



**Program Integrity Division**  
**Operational Report**  
Calendar Year 2020

*“Guarding the Health Care of Those Who Guard Us”*

## **Vision**

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

## **Mission**

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

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### 1.0 Defense Health Agency, Program Integrity Division – General

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

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

DHA PID is part of the DHA Special Staff and reports directly to the DHA Chief of Staff. This reporting structure facilitates DHA PID’s anti-fraud activities. Because of the nature and scope of the work performed by DHA PID, its reporting line is separate and distinct organizationally from the day-to-day operational activities of other departments to avoid the appearance or potential of undue influence or conflict of interest.



The DHA PID staff collective has over 170 years of fraud fighting experience and 140 years of experience specific to TRICARE. Together, DHA PID hold credentials from the American Health Information Management Association (AHIMA), American Association of Professional Coders (AAPC), Association of Certified Fraud Examiners (ACFE), Health Care Compliance Association (HCCA), and National Health Care Anti-Fraud Association (NHCAA).

### 1.1 Vision 2021

As DHA PID looks to the future, there are three main areas for consideration as we modernize the program.



Rebalance Focus on Fraud, Waste and Abuse



Internal Partnerships to Enhance Cost Containment and Cost Controls



Engage Direct-Care (MTFs) to enhance fraud, waste and abuse detection, reporting and training

The current environment focuses on pay-and-chase, looking primarily for fraud while placing limited focus on areas of waste and abuse. DHA PID Vision 2021 focuses on updating program requirements and fully utilizing the numerous pre-payment controls to detect and deter aberrant provider and beneficiary behavior before it

reaches the level of fraud. Additionally, revisions to the T5 contract provides a wider scope of focus, including both pre-payment review and detection as well as post-payment recoveries to provide a robust Program Integrity function addressing all areas of fraud, waste and abuse.

Many issues of waste and abuse are due to program vulnerabilities in both policy and operational application. The current process is to share findings of program vulnerabilities with staff of TRICARE Health Plans (THP), the DHA directorate responsible for the direct oversight and policy making within the TRICARE program. Additionally, DHA PID is often omitted when new policies and benefits are determined. This introduces risk into the process by lacking a cohesive “anti-fraud” review of benefits before they are rolled out. DHA PID Vision 2021 seeks to develop formal lines of communication between DHA PID and THP to identify and mitigate issues early in the process, and deter fraud and abuse before it gets out of control. Additionally, it allows for integrated process teams to address cross-departmental concerns prior to policy implementation. A recent positive example of this was the collaboration between Clinical, Contracting and Program Integrity when revamping the Autism Care Demonstration requirements.

The third area of focus in DHA PID Vision 2021 is enhanced focus and partnership with the Military Medical Treatment Facilities and Direct Care system in developing an enterprise approach to identifying and reporting fraud, waste and abuse. With the proposed deletion of the DODI 5505.12, there is a gap in the formal requirement for fraud, waste and abuse reporting within the MTFs. While this is filled with service specific requirements, as DHA absorbs the MTFs under their purview, an integrated, DHA-wide process is required. Working within the Market transition, DHA PID has partnered with the Functional Champions to work towards an integrated anti-fraud, waste and abuse program. This includes partnering with the Compliance team working on enterprise-wide compliance reviews within the MTFs. As detecting and deterring fraud, waste and abuse throughout the program is everyone’s responsibility, this is an important component to having a strong, enterprise-wide commitment to anti-fraud.

## 2.0 Fraud and Abuse Cases

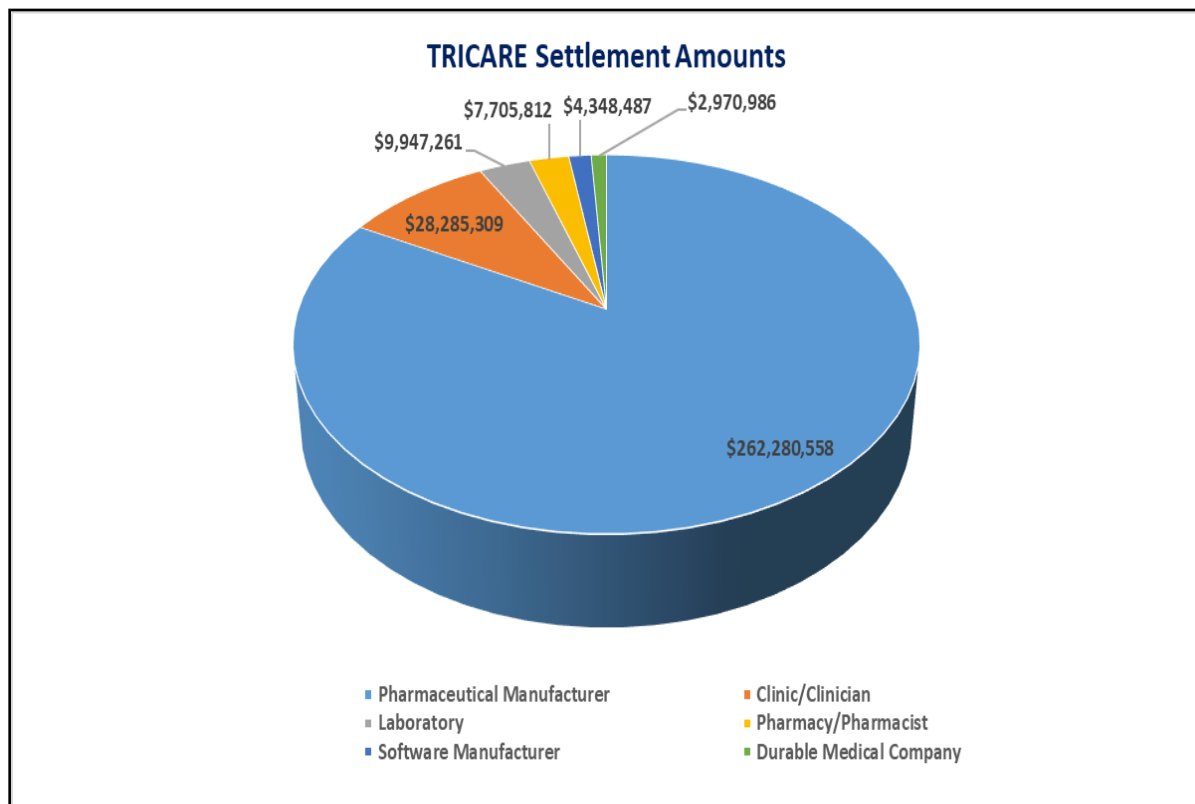
Many operational and worldwide challenges occurred in 2020 with the COVID-19 pandemic, and with that came new fraud schemes and learning to navigate the changing medical environment. During calendar year 2020, 875 investigative cases were actively managed by the team. A total of 433 new cases were opened, and the team responded to over 1,500 lead requests and fraud allegation inquiries. In addition, DHA PID staff members engaged in a multi-agency COVID-19 working group, supported internal DHA partners in mitigation of industry concerns on compound pharmacy recoupments, and supported numerous trials both in person and remote.

### 2.1. Fraud Judgements and Settlements

DHA PID relies upon assistance from DOJ and DCIS to investigate and prosecute cases on behalf of DHA’s interests. Oftentimes TRICARE is also harmed when fraud is committed against other public benefit programs and private sector insurance. During the calendar year 2020, the TRICARE program received a total of \$492,198,488 in judgements and settlements, with 70 civil settlements and 50 criminal judgements. The significance of this is that all monies received are returned directly back to the program to fund continuing care for our beneficiaries.

## 2.2. Significant Civil Cases Involving TRICARE

Case development, support, investigation, and prosecution by DOJ, is an incredible demonstration of teamwork by many health care fraud staff and entities. Cases that arrive at prosecution and when advertised in the DOJ Press Release are perhaps the most significant deterrent by TRICARE, DCIS, and DOJ. These national announcements serve to notify those who may attempt to defraud TRICARE or other government agencies that they will be caught and prosecuted. During CY 2020 there were 70 civil settlements and 50 individuals/entities were ordered to pay restitution to TRICARE or were sentenced based on the severity of their conviction. The following charts and case summaries illustrate the most significant provider categories for civil settlements, court ordered restitution, and convictions.



Summaries of the most significant civil cases from 2020 are included the sections below.

### 2.2.1. Civil Settlement: Purdue Pharma L.P.

Purdue Pharma L.P. entered into global resolution of its criminal and civil investigations in the amount of \$2,800,000,000 for its involvement in fraudulent opioid prescriptions. Purdue Pharma caused doctors to write, and pharmacies to fill, prescriptions for Purdue’s opioid products, some of which were medically unnecessary. In addition, Purdue paid remuneration to healthcare providers, an electronic health records company, and three specialty pharmacies in support of the fraudulent schemes which violated the Anti-Kickback Statute. TRICARE restitution is dependent upon the outcome of the bankruptcy hearings. TRICARE portion of the settlement is \$238,000,000.

### 2.2.2. Civil Settlement: Universal Health Services

Universal Health Services (UHS) headquartered in King of Prussia, Pennsylvania, entered into a \$122 million settlement agreement and a corporate integrity agreement with the Department of Justice to resolve alleged violations of the False Claims Act for billing for medically unnecessary behavioral health services, failing to provide adequate and appropriate services, and paying illegal inducements to federal health care beneficiaries. The period of the alleged conduct ranged from January 2007 to May 2019. UHS owns and operated over 200 behavioral health and psychiatric facilities nationwide. DOJ's settlement with UHS resolves 18 qui tam whistleblower cases filed in multiple judicial districts nationwide. The TRICARE portion of the settlement is \$9,422,147.

### 2.2.3. Civil Settlement: Emerson Pharmacy, et. al

The U.S. Attorney's Office for the Western District of Pennsylvania entered into a civil settlement agreement with Nima Rodefshalom, CEO/President of Emerson Pharmacy d/b/a Loyola Pharmacy of California and Daryoush Kohan President/Director of Econo Pharmacy, Inc. of Texas who participated in improper remuneration in the form of free nutritional shakes to bariatric patients to induce those patients to purchase, order, and/or arrange for purchasing and/or ordering of prescription drugs, namely scar creams and metabolic supplements. The total settlement is \$12,430,043 and TRICARE will receive \$6,215,021

### 2.2.4. Civil Settlement: Logan Labs and Tampa Pain Relief Centers.

Logan Labs and Tampa Pain Relief Centers entered into a civil settlement agreement with the U.S. Attorney's Office of the Middle District of Florida and agreed to pay a total of \$41,000,000 to resolve alleged violations of the False Claims Act for billing federal health care programs for medically unnecessary Urine Drug testing (UDT). Both entities have entered into Corporate Integrity Agreements with HHS-OIG. The TRICARE portion of the settlement is \$3,000,000.

### 2.2.5. Civil Settlement: Genova Diagnostics, Inc.

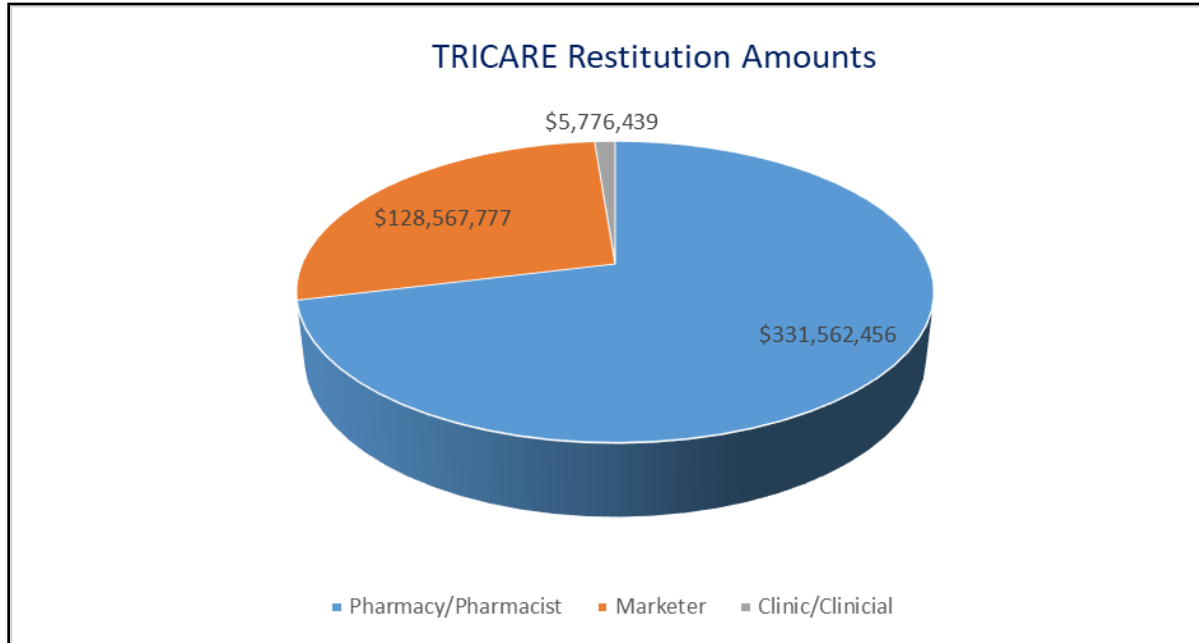
Genova Diagnostics, Inc. has entered into a five year Corporate Integrity Agreement and a civil settlement to pay \$17,000,000, plus up to an additional \$26,000,000 if certain financial contingencies occur. This agreement and settlement is for Genova's actions to submit medically unnecessary claims, engage in improper billing techniques and violations of the physician's self-referral prohibition known as the Stark law. TRICARE portion of the settlement \$1,396,161.

### 2.2.6. Civil Settlement: Gerardo E. Remy, D.C.

The U.S. Attorney's Office for the Southern District of Florida entered into a civil settlement with Gerardo E. Remy, D.C., owner of Spine and Sport Management to settle allegations of billing TRICARE for physical therapy services performed by unauthorized TRICARE providers and violating TRICARE program requirements. TRICARE will receive \$100,000 and an additional \$29,000 in suspended claims returned back to TRICARE. Remy also agreed to a voluntary 20-year TRICARE exclusion.

### 2.3. Significant Criminal Cases involving TRICARE

The burden of proof is different for criminal cases, and criminal litigation is typically reserved for the most egregious of fraud or abuse matters. As such, penalties for criminal cases often include both restitution and incarceration. In calendar year 2020, the majority of criminal cases resolved in favor of TRICARE were related to pharmacy compounding cases. The chart below displays the breakdown of provider types involved in criminal cases resolved in 2020.



Summaries of the most significant criminal cases from 2020 are included the sections below.

#### 2.3.1. Criminal Case: CMGRX

John Paul Cooper, president and co-owner of pharmaceutical marketing group CMGRX, was sentenced to 20 years in federal prison. In December 2019, John Paul Cooper was convicted of one count of conspiracy to commit health care fraud, one count of receipt of illegal kickbacks, and six counts of payment of illegal kickbacks. Mr. Cooper conspired to defraud TRICARE. Evidence showed that CMGRX hired marketers to recruit more than 2,300 patients. Evidence also showed CMGRX paid multiple doctors who had no prior relationship with the patients. Mr. Cooper was also ordered to pay restitution of \$68,327,437 to TRICARE.

#### 2.3.2. Criminal Case: James Chen, Hayeou Pharmacy

James Chen of Monterey Park and owner of Hayeou Pharmacy was sentenced to 34 months in prison. Chen pleaded guilty to health care fraud for his involvement in a compound drug scheme that hired marketers to obtain medically unnecessary compound prescriptions that were billed to TRICARE. Chen also ran a website where beneficiaries could request prescriptions without being examined by a provider. Chen was ordered to pay restitution in the amount of \$28.2 million.

### 2.3.3. Criminal Case: Advantage Pharmacy

Numerous defendants were convicted and sentenced to federal prison for their role in defrauding health care benefit programs by dispensing and marketing compound prescriptions without medical need. Hope Thomley, co-owner of Advantage Pharmacy, was sentenced to fourteen years in federal prison followed by three years of supervised release, and ordered to pay a monetary judgement of \$29,249,018 along with restitution in the amount of \$189,200,787. Thomley also obtained prescribers' signatures on blank prescription forms and filled out the forms in the names of her children and TRICARE beneficiaries that she and her husband, Randy Thomley, recruited. Randy Thomley was sentenced to eight years in federal prison and ordered to pay a monetary judgement of \$3,651,173 along with restitution in the same amount. Glenn Doyle Beach, co-owner of Advantage Pharmacy, was sentenced to thirteen years in federal prison followed by three years of supervised release and ordered to pay a monetary judgement of \$9,109,892 along with restitution in the amount of \$185,407,641. Brantley Nichols and Gregory Parker were also sentenced to federal prison and ordered to pay restitution of over \$1 million jointly.

### 2.3.4. Criminal Case: Dr. Shahjahan Sultan

Dr. Shahjahan Sultan, was sentenced to 48 months in federal prison, followed by 3 years of supervised release in the U.S. District Court, Southern District of Mississippi for conspiracy to commit health care fraud. Sultan was paid 35% for every medically unnecessary compound prescription. The pharmacy billed over \$7.2 million to TRICARE and other health care programs. Dr. Sultan was ordered to pay TRICARE restitution in the amount of \$4,102,635.

### 2.3.5. Criminal Case: Practice Fusion Inc.

As part of the criminal resolution, Practice Fusion has executed a deferred prosecution agreement and agreed to pay over \$26 million in criminal fines and forfeiture. Practice Fusion admitted that it solicited and received kickbacks from a major opioid company in exchange for utilizing its electronic health records software to influence physicians to prescribe opioids. Practice Fusion was ordered to pay TRICARE restitution in the amount of \$4,348,487.

### 2.3.6. Criminal Case: John Garbino

John Garbino, former owner of Trestles RX was sentenced to 18 months home confinement and three years' supervised probation upon release. Garbino pleaded guilty to one felony count of receiving illegal remuneration involving a Federal Health Care Program. It was established that Garbino received illegal payments for referring compounding prescriptions to Trucare Pharmacy that were billed to TRICARE. Garbino was ordered to pay TRICARE restitution in the amount of \$1,425,482.



### 3.0 Cost Avoidance

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

#### 3.1. Prepayment Duplicate Denials

TRICARE's Managed Care Support Contractors (MCSC) along with International SOS (ISOS), Wisconsin Physician Service (WPS), Express Scripts Incorporated (ESI), and United Concordia (UCCI) Dental, Inc. are required to check each claim for duplicate billing to prevent erroneous expenditures. Duplicate detection requires automated and manual procedures to identify and prevent duplicate payments. Each contractor is required, at a minimum, to compare specific fields on each claim line item to ensure appropriate payment. For calendar year 2020 prepayment duplicate denials reported by the contractors to Program Integrity amounted to \$456,117,479.<sup>1</sup>

#### 3.2. Rebundling/Mutually Exclusive Edits

TRICARE's MCSC's, ISOS, and WPS are required to use prepayment claims processing software that utilizes rebundling and mutually exclusive edits. The rebundling edits are designed to detect and correct the billing practice known as unbundling, fragmenting, or code gaming. Unbundling involves the separate reporting of the component parts of a procedure instead of reporting a single code, which includes the entire comprehensive procedure. This practice is improper and is a misrepresentation of the services rendered. Providers are cautioned that such a practice can be considered fraudulent and abusive. For calendar year 2020, the prepayment claims processing software in use by the MCSCs accounted for \$94,736,095 in cost avoidance for TRICARE.<sup>2</sup>

#### 3.3. Prepayment Review

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

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<sup>1</sup> Prepayment Duplicate Denial amounts as reported by TRICARE contractors.

<sup>2</sup> Rebundling/Mutually Exclusive Edit amounts as reported by TRICARE contractors.

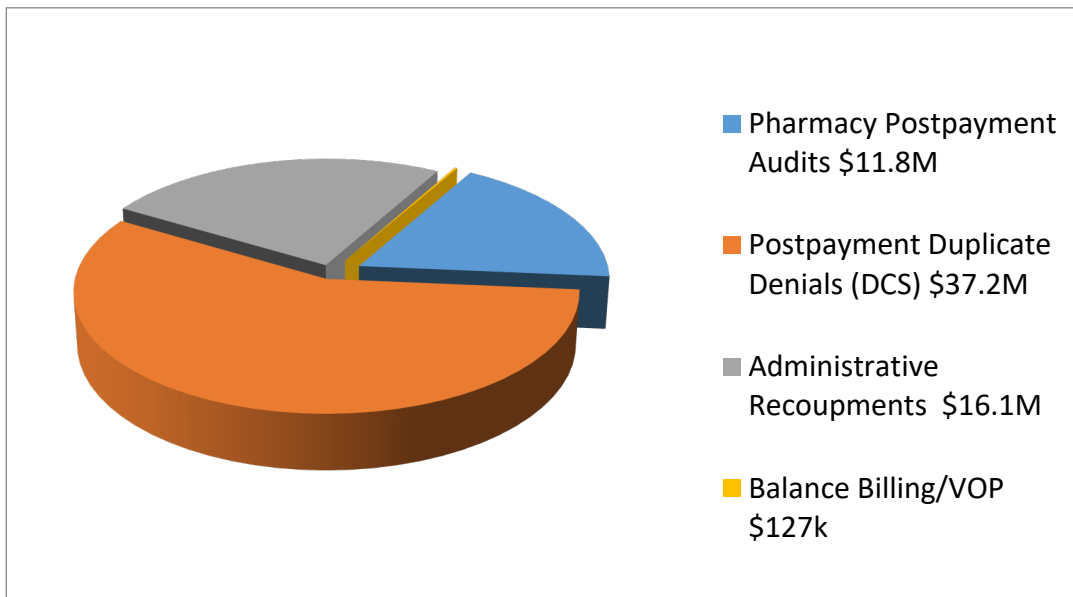
TRICARE Support Contractors	Cost Avoidance
Humana Military Healthcare Services, East Region	\$27,380,152
Health Net Federal Services, West Region	\$6,865,003
International SOS, Overseas	\$3,192,951
WPS TDEFIC	\$1,546,944
UCCI – Dental	\$390,440
<b>TOTALS:</b>	<b>\$39,375,489</b>

### 3.4. Pharmacy Daily Claims Audits

ESI Retail Pharmacy Contract processes claims in "real" time, and as such cost avoidance for pharmacy claims is low because the claims are either approved or denied at point of service. Adding another layer of cost review, the daily claims audit process identified and prevented \$3,653 of inappropriate pharmacy billing errors prior to payment.

### 4.0. Contractor Recoveries and Recoupments

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



#### 4.1. Postpayment Duplicate Claims Denials (DCS)

Postpayment duplicate claim (DCS) software was developed by DHA and is used by the MCSCs. This software was designed as a retrospective auditing tool to identify paid duplicate claims. While most duplicate claims are identified through prepayment screening \$37,187,774 was identified in 2020 for recoupment or offset on a postpayment basis.<sup>3</sup>

#### 4.2. Pharmacy Postpayment Audits

Postpayment audits represent amounts recovered from paid pharmacy claim submission errors identified as part of ESI audit and monitoring activities. In 2020, \$11,755,996 was recovered.<sup>4</sup>

#### 4.3. Administrative Recoupments/Offsets

The Federal Claims Collection Act (FCCA) provides authority for the collection of non-financially underwritten fund recoupments, and was enacted to avoid unnecessary litigation in collecting debts owed to the United States. This authority extends to the TRICARE contracts, and allows for contractors to recoup funds which have been incorrectly disbursed as an underpayment or overpayment for whatever reason. Administrative recoupment of inappropriately paid claims may be either recovered directly from the provider as a recoupment or offset from a providers' future claims. In 2020, \$16,073,985 was recovered through administrative recoupments.<sup>5</sup>

### 5.0. Balance Billing and Violation of Participation Agreements

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

In 2020 the majority of balance billing and violation of participation cases were resolved at the contractor level, resulting in a cost savings to our beneficiaries totaling \$126,885 in Violation of Participating Agreement and Balance Billing efforts.<sup>6</sup>

#### 5.1. Balance Billing

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

Balance Billing matters that cannot be resolved are referred to DHA PID. Four Balance Billing matters were referred to DHA PID in 2020. Additionally two other balance billing cases referred

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<sup>3</sup> Post payment Duplicate Claims Denials as reported by TRICARE Health Plan

<sup>4</sup> Pharmacy Postpayment amounts as reported by TRICARE Pharmacy Benefit Manager.

<sup>5</sup> Data as reported by TRICARE Contractors.

<sup>6</sup> Data as reported by TRICARE Contractors

to DHA PID in the previous year were resolved in 2020. Total resolution for Balance Billing was \$480 returned or collection actions ceased against beneficiaries in 2020.

## 5.2. Violation of the Participation Agreement

DHA PID is also responsible for ensuring participating providers do not collect more than the CMAC when participating on a claim. Participating providers (those marking “yes” to accept assignment on the claim form) are prohibited from collecting from beneficiaries any amount in excess of the CMAC rate. This is commonly referred to as a *Violation of the Participation Agreement*. Violations of Participation Agreement that TRICARE’s MCSC’s are unable to resolve are referred to DHA PID. DHA PID did not receive any violation of participation cases in 2020.

## 6.0 Voluntary (Self) Disclosure Reporting

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

DHA PID receives voluntary self-disclosures in two different ways. The first is through coordination with HHS, who refers self-disclosures impacting the TRICARE program to DHA PID. The second is through the Program Integrity website and Self-Disclosure Program (SDP) for TRICARE <https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity/Voluntary-Self-Disclosure-Reporting>. In 2020, TRICARE received two voluntary disclosures from medical providers totaling \$4,766,071 returned to the TRICARE Program.

## 7.0. Provider Exclusions and Suspensions

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

DHA PID works with the DHA Office of General Counsel to recommend exclusions when necessary. TRICARE’s exclusion list is available on the internet at [www.health.mil/fraud](http://www.health.mil/fraud). This online searchable database allows searches by provider or facility name. During 2020, DHA did

not exclude any provider under its own authority, in part due to COVID-19 and the delays caused by not being able to meet in person.

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

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

## 8.0 Civil Monetary Penalties

In 2020, DHA and the TRICARE program received the authority under Title 32 Code of Federal Regulations (CFR) 200 which allows the Secretary of Defense as the administrator of a Federal healthcare program to impose civil monetary penalties (CMPs or penalties) as described in section 1128A of the Social Security Act against providers and suppliers who commit fraud and abuse in the TRICARE program. This regulation provides authority to establish a program within the DoD to impose civil monetary penalties for certain such unlawful conduct in the TRICARE program. The program to impose civil monetary penalties in the TRICARE program is called the Military Health Care Fraud and Abuse Prevention Program.

## 9.0. Program Integrity Affiliations

Defense Criminal Investigative Services (DCIS) is the primary investigative agency for the DoD TRICARE Program. DHA PID and DCIS work in close cooperation in the fight against health care fraud and abuse. In CY 2020, DCIS continued to recognize health care fraud as one of its investigative priorities. In doing so, DCIS strongly supports DHA PID's anti-fraud program. DCIS' commitment to investigating health care fraud resulted in increased numbers of cases accepted for investigative purposes.

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