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About IDA

IDA is a private, nonprofit corporation that manages three Federally Funded Research and Development Centers. Our mission is to answer the most challenging U.S. security and science policy questions with objective analysis leveraging extraordinary scientific, technical, and analytic expertise.

This newsletter is prepared by IDA's health research team. For more information, visit https://www.ida.org/research-and-publications/research/health-research or email healthteam@ida.org.

JOHN E. WHITLEY, FORMER ACTING SECRETARY OF THE ARMY

John E. Whitley most recently served as the acting Secretary of the Army. Prior to this role, he was the Assistant Secretary of the Army (Financial Management and Comptroller). Prior to this appointment, Whitley was a senior fellow at the Institute for Defense Analyses.

Whitley was born in Florida and grew up in western Maryland. He earned a bachelor of science degree at Virginia Polytechnic Institute and State University (Virginia Tech) and a doctorate in economics at the University of Chicago. He previously served as a health-care analyst on the Military Compensation and Retirement Modernization Commission and an adjunct professor at the Trachtenberg School of Public Policy and Public Administration at George Washington University. Additionally, Whitley served as Director of Program Analysis and Evaluation at the Department of Homeland Security and as an Operations Research Analyst within the Office of the Secretary of Defense in what is now the Office of Cost Assessment and Program Evaluation. Whitley also worked as an Assistant Professor of Economics at the University of Adelaide in Australia. He served in the U.S. Army in the Second Ranger Battalion.

From your perspective, what does the future hold for the Military Health System (MHS)? Where should leadership focus reforms?

When you look at the broad areas of reform in the MHS, there are a few major categories: force structure, infrastructure and facilities, education and training, readiness, and the TRICARE contracts and benefit[s]. I would break the last 30 or so years into three eras. This is a bit imprecise because people were talking about all of these issues during each of the eras, but it is illustrative. There was a strong focus on force structure during the reform discussions of the 1990s to the early 2000s. This would include the original NDAA [National Defense Authorization Act] FY 1992 Section 733 report, which actually did address facilities and footprint as well, but really what is remembered from it is the force structure piece; the 733 update in the late 1990s; and the medical readiness review in the 2000s. I think the focus there was really to come to the reform piece through force structure and tackle that head on. That was partially driven by events such as the stress on the force and challenges we were facing at the time, among other things. Then, I think there was a push from the mid-2000s to mid-2010s to focus on infrastructure. What really kicked this era off was the BRAC [Base Realignment and Closure] round. Lt. Gen. [George] Peach Taylor [M.D., then U.S. Air Force Surgeon General] made significant changes to the footprint in that round. There was also the small hospital study done by the Navy, followed by a similar one by the Army. Then OSD [Office of the Secretary of Defense], Health Affairs, and DHA [Defense Health Agency] picked up on it in the MHS Modernization Study. Then I'd say from the mid-2010s on, the prevailing organizing theme for reform has been readiness. The Military Compensation and Retirement Modernization Commission [MCRMC] started this approach, and I think that it is the right approach and should continue. Focusing on force structure was important and it was valuable, but it made relatively little progress. Focusing on facilities made a little more progress; there were some changes, but again it came back to why are we doing this, is it a budget cutting drill, and so on. I think by focusing on readiness, it really gets to the crux of the issue, which is building and maintaining a ready medical force [prepared] to start the next war with fewer deaths.

So, in terms of the strategic level or the leadership level, I would say we have gone through three phases. We are in this readiness phase and that is the right high-level guiding principle for reform. I think this is going to continue—it is gaining traction, making change happen—and is the most important dimension of the problem. As for where it is headed, I think

military-civilian partnerships will continue to be key and actually get bigger, not smaller. Training, accession, and GME [graduate military education] will all be wrapped up into that; these are all major areas that require reform anyways.

I think the MCRMC framed the issues well and, as I said a moment ago, was the transition to the readiness focus. The last area of reform, the TRICARE contracts, was also raised by the MCRMC, but we have seen much less progress on it. In fact, DoD [Department of Defense] has actually been moving in the wrong direction for the last 20 or so years. From the initial round in the early 90s, with a larger number of regions and a fair bit of experimentation for the time, to what you had by T-3 and T-4 with very rigid, very archaic and anachronistic contracts—long-lived, non-risk bearing, monopoly contracts for very large geographic regions, completely out of step with civilian best practices for purchasing a health-care benefit. I think you're starting to see some of that recede, starting to see Congress weigh in more and more, starting to see more of the department and the MHS realize that reform is needed and not simply trying to change the subject into cost shares. So, I would say that this is the second big focus area moving forward.

I think these two complement each other. If you start to get the military establishment focused on readiness, and then that frees up the ability to have a conversation about the best way to deliver a robust and high-quality health benefit. So, I'd say its readiness first, then TRICARE reform following.

Do you think the standup of the Defense Health Agency (DHA) has helped focus those dual objectives of readiness and beneficiary care?

I think my answer there is a qualified, preliminary yes. I think the theory of the FY 2017 NDAA reforms and the consolidation of the MTFs [military treatment facilities] to DHA is completely sound. The root cause of the problem has always been the dual-mission construct—that the same surgeon is responsible for readiness and beneficiary care. The readiness requirement to deploy and provide life-saving care on the battlefield only comes around every 20 to 30 years, whereas the beneficiary mission is there every day, it's bigger in terms of dollars and in terms of resources, people, and so on. So, when you have this dual-mission framework, it creates a huge conflict of interest. From a management perspective, you are putting a readiness function and a personnel benefit function in the same trade space with each other, which just makes no sense from a management and resource allocation perspective. Readiness functions should be in a trade space with other readiness functions. Personnel benefits should be in a trade space with other forms of compensation. So, this artificial trade space has been created where point-of-the-spear readiness is weighed against a back-office compensation function. One is huge and day-to-day; the other only comes about every 20 to 30 years, so it is not really surprising who won in that competition. The result is lack of readiness and 30 percent or so death-to-survivable-injury rate, [like] we saw on the battlefield in Iraq and Afghanistan.

I think the theory of breaking that artificial construct of two vastly different functions by moving the MTFs, which are primarily beneficiary care delivery to DHA, and telling the surgeons general to focus on the military force and keeping it ready is a good one. If the MTFs have the workload to keep them ready, then great, keep them there. But if not, then you need to go out and put them where they will get the right workload to maintain their clinical currency. So, I think the theory is 100 percent correct and sound.

What have we seen? The direction from NDAA FY 2017 Section 702—we are 5 years and 2 months into that—the progress has been very slow to date. You can blame a little of that on the pandemic and other things, but unfortunately—not to be attacking individuals—the bulk of the delays in progress have been from parochialism and an unwillingness to implement the spirit of that law. When I was acting Secretary of the Army, I saw this and had the ability to tell my surgeon, LTG [Scott] Dingle, your job is readiness, don't come to me with MTF problems. He did a great job with that while I was there, and was really trying to move the Army forward. If there are MTF problems, DHA and the ASD [Assistant Secretary of Defense] for Health Affairs need to take those issues to the Deputy Secretary. That is the proper chain of command for MTF problems. You bring me (service secretary) readiness problems. That was a little bit tough for a while, but he understood that and we were able to change the conversations we had with senior leadership in the Army from "this is happening to

the MTFs" to "here is how I am keeping my force ready." I think we have some preliminary evidence that it is slowly starting to work, but it has taken a lot longer than people wanted it to.

While the resistance to reform and the parochialism of the [military] services part have been widely recognized and have been criticized appropriately, there has been an equal amount of parochialism from DHA that has not been as widely discussed. The FY 2017 NDAA was a clear reform: benefit to DHA and readiness to the services. But the first actions of DHA were not to recruit and build a high-end human capital base of facility managers to prepare for takeover of the MTFs. Instead, the first actions of DHA, directly contrary to the guidance, were to consolidate readiness functions at DHA. For example, blood banking, the Joint Trauma System, and mortuary affairs were all transferred from the services to DHA in the first year or so after the NDAA was passed. Several years of capacity development at DHA were lost as it focused on accumulating readiness functions instead of what it was supposed to be doing. Now we have a DHA struggling to take over the MTFs because it doesn't have the right human capital or management capacity to do so. So, it is important to note that the slow progress has been caused by all of the players in DoD.

NDAA-directed reforms have been a mechanism to force the system to change. Where do you think future provisions will focus? Where would Congress get the biggest bang for its buck?

Not to give the MCRMC too much credit, but it deserves some of the credit. It released its report in 2015. Congress came out and decided to take on retirement provisions first. They did that in the FY 2016 NDAA, and then they held off to tackle the medical provisions in the FY 2017 NDAA. They changed some of the MCRMC recommendations significantly—some for the better, some perhaps not. I expect Congress to continue to be in the lead. One question was, when Senator [John] McCain retired and then unfortunately passed away, would the interest continue since he was really viewed as the driver behind a lot of this, and would the forceful nature of congressional direction continue? I think, so far, we have seen that it has, so I think the congressional interest is enduring. In terms of what they are thinking, I can't speak to that, but my recommendation or my thought would come back to our earlier conversation about readiness and TRICARE contracts. These should be the overarching themes. For readiness, they should continue to try to expand military civilian partnerships and clinical currency training opportunities for the medical force. As a companion to that, they should continue to try to drag the TRICARE contracts into the twenty-first century and direct them to become consistent with civilian best practices for how to deliver a health-care benefit through insurance contracts.

Do you have any thoughts on value-based care and where the department should go on implementing some of these provisions?

I think value-based care is a term that encompasses a lot of different things. It is certainly the trend in the private sector. We could have a very detailed conversation about specific aspects of value-based care, but for now I will put that off to the side. Without endorsing any one approach and taking it as a broad catch-all term to improve incentives through healthcare markets, then I think it is exactly the direction the department should be going. But, and there is a big but, we have to understand what role we play. If we think about how the healthcare market works, outside of the DoD, you have a group of employers, as most private insurance is through employers in the United States. These sponsors engage in contracts with financial intermediaries—the insurance companies—who specialize in things like how to do value-based care and how to manage care. There is a market between the employers and beneficiaries on the one side and the insurance companies on the other side, and then you have a downstream marketplace of the insurance companies interacting with the providers. In most cases, and there are some exceptions, employers and beneficiaries are paying that intermediary to become a specialist on how to implement value-based care and write contracts with proper incentives to the delivery system. DoD has historically not understood this, and so they see that value-based care is the way of the future and think that DoD then needs to go write a value-based care contract from the Pentagon. That can't be done. Value-based care is about aligned incentives and getting care coordinated in an efficient and effective way in local markets across the nation. First off, healthcare is local and you just can't write contracts like that from the Pentagon. Second, the Pentagon does not

have the expertise to write those contracts. It is exactly the right direction to go, but DoD has not historically understood its role of being an upstream purchaser of insurance. Instead, it tries to micromanage the downstream markets from the upstream markets where it writes its contracts. That is just not sound economics and is not going to work.

More on this theme came in this year's NDAA, which went through a slightly unconventional process. Section 724 calls for more integrated medical operations. Given your experience at DoD and DHS, how do you think about integrating domestic operations?

First, I think this is an incredibly important question. I am glad to see it from the perspective of we should have plans for how we are going to regulate returning casualties, and how we are going to ensure returning casualties get the best possible care. I don't think we have solid, sound plans on the books today. Second, I think greater integration through mil-civ [military-civilian] partnerships and other mechanisms is the key programmatic initiative to reform, so that is a positive. Two positive aspects so far. Third, which is a negative, I am very concerned about whether the department has the discipline to look seriously at the question. Senior leadership of the department has a lot on their plate, and these things will get delegated to various organizations across the DoD, and the interests of those organizations will tend to have an outsized influence on how it plays out.

So, it remains to be seen whether the department will do serious and credible work in this space. We have seen the results of when you get it wrong. We were around for the Walter Reed [National Military Medical Center] scandal a few years ago. We know what the foundation of it was: the department was behaving in a kind of insular way and it was trying to keep returning casualties and concentrate them at Walter Reed. We know what is best for returning casualties when they are going to be out of action for an extended period of time, and there is no military necessity to keep them on post. For many of them, perhaps not all, the best approach is going to be to send them back with their families and let them get their health care locally and let them go through the recovery process. For those with no chance or interest in returning to duty, let them begin that transition as they are doing that. Some may prefer to stay on post and that is okay, but we should be giving them the choice of where to live and get their care. And, we weren't doing that at Walter Reed during the scandal. We weren't putting the patients first. Instead, we were trapping a tremendous amount of outpatient care at Walter Reed, putting them up in barracks that didn't have the capacity to support them, forcing family members to travel across the country and stay in hotels and Fisher Houses to be near their loved ones. I don't know what the logic was. For whatever reasons, we weren't putting the needs of the patients first. My concern would be that if the department isn't up to the challenge of seriously addressing the question and is instead putting the parochial interests of various groups within the department first, then we will end up with another piece of paper on the shelf that is not an executable plan, and when the next war starts, we will again be starting from scratch.

What role do you think the military-civilian partnerships could play in the event of returning casualties? Could they expand into this mission?

I don't know if we know the answer to that yet. What we haven't done, at least not in a serious way, is look at a range of returning casualty scenarios to really get a sense of what we are looking at. Another OIF/OEF-level conflict [Operation Iraqi Freedom/Operation Enduring Freedom], another Vietnam-level conflict, or something on the scale of World War II. You can create some size gradations and look who would be headed to inpatient, who could be treated through outpatient, what is the geographic distribution of homes of record and duty stations, and so on. Then you would start to have a sense of how big is this problem. Is this problem 100 inpatient casualties a month? From a logistics perspective, that is a manageable problem. Is it 1,000 inpatient casualties a month? That is a very different situation, but in the context of the bed capacity of the United States, that is still a relatively small problem. If it is 10,000 a month, then that is a fundamentally different scenario all together. I think we would have to start to think of the types and ranges of scenarios we might see. We have to look at the distribution of homes of record, the health-care capacity at homes of record, who is likely to return to duty, where are the VA [Department of Veterans Affairs] facilities, and so on. I think you would have to do this analysis first. Then it would tell you if this a few hundred people spread across the country, then the TRICARE contracts can handle

that just fine. If it is a few thousand people, that's a bigger problem, but probably could be handled with just-in-time contracts. If it is significantly bigger, then you have the situation where that is something that could not be handled by simple contracting. Then you have to weigh the probabilities of all these events.

How should the department think about the sizing of the medical force and getting the right skills but also balancing that with a new physical footprint?

I'll go back to our earlier conversation. Readiness is really the key. I think with a force structure focus, reform advocates were open to criticism that this was a budget-cutting drill. When it was a facilities- and an infrastructure-focused discussion, you were opened up again that this was a hit drill against medical. You created the opportunity for individuals who were less reform-minded to try and undermine reform based on ultimately spurious arguments about motives. When you make it about readiness front and center, about a third of our fatalities from OIF/OEF were potentially survivable and we were not ready for them. Then using the National Defense Strategy as a guide, the next conflict could potentially be worse, so being unprepared for the next war could be significantly more damaging than being unprepared for the last was. I think that argument has started to sink in for folks. The Senate in particular understands this challenge and has the right motivation for reform. That is the approach [that] helps remove this from the politics.

The second piece is coming back to the point about NDAA Section 702 reform. We are starting to see the services recognize that readiness is their job, they won't be able to reverse 702, and so it is time to take it seriously. We are not there yet in terms of a full embrace by the services, but we are part of the way down the road. If that trend continues, maybe in a couple of years, we will have a generation that has been sufficiently influenced so that they view their job as readiness and not going out to fight to protect force structure or infrastructure. The challenge now is that we have created another power center [that] will have the parochial interest to protect the status quo, and that is the Defense Health Agency. We are going to have to think that through seriously—and we have a challenge there in that Health Affairs has often times been held captive to DHA or its predecessor, TMA [TRICARE Management Authority]. We are going to have to think through how to make Health Affairs really be a policy and oversight body and not an organization held captive by DHA. And we have to reverse the DHA acquisition of readiness functions that properly belong in the services.

The pandemic caused changes to the entire medical system at large, but it also challenged notions of what the DoD medical force is for. Are there opportunities to leverage changes stemming from the pandemic to advance MHS reform and modernization? What are the opportunities or risks?

I'd almost lean more to the risks side. If you actually look at the pandemic, and not the caricature of the pandemic, what did you actually see? The highest demand for our deployers were critical care, emergency medicine, and so on. Those were the folks that were needed in the pandemic and are also the same folks we are short of for our operational requirement during wartime. The same readiness issues we face in preparing for war were the shortages that we saw in responding to requests for forces from domestic authorities responding to the pandemic. What we did not see, and that we were very concerned about initially, was a bed surge. We were worried about MTF beds and canceled elective procedures to preserve beds, but we never saw a large patient surge in the Department of Defense. If you look carefully at the data, the same problems we are having on the readiness side were emphasized and reinforced during the pandemic; we were short on critical care, emergency medicine, we did not have the high-end medical skill sets to treat very sick patients that you need for war and during a pandemic. Also, we did not need excess beds and expansion beds at facilities. I think the risk factor with the pandemic is, will the department have the discipline to look at the data and draw conclusions like those or will it unfortunately just use the pandemic as an excuse to advance parochial arguments?

Do you have any final or concluding thoughts that we haven't covered here regarding medical reform?

I'd just reinforce some of the points we have already made. We had somewhere around a third of our casualties from Iraq and Afghanistan die of potentially survivable injuries. This is not to knock the medical community as it was a complex time, but it is to say that we had some readiness challenges, particularly when you note that the rates started higher

and then went down over time. Unfortunately, this historic pattern of readiness decay repeats itself from the end of the last war to the beginning of the next. We saw this in World War II leading into Korea, and Vietnam leading up to Iraq and Afghanistan. We learn a great deal about trauma medicine, combat casualty care, and saving lives on the battlefield, and then we promptly forget it. The most important issue is how do we ensure we are ready to save lives and avoid having to relearn what we learned in the last conflict.

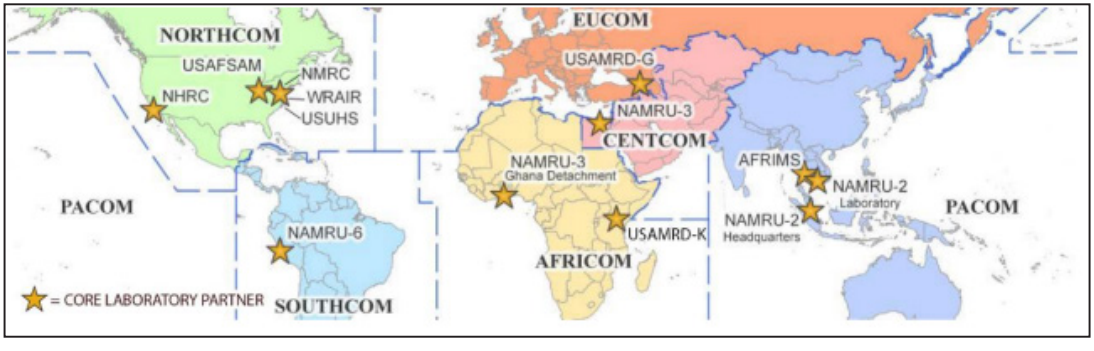
Commentary

OVERSEAS LABORATORIES

W. Patrick Luan

As an emergent global priority, the response to the COVID-19 pandemic has drawn significant attention to the effect of public health on society, government, national security, and the economy. The Department of Defense (DoD), having been a globalized institution since its inception, has not been immune to the pandemic's effects and has launched its own unprecedented response. As the pandemic wanes to endemic, there will be abundant opportunities to advance the mission, resilience, and readiness of the department.

One such opportunity lies with DoD's overseas biomedical laboratories. The department has a unique platform of forward-deployed medical assets that include medical treatment facilities, research infrastructure, and clinical laboratories. A 2011 report by the Center for Strategic and International Studies highlighted the research contributions of the overseas labs. However, the laboratories and their capabilities remain relatively unknown outside the public health and research communities. Both the Army and Navy operate overseas research laboratories for monitoring emerging infectious diseases in key geographic locations, including Kenya, Ghana, Georgia, Egypt, Thailand, Cambodia, Singapore, and Peru. In addition, since the onset of the HIV epidemic in the 1980s, the department has operated the Military HIV Research Program (MHRP). MHRP has established labs and medical clinics in close coordination with local partners across Asia and Africa to provide the necessary infrastructure to conduct clinical trials and study population health.



Locations of DoD Laboratories (Defense Health Agency Armed Forces Health Surveillance Branch: Strategy FY 2019-2021, Global Emerging Infections Surveillance, 3 May 2018.)

Part of the challenge to maximizing the impact of the labs is their alignment to research commands (e.g., the Naval Medical Research Center and the United States Army Medical Research and Development Command) rather than to the geographic combatant commands. As a result, the labs and the researchers they support compete with each other for research funding, most of which comes from DoD's Global Emerging Infections Surveillance (GEIS). The instability of research dollars and priorities has the unintended effect of widening the gap between a lab's activities and its strategic and operational requirements to support the proximate combatant command's theater campaign plans. Therefore, it is essential that DoD ties the activities of the labs to the realities of the region, and not the bureaucracies of centrally managed research programs.

Because funding for pandemic preparedness tends to wane over time, leadership will have a limited window of opportunity to affect enduring changes that could bolster DoD's public health surveillance. Informing a combatant command's force health protection planning is necessary but may not be sufficient to fully justify the maintenance and expense of fully resourced, forward-deployed capability. In short, DoD's overseas labs must evolve to advance the department's mission and national security.

Section 724 of the National Defense Authorization Act (NDAA) for fiscal year 2022 calls for an assessment of biosurveillance and medical research capabilities. In addition, the legislation calls for an assessment of the strategic value, current capabilities, manning, and resourcing of the overseas labs. This assessment should focus on articulating the value of the labs not as a research enterprise, but as a forward-deployed critical national security infrastructure. While laboratory-confirmed epidemiologic surveillance will remain the gold standard, the pandemic has created a resurgence of large data sources that enable new techniques for epidemiologic surveillance. This big data revolution encourages analysis of unconventional data sets that include cell phone data, social media posts, and web searches. The results of such analyses can help researchers and health officials better understand the effect of government measures and regional disease dynamics, moving them closer to realizing real-time health surveillance data and forecasting. The overseas labs could consider developing this capability and integrating with DoD-wide artificial intelligence initiatives such as those championed by the Joint Artificial Intelligence Center. In addition to executing core public health capabilities, these overseas labs offer a valuable form of global health engagement that provides access, builds interoperability, and encourages capacity-building across the globe. These elements of "soft" diplomacy are difficult to measure, but will gain importance as regional stability becomes a priority in the tail of the COVID-19 pandemic.

Research Spotlight

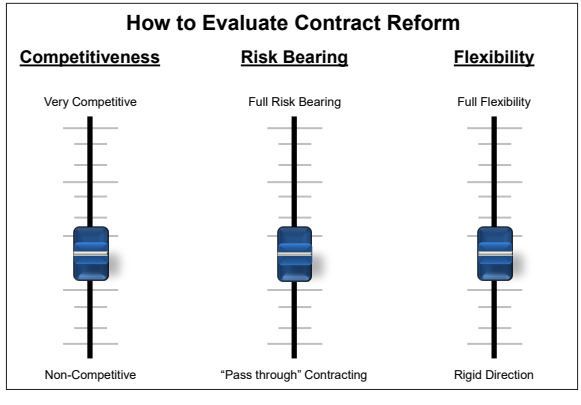
TRICARE REFORM IN THE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2022

Sarah K. John

Our Senior Leader interview with John E. Whitley indicated that reforming TRICARE and modernizing TRICARE contracts are key areas of focus for MIlitary Health System (MHS) leadership. Congress has also continued to call for TRICARE modernization. This year's National Defense Authorization Act (NDAA) contained several provisions affecting the TRICARE program, but Section 703, "Revisions to TRICARE Provider Networks," was the most significant move forward in terms of modernizing the program structure. This provision granted the Secretary of Defense authority to establish multiple provider networks in the same geographic area. To understand why this is important, we review three key principles identified by previous IDA research to incentivize value-based purchasing in the TRICARE program: competition, risk, and flexibility.

Contract competitiveness is characterized by the number of contractors (carriers) offering competing products (health plans) in a given market area. This form of competition is key for ensuring the carriers focus on the preferences of beneficiaries. TRICARE currently has only two major carriers; each works within a distinct geographic region, and both have contract awards lasting 5 years. This arrangement is essentially "winner take all" contracting that creates a 5-year monopoly. (In a limited exception, a handful of market areas offer the U.S. Family Health Plan as an alternative benefit to TRICARE Prime and Standard.) On the other end of the spectrum is the "evergreen" contracting model used by the Federal Employees Health Benefit Program. Under this model, carriers submit plan bids annually, and all plans that meet the quality and cost requirements are allowed to participate in the exchange. Beneficiaries may choose between multiple health-care carriers and plan options

Contract risk-bearing is the degree to which the carrier is at risk for failing to control cost growth. When properly designed, risk-bearing contracts provide incentives to the carriers to manage cost and improve outcomes. Because the current TRICARE program is essentially a fee-for-service contract, the carriers bear little risk and have no incentive to meaningfully manage provider networks to encourage better outcomes at lower costs.



Contract flexibility is the extent to which the contractor is free to design the agreements it enters into with providers and subcontractors. Flexibility allows the risk-bearing carrier to compete and evolve its suite of tools as the market changes and conditions vary across markets. The TRICARE carriers currently have limited flexibility. The next generation of TRICARE contracts (referred to as T-5) may offer additional flexibility through new requirements for value-based care and the ability to implement pilot demonstration programs.

By calling for multiple providers in the same geographic region, Congress is making way for greater competition, which should translate to greater choice for beneficiaries. It may take 5 years or longer before the TRICARE program awards multiple contracts within a region, and this change will likely be incremental. The competition for the T-5 contracts is already well underway, and it is based on the same structure as used now (two regions, one winner per region). However, the department does have the opportunity to use its TRICARE pilot authority to experiment with multiple provider networks

in the near term. For instance, a TRICARE pilot program offered in Atlanta, Georgia, allows TRICARE prime beneficiaries to select enrollment with Kaiser Permanente as a Prime option. The program is designed to test how Kaiser's integrated delivery model can achieve cost efficiencies, care effectiveness, and beneficiary satisfaction.

Special Report

NEW DEFENSE HEALTH AGENCY AUTHORITIES TO COMBAT HEALTH-CARE FRAUD AND ABUSE

Jamie M. Lindly

Health care is both complex and expensive—two important characteristics that make payment processing especially vulnerable to fraud, waste, or abuse by unscrupulous actors across the health-care delivery ecosystem. Consistently and reliably identifying suspected fraud and improper payments is essential to the long-term health of the Military Health System's $22 billion dollar TRICARE program. Examples of these transgressions range from outrageous claims for compound pharmaceuticals (two or more traditional drugs mixed for an individual patient's specific need) that offer little therapeutic value, to financial inducements to perform behavioral health services that are medically unnecessary. While the Program Integrity Office of the Defense Health Agency (DHA) is broadly responsible for combating fraud and improper payments across the myriad of benefit programs that make up TRICARE, Section 713 of the Fiscal Year 2022 National Defense Authorization Act (NDAA) gives the Secretary of Defense new authorities "to prevent and remedy fraud and abuse in health care programs of the Department of Defense" (DoD).

What's in Section 713?

The legislation sets forth new authorities for a joint program between DHA and the DoD Inspector General to combat fraud and abuse in a manner consistent with the enforcement actions available under the Social Security Act. Additionally, recoveries and penalties collected under this program will not only go back to TRICARE, but may also be used to support development and administration of the enforcement program itself, thereby aligning incentives proportionally to the magnitude of the problem.

How Much Money Are We Talking About?

At $22 billion dollars per year in purchased care expenditures across programs, TRICARE dwarfs most major defense acquisition programs in annual spending. The total dollar amounts, coupled with hundreds of millions of individual claims processed annually and the decentralized nature of private health-care provision, makes TRICARE an attractive target for fraud. While the active prosecution of criminal behavior is necessary, additional savings can also be found through identification of improper payments (e.g., wrong amount for the right service or right amount for the wrong service) from well-intentioned providers. The National Health Care Anti-Fraud Association and Government Accountability Office (GAO) estimate fraud to be from 3 to 10 percent of total health-care expenditures. In 2020, this number could translate into more than $2 billion dollars in annual savings to DoD. The following table provides a range of savings estimates across TRICARE

		Savings Assumptions		
Combined Programs	TRICARE Purchased Care Spend (FY 2020, $M)*	3%	6%	10%
Under 65	$14,433	$433	$866	$1,443
Medicare Eligible	$7,142	$214	$429	$714
Total	$21,575	$647	$1,295	$2,158

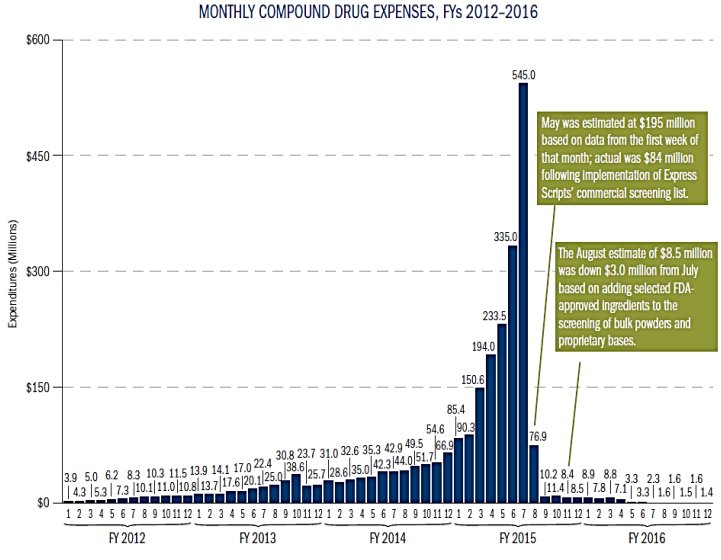
** Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress (Access, Cost, and Quality Data Through Fiscal Year 2020).*

programs. Even small improvements in TRICARE claims-processing systems can have big impacts. At the lower bound, a 3 percent reduction in improper or fraudulent claims translates to more than $640 million in potential annual savings. These savings translate into roughly eight F-35 Lightning fighter jets or 60 Black Hawk (UH-60) helicopters. These improvements arise from methods that reject payment of suspected fraud or hold regional managed care support contractors at risk for improper payments when payments are based on incomplete or erroneous claims information.

Does TRICARE Fraud Really Happen?

Yes—it does! Each year, the DHA Program Integrity Office develops cases for the Department of Justice to prosecute. During calendar year 2020, the TRICARE program received a total of $494 million from 50 criminal judgements and 70 civil settlements, with the largest single settlement of $238 million from Purdue Pharma. While criminal prosecutions and civil settlements have their place, halting the payment of improper claims from the onset is inherently more cost-efficient than the "pay-and-chase" model.

From 2014 to late 2015, the TRICARE pharmacy program experienced dramatic expenditure growth in compound pharmaceuticals. Once a pharmaceutical was identified as a compounded medication, conventional processes for identifying improper payment amounts or questionable combinations of drugs were not applied in the processing of the claim for payment.



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 10/15/2016
[a] Express Scripts is the Pharmacy Benefit Manager under contract with DoD.
Note: Detailed information regarding the compound approval process can be found at http://tricare.mil/CoveredServices/Pharmacy/Drugs/CompoundDrugs.aspx.

The figure at right (from the fiscal year 2017 TRICARE Report to Congress) shows what can happen when fraud spreads unabated under the current pay-and-chase model. Once appro-priate prepayment processes were put in place, expenditures for compound drugs were reduced to 2012 levels. Department of Justice prosecutors are still chasing the hundreds of millions in fraudulent claims from this period.

Why Does Section 713 Matter?

Without strong screening and risk identification, fraud is hard to detect within the several hundreds of millions of claims. Prompt but accurate payment to providers is important for maintaining robust participation in health service networks around military beneficiary populations. The authorities granted in Section 713 could potentially give a joint DHA-inspector general (IG) fraud prevention program improved tools and better incentives to shift from the current pay-and-chase model to a more proactive approach. By combining the enforcement authorities and identification techniques of the IG with the data processing expertise resident in DHA, the new prevention program has the opportunity to apply modern risk-based approaches to TRICARE claims processing. Tools such as artificial intelligence, machine learning, or simultaneous risk-scoring during processing against known fraud are all promising tools for the program. In addition, the partial return of recoveries to the joint program aligns incentives in a way that reinforces activities aimed to protect taxpayer dollars.