injuries received the required screening and counseling before they were separated from the Service for misconduct. Additionally, the risk increased that service members may be inappropriately separated for misconduct without adequate consideration of these conditions' effects on behavior, separation characterization, or eligibility for the Department of Veterans Affairs benefits and services. The GAO recommended that the Secretary of Defense direct the Air Force and Navy to address inconsistencies in their policies with DoD policy related to screening service members and reviewing results prior to separation for misconduct, and training service members to identify mild traumatic brain injuries in a deployed setting. The GAO also recommended that the Secretary of Defense ensure that the military Services routinely monitor adherence to those policies and policies related to counseling on Department of Veterans Affairs benefits and services. The DoD agreed with the recommendations.

Suicide Prevention

As noted above, suicide prevention continues to be a challenge for the DoD. As of the 4th Quarter, FY 2016, the total number of suicide deaths for DoD was 276 for the Active Component and 203 for the Reserve Component. In response to the number of suicides, the DoD developed and promoted prevention policies, practices, and programs to attempt to reduce military suicide. For example, the Defense Suicide Prevention Office was established in FY 2011 to provide advocacy, program oversight, and policy for DoD suicide prevention, intervention, and follow-up efforts to reduce suicidal behaviors in service members, civilians, and their families. It also leads working groups of representatives from the Services, the Office of the Assistant Secretary of Defense (Health Affairs), and other interested organizations, related to expanding access to behavioral health care for service members. In FY 2015, the Defense Suicide Prevention Office also implemented the DoD Strategy for Suicide Prevention, which is designed to guide and coordinate suicide prevention efforts across the DoD. As one part of that effort, the Defense Suicide Prevention Office published and distributed guides to military family members on suicide warning signs, risk factors, and actions to take in a crisis. The office also sponsors research initiatives and training that address gaps in suicide prevention and resilience policies and practices. The DoD collaborated with the Department of Veterans Affairs to develop suicide prevention and intervention policy. For example, in June 2013, the DoD and Department of Veterans Affairs jointly developed the Clinical Practice Guideline, "Assessment and Management of Patients at Risk for Suicide," which recommended best practices for assessing and managing the risk of suicide among active duty military and veterans. The DoD OIG has performed several evaluations to assess DoD suicide prevention efforts. For example, in September 2015, a DoD OIG evaluation found that the DoD lacked a clearly defined governance structure and alignment of responsibilities for the Defense Suicide Prevention Program. In addition, the DoD OIG identified the lack of clear processes for planning, directing, guiding, and resourcing to effectively develop and integrate the Suicide Prevention Program within the DoD. In response to the DoD OIG's recommendations, the Defense Suicide Prevention Office issued and implemented the 2015 Strategy for Suicide Prevention, noted above, to coordinate suicide prevention efforts across the DoD. In response to another DoD OIG evaluation report in November 2014, the Defense Suicide Prevention Office developed and is in the process of issuing guidance for data collection and reporting on suicide events. In November 2014, the DoD OIG recommended that the Under Secretary of Defense for Personnel and Readiness publish guidance requiring suicide event boards to establish a multidisciplinary approach for obtaining the data necessary to make comprehensive DoD Suicide Event Report submissions. The DoD OIG reported this as a key open recommendation in its July 2017 Compendium of Open Recommendations. Without a comprehensive and complete DoD Suicide Event Report submission, it will be difficult for the DoD to conduct the trend or causal analysis necessary to develop effective suicide prevention policy and programs to reduce suicide rates across the force. In summary, the DoD needs to continue to pursue programs to diagnose behavioral health issues and risk factors for military personnel and its other health care beneficiaries.

Increasing Health Care Costs

The DoD faces a continuing challenge to contain costs and prevent health care fraud. Over the last decade, health care costs in the United States have grown dramatically, and DHP Enterprise costs have been no exception. For example, the DoD FY 2016 appropriations for health care were $32.3 billion, almost triple the FY 2001 appropriation of $12.1 billion. In its FY 2018 budget, the DoD requested $33.7 billion for the DHP Enterprise. One of the leading contributors to health care cost is fraud. Health care fraud is one of the top investigative priorities for the Defense Criminal Investigative Service (DCIS). As of July 7, 2017, DCIS had 523 open health care investigations. In FY 2016 and FY 2017 combined, DCIS health care fraud investigations resulted in 100 criminal charges and 68 convictions, the seizure of $53 million in assets, and $117 million in recoveries for TRICARE and the DHP Enterprise. However, health care fraud schemes are constantly evolving. As one vulnerability is closed, corrupt individuals look for another vulnerability within the health care payment system to exploit. Therefore, the DoD needs to be constantly vigilant to detect health care fraud, and to establish strong internal controls to determine areas at risk for health care fraud.

Pharmaceuticals

The DCIS continues to vigorously investigate fraud epidemic that exploited TRICARE in FY 2014 and 2015, mixing, or altering two or more ingredients to create a customized medication for an individual patient. In FY 2015, the DHP Enterprise experienced a dramatic increase in compounding pharmacy fraud, with $1.6 billion spent on compound medications in that 1 year alone. Much of expenditures were fraudulent. For example, compound drug fraud schemes involved providers who prescribed compound drugs, including various pain and other creams, without examining or even meeting the patient; medication refills sent without the consent of the patient; kickbacks paid to providers, marketers, and patients; and grossly inflated bills for prescriptions. These schemes took advantage of a TRICARE reimbursement policy that allowed for full and immediate reimbursement of prescribed compound drugs. The DHP Enterprise changed its reimbursement policy for compound drugs in response to the significant losses it realized. As a specific example of this type of fraud, one compounding pharmacy in Florida sought reimbursement for compounding pharmaceutical prescriptions that were not medically necessary and were prescribed by physicians that had never actually examined or even seen the patients. Further, a military member involved in the scheme committed identity theft by stealing fellow military members' personally identifiable information in order to facilitate additional billings to TRICARE in exchange for kickbacks. In this case, 14 individuals have been convicted of various crimes, $31 million has been court-ordered back to the DHP Enterprise as restitution, and approximately $10 million in assets have been seized. In May 2015, the DHP Enterprise implemented new controls, which reduced payments for compound drugs from $497 million in April 2015 to $10 million in June 2015. In an audit report issued in July 2016, the DoD OIG found that, while the controls were effective in reducing costs for compound drugs, additional controls were necessary to prevent reimbursement for certain non-covered compound drug ingredients. The DHP Enterprise agreed with the recommendation and took actions to improve controls related to compound drugs. Fraud and escalating costs also occur in non-compound pharmaceuticals. The DoD OIG has two ongoing audits related to pharmaceuticals, including an audit reviewing the DHP Enterprise's process for implementing controls in response to escalating costs for non-compound pharmaceuticals, and an audit to determine whether the Defense Logistics Agency Troop Support managed its Pharmaceutical Prime Vendor Program to effectively control health care costs.

Autism Treatment

One emerging fraud trend involves Applied Behavioral Analysis, which employs techniques and principles to encourage a meaningful and positive change in behavior. Applied Behavioral Analysis is a benefit offered by TRICARE for children with a diagnosis on the Autism Spectrum. In a March 2017 audit, the DoD OIG determined that the DHP Enterprise made improper payments for autism services to five companies in the TRICARE South Region. Specifically, the DHP Enterprise improperly paid for services where the beneficiary was not present; the beneficiary was napping; providers were not authorized by TRICARE; documentation to support services was lacking; and the provider billed for higher qualified health

care professionals than those who actually performed the services. As a result, the audit determined that the DHP Enterprise improperly paid $1.9 million of the total $3.1 million paid to the five companies in FY 2015. The DCIS also investigated an Applied Behavioral Analysis therapy clinic that allegedly provided therapy using personnel who were not properly trained per the DHP Enterprise guidelines, billed group therapy as one-on-one therapy, and billed for services never rendered. The investigation resulted in the indictment and conviction of the clinic owner and the reassignment of TRICARE beneficiaries from this clinic to others in the area.

Payment Collections

Another aspect of controlling health care costs involves ensuring collections are made for services provided at MTFs. The DoD OIG issued six reports from August 2014 through January 2017 related to collections from non-DoD beneficiaries, which concluded that MTFs did not actively pursue collections from non-DoD beneficiaries for 129 accounts, valued at $13.1 million, of the 145 accounts the DoD OIG reviewed. The MTFs also did not appropriately transfer funds to the U.S. Treasury for 114 delinquent accounts, valued at $13.4 million, of the 145 accounts the DoD OIG reviewed for collection. In 2017, the DoD OIG plans to perform another audit to review billing and reimbursement for health care provided to Department of Veterans Affairs patients at selected Army MTFs. While the DHP Enterprise has made progress in controlling some costs, people committing fraud will continue to look for new vulnerabilities to exploit. As internal controls are tightened in one area, those intent on committing fraud seek other vulnerabilities to exploit. For example, emerging areas of concern for fraud within the DoD health care system involve genetic and DNA testing, durable medical equipment, and opioids. The DHP Enterprise needs to be vigilant in reviewing billing trends to look for the next fraud schemes and implement effective controls to help prevent payments for fraudulent claims.

Electronic Health Records

In addition, the DoD faces challenges with the security of electronic health records and integration of those records with the Department of Veteran Affairs. According to a media report, more than 115 million patient records in the United States were compromised in FY 2015, and more than 25 million records were compromised from January to October 2016. The DoD has a responsibility to protect the patient health information for its 9 million beneficiaries and transfer records as needed to the Department of Veterans Affairs. The DoD OIG also found security weaknesses within the DoD's electronic health records. A July 2017 DoD OIG audit reported that DHP Enterprise and Army officials did not consistently implement effective security protocols to protect systems that stored, processed, and transmitted electronic health records and electronic patient health information. Specifically, DHP Enterprise and Army officials did not enforce the use of Common Access Cards to access five electronic health record systems and did not comply with DoD password complexity requirements for three systems. In addition, the DoD OIG reported that system and network administrators at three Army facilities did not consistently mitigate known vulnerabilities affecting Army networks, protect stored data for five systems, and grant user access to the seven systems based on the user's assigned duties. The DoD OIG began a similar audit in April 2017 of the Navy and Air Force electronic health records. In addition to the security of health records, according to congressional testimony by a GAO official in FY 2016, the DoD and the Department of Veterans Affairs have failed in several attempts to integrate their respective electronic health records since FY 1998. The testimony noted that the Department of Veterans Affairs has undertaken a patchwork of initiatives with the DoD to allow their health information systems to exchange information and increase interoperability. These have included initiatives to share viewable data in their existing (legacy) systems, link and share computable data between their updated health data repositories, and jointly develop a single integrated system that would be used by both departments. The National Defense Authorization Act for FY 2017 directed the DoD and the Department of Veterans Affairs to integrate their electronic health records and gave the Departments 5 years to meet this requirement. The Secretary of the Department of Veterans Affairs announced in FY 2017 that the Department of Veterans Affairs will acquire the same system as DoD. The DoD should monitor this acquisition and work closely with the Department of Veterans Affairs to ensure that the system will be interoperable with the DoD system.

The DoD should work closely with the Department of Veterans Affairs to ensure interoperability between the Departments' electronic health records and ensure that sensitive patient health information contained in electronic health records are adequately protected. In summary, providing quality, cost-effective health care to the DoD's 9 million beneficiaries will continue to be a significant challenge for the DoD. The DoD must continue to seek efficiencies to control costs without undermining timely access to quality health care. That is not an easy task. At the same time, the DoD needs to address behavioral disorders and aggressively seek to reduce the number of suicides within the military. In addition, the DoD must protect patient health information within its electronic health records and work closely with the Department of Veterans Affairs to integrate electronic health records between the Departments. The DoD OIG will continue to perform reviews of high-risk health care issues and monitor progress in these areas to identify additional ways to improve health care for DoD beneficiaries.

Payment Integrity[14]

The Federal Improper Payments Coordination Act of 2015 amended the Improper Payment Elimination and Recovery Improvement Act of 2012 (IPERIA) and earlier legislation affecting improper payment and requires extension of DoD reporting of its data analytics performance. The intent is to ensure federal and state entities maintain strong financial management controls to better detect, prevent, and report improper payments to the president and the Congress in the annual AFR.

OMB Circular No. A-123, Appendix C, defines an improper payment as any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or services, any payment that does not account for credit for applicable discounts, payments that are for an incorrect amount, and duplicate payments). An improper payment also includes any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments authorized by law). In addition, when an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an improper payment.

The DHA reports its improper payments and payment recapture programs in accordance with applicable laws and regulations. The following subcategories are included in this section:

I. Risk assessment
II. Payment reporting
    A. Root causes
    B. Corrective actions
III. Recapture of improper payments reporting
IV. Agency improvement of payment accuracy with the Do Not Pay Initiative
V. Barriers
VI. Accountability
VII. Agency information systems and other infrastructure
VIII. Sampling and estimation
IX. Significant accomplishments

The DHA reports improper payments for the MHS TRICARE purchased health care program for payments made by the DHA to private sector contractors for delivery of health care services to TRICARE eligible beneficiaries. For FY 2018 the Agency reports improper payments for the following private sector contracts, DHA administrative costs and other plans and programs:

- Managed care support contracts (MCSCs):
    - T-3 North Region, HealthNet Federal Services
    - T-3 South Region, Humana Government Business
    - T-3 West Region, UnitedHealthcare Military and Veterans
- TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)

[14] Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)

- TRICARE Overseas Program (TOP)
- TRICARE Pharmacy Program (TPharm)
- Active Duty Dental Program (ADDP)
- DHA Administrative Contract Cost
- Other:
  - Uniformed Services Family Health Plan (USFHP)
  - Women, Infants, and Children (WIC)
  - TRICARE Dental Program
  - TRICARE Retiree Dental Program
  - Mail-Order Pharmacy

I. Risk Assessment

The DHA risk assessment process is managed through contracts with an external independent contractor (EIC) to provide an independent, impartial review of reimbursements and claims processing procedures used by DHA's purchased-care contractors. The EIC identifies improper payments resulting from the contractors' noncompliance with the military health care system (collectively referred to as TRICARE in this report) benefit and/or reimbursement policies, regulations, and contract requirements. The risk level of programs is evaluated based on results of these compliance reviews.

In FY 2018, the Agency applied statistical sampling estimation methods to produce and report statistically valid improper payment estimates for the military health benefits program. In accordance with OMB Circular A-123, Appendix C, agencies are not required to perform additional risk assessments on programs reporting improper payment estimates. However, any new programs identified must be assessed for improper payment risk prior to reporting an improper payment estimate. DHA had no new program(s) implemented in FY 2017, and therefore no additional risk assessment was required for FY 2018 reporting.

II. Payment Reporting

Table 1 reports the estimated amounts that were improperly paid and the corresponding percent by program for FY 2018. It also reports the estimated amount of improper payments that resulted in overpayments or underpayments and the DHA contractual reduction targets by program for FY 2019.

Table 1: *Improper payment reduction outlook*

(dollars in thousands)

Program Name	FY 2017 Outlays	FY 2017 IP Amount	FY 2017 IP Rate	FY 2018 Outlays	FY 2018 IP Amount	FY 2018 IP Rate	FY2018 Over payment $	FY2018 Under-payment $	FY2019 Est. Outlays [2]	FY2019 Est. IP %[3]	FY2019 Est. IP $	12-Month Sampling[1] Time Frame for FY 2018 Data: Month and Year Start Date for Data	12-Month Sampling[1] Time Frame for FY 2018 Data: Month and Year End Date for Data
T3 North Region	$ 3,513,321.91	$ 18,285.16	0.52%	$ 3,548,471.18	$ 12,902.22	0.36%	$ 6,847.19	$ 6,055.02	$ 3,686,861.56	0.85%	$ 31,338.32	10/1/2016	9/30/2017
T3 South Region	$ 4,632,307.25	$ 18,407.04	0.40%	$ 4,451,158.26	$ 29,708.84	0.67%	$ 25,570.67	$ 4,138.17	$ 4,624,753.43	1.29%	$ 59,659.32	10/1/2016	9/30/2017
T3 West Region	$ 3,985,064.60	$ 32,211.62	0.81%	$ 3,668,395.99	$ 23,715.69	0.65%	$ 18,341.52	$ 5,374.17	$ 3,811,463.44	0.93%	$ 35,446.61	10/1/2016	9/30/2017
TDEFIC	$ 3,558,675.79	$ 7,595.91	0.21%	$ 3,531,990.60	$ 8,480.08	0.24%	$ 6,080.54	$ 2,399.54	$ 3,669,738.23	0.66%	$ 24,220.27	10/1/2016	9/30/2017
TOP	$ 238,372.49	$ 2,707.85	1.14%	$ 234,321.36	$ 3,358.97	1.43%	$ 2,802.41	$ 556.56	$ 243,459.90	1.28%	$ 3,116.29	9/1/2016	8/31/2017
TPharm	$ 3,161,134.46	$ 70,213.07	2.22%	$ 2,758,492.03	$ 11,864.59	0.43%	$ 11,745.51	$ 119.07	$ 2,866,073.22	1.35%	$ 38,691.99	11/1/2016	10/31/2017
ADDP	$ 81,260.69	$ 746.88	0.92%	$ 82,787.70	$ 1,211.29	1.46%	$ 995.52	$ 215.77	$ 86,016.42	1.62%	$ 1,393.47	8/1/2016	7/31/2017
DHA Administrative [4]	$ 1,225,766.16	$ -	0.00%	$ 751,728.53	$ -	0.00%	$ -	$ -	$ 781,045.95	0.00%	$ -	10/1/2016	9/30/2017
Other [5]	$ 3,487,396.60	$ -	0.00%	$ 4,269,209.00	$ -	0.00%	$ -	$ -	$ 4,435,708.15	0.00%	$ -	10/1/2016	9/30/2017
TOTAL	**$ 23,883,299.95**	**$ 150,167.53**	**0.63[6]%**	**$ 23,296,554.65**	**$ 91,241.68**	**0.39%**	**$ 72,383.36**	**$ 18,858.30**	**$ 24,205,120.30**	**0.80%**	**$ 193,866.27**		

Footnotes:

1 – DHA reports data 12 months in arrears, thus this FY2018 AFR includes data from FY2017 reviews.

2 – The FY2019 Est. Outlays were calculated using the OMB CPI-U Annual Averages and Percent Change Table. As DHA reports 12 months in arrears, the FY 2018 CPI-U medical percent change was used to calculate the FY 2019 outlay estimates.

3 – DHA established its FY2019 Est. IP % based on a trend of actual improper payment data from prior years. These figures are estimated to be higher than the FY 2018 actuals as a result of DHA's implementation of medical record reviews (which have the potential to identify additional improper payments) and the implementation of NDAA 2017 legislative requirements, which established changes to the TRICARE program that could result in increased payment errors.

4 – DHA Administrative data represents payments shared among multiple contractors to administer the TRICARE program. These costs include contractually defined claim rates for processing TRICARE claims, and non-claim rate administrative costs (i.e., contract change orders, per member per month charges, and contract incentive payments). Payments are validated via TED system program edits, COR review/validation procedures, and/or internal/external financial audits.

5 – Other data represents contracts that are not included in DHA EIC independent audits but which have internal and external pre- and post-payment controls. The following contracts are included in the "other" category:

a. Uniformed Services Family Health Plan ("USFHP")

b. Women, Infants, and Children ("WIC")

c. TRICARE Dental Program ("TDP")

d. TRICARE Retiree Dental Program ("TRDP")

e. Mail Order Pharmacy ("MOP")

6 – The FY 2017 IP Rate of 0.63% does not represent a true statistical estimate for the agency because the 2015'10-2016'09 low dollar TPharm audit that was not conducted (due to the contractor opting out of participating in the audit, as approved by the Contracting Officer). This audit represented $138,057,695 paid dollars.

Chart A below reports the estimated amount and percentage of payments made correctly under the DHA health benefits program in FY 2017.

Chart A: *Amount and percentage of DHA improper vs. proper payments*

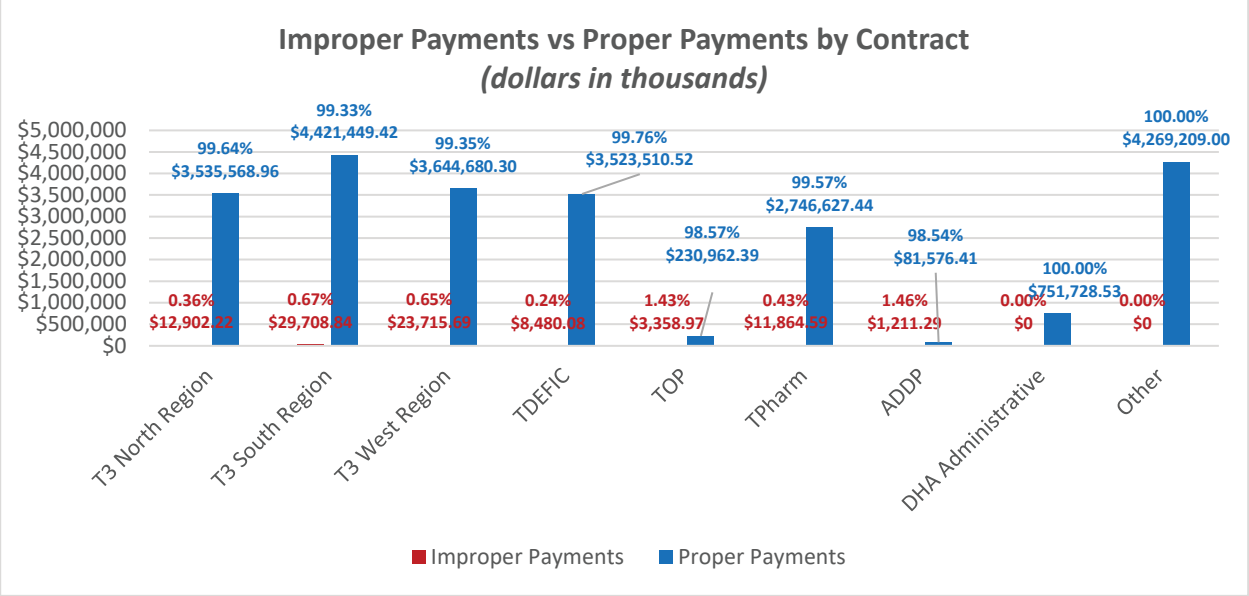

Table 2 below provides current year estimate statistical information.

Table 2: *Current year estimate statistical information*

Program Name	CY Confidence Level	CY Margin of Error
T3 North Region	90%	0.20%
T3 South Region	90%	0.25%
T3 West Region	90%	0.27%
TDEFIC	90%	0.29%
TOP	90%	0.33%
TPharm	90%	0.25%
ADDP	90%	0.56%
DHA Administrative	90%	0.00%
Other	90%	0.00%
TOTAL	**90%**	**0.09%**[1]

Footnotes:

1 – The TOTAL CY Margin of Error (0.09%) is not a direct sum of CY Margin of Error values from this table, because the values must be weighted according to the outlays. The final value was derived as the square root of the variance of all contracts (not shown in this table) times the z-score, divided by the total outlays (from Table 1).

Table 3 reports the root cause for overpayments and underpayments by amount and by program for FY 2018.

Table 3: *Improper payment root cause category matrix[1]*

(dollars in thousands)

Program Name	Payment Type	Program Design or Structural Issue	Inability to Authenticate Eligibility: Inability to Access Data	Inability to Authenticate Eligibility: Data Needed Does Not Exist	Failure to Verify: Death Data	Failure to Verify: Financial Data	Failure to Verify: Excluded Party Data	Failure to Verify: Prisoner Data	Failure to Verify: Other Eligibility Data (explain)	Administrative or Process Errors Made by: Federal Agency	Administrative or Process Errors Made by: State or Local Agency	Administrative or Process Errors Made by: Other Party (e.g., participating lender, health care provider, or any other organization administering Federal dollars)	Medical Necessity	Insufficient Documentation to Determine	TOTAL
T3 North Region	OP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 6,847.19	$ -	$ -	$ 6,847.19
T3 North Region	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 6,055.02	$ -		$ 6,055.02
T3 South Region	OP	$ -	$ 16.04	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 25,553.12	$ -	$ 1.52	$ 25,570.68
T3 South Region	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 4,138.17	$ -		$ 4,138.17
T3 West Region	OP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 18,341.36	$ -	$ 0.16	$ 18,341.52
T3 West Region	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 5,374.17	$ -		$ 5,374.17
TDEFIC	OP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 6,080.54	$ -	$ -	$ 6,080.54
TDEFIC	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 2,399.54	$ -		$ 2,399.54
TOP	OP	$ -	$ 1.01	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 2,746.59	$ -	$ 54.81	$ 2,802.41
TOP	UP	$ -	$ 0.89	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 555.67	$ -		$ 556.56
TPharm	OP	$ -	$ 0.22	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 11,650.11	$ 85.59	$ 9.59	$ 11,745.51
TPharm	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 119.07	$ -		$ 119.07
ADDP	OP	$ -	$ 6.16	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 748.75	$ 96.01	$ 144.60	$ 995.52
ADDP	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ 215.77	$ -		$ 215.77
DHA Enterprise Admin.	OP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -
DHA Enterprise Admin.	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -		$ -
Other	OP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -
Other	UP	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -		$ -
Total		**$ -**	**$ 24.32**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		**$ -**	**$ -**	**$ 90,825.07**	**$ 181.60**	**$ 210.68**	**$ 91,241.67**

Footnotes:

1 – Figures were derived by multiplying the proportion of sample error dollars for each error category by the extrapolated overpayment (OP) or underpayment (UP) dollars from Table 1. For example, for TPharm, Medical Necessity overpayments from samples totaled $1,143.89. All sample overpayments from the TPharm samples totaled $156,973.23. Therefore, this error category accounted for 0.7287% of total sample overpayment dollars ($1,143.89 divided by $156,973.23). 0.7287% of the TPharm FY2018 Over-payment $ from Table 1 ($11,745,514.25) yields $85,591.51. Rounded to millions, this number becomes $0.86 (which is shown in this table). This process was repeated for each cell in the table.

A Root Causes

The following section provides additional information regarding the root causes of improper payments for each program reported in Table 3 above.

The DHA contracts with an external independent contractor (EIC) to conduct quarterly, semiannual, and annual compliance reviews of previously processed health care claims. EIC auditors review claims to identify improper payments and to validate the accuracy of the claims processing procedures used by TRICARE private sector contractors. Overpayment or underpayment errors can be assessed for (but not limited to) payments in the correct amount being sent to the wrong payee, incorrect denial of a payable claim, misapplication or calculation of a patient's deductible or co-payment/share liability, or payment of a non-covered service or supply. In FY 2017, EIC compliance reviews determined the root cause for over/underpayment errors was the result of the following:

- ***Inability to Authenticate Eligibility***: DHA private sector contractors incorrectly paid or denied health care claim(s) as a result of an incorrect patient eligibility determination.
- ***Administrative or Process Errors Made by Other Party***: DHA's EIC determined throughout the course of compliance reviews that DHA private sector contractors incorrectly processed health care claims by either:
  - Applying an incorrect reimbursement determination or methodology when processing a health care claim
  - Incorrectly calculating the government's liability after consideration of other health insurance (OHI) payment(s)
  - Based on a patient's health care claims history, incorrectly made duplicative payments for previously paid health care services or supplies
  - Miscalculated the patient's cost-share or benefit deductible liability
  - Made a payment for services or supplies which were not a TRICARE benefit or incorrectly denied payment for services or supplies that were a TRICARE benefit
  - Incorrectly calculated the government's reimbursement of health care based on a billed amount other than what was being reported on a health care claim form or itemized medical bill
  - Incorrectly based its reimbursement determination/methodology on an incorrect procedure code
  - Claims processor failing to follow TRICARE authorization or pre-authorization requirements prior to processing a payment
  - Claims required further development prior to payment (i.e. additional or correct information needed)
  - Other health insurance payments omitted when calculating government liability
  - Reimbursement rates miscalculated for institutions subject to Diagnosis Related Group (DRG) reimbursement system.
- ***Medical Necessity***: The claims processor failed to follow TRICARE medical necessity review policy requirements prior to processing and paying a health care claim or failed to provide the medical necessity review documentation needed to support or substantiate the adjudication of the claim being reviewed during audit.
- ***Insufficient Documentation to Determine***: The EIC determined during a compliance review that the claims documentation provided by private sector contractors was insufficient and/or did not support the adjudication of the health care. As a result the EIC determined the services or procedures rendered should not have been paid.

Table 4 below reports the amount of improper payments identified in samples by contract that resulted in actual monetary losses to the government. The purpose of this classification is to estimate the monetary loss to the Federal Government due to improper payments. Monetary loss to the Government would be an amount that must not have been paid and in theory should/could be recovered (e.g. improper overpayment errors). This table excludes improper underpayments.

Table 4: *Improper payment classification*

(dollars in thousands)

Program Name	Actual Monetary Loss to the Government Identified in Sample	Estimated Total Monetary Loss to the Government
T3 North Region	$ 191.19	$ 6,847.19
T3 South Region	$ 1,961.11	$ 25,570.68
T3 West Region	$ 1,198.04	$ 18,341.52
TDEFIC	$ 131.49	$ 6,080.54
TOP	$ 480.72	$ 2,802.41
TPharm	$ 156.97	$ 11,745.51
ADDP	$ 20.95	$ 995.52
DHA Administrative	$ -	$ -
Other	$ -	$ -
TOTAL	**$ 4,140.47**	**$ 72,383.37**

B Corrective Actions

Military Health Benefits (FY 2018 IP Amount = $91.24m)

DHA private sector contractors are monetarily incentivized or dis-incentivized, through payment accuracy performance standards, to reduce and/or eliminate improper payments. The fewer improper payments the contractors make, the less money is deducted from their reimbursements. Additionally, details of the EIC compliance reviews are shared with the private sector contractors, DHA program offices, private sector contract contracting officers, and contracting officer representatives (CORs) to coordinate appropriate corrective action plans with the respective private sector contractor. Moreover:

- Upon completion of an EIC compliance review, contractors review results, formulate an action plan to mitigate future findings, and derive a process to avoid future improper payments.
- If warranted, contractor claims processing systems are modified to meet the Department's health care policy, reimbursement, or benefit requirements.
- If review results show a potential error pattern for a certain type of claim, additional claims are pulled to conduct a focused study, and adjustment actions are taken as appropriate.

Each private sector contractor has its own business process for evaluating compliance review results, conducting root cause analyses to ensure the accuracy of future claims payment, and developing internal corrective action plans. If required, DHA contracting officers and contracting officer representatives issue contractor corrective action plans (CAPs) to resolve and track noncompliance with TRICARE health care policy/regulations and purchased-care contracts.

For each payment error/root cause category assessed as a result of ongoing compliance reviews, DHA will continue to instruct private sector contractors to follow Code of Federal Regulation (CFR) Chapter 199.11, *Overpayments recovery*, instructions and to investigate and make necessary adjustments to those claims identified as having payment errors. In addition, DHA will:

- Modify TRICARE purchased care contracts requiring contractors to develop procedures for reporting CAPs for each payment error category/root cause assessed against a claim during a quarterly or semi-annual compliance review cycle as well as developing procedures for government entities to validate proposed CAPs

- Develop Contract Data Requirements List (CDRL) requirements that require contactors to provide monthly status reports on CAPs established for each payment error category/root cause assessed for a specified compliance review cycle (reference TRICARE Operations Manual (TOM), Chapter 14, for additional information regarding DHA CDRL requirements)
- Include TRICARE private sector contractor CAP reports as part of DHA's AFR reporting to the DoD Comptroller annually
- Develop database or tracking tool to monitor TRICARE private sector contractor CAP reporting and contractor actions taken

III. Recapture of Improper Payments Reporting

Table 5 below reports each program or activity that exceeds $1 million or more annually that recapture payments outside of a payment recapture audit and the amounts recovered through sources other than recapture audits.

DHA utilizes a number of different mechanisms to prevent, identify, and collect improper payments. These include claims auditing by an EIC, contractor utilization of DHA's Duplicate Claims System, and periodic independent reviews of private sector payments. This process employs pre- and post-payment review techniques, performed internally and by external contractors, with overpayment recoveries returned to the military health benefits program.

Contract payments make up a large volume of transactions with high-dollar values; therefore, DHA is vigilant to ensure payment accuracy. In addition to the pre- and post-payment reviews, DHA also uses various internal manual and automated prepayment initiatives to prevent improper payments. During FY 2017, DHA recovered $22.482 million in overpayments as a result of overpayment errors identified by the EIC, refunds occurring in the course of routine claims adjustments, and ongoing private sector contractor internal audits, resulting in a 543 percent overpayment recovery rate.

Table 5: *Overpayment Payment Recaptures with and without Recapture Audit Programs*

(dollars in thousands)

		Overpayments Recaptured Through Payment Recapture Audits				Overpayments Recaptured Outside of Payment Recapture Audits	
Does This Include Funds Recaptured From a High-Priority Program (Y/N)	Program or Activity	Amount Identified in FY 2018	Amount Recaptured in FY 2018	Recapture Rate in FY 2018	FY2019 Recapture Rate Target	Amount Identified in FY 2018[1]	Amount Recaptured in FY 2018[2]
N	T3 North Region	-	-	-	-	$ 191.19	$ 3,858.58
N	T3 South Region	-	-	-	-	$ 1,961.11	$ 5,609.41
N	T3 West Region	-	-	-	-	$ 1,198.04	$ 7,072.21
N	TDEFIC	-	-	-	-	$ 131.49	$ 1,916.41
N	TOP	-	-	-	-	$ 480.72	$ 952.62
N	TPharm	-	-	-	-	$ 156.97	$ 3,001.29
N	ADDP[3]	-	-	-	-	$ 20.95	$ 71.72[3]
N	DHA Administrative	-	-	-	-	$ -	$ -
N	Other	-	-	-	-	$ -	$ -
	TOTAL	-	-	-	-	$ 4,140.47	$ 22,482.24

Footnotes:

1 – Amount Identified in FY 2018 represents the total overpayment dollars from sampled claims.

2 – These numbers include recoupments for overpayments identified in audits as well as refunds occurring in the course of routine claim adjustments (for claims initially paid in FY 2017 and other fiscal years). DHA has no way to distinguish overpayment recoupments from routine claim adjustments.

3 – The Active Duty Dental Program refunds were calculated differently. The amount recovered in FY 2018 figure for ADDP represents refunds shown on contractor invoices to DHA. ADDP data is not included in the TED system, so contractor invoices were used because TED transactions are not available.

IV. Agency Improvement of Payment Accuracy with the Do Not Pay Initiative

Individual Payments: The DHA processes relatively few (5–20) case recoupment refunds each month for small dollar amounts ($5–$20,000). The Single Online Search service is utilized pre-payment for 100% of all case recoupment refunds to verify (1) a business or individual has not been placed on the List of Excluded Individuals/Entities (LEIE) and (2) an individual has not died. Any matches will be referred to the DHA Office of General Counsel.

Vendor, Contract Payments: The DHA processes approximately 226 routine payments per month for thirteen unique contractor payees. The Single Online Search service is utilized pre-payment once a month to verify a DHA contractor payee has not been placed on the Excluded Parties List System (EPLS) or the LEIE. Any matches are validated with the Treasury Offset Program (TOP) ensuring the contractor does not have the same Employer Identification Number (EIN) as a person's Social Security Number (SSN). The contractor is responsible for resolving these matching issues due to proprietary reasons. If the contractor is on the list, the finding is referred to the assigned Contracting Officer. DHA processed approximately 312 payments totaling $2,088,582,881.81 with no matches on the Do-Not-Pay system for Fiscal Year of 2018.

The risk for payments to a subcontractor or individual via the contractor, however, lies outside of DHA control. DHA contractors are not required to utilize the Do-Not-Pay database, and there is no current mechanism in place to require the contractors to use the Do-Not-Pay databases at the prepayment phase to comply with IPERA.

Table 6 below provides results of the Do Not Pay Initiative for DHA's Military Health Benefits program.

Table 6: *Results of the Do Not Pay Initiative in Preventing Improper Payments*

(dollars in thousands)	Number (#) of Payments Reviewed for Possible Improper Payments	Dollars ($) of Payments Reviewed for Possible Improper Payments	Number (#) of Payments Stopped	Dollars ($) of Payments Stopped	Number (#) of Potential Improper Payments Reviewed and Determined Accurate	Dollars ($) of Potential Improper Payments Reviewed and Determined Accurate
Reviews with the IPERIA-specified databases	312	$ 2,088,582.88	0	$ 0	312	$ 2,088,582.88
Reviews with databases not listed in IPERIA	0	$ 0	0	$ 0	0	$ 0

V. Barriers

The Agency did not identify any statutory or regulatory barriers limiting its corrective actions in reducing improper payments in those programs determined in FY 2018 to be susceptible to significant improper payments.

VI. Accountability

The Under Secretary of Defense (Comptroller)/Chief Financial Officer is the Accountable Official for the Department and is responsible for ensuring that, to the greatest extent possible, all DoD disbursements are accurate.

Certifying Officer Legislation, *10 U.S.C. 2773a,* holds Certifying and Disbursing Officers accountable for government funds. In accordance with this law, pecuniary liability attaches automatically when there is a fiscal irregularity, i.e., (1) a physical loss of cash, vouchers, negotiable instruments, or supporting documents, or (2) an improper payment. This is further captured in the *DoD Financial Management Regulation (DoDFMR), Volume 5, Chapter 33*, entitled "Certifying Officers,

Accountable Officials, and Review Officials." The Department's efforts to recover overpayments from a recipient must be undertaken in accordance with the debt collection procedures outlined in the *DoDFMR, Volume 5,Chapter 28*, "Management and Collection of Individual Debt," and *DoDFMR, Volume 10, Chapter 18,* "Contractor Debt".

The DoD FMR contains other policies that specifically address Improper Payments (*DoDFMR Volume 4, Chapter 14)* and Recovery Auditing (*DoDFMR* Volume 10, Chapter 22). Beginning in Quarter 3, FY 2013, all reporting DoD Components were required to begin downloading their improper payment reports to the DFAS ePortal, as the Office of the Deputy Chief Financial Officer's Accounting & Finance Policy Directorate was designated as the Executive Agent to manage this information and its associated reporting requirements. This centralized electronic system allows the reporting Components to access improper payment information without regard to the time zone in which they are located. More importantly, it allows management to ensure all Components' submissions are timely and accurate.

VII. Agency Information Systems and Other Infrastructure

DHA has much of the information and infrastructure needed to reduce improper payments. DHA Purchased Care Program (managed by the Contract Resource Management Office) includes an immense volume of claims processed by TRICARE purchased care contractors. To track programs, CRM uses the following systems:

- ***TRICARE Encounter Data Set (TEDS):*** TEDS is a financial feeder system, through which all claims are processed to Oracle Federal Financials. TEDS is the entry point of claims information from DHA purchased care contractors. TEDS records provide detailed information for each treatment encounter and are submitted as either an institutional or non-institutional record. TEDS is primarily required by DHA to account for the expenditure of government funds, develop statistical information, and is a data source of records for EIC audits. Records submitted through the TEDS must pass numerous validation edits prior to being accepted into TEDS.
- ***E-Commerce System (ECS):*** ECS is an integrated, centralized major system that improves DHA's core financial, contracting and business process by providing seamless integrated financial and contracting systems.
- ***Oracle Federal Financials (OFF):*** OFF is the financial subsystem of the DHA ECS. It supports budget and accounting/financial functions and health care (TEDS) claims processing and contains TRICARE Claims Management, Accounts Receivable, Accounts Payable, Purchase Orders and the General Ledger modules. CRM uses OFF to track commitments and obligations. These transactions are submitted to DFAS and become the primary source into financial statements.

In addition to internal DHA financial systems, DHA purchased care contractors claims processing systems are developed and designed in accordance with TRICARE System Manual http://manuals.tricare.osd.mil/pages/v3/DisplayManual.aspx?SeriesId=TS15 requirements and contain numerous system edits. These edits include patient eligibility (verified via the Defense Enrollment Eligibility Reporting System (DEERS)), provider eligibility, and more. If a claim passes initial eligibility edits, benefit calculations occur based on programmed payment rules and reimbursement methods determined by TRICARE Reimbursement Policy. The claims processing systems are able to determine the appropriate reimbursement methodology based on information included in the healthcare claim such as type of service, claim form type, provider specialty, etc.

Further, DHA has developed the TRICARE Duplicate Claims System (DCS). This tool facilitates the identification of duplicate claim payments, the initiation and tracking of recoupments, required by purchased care contractors, and the ultimate cancellation of duplicate records from the TEDS database. DHA purchased care contractors are contractually required to use the DCS and resolve duplicate payments.

VIII. Sampling and Estimation[15]

DHA followed OMB Circular A-123, Appendix C, dated October 20, 2014, when developing its sampling methodology to select FY 2017 claims for its EIC compliance review. This statistically valid sampling methodology met OMB's requirements of a 90 percent confidence level and a margin of error of ±2.5 percent. By using this methodology, DHA is able to identify valid sample sizes and project improper payment percentages for the Agency's improper payment program. DHA performs 100 percent pre-payment reviews of its administrative and other program disbursements.

DHA defines samples (sets strata boundaries, calculates sample sizes, and randomly selects claims for review) and the EIC reviews the selected claims to identify improper payments. Payment accuracy compliance reviews include two sample types: a payment sample (to ensure payment accuracy by identifying underpayment and overpayments) and a denied sample (to ensure appropriate claim denial). Paid samples are conducted as a stratified random sample based on paid amounts and denied samples are conducted as a stratified random sample based on billed amounts. Samples are drawn on either a quarterly or semi-annual basis, respective of DHA purchased care contract requirements.

- Payment Sample: Paid samples are conducted to identify improper payments and measure payment accuracy. Depending on the private sector contract type (i.e., MCSC, TDEFIC, TOP, etc.), the universe for a paid sample may contain between several hundred thousand to 30 million claims. All claims with government payment amount above a high-dollar threshold (i.e., $200,000) are reviewed by the EIC. Claims between the high-dollar threshold and a low-dollar threshold (i.e., $100) are randomly sampled based on stratification of the government payment amount and reviewed by the EIC. Claims below the low-dollar threshold are not included in EIC audits (but are represented by DHA Low-Dollar Internal Reviews).
    - Samples for paid claims include between four and 12 strata, depending on the composition of the claims in the universe. Mathematical formulas are utilized to identify optimal strata boundary points, and sample sizes are calculated to meet (or exceed) an estimate with a minimum of 90 percent confidence plus or minus 2.5 percentage points (as stipulated in the OMB Circular A-123, Appendix C guidelines).
- Low-Dollar Internal Review*:* In addition to the ongoing EIC quarterly and semi-annual reviews, the EIC conducts an annual statistically valid review of low-dollar claims that fall below the low-dollar threshold for payment samples. Audits for these EIC reviews are stratified if appropriate, given the composition of the universe data.
- Denied Sample. The primary purpose of the denied payment samples is to ensure that health care/supplies are not being denied inappropriately (which may represent obstacles in TRICARE beneficiaries' access to care) by private sector contractors. Records that encompass the denied payment sample universe are limited to records with government payment amount equal to $0. All denied claims with a billed amount above a high-dollar threshold are reviewed, and claims below this threshold are randomly sampled based on stratification of the billed amount. Depending on the contract type, a denied audit universe may contain between several thousand to over 1 million claims.
    - The denied payment sample is similar in design to the payment sample; the primary difference is that the denied sample is stratified based on billed amount since the paid amount for a denied claim is equal to $0.
- Combining the Samples: Results from the payment sample, denied sample, and DHA's internal low-dollar review are all considered when DHA calculates the overall improper payment rate.

IX. Significant Accomplishments

The DHA is committed to full compliance with the requirements of IPERIA. As part of the Agency's audit efforts, DHA Components diligently review and report all payments subject to IPERIA, as well as examining processes for identifying the complete universe of payments. Moreover, DHA continues to explore measures to improve its internal controls to prevent improper payments, and strengthen post payment reviews to identify and recover improper payments. To ensure the

[15] FY 2018 Sampling Methodology for FY 2017 Purchased Health Care Costs

accurate and reliable reporting of improper payments, DHA modified the TRICARE pharmacy contract to require the contractor to participate in the annual low-dollar pharmacy claim reviews. As a result, DHA's reported improper payment estimates includes the complete universe of payments, as required by OMB guidance.

Fraud Reduction Report

OMB Circular No. A-136 requires that, "Under the Fraud Reduction and Data Analytics Act of 2015, each agency must include in its Agency Financial Report or Performance and Accountability Reports a report on its fraud reduction efforts undertaken in FY 2018." The DHA OIG began working towards its goal of preventing fraud, waste, and abuse a little over two years ago. Prior to the Deputy IG's arrival in April 2016, the DHP Enterprise did not have an IG – it relied on the services and the DoD IG to provide a hotline program and other IG services. The DHA OIG currently has five civilian government employees and three contract support personnel. As the DHA OIG becomes fully staffed, they will operationalize the four major IG functions of inspection, investigations, teach and train, and assistance. The office will also evolve from a reactive to proactive model where it spends concerted effort helping the DHP Enterprise identify and address problems through inspections before occurrence, promoting organizational health, and enabling DHP Enterprise readiness.

The DHA OIG derives its authority to inspect and investigate from the Director, DHP Enterprise. The DHA OIG control and reporting relationship may not be further delegated. Approval with written authority must be gained from the director to conduct inspections or full investigations. However, the DHA OIG can respond to requests for assistance and can conduct informal inquiries, generally to gather initial facts to determine if a formal investigation is warranted, without the director's personal approval. The DHA OIG staff are impartial and independent whose loyalty rests with the Agency, not just with the director.

In accordance with the authority in DoD Directive 5106.01, the DHA OIG maintains the DHP Enterprise Hotline Program, ensuring that inquiries resulting from allegations are conducted in accordance with applicable laws, DoD regulations, and policies. Per DoD Instruction (DoDI) 7050.01, the DHP Enterprise Hotline Program provides a confidential, reliable means for individuals to report fraud, waste and abuse; violations of law, rule or regulation; mismanagement; and classified information leaks involving the DHP Enterprise. The detection and prevention of threats and danger to the public health and safety of the DoD and the United States are essential elements of the hotline mission. The DHP Enterprise Hotline Program maintains a public awareness campaign ensuring that the current DoD fraud, waste, and abuse hotline poster, prepared by the DoD Office of the Inspector General, is displayed in common work areas.

Allegations of Fraud

Hotline personnel promptly report all allegations of fraud to the appropriate Defense Criminal Investigative Organization in accordance with DoDI 5505.02, *Criminal Investigations of Fraud Offenses*, August 29, 2013, as amended. Fraud is defined by DoD regulations as any intentional deception designed to deprive the United States unlawfully of something of value or to secure from the United States a benefit, privilege, allowance, or consideration to which a person or entity is not entitled. Such practices include, but are not limited to:

- Offering to make a payment or accepting bribes or gratuities
- Making false statements
- Submitting false claims
- Using false weights or measures
- Evading or corrupting inspectors or other officials
- Deceiving either by suppressing the truth or misrepresenting material fact
- Adulterating or substituting materials
- Falsifying records and books of accounts
- Arranging for secret profits, kickbacks, or commissions
- Conspiracy to do any of the above

Performance Metrics and Trend Analysis

Hotline personnel collect and analyze data to:

- Identify opportunities to improve the management of hotline complaints from receipt to resolution
- Identify trends that will help DHP Enterprise decision-makers combat fraud, waste, abuse, and mismanagement in DHP Enterprise programs and operations more effectively

Preventing and Deterring Fraud

Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries. Fraud schemes shift over time, but certain health care services have been consistent targets. They include services provided by durable medical equipment (DME) suppliers, pharmacy companies, and providers. To secure the future of health care for our beneficiaries, the DHP Enterprise must be vigilant in reducing wasteful spending and promoting better health outcomes at lower costs. As the DHA OIG evolves and coordinates with offices to include DHP Enterprise Program Integrity and the appropriate Defense Criminal Investigative Organization, cost savings will continue to be recognized.

DHA OIG will ensure the workforce and culture continue to serve as a reflection of core Department values – values that are rooted in the belief of doing the right thing.

Grants Oversight and New Efficiency (GONE) Act Requirements

Army MEDCOM			
Category	**2–3 Years**	**>3–5 Years**	**>5 Years**
Number of grants/cooperative agreements with zero-dollar balances	0	0	0
Number of grants/cooperative agreements with undisbursed balances	0	0	0
Total amount of undisbursed balances	-	-	-
Navy BUMED			
Category	**2–3 Years**	**>3–5 Years**	**>5 Years**
Number of grants/cooperative agreements with zero-dollar balances	0	0	0
Number of grants/cooperative agreements with undisbursed balances	0	0	0
Total amount of undisbursed balances	-	-	-
Air Force SG			
Category	**2–3 Years**	**>3–5 Years**	**>5 Years**
Number of grants/cooperative agreements with zero-dollar balances	0	0	0
Number of grants/cooperative agreements with undisbursed balances	0	0	0
Total amount of undisbursed balances	-	-	-
DHA/FOD			
Category	**2–3 Years**	**>3–5 Years**	**>5 Years**
Number of grants/cooperative agreements with zero-dollar balances	0	0	0
Number of grants/cooperative agreements with undisbursed balances	0	0	0
Total amount of undisbursed balances	-	-	-

Uniformed Services University of the Health Sciences			
Category	**2–3 Years**	**>3–5 Years**	**>5 Years**
Number of grants/cooperative agreements with zero-dollar balances	0	0	0
Number of grants/cooperative agreements with undisbursed balances	0	0	0
Total amount of undisbursed balances	-	-	-
National Capital Region MD			
Category	**2–3 Years**	**>3–5 Years**	**>5 Years**
Number of grants/cooperative agreements with zero-dollar balances	8	0	0
Number of grants/cooperative agreements with undisbursed balances	1	0	0
Total amount of undisbursed balances	$319.00*	-	-
*The $319.00 balance represents expired FY 2016/17 funds. A DD 448-2 MIPER Addendum will be sent to the grantor in the amount of $319.00 to close out this action.			
DHA Contract Resource Management			
Category	**2–3 Years**	**>3–5 Years**	**>5 Years**
Number of grants/cooperative agreements with zero-dollar balances	0	0	0
Number of grants/cooperative agreements with undisbursed balances	0	0	0
Total amount of undisbursed balances	-	-	-

Table 7: *Total number of Federal grant and cooperative agreement awards and balances for which closeout has not yet occurred but the period of performance has elapsed by more than two years.*