allegations of fraud, waste and abuse within the DHA program continue to match national fraud trends, with the majority of cases and leads coming out of Florida, California and Texas.

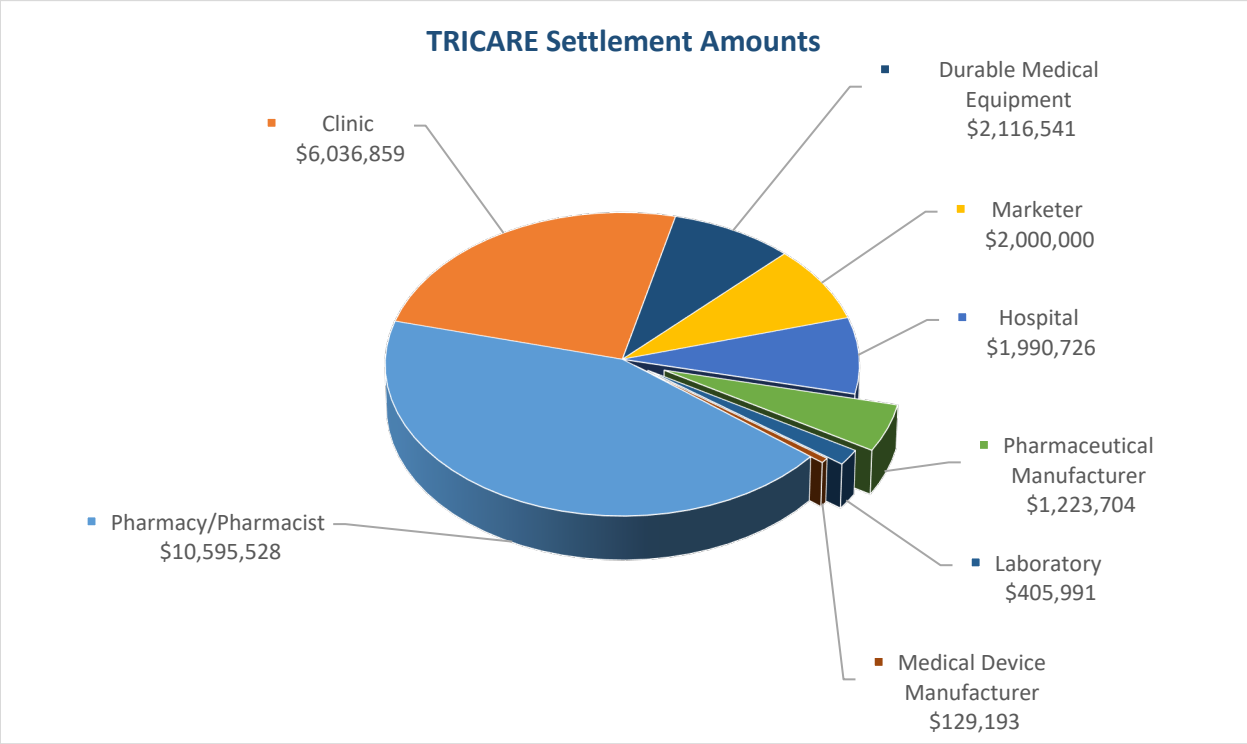


2.1. Fraud Judgements and Settlements

DHA PID relies upon assistance from the Department of Justice (DOJ) and Defense Criminal Investigative Service (DCIS) to investigate and prosecute cases on behalf of DHA's interests. Oftentimes TRICARE is also harmed when fraud is committed against other public benefit programs and private sector insurance. During the calendar year 2021, the TRICARE program received a total of $496,381,355 in judgements and $24,498,541 in settlements, with 66 civil settlements and 60 criminal judgements. Unique to DHA/TRICARE, all monies received are returned directly back to the program to fund continuing care for our beneficiaries.

2.2. Significant Civil Cases Involving TRICARE

Case development, support, investigation, and prosecution by DOJ, is an incredible demonstration of teamwork by many health care fraud staff and entities. These cases are highlighted in DOJ Press Releases, which serve to notify those who may attempt to defraud TRICARE or other government healthcare agencies of the potential monetary penalties or civil prosecution. The following charts and case summaries illustrate the most significant provider categories for civil settlements, court ordered restitution, and convictions.



Summaries of the most significant civil cases from 2021 are included the sections below.

2.2.1. Civil Settlement: CV McDowell and J&J Tel Marketing

The U.S. Attorney's Office for the Middle District of Florida entered into a civil settlement agreement with Jack Lee Stapleton and Jack Hunter Stapleton, former owners of marketing companies CV McDowell and J&J Tel Marketing, who generated compound drug prescriptions and referred those prescriptions to pharmacies in exchange for illegal kickbacks. It is alleged the Stapletons used telemarketing to solicit TRICARE patients to accept compounded drugs without medical necessity, then sent the prescriptions to compounding pharmacies that paid the Stapleton entities half of the amount TRICARE reimbursed for each prescription. Total settlement amount is $4,000,000. TRICARE portion of the settlement is $2,000,000.

2.2.2. Civil Settlement: Surgical Care Affiliates and Orlando Center for Outpatient Surgery

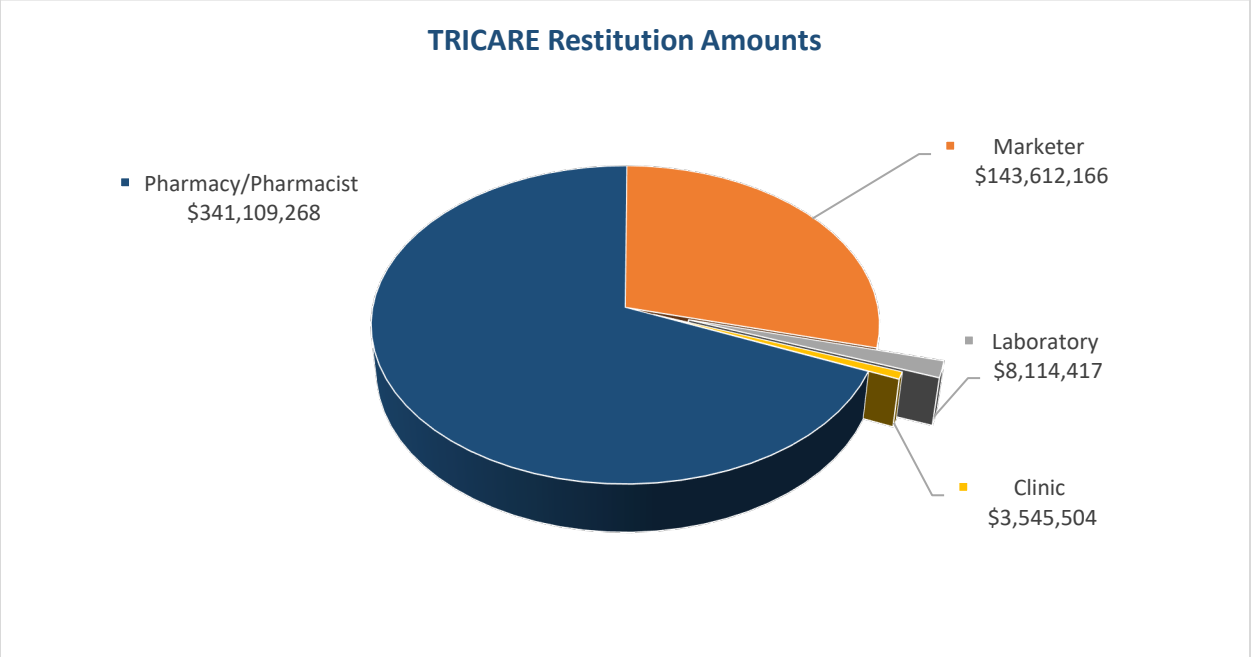
In June 2021, the U.S. Attorney's Office for the Middle District of Florida entered into a civil settlement agreement with Surgical Care Affiliates and Orlando Center for Outpatient Surgery to settle allegations of false claims submitted to Medicare and TRICARE from January 2010 through April 2016, for medically unnecessary extracorporeal shock wave lithotripsy and ultrasound procedures involving kickbacks and overutilization of services. The defendants have agreed to pay a total settlement amount of $3,400,000. TRICARE portion of the settlement is $1,485,120.

2.2.3. Civil Settlement: The Shape of Behavior

The U.S. Attorney's Office for the Southern District of Texas entered into a civil settlement agreement with Domonique Randall (Randall), former and sole owner of The Shape of Behavior (TSOB), an Applied Behavior Analysis therapy services provider with approximately 9 offices located throughout the state of Texas. TSOB submitted false claims to TRICARE where they misrepresented the actual rendering providers, failed to provide medical records to substantiate the rendering services, and billed excessive numbers of hours on individual dates of service. Total settlement amount is $2,729,083. TRICARE portion of the settlement is $2,729,083.

2.3. Significant Criminal Cases involving TRICARE

The burden of proof is different for criminal cases, and criminal litigation is typically reserved for the most egregious of fraud or abuse matters. As such, penalties for criminal cases often include both restitution and incarceration. In calendar year 2021, the majority of criminal cases resolved in favor of TRICARE were related to pharmacy compounding cases. The chart below displays the breakdown of provider types involved in criminal cases resolved in 2021.



Summaries of the most significant criminal cases from 2021 are included in the sections below.

2.3.1. Criminal Case: Wade Ashley Walters

In January 2021, Wade Ashley Walters of Hattiesburg, a co-owner of numerous compounding pharmacies and pharmaceutical distributors, was sentenced on his guilty plea to one count of conspiracy to commit health care fraud and one count of conspiracy to commit money laundering. Walters is to serve a total of 18 years in prison and ordered to pay $287,659,569 in restitution. Walters was remanded into custody following the sentencing hearing. Walters was further ordered to forfeit $56,565,963, representing the proceeds he personally derived from the fraud scheme. TRICARE Restitution is $287,659,569.

2.3.2. Criminal Case: Dr. Peter Steiner

In February 2021, Dr. Peter Steiner, Louisville, KY, was sentenced in the U.S. District Court for the Western District of Kentucky (WDKY). Dr. Steiner, who is a Psychiatrist, had been indicted on one count of Conspiracy to Distribute Controlled and twenty-five counts of Unlawful Distribution and Dispensing of Controlled Substances. In the Plea Agreement, Steiner agreed that between 2012 and 2018, he dispensed Schedule II and III controlled substances without medical necessity, including to patients he was aware were addicts; that he prescribed controlled substances in exchange for inappropriate sexual favors; and that he prescribed dangerous combinations of controlled substances. Although Steiner was not charged in connection with any patient deaths, the investigation which resulted in Steiner's guilty plea revealed that he was implicated in at least 13 patient deaths, including the deaths of two TRICARE beneficiaries. Steiner was sentenced to 60 months of imprisonment; a $225,000 forfeiture paid to the DEA, and three years of supervised release following the term of imprisonment.

2.3.3. Criminal Case: Richard Robert Cesario

In May 2021, Richard Robert Cesario of Dallas, Texas, CEO and co-owner of Dallas-based pharmaceutical marketing group CMGRX, was sentenced in the Northern District of Texas, after pleading guilty to criminal conspiracy to commit health care fraud in a scheme to submit over $124 million in medically unnecessary compound drug prescriptions to TRICARE from September 2014 to May 2015, and receiving illegal kickbacks for compound drug prescription referrals. Cesario was sentenced to 10 years in prison, three years' probation, and ordered to pay $70,417,883 restitution to TRICARE.

2.3.4. Criminal Case: Andrew Joseph Baumiller

In May 2021, Andrew Joseph Baumiller of Dallas, Texas, president and co-owner of Trilogy Pharmacy in Dallas, Texas, was sentenced in the Northern District of Texas, after pleading guilty to criminal conspiracy to commit health care fraud in a scheme to submit over $50 million in medically unnecessary compound drug prescriptions to TRICARE from September 2014 to May 2015, and conspiring with others to pay illegal kickbacks in exchange for filling prescriptions. Baumiller was sentenced to six years in prison, two years' probation, and ordered to pay $38,570,145 restitution to TRICARE.

3.0 Cost Avoidance

Cost avoidance is a way to decrease costs by lowering potential increases in expenses. In the context of healthcare, cost avoidance includes administrative remedies and measures to ensure claims are paid appropriately. Within TRICARE, cost avoidance includes claims software that identifies duplicate claims, edits to identify mutually exclusive or unbundled claims, prepayment review, and claims audits. As claims processing is the responsibility of TRICARE contractors, the majority of cost containment savings are due to contractor administrative actions.

3.1. Prepayment Duplicate Denials

TRICARE's Managed Care Support Contractors (MCSC) along with International SOS (ISOS), Wisconsin Physician Service (WPS), Express Scripts Incorporated (ESI), and United Concordia (UCCI) Dental, Inc. are required to check each claim for duplicate billing to prevent erroneous

expenditures. Duplicate detection requires automated and manual procedures to identify and prevent duplicate payments. Each contractor is required, at a minimum, to compare specific fields on each claim line item to ensure appropriate payment. For calendar year 2021 prepayment duplicate denials reported by the contractors to Program Integrity amounted to $520,019,678. [1]

3.2. Rebundling/Mutually Exclusive Edits

TRICARE's MCSC's, ISOS, and WPS are required to use prepayment claims processing software that utilizes rebundling and mutually exclusive edits. The rebundling edits are designed to detect and correct the billing practice known as unbundling, fragmenting, or code gaming. Unbundling involves the separate reporting of the component parts of a procedure instead of reporting a single code, which includes the entire comprehensive procedure. This practice is improper and is a misrepresentation of the services rendered. Providers are cautioned that such a practice can be considered fraudulent and abusive. For calendar year 2021, the prepayment claims processing software in use by the MCSC's accounted for $114,145,012 in cost avoidance for TRICARE. [2]

3.3. Prepayment Review

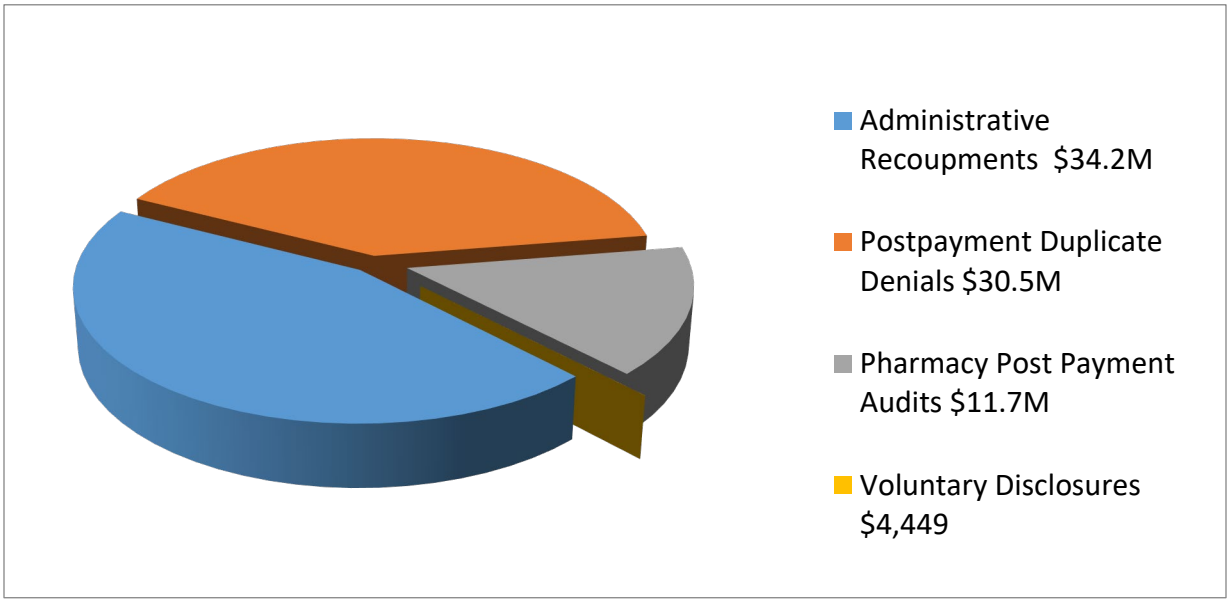
Prepayment review prevents payment for questionable billing practices or fraudulent services. As an administrative remedy, providers/beneficiaries with atypical billing patterns may be placed on prepayment review. Once on prepayment review, their claims and supporting documentation are subject to prepayment screening to verify that the claims are free of billing problems and the documentation supports services billed. The results of a review may result in a reduction of what was claimed or a complete denial of the claim. The following chart shows costs avoided that were a result of prepayment review activities by each contractor.

TRICARE Support Contractors	Cost Avoidance
Humana Military Healthcare Services, East Region	$52,796,437
Health Net Federal Services, West Region	$9,695,164
International SOS, Overseas	$2,846,031
WPS TDEFIC	$955,422
UCCI – Dental	$357,850
TOTALS:	**$66,650,904**

[1] Prepayment Duplicate Denial amounts as reported by TRICARE contractors.
[2] Rebundling/Mutually Exclusive Edit amounts as reported by TRICARE contractors.

4.0. Contractor Recoveries and Recoupments

This section details recoveries and recoupments through anti-fraud initiatives at the support contractor level. Money recovered and recouped is applied back into the program to fund beneficiary healthcare entitlements.



4.1. Postpayment Duplicate Claims Denials (DCS)

Postpayment duplicate claim (DCS) software was developed by DHA and is used by the MCSC's. This software was designed as a retrospective auditing tool to identify paid duplicate claims. While most duplicate claims are identified through prepayment screening, $30,510,574 was identified in 2021, for recoupment or offset on a postpayment basis. [3]

4.2. Pharmacy Postpayment Audits

Postpayment audits represent amounts recovered from paid pharmacy claim submission errors identified as part of ESI audit and monitoring activities. In 2021, $11,673,468 was recovered. [4]

4.3. Administrative Recoupments/Offsets

The Federal Claims Collection Act (FCCA) provides authority for the collection of non-financially underwritten fund recoupments, and was enacted to avoid unnecessary litigation in collecting debts owed to the United States. This authority extends to the TRICARE contracts, and allows for contractors to recoup funds which have been incorrectly disbursed as an underpayment or overpayment for whatever reason. Administrative recoupment of inappropriately paid claims may be either recovered directly from the provider as a recoupment

[3] Post payment Duplicate Claims Denials as reported by TRICARE Health Plan
[4] Pharmacy Postpayment amounts as reported by TRICARE Pharmacy Benefit Manager.

or offset from a providers' future claims. In 2021, $35,063,744 was recovered through administrative recoupments. [5]

5.0. Balance Billing and Violation of Participation Agreements

In addition to handling the more familiar types of health care fraud against the program, DHA PID is also dedicated to addressing issues involving billing violations of participation agreements.

In 2021, the majority of balance billing and violation of participation cases were resolved at the contractor level, resulting in a cost savings to our beneficiaries totaling $1,721,064 in Violation of Participating Agreement and Balance Billing efforts. [6]

5.1. Balance Billing

When TRICARE MCSC's cannot resolve Balance Billing issues at their level, DHA PID takes steps to ensure that non-participating providers comply with Public Law 102-396, Section 9011, passed by Congress as part of the DoD Defense Authorization Act of 1993. The text of this Public Law limits the payment of charges to no more than 115% of the allowable rate. This law specifies that non-participating providers are allowed to collect a maximum of 15% over the CHAMPUS Maximum Allowable Charge (CMAC) from a TRICARE beneficiary. The term "Balance Billing" has been derived from this limitation.

Balance Billing matters that cannot be resolved are referred to DHA PID. Four Balance Billing matters were referred to DHA PID in 2021. Additionally, two other balance billing cases referred to DHA PID in the previous year were resolved in 2021. Total resolution for Balance Billing was $37,518 returned or collection actions ceased against beneficiaries in 2021.

5.2. Violation of the Participation Agreement

DHA PID is also responsible for ensuring participating providers do not collect more than the CMAC when participating on a claim. Participating providers (those marking "yes" to accept assignment on the claim form) are prohibited from collecting from beneficiaries any amount in excess of the CMAC rate. This is commonly referred to as a *Violation of the Participation Agreement*. Violations of Participation Agreement that TRICARE's MCSC's are unable to resolve are referred to DHA PID. DHA PID did not receive any violation of participation cases in 2021.

[5] Data as reported by TRICARE Contractors.
[6] Data as reported by TRICARE Contractors

6.0 Voluntary (Self) Disclosure Reporting

Identifying and addressing fraud, waste and abuse within the TRICARE program is everyone's responsibility. With this in mind, DHA encourages providers to "police" themselves by engaging in compliance and conducting voluntary self-evaluations and making voluntary disclosures. By participating in voluntary disclosure programs, providers hope to avoid being subjected to criminal penalties and civil actions. While not protected from civil or criminal action under the FCA, the disclosure of fraud or self-reporting of wrongdoing by a provider could be a mitigating factor in recommendations to prosecuting agencies. Self-reporting offers providers the opportunity to minimize the potential cost and disruption of a full scale audit and investigation by reaching a settlement with the government. Because a provider's disclosure may involve anything from a simple error to outright fraud, full disclosure and cooperation generally benefits the individual or company. As a result of the voluntary compliance and self-audits by medical providers under the current program, DHA receives voluntary disclosures of overpayments.

DHA PID receives voluntary self-disclosures in two different ways. The first is through coordination with HHS, who refers self-disclosures impacting the TRICARE program to DHA PID. The second is through the Program Integrity website and Self-Disclosure Program (SDP) for TRICARE https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity/Voluntary-Self-Disclosure-Reporting. In 2021, TRICARE received one voluntary disclosure from medical providers totaling $4,449 returned to the TRICARE Program.

7.0. Provider Exclusions and Suspensions

DHA has exclusion authority based on Title 32, Code of Federal Regulations (CFR) 199.9(f). No payment will be made for any item or service furnished during the exclusion period.

DHA PID works with the DHA Office of General Counsel to recommend exclusions when necessary. TRICARE's exclusion list is available on the internet at www.health.mil/fraud. This online searchable database allows searches by provider or facility name. During 2021, DHA did not exclude any provider under its own authority, in part due to COVID-19 and the delays caused by not being able to meet in person.

From this website, users may also access the Department of Health and Human Services (HHS), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE). The LEIE is an online searchable database which allows searches by provider or facility name.

An agreement between DHA PID and the HHS OIG enables sharing of information between our two agencies. As part of the agreement, HHS OIG provides DHA PID with updates from its LEIE on a monthly basis, which lists providers who have been excluded, terminated, or suspended, as well as a list of providers who have been reinstated. This list is used by TRICARE contractors to flag sanctioned providers to ensure that no payments are made for services prescribed or provided by sanctioned providers. Those providers identified on the HHS List of Excluded Individuals and Entities (LEIE) are excluded from the TRICARE Program as well, and do not require separate DHA exclusion notification. The basis for exclusion includes convictions for program-related fraud, patient abuse, and state licensing board actions.

8.0 Civil Monetary Penalties

In late 2021, DHA and the TRICARE program received Civil Monetary Penalty (CMP) authority under Title 32 Code of Federal Regulations (CFR) 200, which allows the Secretary of Defense as the administrator of a Federal healthcare program to impose civil monetary penalties as described in section 1128A of the Social Security Act against providers and suppliers who commit fraud and abuse in the TRICARE program. This regulation provides authority to establish a program within the DoD to impose civil monetary penalties for certain such unlawful conduct in the TRICARE program. The program to impose civil monetary penalties in the TRICARE program is called the Military Health Care Fraud and Abuse Prevention Program, and was mandated in the passage of the National Defense Authorization Act (NDAA) for fiscal year 2022. DHA PID continues to work with internal partners to develop a pilot process for CMPs, with the program anticipated to be self-funding within the next 10 years.

9.0. Program Integrity Affiliations

Defense Criminal Investigative Services (DCIS) is the primary investigative agency for the DoD TRICARE Program. DHA PID and DCIS work in close cooperation in the fight against health care fraud and abuse. In CY 2021, DCIS continued to recognize health care fraud as one of its investigative priorities. In doing so, DCIS strongly supports DHA PID's anti-fraud program. DCIS' commitment to investigating health care fraud resulted in increased numbers of cases accepted for investigative purposes.

DHA PID also routinely collaborates with Military Criminal Investigative Offices (MCIO), Federal prosecutors and investigators (e.g., DOJ, HHS IG, FBI, and DEA) as well as those on state and local levels. Additionally, DHA PID is engaged in public-private sector partnerships with the National Health Care Anti-Fraud Association (NHCAA), Healthcare Fraud Prevention Program (HFPP) and as a Government Liaison member with the Association of Certified Fraud Examiners. DHA PID also actively participates on health care task forces throughout the United States.