Defense Health Agency

Office of the Inspector General

Health Care Fraud Resolution

Operational Report — 2024

Safeguarding Healthcare, Empowering Trust

The Defense Health Agency, Office of the Inspector General, Health Care Fraud Resolution Division remains steadfast in its commitment to enabling exceptional health care to Military Health System beneficiaries by ensuring responsible stewardship of taxpayer dollars. This report outlines DHA achievements in 2024 to prevent, detect, and deter healthcare fraud, waste, and abuse.

Health Care Fraud Resolution Strategic Plan 2024-2029

The Health Care Fraud Resolution strategic plan delineates a comprehensive approach to enhance DHA anti-fraud controls, promote responsible stewardship of healthcare resources, and safeguard beneficiary benefits. The plan focuses on three strategic goals: prevention, detection and deterrence of healthcare fraud, waste and abuse. These goals are achieved by fostering a culture of compliance, leveraging data analytics, and strengthening partnerships within the Federal Government.

Strategic Goal: Prevent Healthcare Fraud, Waste, and Abuse

The desired outcome for prevention is to minimize opportunities and instances of fraud, waste, and abuse before they occur. Strategic objectives include enhancing DHA healthcare fraud education and training enterprise-wide; clarifying and streamlining policies and procedures to mitigate potential for fraud; implementing data analytics to identify high-risk areas and to pinpoint potential fraud vulnerabilities; and establishing clear communication channels and reporting mechanisms to report suspected fraud, waste and abuse.

Strategic Goal: Detect Healthcare Fraud, Waste, and Abuse

The desired outcome for detection is to promptly and accurately identify healthcare fraud, waste, and abuse. Strategic objectives include sustaining a robust health care fraud data analytics capability that leverages machine learning and establishes predictive modeling to identify anomalies and healthcare trends specific to the DHA beneficiary population. Similarly, in coordination with DHA TRICARE Health Plans, Health Care Fraud Resolution is chartering an integrated project team that will improve cost containment efforts by implementing a multitiered review process and provide a forum to present cross functional recommendations to leadership intended to address program vulnerabilities and risks. Further, Health Care Fraud Resolution will support requirements delineated in the TRICARE Operations Manual, Chapter 13, for the TRICARE Regional Contractors who administer the TRICARE program. Specifically, each TRICARE Regional Contractor is required to have a dedicated Program Integrity staff, pre-payment and post-payment controls, and advanced data analytics for real-time detection of anomalous or suspicious claims.

Strategic Goal: Deter Healthcare Fraud, Waste and Abuse

The desired outcome for deterrence is a culture and environment that discourages fraud by holding individuals and entities found in violation of program rules, policies, regulations, and laws accountable. Strategic objectives include stopping fraudulent payments before they occur as well enforcing a zero-tolerance policy; increasing public awareness of the consequences of fraud; strengthening collaboration with anti-fraud task forces; conducting joint training with other Federal agencies; and participating in information sharing programs to include the Healthcare Fraud Prevention Partnership and the National Health Care Anti-Fraud Association.

Key Accomplishments

Prevention:

Cost avoidance decreases costs by lowering potential expenses. In the context of health care, cost avoidance includes administrative remedies and measures designed 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. Claims processing is the responsibility of TRICARE contractors so most cost containment savings result from contractor administrative actions.

TRICARE Regional Contractors' Program Integrity administrative remedies included prepayment review of providers and beneficiaries for suspected fraud, sanctioned provider denials, and violations of participation agreements or balance billing. During calendar year 2024, TRICARE contractors avoided payment of $171,485 for sanctioned providers, stopped payment on over $79.6M in claims based on prepayment review, and recovered $413,041 on behalf of beneficiaries related to provider violations of participation agreements.

Health Care Fraud Resolution promoted its anti-fraud campaign and enabled agency-wide training by adding a DHA Fraud Prevention course to the Joint Knowledge Online platform. This training is designed to strengthen agency defenses at the front line, mitigate risks of fraud and abuse, and foster a culture of awareness. The Joint Knowledge Online training educates the workforce on healthcare fraud trends, provides an overview of contracting and Government Purchase Card fraud, and encourages fraud, waste, and abuse reporting.

The DHA identified a need for integrated cost containment activities which was supported by Government Accountability Office and Department of Defense Inspector General Audit findings. In December 2024, the Director, TRICARE Health Plans endorsed the creation of an Integrated Project Team to address the multi-faceted challenge of cost containment. This Integrated Project Team intends to optimize resource allocation, enhance efficiency, and control healthcare costs without compromising quality of care by leveraging current technology, data analytics, and through cross-functional collaboration. The Integrated Project Team will include subject matter experts from Health Care Fraud Resolution, J-8 Contract Resource Management, TRICARE Health Plans policy and claims, and the Office of General Counsel. The first meeting is scheduled for May 2025.

Detection:

The DHA prioritizes healthcare fraud detection to safeguard limited financial resources. Accordingly, it mandates that contractors employ various anti-fraud tools and strategies to prevent, detect, and report fraudulent activities. In addition to anti-fraud mandatory training programs, provider credentialing and screening measures, and instituting internal controls, TRICARE Contractors are required to comply with the TRICARE Operations Manual, Chapter 13. This includes sustaining a robust, anti-fraud program, utilizing predictive analytics and data to identify fraud trends and potentially fraudulent providers, and to refer cases of potential fraud to Health Care Fraud Resolution. In 2024, TRICARE Contractors referred a total of 42 cases. Of the cases referred, 10 were forwarded to the Defense Criminal Investigative Service. An additional 6 cases were accepted by the Department of Justice for intervention. The remaining 26 cases were returned to the contractor for administrative action such as recoupment or provider education.

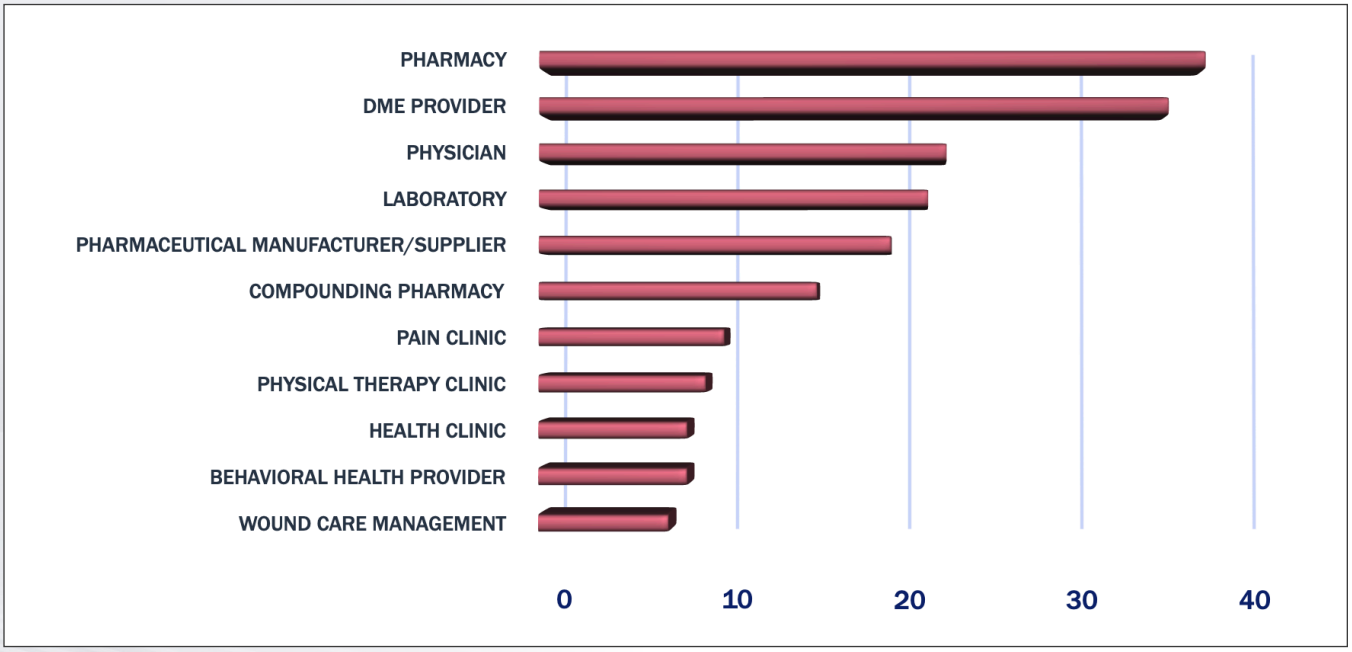
In August 2023, the DHA executed a contract to support health care fraud data analytics and restore data mining functional capability. This contract, *Analysis and Detection of Fraud, Waste and Abuse Indicators to Strengthen Anti-Fraud Activities in the DHA*, enables data collection, analysis, and interpretation of specialized data in support of healthcare fraud investigations as well as publication of monthly and quarterly reports. The fraud data analytics contract was extended in September 2024, resulting in enhanced capability to include trend analysis, target identification, emerging fraud scheme recognition, and machine-learning and artificial intelligence adoption. The health care fraud data analytics team efforts have resulted in increased Department of Justice court action engagement and inclusion of DHA in National Health Care Fraud Takedown actions by the Health Care Fraud Prevention and Enforcement Action Team,

a joint initiative between Health and Human Services Office of the Inspector General and the Department of Justice.

Deterrence:

In 2024, Health Care Fraud Resolution actively managed 301 investigative cases. A total of 171 new cases were opened and the team responded to over 378 lead requests and inquiries concerning allegations of fraud. Key fraud trends consisted of excessive billing, services not rendered, and a misrepresentation of services provided. The top fraudulent provider types included Pharmacy, Durable Medical Equipment, Physicians, Independent Laboratories, Pharmaceutical Companies and Distributors, Pain Clinics, Physical Therapy Clinics, Behavioral Health Providers, and Wound Care. These fraud trends mirrored those of the broader healthcare industry.

Open Cases by Top Provider Types



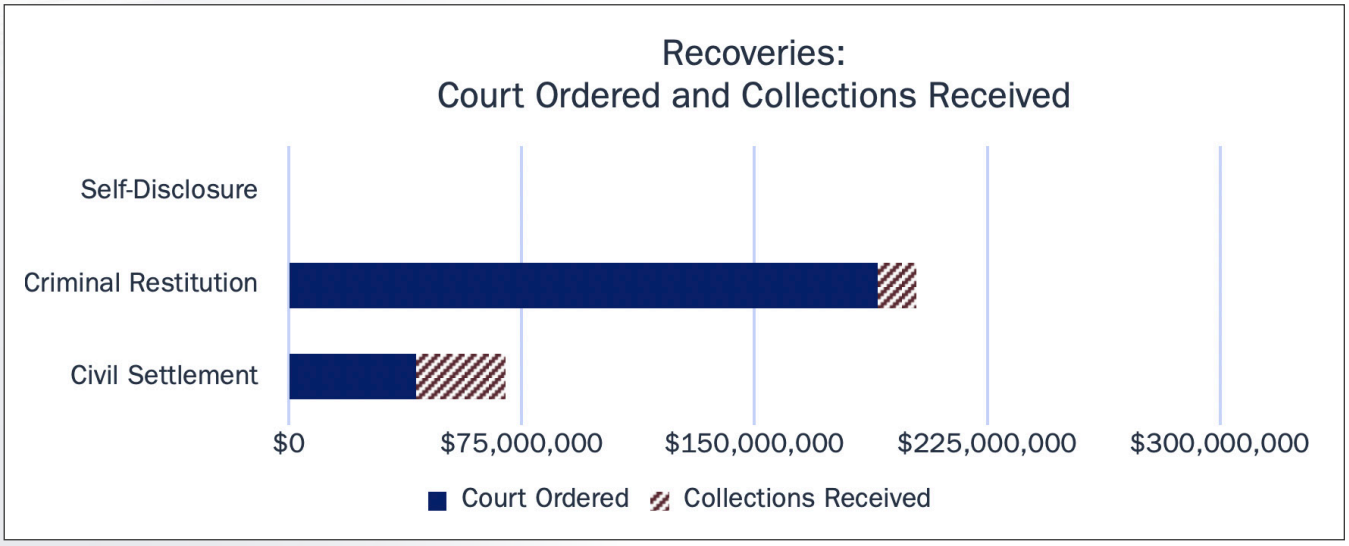
In addition to case referrals from internal and external sources, the Health Care Fraud Resolution also receives *qui tam*, or whistleblower inquiries from the Department of Justice. In 2024, Health Care Fraud Resolution responded to 334 qui tams from hospitals, medical clinics, medical supply companies and pharmacies.

Fraud Judgements and Settlements

The DHA partners with the Department of Justice to adjudicate health care fraud cases. In 2024, Department of Justice intervened on 52 civil cases resulting in a total of $40,948,145 in negotiated settlements and 26 criminal cases resulting in a total of $189,597,408 in court ordered restitution. While the funds from negotiated settlements and court ordered restitution are captured for overall efficacy of the program, there is

sometimes a delay in the funds being returned to the program. This is especially true with court ordered restitution which is most frequently paid in installments.

For 2024, DHA received $28,760,058 in civil settlements, $12,477,149 in court ordered restitution, and $333,065 in self-disclosures. These figures represent a direct return to DHA and are applied as current year purchase care (Defense Health Program Budget Activity Group 2) funds and may include court ordered actions from previous years.



Provider Exclusions and Suspensions

The DHA the authority to exclude providers through the authority delineated in Title 32, Code of Federal Regulations 199.9(f). Additionally, the DHA also institutes exclusions made by the Department of Health and Human Services. No payment is made for item or service during the exclusion period. Health Care Fraud Resolution works with the Office of General Counsel to recommend exclusions when necessary. The DHA Director also has the authority, according to Title 32 CFR 199.9(g), to temporarily suspend claims payment based on credible allegations of fraud or Department of Justice court actions. In 2024, one provider was placed on temporary claims payment suspension.

Partnerships and Collaboration

DCIS is the primary investigative agency for the DoD TRICARE Program. Health Care Fraud Resolution and the Defense Criminal Investigative Service work in tandem to combat health care fraud, waste and abuse. Health Care Fraud Resolution also routinely collaborates with various Military Criminal Investigative Offices; Federal prosecutors; Federal Bureau of Investigations, Drug Enforcement Agency, Department of Health and Human Services, and Department of Justice investigators; and state and local entities.

Health Care Fraud Resolution is engaged in public-private sector partnerships with the National Health Care Anti-Fraud Association, Healthcare Fraud Prevention Partnership and serves as Government Liaison member with the Association of Certified Fraud Examiners. Health Care Fraud Resolution also actively participates in health care task forces throughout the United States.

Looking Ahead

The DHA fight against healthcare fraud is an ongoing effort requiring constant adaptation, innovation, and improvement. Follow on steps to achieve the Health Care Fraud Resolution strategic goals of prevention, detection and deterrence include further leveraging current fraud detection technology, strengthening Program Integrity activities, enhancing enforcement, and focusing on emerging threats.

The DHA Fraud Prevention training is expected to be available enterprise-wide in 2025. Ongoing collaboration and coordination through the Cost Containment Integrated Project Team, and other initiatives, is expected to sustain anti-fraud momentum to enhance prevention, detection and deterrence across the agency.

Conclusion

The DHA and Health Care Fraud Resolution remain dedicated to upholding the highest standards of economy, integrity and accountability. We are confident that our proactive approach in combating healthcare fraud, waste, and abuse will continue to yield positive results, ensuring the sustainability of our healthcare system, and protecting the health and well-being of our beneficiaries.