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Statement of

Michael J. Roark

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on

"Potential budgetary efficiencies achieved through improvement to management and planning processes within Department of Defense personnel programs"

Good afternoon Chairwoman Warren, Ranking Member Scott, and distinguished members of the Subcommittee. Thank you for inviting me to appear before you today to discuss our oversight work on the Department of Defense (DoD) health care.

Providing for the health and well-being of Service members and their families is critical to DoD recruitment, retention, and readiness. The annual DoD OIG DoD top management and performance challenge reports have consistently highlighted the important challenges facing DoD health care, including rising health care costs. For example, in 2020, the DoD OIG reported that the DoD must reduce vulnerabilities for health care fraud within the Military Health System and control rising health care costs. In 2021, the DoD OIG reported that the DoD faced challenges, such as fraud, acquisition reforms, and payments for health care services with limited or no cost controls.

One of the leading contributors to increasing health care costs is fraud. Health care fraud continues to be one of the top investigative priorities for the DoD OIG's Defense Criminal Investigative Service (DCIS). DCIS investigations span the spectrum of health care fraud, to include pharmacy services, TRICARE, public health, medical facilities, medical practitioners, health care kickbacks, and pharmaceutical fraud. DCIS is primarily responsible for most TRICARE related fraud investigations, and currently has an investigative case count of over 600 cases up from 565 cases in FY 2022.

The DoD OIG also conducts audits and evaluations to provide oversight of DoD health care. Today I will discuss three audit reports, two reports where we identified that additional procedures were needed to contain health care costs, and one report that showed that the DoD effectively implemented procedures to control costs.

TRICARE Payments for Breast Pumps and Replacement Parts

On April 25, 2018, we issued a report on TRICARE payments for breast pumps and replacement parts.[1] The objective of this audit was to determine whether the DoD paid reasonable prices for standard electric breast pumps and replacement parts from suppliers in the TRICARE program.

In December 2014, Public Law authorized the Defense Health Agency (DHA) to pay for manual and standard electric breast pumps and replacement parts.[2] The DHA implemented a policy, effective December 19, 2014, allowing beneficiaries to obtain either one manual breast pump or one standard electric breast pump per birth event. This policy also permitted beneficiaries to receive breast pump replacement parts, including tubing, adapters, bottle caps, shields, bottles, and locking rings, as necessary for up to 36 months.

The DHA reimburses medical procedures, services, and supplies using various reimbursement methodologies to establish maximum reimbursement rates to ensure that payments are reasonable. A TRICARE maximum allowable reimbursement rate is the payment ceiling for reimbursement to providers. However, the DHA did not implement maximum reimbursement rates for breast pumps and replacement parts. Instead, the DHA paid the amount that the suppliers billed for the breast pumps and replacement parts, unless the TRICARE regional contractor had a negotiated rate with the suppliers.

We determined that the DHA overpaid for standard electric breast pumps and replacement parts for TRICARE beneficiaries in the three TRICARE regions in 2016. Specifically, the DHA overpaid for:

[1] DoD OIG Report No. DODIG-2018-108, "TRICARE Payments for Standard Electric Breast Pumps and Replacement Parts," April 25, 2018.
[2] Public Law 113-291, "Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act for 2015," December 19, 2014.

• 54,006 of 59,241 breast pumps (91.2 percent); and

• 380,911 of 671,112 replacement parts (56.8 percent).

This occurred because the DHA did not require contractors for the three TRICARE regions to use only suppliers that had fixed reimbursement rates for breast pumps and replacement parts. As a result, we calculated that the DHA overpaid $16.2 million for standard electric breast pumps and replacement parts provided to TRICARE beneficiaries in all three TRICARE regions in 2016.

We made two recommendations to address the deficiencies we identified. We recommended that the DHA Director use only suppliers that have entered into agreements that have fixed reimbursement rates to provide standard electric breast pumps and replacement parts throughout all TRICARE regions. We also recommended that the DHA Director review and pursue appropriate action, such as recouping any overpayments from the suppliers that billed excessive amounts for breast pumps and replacement parts. Both recommendations are closed.

TRICARE Payments for Health Care Services and Equipment

On August 20, 2019, we issued a report on TRICARE payments for various health care services and equipment.[3] The objective of this audit was to determine whether the DHA paid higher prices than necessary for TRICARE health care services and equipment where it did not establish or use existing TRICARE maximum allowable reimbursement rates.

We focused on claims for which the DHA paid the amount the provider billed (paid-as-billed) for vaccines and contraceptive systems, such as human papillomavirus (HPV) vaccines and intrauterine devices; compression devices; oral appliances for the treatment of obstructive sleep apnea; charges for the installation of medical equipment; and costs associated with obtaining stem

[3] DoD OIG Report No. DODIG-2019-112, "Audit of TRICARE Payments for Health Care Services and Equipment That Were Paid Without Maximum Allowable Reimbursement Rates," August 20, 2019.

cells that were provided to beneficiaries in the TRICARE North, South, and West Regions in 2017. We selected those services for review because of their high claim costs.

We determined that the DHA regularly paid more than other pricing benchmarks for services and equipment where it did not establish or use existing TRICARE maximum allowable reimbursement rates. Specifically, the DHA paid more than other pricing benchmarks for vaccines, contraceptive systems, compression devices, oral appliances, costs associated with the installation of medical equipment, and stem cell acquisition provided to TRICARE beneficiaries in the three TRICARE regions in 2017. For example, the DHA paid more than other pricing benchmarks for 70,248 of 107,953 vaccines (65 percent), and 1,341 of 5,450 contraceptive systems (25 percent).

This occurred because the DHA did not:

- use existing TRICARE maximum allowable reimbursement rates or other industry pricing benchmarks to pay TRICARE claims for vaccines and contraceptive systems;
- identify services and equipment that were paid at prices that exceeded other pricing benchmarks;
- define in TRICARE guidance what would constitute an excessive payment for TRICARE services and equipment, and provide instructions to its TRICARE contractors to identify and limit these charges; or
- consistently revise TRICARE reimbursement methodology to align with Medicare reimbursement methodologies when paying for TRICARE services and equipment.

As a result, of the $18.1 million reimbursement that we reviewed, the DHA paid $3.9 million more than other pricing benchmarks for vaccines and contraceptive systems provided to TRICARE beneficiaries in the three TRICARE regions in 2017.

We also identified examples of the DHA paying more than other pricing benchmarks for durable medical equipment, and costs associated with obtaining stem cells. While we were unable to quantify the total magnitude, the examples showed that the DHA paid excessive prices and continues to waste funds on other services and equipment that are paid-as-billed. For example, the DHA paid a supplier as much as $5,000 per month to rent a vascular compression device while two other suppliers rented the same device for approximately $700 per month.

Finally, DHA policy requires beneficiaries in certain TRICARE categories to pay cost shares for equipment. Therefore, TRICARE beneficiaries will continue to pay higher out-of-pocket costs if the DHA does not establish or use existing TRICARE maximum allowable reimbursement rates. For example, DHA policy requires beneficiaries in certain TRICARE categories to pay a 20-percent cost share for durable medical equipment. TRICARE beneficiaries paid costs of $1,000 when a TRICARE supplier billed $5,000 for the vascular compression device rental discussed earlier. This $1,000 cost share far exceeded the prices offered by two other DME suppliers that rented the same device for approximately $700.

We made a total of 7 recommendations to the DHA Director:

- identify the reasons why TRICARE region contractors did not use existing TRICARE maximum allowable reimbursement rates, take immediate actions to confirm that TRICARE claims for vaccines and contraceptive systems are paid using the TRICARE maximum allowable reimbursement rates, and recoup overpayments;
- determine whether TRICARE region contractors applied TRICARE maximum allowable reimbursement rates to health care services, other than just vaccines and contraceptive systems;

- determine whether the DHA should adopt vaccine manufacturer rates as reported by the CDC when reimbursing TRICARE claims for vaccines, and if adopted, regularly update rates to stay current with the vaccine manufacturer rates;
- conduct annual reviews to identify health care services, supplies, and equipment for which TRICARE paid higher prices, and establish and implement new TRICARE maximum allowable reimbursement rates accordingly;
- revise TRICARE policy to incorporate wording regarding reasonable cost and being a prudent buyer similar to the related clauses in 42 Code of Federal Regulations (CFR) 405.502 and Centers for Medicare and Medicaid Services Publication 15-1, "Provider Reimbursement Manual";
- revise TRICARE reimbursement methodologies to align with the Medicare program, and establish an annual process to identify recent changes to Medicare reimbursement methodologies; and
- seek voluntary refunds from TRICARE providers where the DHA paid more than other pricing benchmarks identified in this report. As of March 2023, 6 recommendations were closed, and one recommendation is resolved, but open.

DHA Controls Implemented to Control Costs for TRICARE COVID-2019 Related Services

On September 3, 2020, we issued a special report on the actions the DHA took to control costs for health care claims in the first year of the coronavirus disease-2019 (COVID-19) pandemic.[4]

[4] DoD OIG Report No. DODIG-2020-125, "Special Report: Controls Implemented by the Defense Health Agency to Control Costs for TRICARE Coronavirus Disease-2019 Pandemic Related Services," September 3, 2020.

The DHA issued several letters to the managed care support contractors (MCSCs) providing guidance on claims processing for COVID-19 related claims. The letters included clarifying guidance and various new requirements for the MCSCs to implement related to:

- eliminating co-payments and cost shares for COVID-19 diagnostic testing;
- clarifying access to behavioral health services via telehealth;
- eliminating co-payments and cost shares for COVID-19 serology testing; and
- implementing temporary TRICARE regulation changes in response to COVID-19.

As a result, the MCSCs deferred or manually paid claims pending system and pricing updates and created dashboards to share information and perform data analytics on health care claims related to COVID-19. The DHA also implemented other initiatives. For example, the DHA:

- established work groups to monitor and address COVID-19 issues related to DoD healthcare;
- updated the pricing system and instituted special processing codes to ensure COVID-19 claims are paid and tracked properly; and
- added parameters to the annual risk registry that allows the DHA to monitor and track potential fraudulent COVID-19-related services.

Through these actions, the DHA took steps to reduce the risk of medical providers exploiting the pandemic for personal gain and possibly prevented potential improper payments before they could occur. With the elimination of co-payments and cost shares and the expansion of telehealth and behavioral management services, the DHA provided more flexibility for providers and beneficiaries during the COVID-19 pandemic, which enabled beneficiaries to receive the care they needed.

This concludes my statement and I would be happy to answer any questions you have.