



FEDERAL COVID-19 TESTING REPORT

DATA INSIGHTS FROM SIX FEDERAL HEALTH CARE PROGRAMS



Message from the Pandemic Response Accountability Committee

The CARES Act, coupled with subsequent legislation including the December 27, 2020 enactment of \$900 billion in supplemental pandemic relief funding, has brought over \$3 trillion dollars in pandemic relief funding to a nation reeling from COVID-19's effects on our communities, schools, workplaces, health care system, and economy. The CARES Act created the Pandemic Response Accountability Committee (PRAC) to coordinate oversight of the Federal government's pandemic response and this historic level of spending. The PRAC's Health Care Subgroup is comprised of Offices of Inspector General (OIGs) that oversee federal agencies providing or reimbursing for health care services. By working together and sharing data, these OIGs are providing coordinated oversight across agencies and programs.

This report developed by the PRAC Health Care Subgroup, *Federal COVID-19 Testing Report: Data Insights from Six Federal Health Care Programs*, provides insights on testing efforts from February 1, 2020, to August 31, 2020—the first seven months following declaration of a public health emergency in the United States. The six programs include: Department of Defense, Medical Treatment Facilities; Department of Health and Human Services, Medicare Part B; Department of Justice, Bureau of Prisons; Department of Labor, Workers' Compensation; Department of Veteran Affairs, Veterans Health Administration; and Office of Personnel Management, Federal Employee Health Benefits Program. This report provides a detailed look at testing data in each of these federal health care programs, which together offer services to about 64 million individuals.

Data collection by the six participating OIGs focused on the following questions:

1. How many COVID-19 tests were administered, and when?
2. Who was tested?
3. What types of COVID-19 tests were administered?
4. How much did each health care program pay for testing?
5. In what health care settings did people access testing?
6. How long did it take to return test results?

We found that 10.7 million tests were administered or paid for by the six federal health care programs covered in this report, representing 12.7% of all tests performed in the United States between February and August 2020. This report examines the characteristics of these tests, including trends, demographics, and cost, and provides insights on early COVID-19 testing to serve as a data point in the discussion among the oversight community, Congress, federal and state agencies, health care entities, and the public about effective pandemic response efforts. These insights include:

- Trends in COVID-19 testing in the six federal health care programs largely followed the same pattern as national testing trends from February through August 2020.
- Testing of beneficiaries in Medicare Part B and Bureau of Prisons was generally proportional to the demographic characteristics of the populations they serve;



the other four federal health care programs (Veterans Health Administration, Federal Employee Health Benefits Program, Workers' Compensation, and DOD Medical Treatment Facilities), had varying levels of demographic information available.

- The majority of COVID-19 tests that the six federal health care programs administered or paid for were viral tests, which detect current SARS-CoV-2 infections and identify those who could transmit the virus.
- Federal reimbursement for COVID-19 viral tests varied across the federal health care programs. Average costs for COVID-19 viral tests, which accounted for the vast majority of COVID 19 tests that the six federal health care programs administered and paid for, varied by program.
- Information on COVID-19 test turnaround time was only available from the three federal health care programs that administered tests (Bureau of Prisons, Veterans Health Administration, and DOD Medical Treatment Facilities) with Veterans Health Administration and DOD reporting that test processing times decreased over time.

The report raises significant questions for policymakers to consider as they refine their response to the pandemic. Specifically:

- » What factors (e.g., regulations, public health infrastructure, and private market incentives) hindered the rapid development and deployment of COVID-19 tests?
- » Was access to testing sufficient?
- » Was testing available to populations most impacted by SARS-CoV-2?

- » What are the most cost-effective and cost-efficient forms of testing?
- » What payment policies are appropriate for testing during a public health emergency?
- » What data is needed to ensure effective and efficient testing efforts?

The PRAC encourages policymakers, as well as the oversight and research communities, to seek answers to these compelling questions. The PRAC is committed to continuing its efforts to provide accountability to the government's spending and response to COVID-19 by promoting transparency; detecting fraud, waste, abuse; and mitigating risks that cut across federal agencies.

The Honorable Michael E. Horowitz
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Data Report

Insights on COVID-19 Testing Across Six Federal Health Care Programs

This report provides insights and data on COVID-19 testing efforts from six federal health care programs from February 1, 2020, to August 31, 2020—the first seven months following the declaration of a public health emergency in the United States.¹ These insights and data are intended to help stakeholders—such as Congress; federal and state agencies; and health care entities—understand and plan for current and future response efforts.

This report does not represent a comprehensive view of the Federal Government’s testing efforts, but it does provide insights on the populations covered by a variety of federal health care programs. This report provides data and insights that offer an initial view into testing efforts through existing federal health care programs and raises important questions for further consideration. Among these questions are whether these programs were successful in providing sufficient access to testing and whether testing was available to the populations most impacted by the SARS-CoV-2 virus. This report also raises questions about cost-effectiveness, such as whether programs provided the most efficient, effective forms of testing and set appropriate payment rates and policies related to testing. Lastly, this report highlights the importance of agencies having complete, timely, and accurate data to help ensure efficient testing and to detect gaps or vulnerabilities in their testing efforts.

COVID-19 testing in six federal health care programs

From February through August 2020 six federal health care programs paid for or administered

10.7 million

COVID-19 tests, which constituted

12.7% of all tests

performed in the United States during that time.

Source: PRAC analysis of COVID-19 testing data from six federal health care programs, February–August 2020

HOW WE CONDUCTED THIS STUDY

The PRAC Health Care Subgroup comprises six OIGs responsible for the oversight of agencies that provide or are involved with the provision of health care services. These agencies are HHS, OPM, DOL, VA, DOD, and DOJ. Each of the six OIGs selected a health care program within its agency for which it could obtain reasonably reliable and complete data on COVID-19 testing that took place during this report’s data collection period.

Each OIG collected and analyzed COVID-19 testing data from its selected health care program(s). OIGs at three agencies—HHS, OPM, and DOL—analyzed health care claims data for COVID-19 tests. OIGs at the other agencies—VA, DOD, and DOJ—scoped their analysis to COVID-19 tests provided at facilities that they manage or operate. These facilities provide varying levels of health care services on site, such as COVID-19 tests, and may also reimburse commercial providers for certain services. For example, the DOJ OIG analyzed data on COVID-19 tests that were performed on site at Bureau of Prisons facilities as well as tests performed by commercial labs and reimbursed by the program. The data that each of the six OIGs collected focused on six testing questions:

- 1. How many COVID-19 tests were administered, and when?**
- 2. Who was tested?**
- 3. What types of COVID-19 tests were administered?**
- 4. How much did each health care program pay for testing?**
- 5. In what health care settings did people access testing?**
- 6. How long did it take to return test results?**

See Exhibit 1 for the six federal health care programs represented in this report, the populations that each program covers, and the number of federal beneficiaries who received a COVID-19 test by program. People who receive care from these six health care programs include many people with an elevated risk of complications from COVID-19, such as those age 65 and older and those with comorbidities like renal failure. The General Methodology section in this report and the more detailed methodologies in the appendices contain additional information on how each OIG conducted its analysis.

Exhibit 1. Federal health care programs covered in this report and the populations that they serve.

	Health care programs that process claims and <u>pay</u> for COVID-19 testing			Health care programs that <u>provide</u> COVID-19 testing at facilities they manage or operate		
	HHS	OPM	DOL	VA	DOD	DOJ
<i>Federal Health Care Program</i>	Medicare Part B	Federal Employees Health Benefits Program (FEHBP)	Office of Workers' Compensation Program	Veterans Health Administration	Medical Treatment Facilities	Bureau of Prisons
<i>Population Served*</i>	38.9 million adults age 65 years and older, as well as those with end-stage renal disease and people with a qualifying disability	6.2 million federal employees, retirees, and eligible family members enrolled in two of the largest FEHB carriers	More than 223,000 federal employees who filed for workers' compensation; current or former Department of Energy workers and contractors; and former coal miners and their surviving dependents	9 million enrolled veterans, employees, and other nonveterans, who meet specific criteria	9.6 million military personnel and their families	More than 218,000 federal inmates assigned to federal prisons operated by the Bureau of Prisons; contract prisons; and residential reentry centers (also known as halfway houses)
<i>Number of people who received at least one COVID-19 test</i>	5,090,175	473,440	1,098	553,687	319,674	66,587

*For detailed descriptions of the population that each program serves, see the section for each agency.
 Source: PRAC analysis of COVID-19 testing data from six federal health care programs, February–August 2020.

INSIGHTS

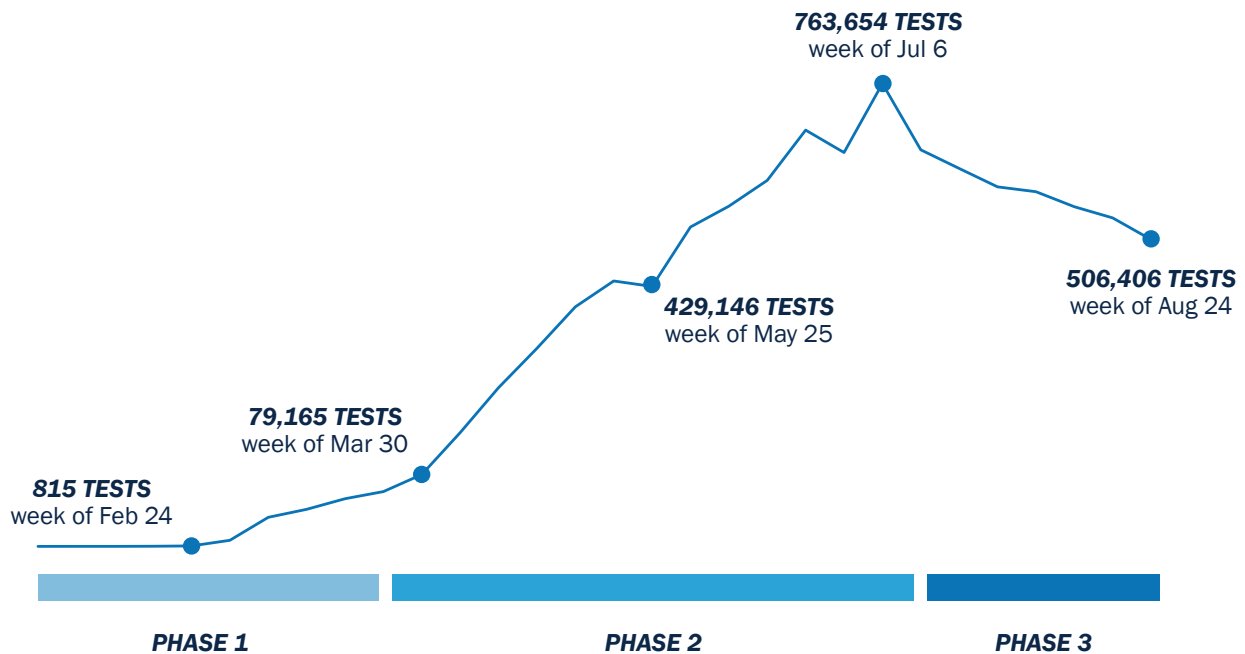
TESTS PROVIDED

Insight: Trends in COVID-19 testing in six federal health care programs largely followed the same pattern as national testing trends from February through August 2020.

COVID-19 testing is used to screen or diagnose both symptomatic and asymptomatic individuals to guide contact tracing and identify treatment options and isolation requirements.² Close to 84 million COVID-19 tests were administered in the United States from February 1, 2020, to September 1, 2020.³ The six federal health care programs covered in this report administered or paid for 10.7 million of those COVID-19 tests from February 1, 2020 to August 31, 2020.

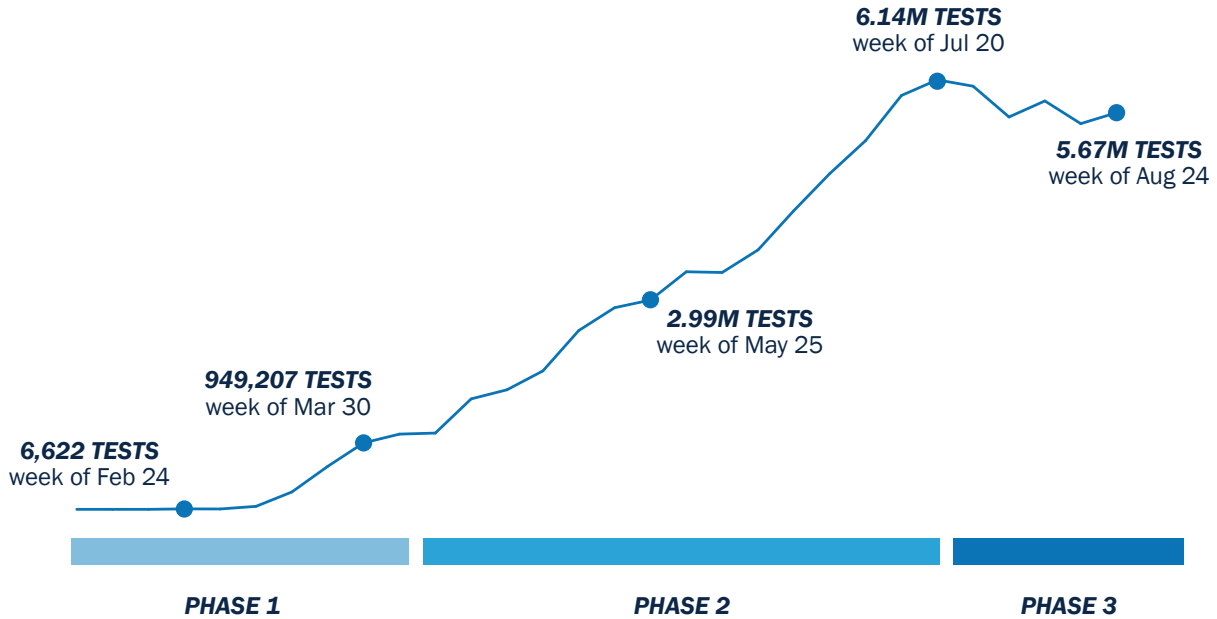
Testing in the six federal health care programs during the first seven months of the pandemic had three distinct phases: (1) relatively little testing occurred in February and March 2020; (2) the number of tests administered began increasing in mid-April 2020 and peaked in early July 2020; and (3) testing began decreasing in late July 2020 and into August 2020. This trend in the number of tests per month was similar to the testing trend nationally. See Exhibits 2 and 3 for trends in testing in the six federal health care programs and in the United States, respectively.

Exhibit 2. Tests administered or paid for by the six federal health care programs from February through August 2020, by week.



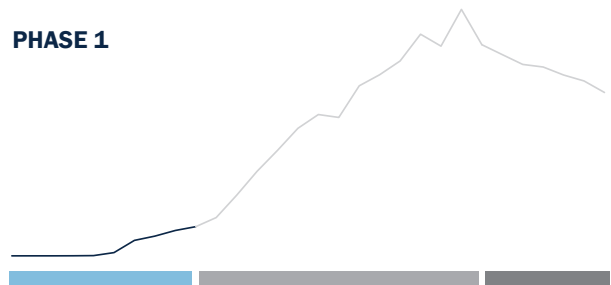
Source: PRAC analysis of COVID-19 testing data from six federal health care programs, February–August 2020.

Exhibit 3. Tests administered in the United States from February through August 2020, by week.



Source: PRAC analysis of data collected by “The COVID-19 Tracking Project” at The Atlantic, February–August 2020.

February–March 2020. Testing in the six federal health care programs and nationally was relatively low during the first months of the pandemic. These numbers were consistent across programs, whether beneficiaries accessed tests in commercial settings that billed a federal payer, such as Medicare Part B, or directly from federal health care providers, such as the Veterans Health Administration.



During this period and subsequently, various factors affected testing of federal beneficiaries and the nationwide population, including the availability of COVID-19 tests, evolving CDC guidance on who should be tested, and shortages in medical supplies used to administer tests.

Availability of COVID-19 tests. The United States began distributing a limited number of CDC developed COVID-19 test kits to domestic and international laboratories on February 5, 2020, a few days after the World Health Organization began dispatching its own diagnostic test kits for use in other countries.^{4,5} CDC developed two types of test kits.⁶ The CDC-developed diagnostic test—for which the Food and Drug Administration (FDA) granted emergency use authorization⁷—was the first

test available in the United States and its use was limited to CDC-qualified laboratories.⁸ This first test kit was used to test specimens that CDC received from public health authorities, hospitals, and other providers.⁹ The second kit was produced for use by public health laboratories until commercial testing became available.¹⁰

A few days after CDC distributed the test kits, CDC began receiving complaints that public health laboratories were unable to validate the tests, meaning that a negative control gave a positive COVID-19 result.^{11,12} CDC's investigation identified that one of the reagents in the test kits was likely contaminated in the initial batch that CDC manufactured.¹³ After identifying the problem in late February, CDC recognized that public health laboratories could run tests without the contaminated reagent and worked with FDA to allow the tests to be run without it.¹⁴ Thus, a reliable COVID-19 test for use in public health laboratories was not available until late February 2020.

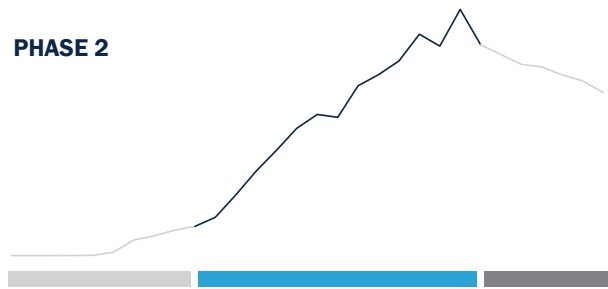
In mid-March 2020, the first commercial COVID-19 test became available in the United States. On March 12, 2020, FDA granted emergency use authorization for the first commercial COVID-19 molecular test.¹⁵ Molecular tests use technical processes, such as reverse transcriptase polymerase chain reaction (RT-PCR), to identify genetic material of SARS-CoV-2.¹⁶ This test can be extremely accurate but processing results can take time depending on the type of molecular test and a laboratory's capacity to run the tests.¹⁷

CDC guidance on testing. CDC's initial guidance recommended that only certain symptomatic or high-risk individuals be tested.¹⁸ On February 1, 2020, CDC provided guidance on who should be tested in the United States. CDC's early guidance recommended testing for patients who had traveled to China or had been in close contact with a person presumed or confirmed to have a SARS-CoV-2 infection and had a fever and showed symptoms of lower respiratory illness (e.g., coughing and/or shortness of breath).¹⁹

As the pandemic in the United States evolved, CDC later expanded the recommended populations to be tested. On March 8, 2020, CDC issued updated guidance identifying who should be tested.^{20,21} This guidance recommended that priority testing be given to the following categories of people: (1) hospitalized patients who showed symptoms of COVID-19; (2) other symptomatic individuals such as older adults and those with chronic conditions and/or who were immunocompromised; (3) anyone—including hospital staff—who showed symptoms of a SARS-CoV-2 infection after being in close contact with a presumed or confirmed COVID-19 patient; and (4) anyone who showed symptoms of a SARS-CoV-2 infection after traveling from affected geographic areas.²² People showing mild symptoms were encouraged to stay home to minimize the risk of exposure to others.²³

Medical supply shortage. Health care facilities across the country reported shortages of medical supplies throughout the spring of 2020.²⁴ Frontline health care workers faced limited supplies needed to administer COVID-19 tests, such as nasal swabs, viral transfer media, reagents used to detect the virus, and personal protective equipment.²⁵

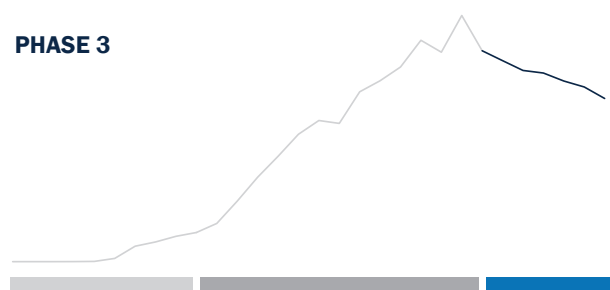
April–early July 2020. COVID-19 testing of federal beneficiaries in the six federal health care programs increased starting in mid-April as the virus began to spread in the United States. One factor that contributed to the increase in testing was the introduction of rapid tests^{26,27} and new commercial tests that could provide test results quickly.²⁸ For example, in April 2020, the Bureau of Prisons began receiving rapid molecular RNA testing machines and testing supplies from the Strategic National Stockpile.^{29,30} The Bureau of Prisons reported that results from these testing machines were typically available in minutes.³¹



On May 9, 2020, FDA issued emergency use authorization for the first antigen test.³² The antigen test, a then-new type of COVID-19 diagnostic test, quickly detects certain proteins found on or within the virus.³³ Although antigen tests can return results in minutes, they are more likely than molecular tests to have false negative results.³⁴ FDA explained that antigen tests can generally be produced at a lower cost than molecular PCR tests and—because they have a simpler design—they could be potentially scaled to test millions of Americans per day, which would help the United States identify infection rates closer to real time.³⁵

Another factor that contributed to the increase in testing was CDC’s updated recommendations on who should be tested. On June 13, 2020, CDC included in its guidance a recommendation to test asymptomatic persons to help track the spread of SARS-CoV-2.³⁶ As shown in Exhibit 2, testing across all six federal health care programs peaked at more than 763,000 tests in early July 2020.

Mid-July–August 2020. After the peak in July 2020, all but one of the six federal health care programs saw a plateau or decline in the number of COVID-19 tests administered to federal beneficiaries. This trend in testing also occurred nationally. The decline in testing in five of the federal health care programs could be due to a number of possible factors, such as fewer people seeking COVID-19 tests or delays in processing test claims. The only federal health care program that did not experience a decline in testing in late summer 2020 was the Bureau of Prisons. Given that the Bureau of Prisons provides care for people that live together in a congregate care setting—a known high-risk environment for transmitting COVID-19—it is not surprising that the trend in COVID-19 testing at the Bureau of Prisons would be different than that for the general population.



The overall decrease in testing in the six federal health care programs and nationally, as shown in Exhibits 2 and 3, was similar to a decreasing trend in COVID-19 cases in the United States during that same time period.³⁷ According to public health experts at the Johns Hopkins Coronavirus Resource Center, COVID-19 testing should be scaled to the size of the epidemic, not the size of the population.³⁸ Thus, it would seem natural that the rate of testing—both in the federal health care programs and nationwide—would dip at the same time as the number of COVID-19 cases in the United States.

However, public health experts at the Coronavirus Resource Center also noted that analyzing total testing is insufficient to understand whether the United States is testing enough.³⁹ Instead, they stated that the positivity rate (i.e., how many COVID-19 tests came back positive out of all COVID-19 tests conducted) is the most reliable way to determine whether a government is testing enough.⁴⁰ A high rate of positive tests indicates that a government is testing only the sickest patients who seek out medical attention and is not casting a wide enough net to understand how the virus is affecting the community.⁴¹ As of August 1, 2020, the COVID-19 positivity rate in the United States was 7.4%.⁴² The World Health Organization has issued guidance stating that governments should see positivity rates below 5% for at least 14 days before relaxing social distancing measures.⁴³ This guidance raises the question of whether the United States was testing enough in August to understand how and where the virus was continuing to spread. This report did not focus on surveillance testing, which is considered essential to effectively combatting infectious disease. This area would be ripe for future research, including the best way to conduct and pay for such testing.

PEOPLE TESTED

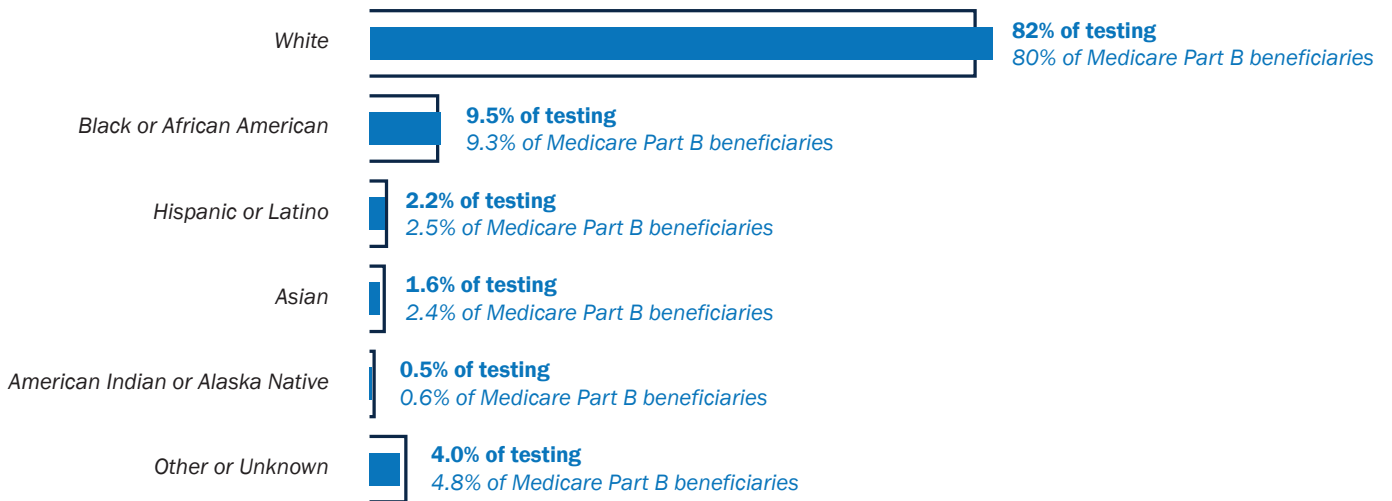
Insight: Testing of beneficiaries in two federal health care programs was generally proportional to beneficiaries' demographic representation among the populations that those programs served.

With respect to most demographic characteristics (i.e., gender, age, and race or ethnicity), testing of federal beneficiaries in Medicare Part B and the Bureau of Prisons was generally proportional to the demographic characteristics of the population that each program served.

According to CDC, people in certain racial or ethnic groups are known to be disproportionately affected by COVID-19.^{44,45} For example, Blacks/African Americans and Hispanics/Latinos, have an elevated risk for COVID-19 and for adverse outcomes related to COVID-19.^{46,47} In August 2020, CDC's case-level data for COVID-19 showed that Blacks/African Americans were 2.6 times more likely and Hispanics/Latinos were 2.8 times more likely to be diagnosed with a SARS-CoV-2 infection than Whites were.⁴⁸

Although certain groups are known to be disproportionately affected, the rates of COVID 19 testing among minority racial or ethnic groups in Medicare Part B and the Bureau of Prisons were not disproportionately larger than the populations those programs serve. For example, according to Medicare Part B data analyzed for this report, 9% of Medicare Part B beneficiaries identify as Black/African American. This closely aligns with the proportion of Black/African American Medicare Part B beneficiaries who were tested for COVID-19. Almost 10% of Medicare Part B beneficiaries that received a COVID-19 test identified as Black/African American.⁴⁹ See Exhibit 4 for COVID-19 testing and Medicare Part B enrollment percentages by race/ethnicity. In the Bureau of Prisons, 33% of the inmate population identified as Hispanic/Latino. However, a slightly lower proportion of inmates who were tested for COVID-19 identified as this racial group; 28% of inmates who received a COVID-19 test identified as Hispanic/Latino.

Exhibit 4. The proportion of Medicare Part B beneficiaries tested in each race/ethnicity group largely matched the distribution across overall Medicare Part B enrollment.



Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

Note: “Non-Hispanic” has been truncated from category descriptors.

Percentages may not sum to 100% because of rounding.

VA OIG reported the demographic data that the Veterans Health Administration collected on both its enrolled and nonenrolled populations that received tests at VHA facilities. VA OIG only commented on the demographics of those who received testing, in that the total number of nonenrolled people accessing VHA services as part of the execution of VA’s Fourth Mission is variable and would limit an accurate proportional analysis.

Although other factors play a role in who is tested, the data in this report raises the question of whether providing certain populations with greater access to testing would benefit communities that are at higher risk of both infection and severe illness or death.

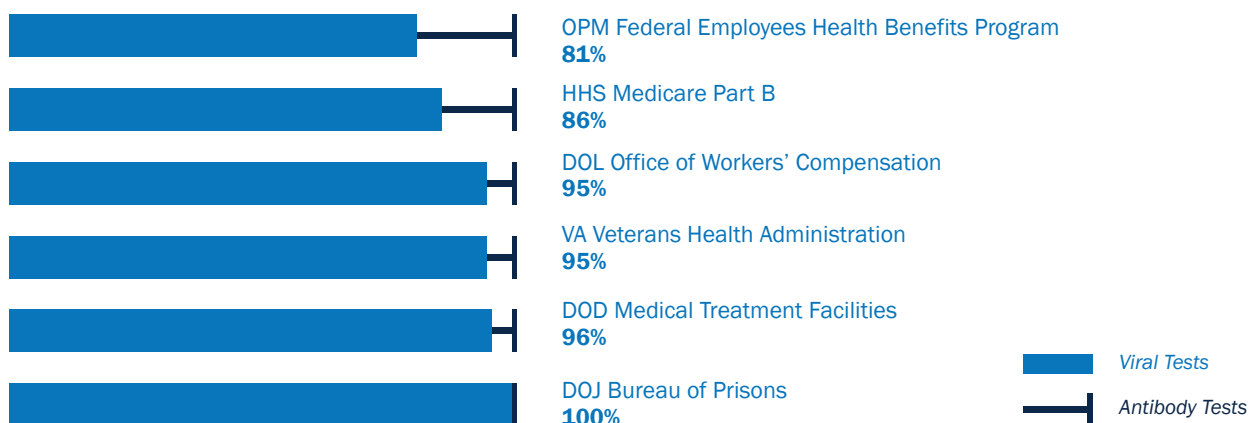
Three federal health care programs had varying levels of demographic information. Information on beneficiary race or ethnicity was not available in the testing data that the OPM OIG, DOL OIG, and DOD OIG analyzed for this report. Readily available demographic information on people that received a COVID-19 test could help inform policy decisions that impact testing strategies and targeted testing efforts, identify SARS-CoV-2 infections in certain communities, and monitor public health in disproportionately impacted groups.

TYPES OF TESTS

Insight: Viral tests constituted the majority of the COVID-19 tests that the six federal health care programs administered or paid for.

The majority of the COVID-19 tests that the six federal health care programs administered or paid for were viral tests, which detect current SARS-CoV-2 infections and identify individuals who could transmit the virus.⁵⁰ Five of the federal health care programs also administered or paid for a much smaller number of antibody tests, which detect previous SARS-CoV-2 infections and can assist in the diagnosis of a current infection.⁵¹ Exhibit 5 shows what proportion of viral and antibody COVID-19 tests paid for or administered by the six federal health care programs.

Exhibit 5. Distribution of viral and antibody COVID-19 tests paid for or administered by the six federal health care programs.



Source: PRAC analysis of COVID-19 testing data from six federal health care programs, February–August 2020.

Because viral tests are diagnostic tools that detect current infections, it is not surprising that they constitute the vast majority of COVID-19 tests that the six federal health care programs paid for or administered. Viral tests are useful in diagnosing people who show symptoms that may indicate a SARS-CoV-2 infection. In addition, viral tests are helpful in identifying asymptomatic people after a known exposure or as part of public health surveillance testing. Types of viral tests include molecular tests and antigen tests. Many of the viral tests that the Bureau of Prisons administered were rapid molecular RNA tests, which provide quick diagnostic results of a SARS-CoV-2 infection. These rapid tests were used in prison facilities, where it is generally difficult for federal inmates to practice physical distancing.

Antibody tests can have clinical value in assessing and treating patients who are experiencing symptoms that are potentially related to a previous SARS-CoV-2 infection. However, the CDC states that antibody tests are primarily valuable for understanding the virus's epidemiology in the general population and in identifying groups at risk for infection. Antibody tests can also help to determine the proportion of a population that was previously infected with the SARS-CoV-2 virus, even those who never experienced symptoms.⁵² Of the six federal health care programs, the FEHBP had the largest proportion of antibody testing relative to viral testing; 19% of the tests for which the FEHBP paid were antibody tests.

SPENDING

Insight: Federal reimbursement for COVID-19 viral tests varied across the federal health care programs.

Average costs for COVID-19 viral tests, which accounted for the vast majority of COVID 19 tests that the six federal health care programs administered and paid for, varied by program. Four of the six programs—Medicare Part B, the FEHBP, Workers' Compensation, and the Bureau of Prisons—reported per-test costs for viral tests processed at commercial labs, and these four programs paid an average of \$69 to \$130 per commercial viral test.⁵³

Of the federal health care programs that ordered and performed testing at facilities that they manage or operate, two programs—DOD Medical Treatment Facilities and the Bureau of Prisons—had data on average cost of viral tests. DOD Medical Treatment Facilities' average per-test cost for viral tests ordered and performed at those facilities was \$57. In addition to sending tests to commercial labs for processing, the Bureau of Prisons performed COVID-19 viral testing onsite at prison facilities by using rapid molecular RNA testing machines from the Strategic National Stockpile. HHS provided these rapid testing machines and test supplies to the Bureau of Prisons. As a result, the Bureau of Prisons' average cost to its program for these rapid molecular RNA tests was \$0.

At the time of the data collection for this report, the Veterans Health Administration had no cost data to report. It could not calculate the per-test cost because funds were allocated to medical centers on the basis of patient workload rather than for individual services.

Variation in viral test prices likely reflects a number of factors, including the use of different FDA-authorized COVID-19 tests; supplies used to administer the tests; the mix of standard testing versus more costly complex tests; and the structure and rules that govern reimbursement policies for each program. It is worth noting that per-test reimbursement changed over the review period. For example, per-test payments for Medicare Part B and the FEHBP increased during the period of February through August 2020. Several factors may have contributed to increasing costs, including the uptake of more efficient or accurate testing technologies and support for faster test processing.⁵⁴ The variation in test payment rates raises the question as to whether there are more efficient approaches to creating and paying for testing for novel emerging infectious diseases.

From February to August 2020, the six federal health care programs spent at least \$659.5 million on COVID-19 tests for their beneficiaries. This amount does not account for testing at the Veterans Health Administration, and it represents only a portion of testing administered or paid for by some of the federal health care programs. For example, test costs for DOD Medical Treatment Facilities include only tests that were ordered and performed at these facilities and excludes tests ordered at DOD Medical Treatment Facilities but performed at commercial laboratories. Thus, the amount spent on COVID-19 testing in the six federal health care programs is an underestimate. Of the \$659.5 million spent on COVID-19 tests, 78% of spending occurred from June through August 2020, as testing volume increased.

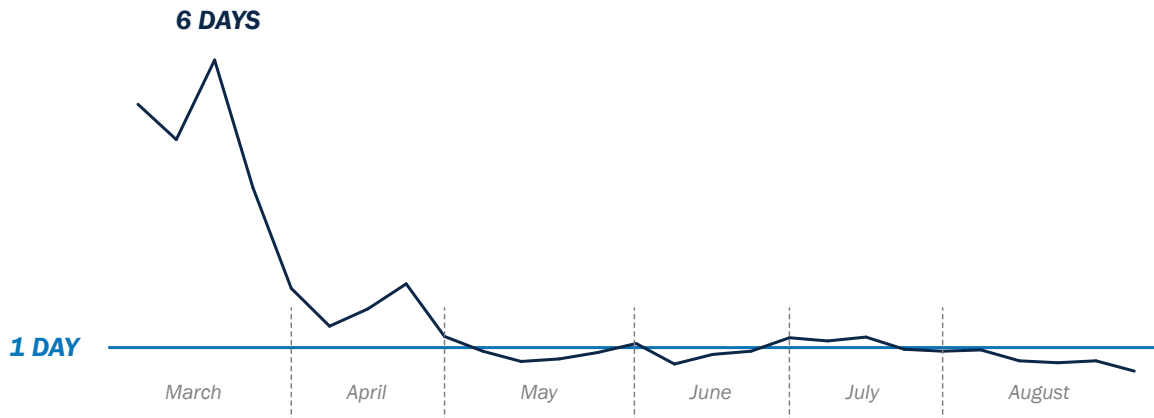
TEST RESULT PROCESSING TIME

Insight: Readily available information on turnaround times for COVID-19 tests was available only from the three federal health care programs that administered tests; two of these programs reported that test processing times decreased over time.

Timely processing of tests is key to effectively identifying infection and controlling the spread of COVID-19. Test processing time can also indicate a laboratory's capacity to meet testing demands.

Two federal health care programs that provide COVID-19 tests at their facilities reported that the processing time for test results had decreased from the early months of the pandemic. The Veterans Health Administration and DOD Medical Treatment Facilities reported that by July 2020, it took about one day to process results. In March 2020, these two federal health care programs had reported testing turnaround times of more than four days and three days, respectively. Exhibit 6 shows a decrease in test processing time for the Veterans Health Administration.

Exhibit 6. Veterans Health Administration reported that by July it took about a day to process results.



Source: PRAC analysis of COVID-19 testing data from six federal health care programs, February–August 2020.

The Bureau of Prisons also had information on test turnaround time. The Bureau of Prisons both processed tests onsite using rapid molecular RNA testing machines and sent tests to commercial labs for processing. Tests conducted onsite using these machines returned results in as little as 15 minutes. However, tests sent to commercial labs took, on average, at least a day to provide the results. Some Bureau of Prisons officials observed that in late July and August 2020, these tests could take as long as 14 days to process because a surge in COVID-19 cases led to a nationwide increase in demand for testing and test processing. The delay in processing test results for some Bureau of Prisons facilities followed a trend that national laboratory associations also reported. The American Clinical Laboratory Association, whose members include large commercial laboratories that process COVID-19 tests, signaled in mid-July 2020 that many labs were receiving more test orders than they were able to process in a day.⁵⁵

Other programs that reimbursed commercial labs for COVID-19 tests—Medicare Part B, the FEHBP, and Workers’ Compensation—could not report on processing times for test results. This information was not captured in the claims data used in the analysis for this report. While the amount of time to process tests is captured in other sources, such as laboratory records or public health monitoring systems, it is not readily available to assist these programs in determining the impact on their patient populations.

The lack of data on test turnaround time raises questions about how the timeliness of processing tests affects patient care, program integrity, and oversight activities. Payers may lack effective and ready access to data that would help them determine whether testing is of sufficient timeliness and quality to warrant payment, and whether beneficiaries are receiving needed health care related to COVID-19.

CONCLUSION

This report provides insights and data on the COVID-19 testing efforts of six federal health care programs from February 1, 2020, to August 31, 2020—the first seven months following the declaration of a public health emergency in the United States.⁵⁶ Although this report does not represent a comprehensive view of the Federal Government’s testing efforts, it provides insights on the populations covered by a variety of federal health care programs. The insights summarized below are intended to help stakeholders—such as Congress; federal and state agencies; and health care entities—understand and plan for current and future response efforts.

- Trends in COVID-19 testing in six federal health care programs largely followed the same pattern as national testing trends from February through August 2020.
- With respect to gender, age, and race or ethnicity, COVID-19 testing of federal beneficiaries was generally proportional to the demographic characteristics of the population that two federal health care programs served.
- The majority of COVID-19 tests that the six federal health care programs administered or paid for were viral tests, which detect current SARS-CoV-2 infections and identify individuals who could transmit the virus.
- Federal reimbursement for COVID-19 viral tests varied across the federal health care programs.
- Readily available information on turnaround times for COVID-19 tests was available only from the three federal health care programs that administered tests; two of these programs reported that test processing times decreased over time.

These insights also raise important questions for further consideration:

- » What factors (e.g., regulations, public health infrastructure, and private market incentives) hindered the rapid development and deployment of COVID-19 tests?
- » Was access to testing sufficient?
- » Was testing available to populations most impacted by SARS-CoV-2?
- » What are the most cost-effective and cost-efficient forms of testing?
- » What payment policies are appropriate for testing during a public health emergency?
- » What data is needed to ensure effective and efficient testing efforts?

The PRAC encourages the policymaking, oversight, and research communities to seek answers to these compelling questions. The PRAC is committed to continuing its mission to provide accountability for the government’s spending and response to COVID-19 by promoting transparency to the public; detecting fraud, waste, and abuse; and mitigating risks that cut across federal agencies.

GENERAL METHODOLOGY

The PRAC Healthcare Subgroup consists of six OIGs that oversee agencies that provide or are involved with the provision of health care services. These agencies are HHS, OPM, DOL, VA, DOD, and DOJ. Each of the six OIGs selected a health care program within its agency for which it could obtain reasonably reliable and complete data on COVID-19 testing for the time period of February 1, 2020, through August 31, 2020.

Data Collection and Analysis

Each OIG collected and analyzed data from its selected health care program. The data addressed the following topics:




1. How many tests were administered, and when?
2. Who was tested?
3. What types of COVID-19 tests were administered?
4. How much did the health care program pay for COVID-19 tests?
5. In what health care settings did people access testing?
6. How long did it take to return COVID-19 test results?

Data collection. To ensure a level of standardization and consistency, HHS OIG, in collaboration with the PRAC, developed data collection tools and a model analysis plan to aid each OIG's efforts in collecting and analyzing data. Demographic categories for age and race and ethnicity were based on CDC-published risk categories for COVID-19 hospitalization and death.^{57,58}

Each OIG determined which data source(s) to use in its analysis of COVID-19 testing data and coordinated as necessary with officials from federal health care programs to obtain this data. Exhibit 7 on the next page describes the data points that each OIG was asked to collect for this report and notes the instances in which data related to COVID-19 testing was complete, partial, or not available.

Data analysis. Each OIG analyzed the COVID-19 testing data for its selected health care program and provided HHS OIG with the results of its analysis. In collaboration with the PRAC, HHS OIG worked with each OIG to present the COVID-19 testing data responsive to the six questions and to identify trends and patterns in each set of data. HHS OIG also analyzed COVID-19 testing data across all six federal health care programs to provide broader insights and shared the insights with the other OIGs for review. Finally, HHS OIG reviewed national COVID-19 testing data from "The COVID Tracking Project" at *The Atlantic* to present the number of tests administered in the United States. For agency-specific details about the data and analysis, refer to the methodology section in the respective appendix.

Exhibit 7. Data availability for each of the six federal health care programs

-  Blue indicates that data was available for all data elements for the full data collection time period for the scope of the program included in this report.
-  Gray indicates that partial data was reported. For example, agencies could report data for a portion of the data collection period or some data elements (e.g., race of enrollees tested) were not available.
-  White indicates that the data elements were not available.

Criteria	HHS Medicare Part B	OPM The FEHBP	DOL Office of Workers' Compensation Programs	VA Veterans Health Administration	DOD Military Treatment Facilities	DOJ Bureau of Prisons
Number of tests performed	Blue	Blue	Blue	Blue	Blue	Blue
Date of Testing	Blue	Blue	Blue	Blue	Blue	Blue
Gender, age, and race/ethnicity of people tested	Blue	Gray	Gray	Blue	Gray	Blue
Types of Tests	Blue	Blue	Blue	Blue	Blue	Blue
Program spending for tests	Blue	Blue	Gray	White	Blue	Gray
Health care settings	Blue	Blue	Blue	Blue	Blue	Gray
Geographic location of testing	Blue	Blue	Blue	Blue	Blue	Blue
Test return time	White	White	White	Blue	Gray	Gray

Source: PRAC analysis of data from six federal health care programs, February–August 2020.

Data visualization. HHS OIG coordinated with the PRAC to develop the data visualization elements as part of this report, using agency data as the source. In order to create the departmental maps, each OIG identified the appropriate geographic location related to COVID-19 testing and submitted the number of tests performed for each county or facility. HHS OIG used ArcGIS mapping software to establish quantiles for county-level testing data. Although federal beneficiaries in the territories are included in the testing data, the maps do not show the territories because of their relatively small beneficiary population.

Limitations

This report does not present a comprehensive view of the Federal Government's testing efforts. The data and insights are limited to the six selected federal health care programs. There are other federal, state, local, and private efforts to provide testing. Some beneficiaries of these six federal health care programs may have received testing through one of these alternative sources. Further, some federal beneficiaries may be enrolled in more than one of the federal health care programs in this review and could have received testing from both programs. Wherever possible, instances of potential overlap are noted in the text. For agency-specific limitations, see each OIG's detailed methodology in the agency's appendix.

Standards

Each OIG conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency (CIGIE). Each OIG followed its own processes to ensure that its contributions to this report met CIGIE standards and provided an attestation to the PRAC describing how it met those standards.

Glossary

COVID-19 TESTING TERMS

Antigen tests. A type of viral test that detects certain proteins of SARS-CoV-2. Although antigen tests can return results in minutes, there is an increased risk of false-negative results.

Antibody tests. Tests that detect the presence of antibodies in the blood of people who are tested after having a SARS-CoV-2 infection. These tests may also be referred to as serology tests.

COVID-19. Coronavirus disease 2019 (COVID-19) is a serious respiratory illness caused by the SARS-CoV-2 pathogen, characterized by symptoms including cough; fever or chills; shortness of breath and difficulty breathing; fatigue; and others.

Molecular tests. Tests for the diagnosis of current COVID-19 infection, which use a technical process called reverse transcriptase polymerase chain reaction (RT-PCR) to identify genetic material (nucleic acids) of SARS-CoV-2. These tests are sometimes referred to as nucleic acid tests.

Rapid molecular RNA tests. Rapid point-of-care diagnostic tests that use a mucus sample from the nose or throat. These tests can be analyzed where the sample is collected and results may be available in minutes.

SARS-CoV-2. Severe acute respiratory syndrome coronavirus 2 is the virus responsible for causing COVID-19, which is known to be highly infectious and spreads mainly from person to person through respiratory droplets emitted by activities such as coughing, sneezing, or talking.

Viral tests. Authorized assays for viral testing include molecular tests that detect SARS-CoV-2 nucleic acid and antigen tests that detect certain proteins of SARS-CoV-2. Both molecular and antigen tests check samples from the respiratory system—such as nasal or oral swabs or saliva—to determine whether an infection with SARS-CoV-2, the virus that causes COVID-19, is present.

FACILITY AND POPULATION TERMS

BOP facilities. A collective term used in this report to describe all types of facilities housing federal inmates in BOP custody.

BOP-operated prisons. Facilities operated directly by the BOP, including correctional institutions, detention centers, and U.S. penitentiaries. The BOP houses most of its inmates within 122 BOP-operated prisons.

Contract prisons. Prison facilities operated by private contractors, which the BOP commonly uses to house criminal alien inmates. Contract prisons account for 9% of BOP inmates.

Critical access hospitals. A designation given by CMS to eligible hospitals in order to reduce financial vulnerabilities and keep essential services in rural communities.

DOD Medical Treatment Facility (MTF). A military facility established for the purpose of furnishing medical care to eligible individuals.

Hospital labs. Labs affiliated with or located on a hospital campus for both inpatient and outpatient care.

Independent labs. Standalone lab testing sites that are not associated with an institution or a physician's office.

Physician office labs. Locations not associated with a hospital or nursing facility, where health care professionals routinely offer examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Residential Reentry Centers (RRC). Also known as halfway houses or community corrections, these locations traditionally supervise BOP inmates nearing the completion of their sentences. These inmates may reside in either RRC facilities or home custody settings.

Retail walk-in clinics. Health clinics located within a retail operation.

Urgent care facilities. Locations not associated with a hospital or nursing facility, where health care professionals offer care on an unscheduled, as opposed to routine, basis for patients seeking immediate medical attention.

VHA enrolled population. For the purposes of this report, the enrolled population is the total number of individuals enrolled in the VHA health care program, and includes veterans and veteran-employees.

VHA nonenrolled population. For the purposes of this report, nonenrolled individuals include nonveteran employees, TRICARE, active duty, CHAMPVA beneficiaries, VHA volunteers, and those who were served on a humanitarian basis.

Agency Details

U.S. Department of Health and Human Services (HHS)

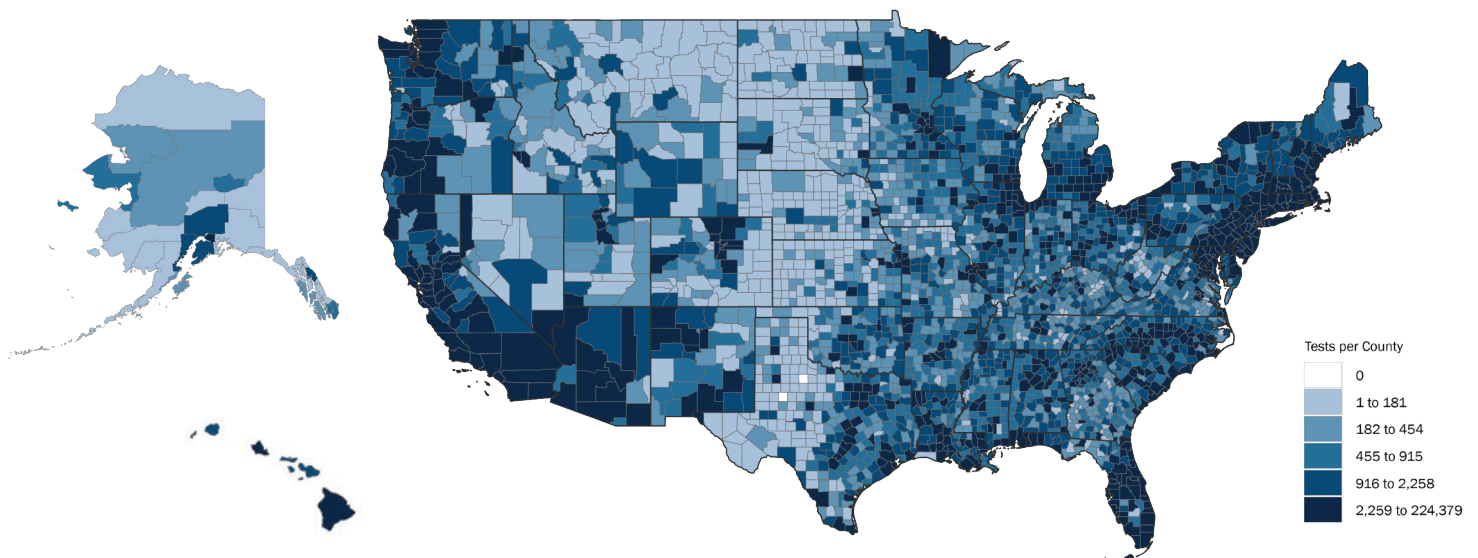
HHS's Centers for Medicare and Medicaid Services (CMS) administers the Medicare program, which provides health care coverage to beneficiaries who are age 65 or older, disabled, or have end-stage renal disease. Medicare beneficiaries include many people with an elevated risk of complications from COVID-19.

Testing in Medicare. Medicare Part B is one of the main ways through which Medicare pays for outpatient services to Medicare beneficiaries, including testing for COVID-19. Part B covers more than 38 million beneficiaries, or 61% of all Medicare enrollees. In 2019, Part B processed claims for more than 432 clinical diagnostic laboratory tests for about 27 million beneficiaries. In April 2020, Medicare Part B began accepting claims for COVID-19 viral tests, retroactive to tests performed in February 2020, and antibody tests.

Scope of HHS Brief. This data brief provides information on COVID-19 testing paid for by Medicare Part B from February 1, 2020, to August 31, 2020. Tests that Medicare Part B beneficiaries received through other programs, such as community testing efforts, were not included, unless they were paid for by Medicare Part B. COVID-19 tests paid for under Medicare Part A and Part C programs were excluded. (See [Appendix A: HHS](#) for HHS OIG's methodology.)

Exhibit 1. COVID-19 testing among Medicare Part B beneficiaries from February through August 2020.

About 17% of all COVID-19 tests paid by Medicare Part B were administered in rural counties. 20% of Medicare Part B beneficiaries live in rural counties.

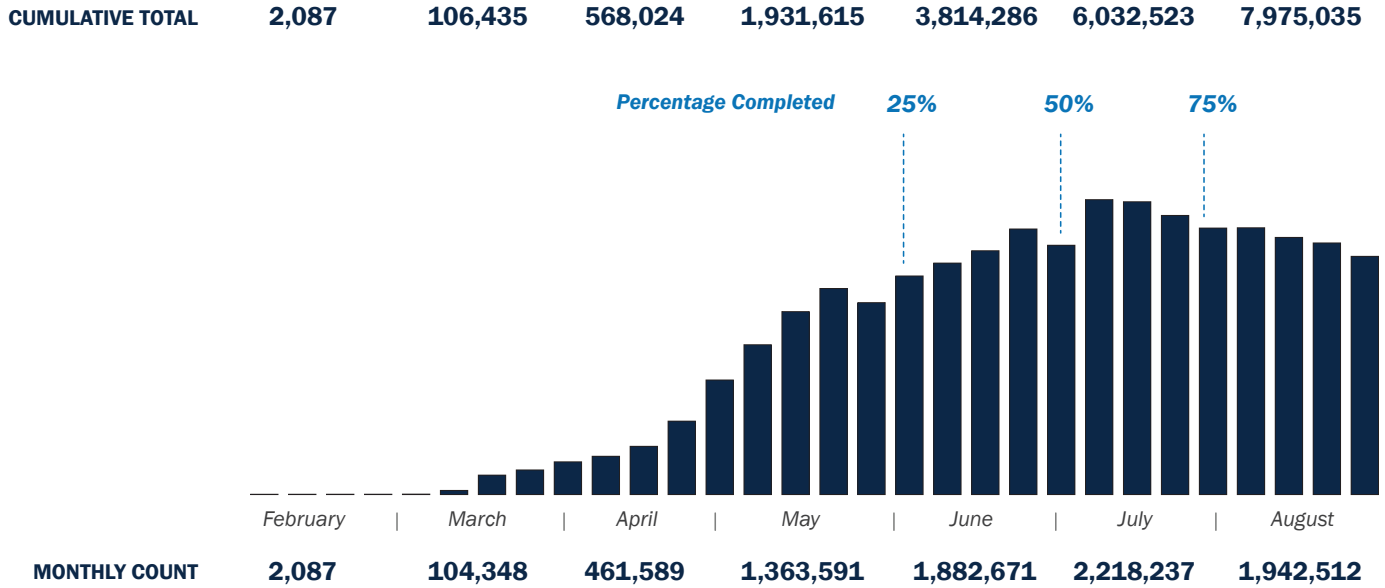


Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

HOW MANY TESTS WERE ADMINISTERED, AND WHEN?

Exhibit 2. Medicare Part B paid for 7.98 million tests from February through August 2020.

The number of tests per week in Medicare Part B increased dramatically from February to June, peaking in early July.

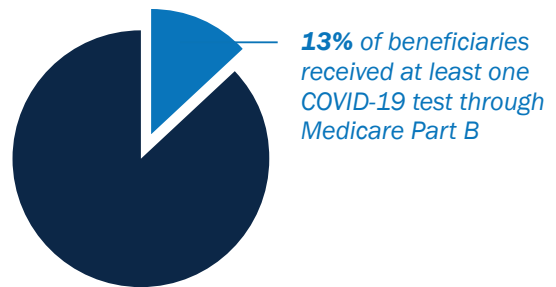


Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

WHO WAS TESTED?

Exhibit 3. 5,090,175 beneficiaries received at least one COVID-19 test paid for by Medicare Part B from February through August 2020.

More than 5 million beneficiaries received at least one COVID-19 test from February through August 2020. Close to 38.9 million beneficiaries were enrolled in Medicare Part B during this period.



Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

Exhibit 4. COVID-19 testing for women and men aligned with demographics of those enrolled in Medicare Part B.

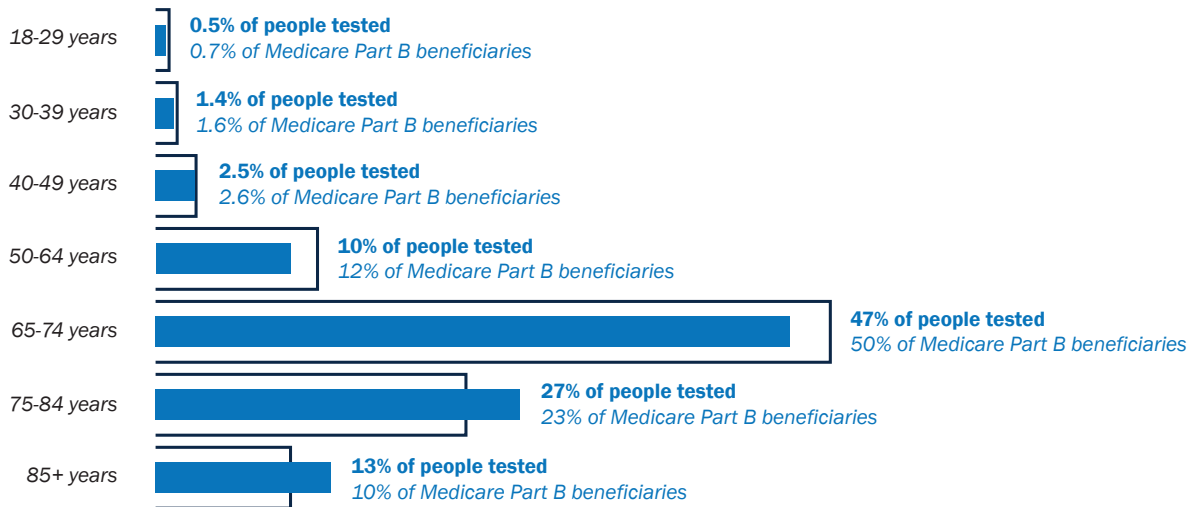
57% of Medicare Part B beneficiaries who received a COVID-19 test were women, which is proportional to the population of enrolled Medicare Part B beneficiaries. Among all beneficiaries enrolled in Medicare Part B, 14% of women and 12% of men received at least one COVID-19 test.



Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

Exhibit 5. The proportion of Part B beneficiaries tested in each age group largely matched the distribution across overall Medicare Part B enrollment.

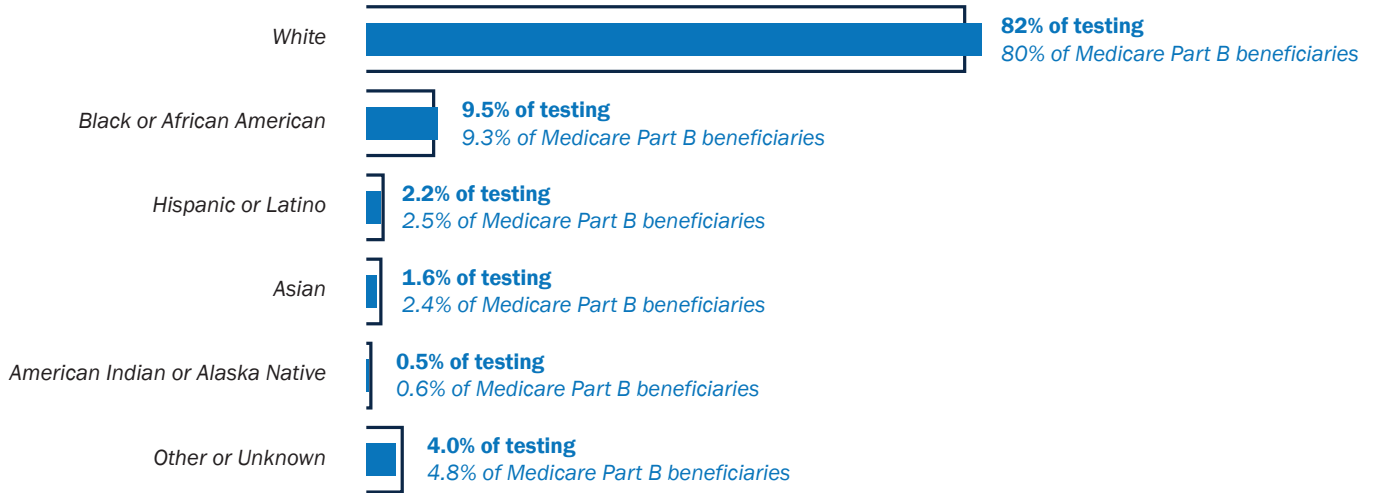
86% of Medicare Part B beneficiaries who received a COVID-19 test were age 65 or older.



Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

Note: People age 0–17 represent 0.004% of people enrolled in Medicare Part B and 0.01% of people tested. Percentages may not sum to 100% because of rounding.

Exhibit 6. The proportion of Part B beneficiaries tested in each race/ethnicity group largely matched the distribution across overall Medicare Part B enrollment.

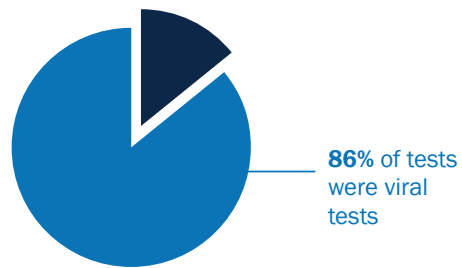


Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.
 Note: “Non-Hispanic” has been truncated from category descriptors.
 Percentages may not sum to 100% because of rounding.

WHAT TYPES OF TESTS WERE ADMINISTERED?

Exhibit 7. 6,875,924 of the COVID-19 tests administered to Medicare Part B beneficiaries were viral tests.

Medicare Part B paid for 7,975,035 COVID-19 tests from February through August 2020. The majority of those (86%) were viral tests, which detect current COVID-19 infections. The remaining 14% were antibody tests, which detect previous COVID-19 infections.

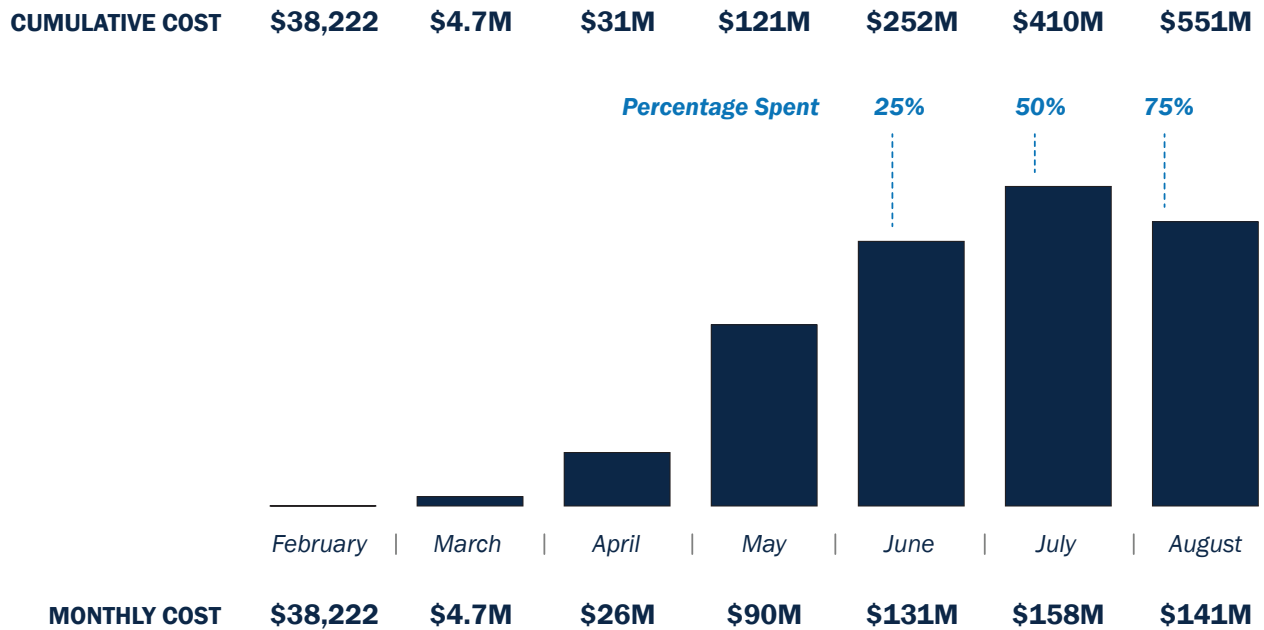


Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

HOW MUCH DID MEDICARE PART B PAY FOR TESTS?

Exhibit 8. Medicare Part B paid more than \$551 million for COVID-19 tests administered from February through August 2020.

The monthly cost of testing increased from February to July, in line with the volume of testing.



Source: HHS OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

Exhibit 9. Medicare Part B paid an average of \$69 for a COVID-19 test.

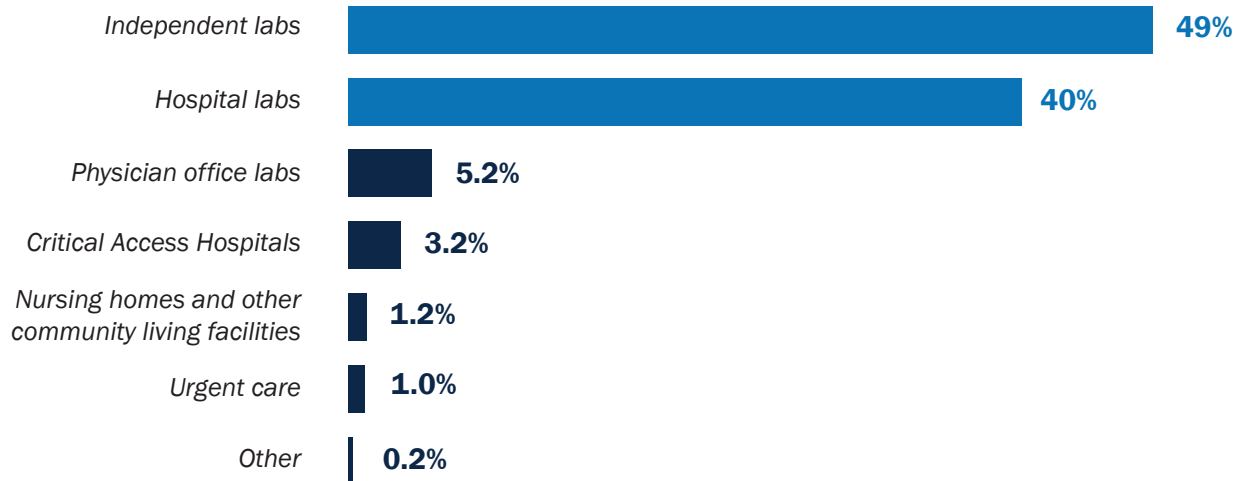
Medicare Part B paid an overall average of \$69 per COVID-19 test. This figure includes payment for both viral and antibody tests and gives an indication of average spending for COVID-19 testing. The average payment per test fluctuated over time and increased slightly as COVID-19 testing technology evolved and CMS adjusted payment rates. Medicare Part B payment rates for viral tests ranged from \$36 to \$100. Medicare Part B payment rates for antibody tests ranging from \$18 to \$45.



Source: HHS-OIG analysis of Medicare Part B claims data, February 1–August 31, 2020.

IN WHAT HEALTH CARE SETTINGS DID PEOPLE ACCESS TESTING?

Exhibit 10. 89% of COVID-19 tests for Medicare Part B beneficiaries were performed at independent labs or hospital labs.



Source: HHS OIG analysis of billing providers in Medicare Part B claims data, February 1–August 31, 2020.

Note: Medicare Part B beneficiaries may access COVID-19 tests directly from independent and hospital labs. In some cases, Medicare Part B beneficiaries may visit other health care providers (e.g., a general practitioner), who refer patients to independent or hospital labs. These labs then bill Medicare for the tests.

Percentages may not sum to 100% because of rounding.

Nursing homes and other community living facilities accounted for less than 2% of COVID-19 tests because Medicare Part B is not the primary payer for care provided in these settings. Nursing home care is primarily covered by Medicare Part A.

HOW LONG DID IT TAKE TO RETURN TEST RESULTS?

HHS OIG was unable to report testing turnaround time because this data point was not available in Medicare Part B claims data. Test results are typically included in medical records or noted in other sources.

HHS OIG confirmed with CMS and CDC that no other data sources were readily available that would identify testing turnaround time specific to the Medicare Part B population.

Rapid antigen tests, with results typically available in as little as 15 minutes, increased in volume in Medicare Part B, from only 0.02% of all COVID-19 claims in early June to 3% by the end of August.

U.S. Office of Personnel Management (OPM)

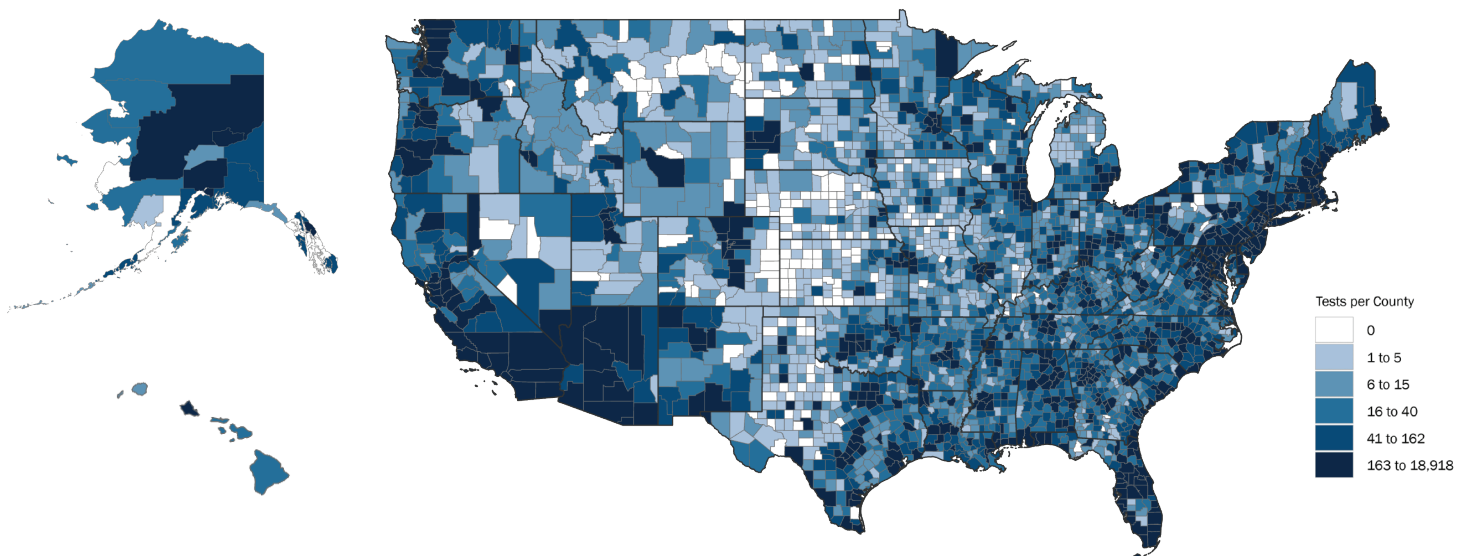
OPM contracts with about 187 health insurance carriers to provide health care benefits to more than 8 million federal employees, dependents, and eligible retirees through the Federal Employees Health Benefits Program (FEHBP). Contracted FEHB carriers process and pay health care claims; provide customer service and access to health care providers and hospitals; and deliver other health care related services and benefits. OPM administers three types of FEHBP carrier contracts: an experience-rated fee-for-service contract, an experience-rated health maintenance organization contract, and a community-rated health maintenance organization contract.

Testing in FEHBP. While the FEHBP did not benefit directly from CARES Act funding, OPM issued Carrier Letter No. 2020-08 in response to this Act to all participating health insurance carriers on April 23, 2020. In this letter, OPM set forth responsibilities and provided information to its health insurance carriers about coverage of testing, preventive services, and telehealth for COVID-19. Specifically, the letter waived cost-sharing and prior authorization requirements for most COVID-19 tests.

Scope of OPM Brief. This brief provides information on COVID-19 testing paid for by two of the larger FEHBP carriers, together covering approximately 76% of the FEHBP population, during the time period of February 1, 2020, to August 31, 2020. (See [Appendix B: OPM](#) for OPM OIG’s methodology.)

Exhibit 1. COVID-19 testing among FEHBP enrollees from February through August 2020.

89% of COVID-19 testing in the selected FEHBP plans from February through August 2020 occurred in urban counties. Most FEHBP enrollees live in urban counties. 4.3% of FEHBP enrollees living in rural counties received at least one test, compared to 7.6% of enrollees in FEHBP overall who received at least one test.

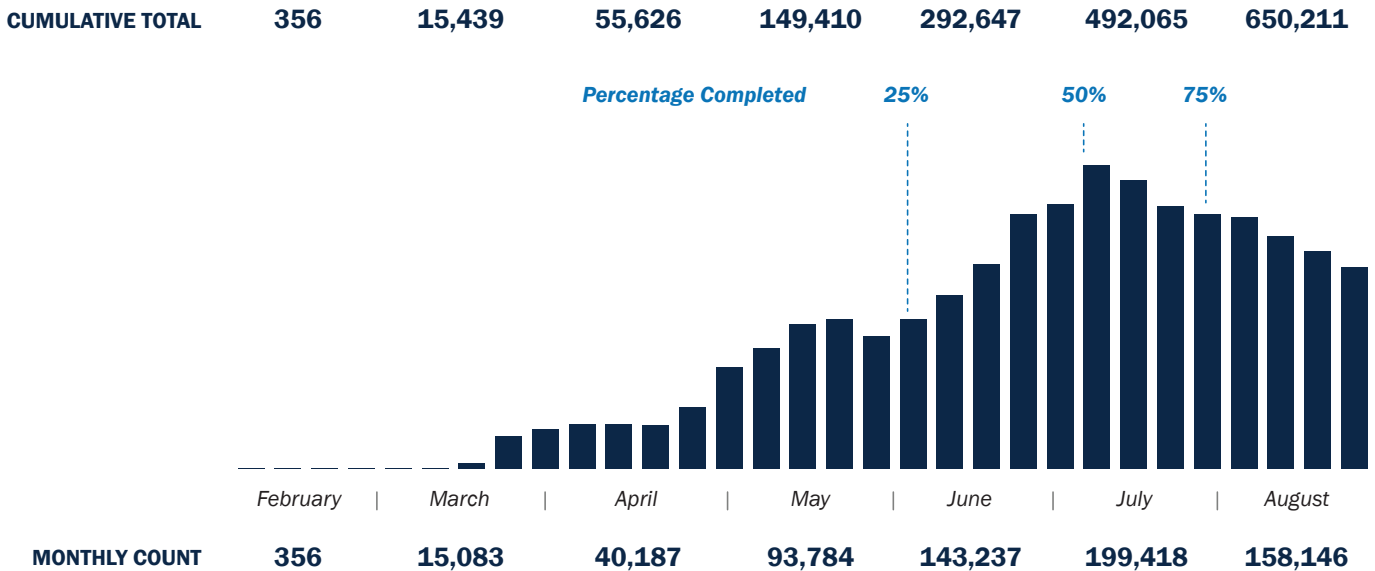


Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

HOW MAY TESTS WERE ADMINISTERED, AND WHEN?

Exhibit 2. FEHBP plans paid for 650,211 tests from February through August 2020.

Testing of enrollees in the FEHBP increased substantially from February to June, then peaked in the second week of July.

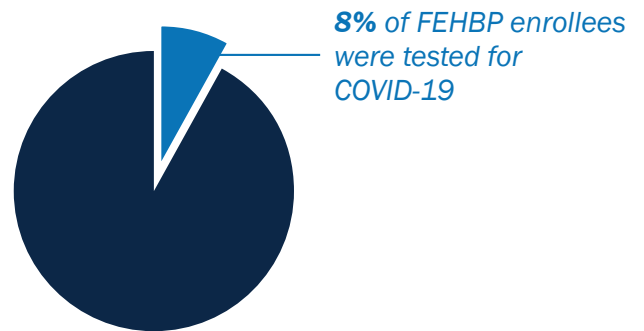


Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

WHO WAS TESTED?

Exhibit 3. 473,440 enrollees in two of the larger FEHBP health insurance carriers were tested for COVID-19 during February through August 2020.

Two of the FEHBP’s larger health insurance carriers cover about 76% of all FEHBP enrollees. The FEHBP is currently the largest employer-sponsored group health insurance program in the world, covering more than 8 million federal employees, retirees, and their family members.



Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

Exhibit 4. COVID-19 testing for women and men aligned with the demographics of those enrolled in the FEHBP.

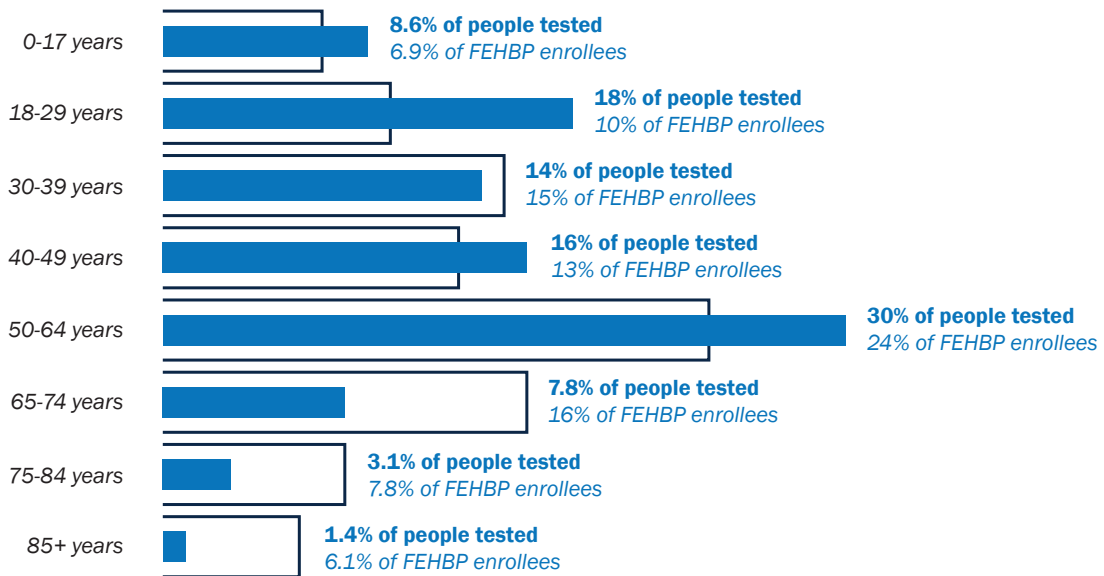
More women were tested than men, which corresponds to the composition of FEHBP enrollment: 54% women and 46% men.



Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

Exhibit 5. 43% of enrollees in the FEHBP who received a COVID-19 test were age 50 or older.

Those tested who were above the standard retirement age of 65 may be current federal workers; retired federal workers with continued benefits; or the spouses and/or dependents of federal workers. Test recipients younger than age 18 were enrolled as dependents of federal workers.



Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

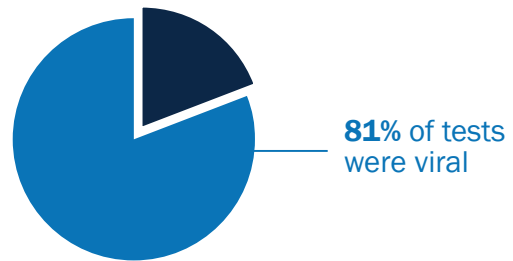
Note: Percentages may not sum to 100% because of rounding.

This section does not include demographic information on race/ethnicity because FEHBP claims and enrollment data does not have this type of demographic information on enrollees.

WHAT TYPES OF TESTS WERE ADMINISTERED?

Exhibit 6. 525,491 COVID-19 tests administered to enrollees in the FEHBP were viral tests.

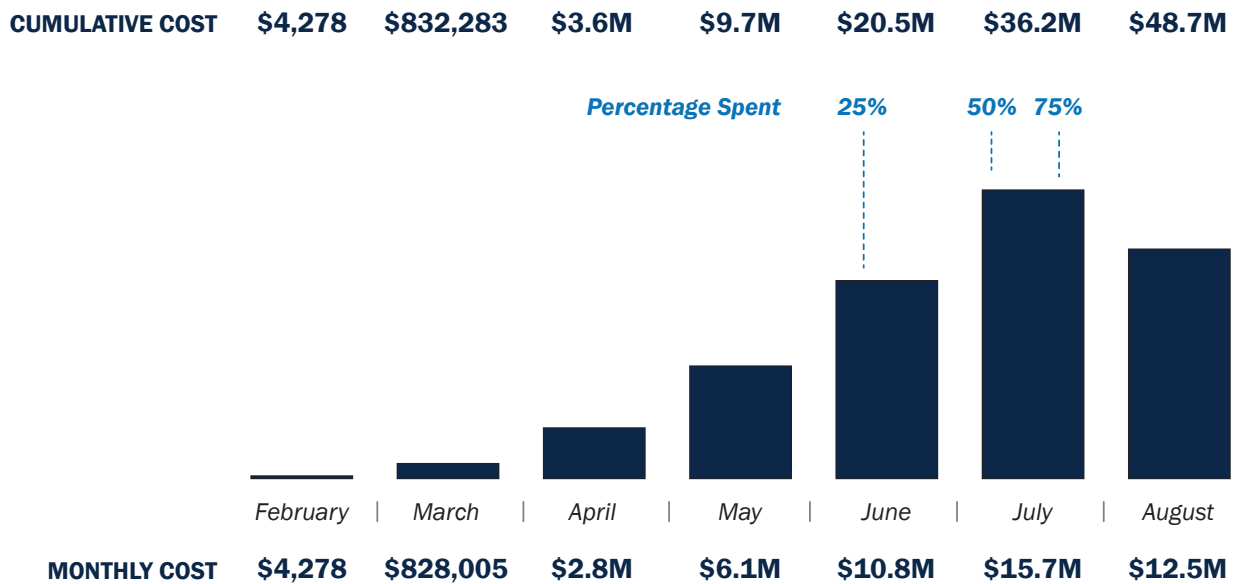
The FEHBP paid for 650,211 COVID-19 tests from February through August 2020. The majority of those (81%) were viral tests, which detect current COVID-19 infections. The remaining 19% were antibody tests, which detect previous COVID-19 infections.



Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

HOW MUCH DID THE FEHBP PAY FOR TESTS?

Exhibit 7. The FEHBP paid at least \$48.7 million for COVID-19 testing from February through August 2020.



Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

Note: Because this amount is from only two of the FEHBP’s larger carriers, the FEHBP likely paid more for COVID-19 tests.

Exhibit 8. The FEHBP paid an average of \$75 for a COVID-19 test.

The cost per test paid by FEHB carriers ranged from \$0 to \$300. The average cost of testing fluctuated over time, increasing overall as COVID-19 testing technology developed and the FEHBP reimbursement rates were established for new tests.

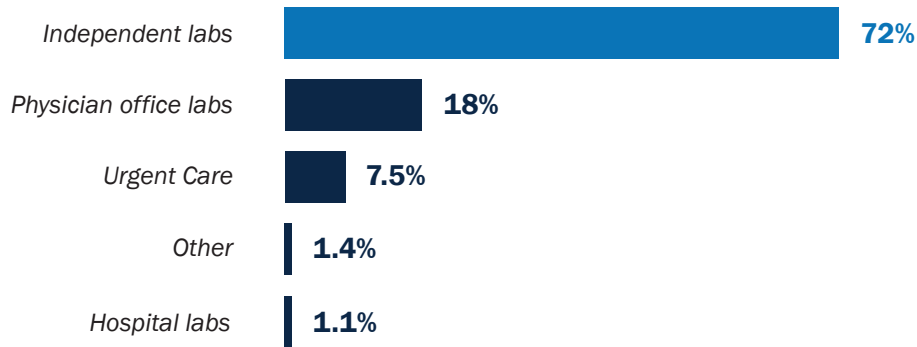


Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

IN WHAT HEALTH CARE SETTINGS DID PEOPLE ACCESS TESTING?

Exhibit 9. Nearly all COVID-19 tests for enrollees in the FEHBP occurred in independent labs, physician office labs, and urgent care facilities.

Retail walk-in clinics represented the largest proportion of testing accessed through “Other Facilities.”



Source: OPM OIG analysis of FEHBP claims data, February 1–August 31, 2020.

Note: Percentages may not sum to 100% because of rounding.

HOW LONG DID IT TAKE TO RETURN TEST RESULTS?

Because test results are typically noted in medical records, this data point was not available in FEHBP claims data.

Rapid antigen tests, with results typically available in as little as 15 minutes, made up almost 5% of all viral testing during the time period from February through August 2020.

U.S. Department of Labor (DOL)

Within DOL, the Office of Workers' Compensation Programs (OWCP) administers four major disability compensation programs, which provide wage replacement benefits, medical treatment, vocational rehabilitation, and other benefits to certain workers or their dependents who experience work-related injury or occupational disease.

OWCP role in COVID-19 response. Three disability compensation programs have roles in responding to COVID-19 within OWCP:

- **Federal Employees' Compensation Act (FECA) Program.** FECA provides workers' compensation coverage to federal workers in the event of workplace injury or illness, including developing COVID-19 while in the performance of their federal duties. The FECA Program is responsible for adjudicating COVID-19 claims for benefits and managing ongoing cases; paying medical expenses and compensation benefits to workers and survivors; and helping employees return to work when they are medically able to do so.
- **Energy Workers Program.** The Energy Employees Occupational Illness Compensation Program Act provides compensation and medical benefits to current or former Department of Energy employees and contractors who contracted certain illnesses as a result of occupational exposure during the production of nuclear weapons. The Energy Workers Program is responsible for helping to ensure beneficiaries continue to receive their benefits during the COVID-19 public health emergency.
- **Black Lung Program.** The Black Lung Benefits Act provides compensation to coal miners who are totally disabled by pneumoconiosis arising out of coal mine employment, and to eligible survivors in the event of their death. The Act also provides eligible miners with medical coverage for the treatment of lung diseases related to pneumoconiosis, which may include coverage for COVID-19 services. The Black Lung Program is responsible for continuing to process claims and issue benefit payments while working to ensure claimants are safe during this crisis.

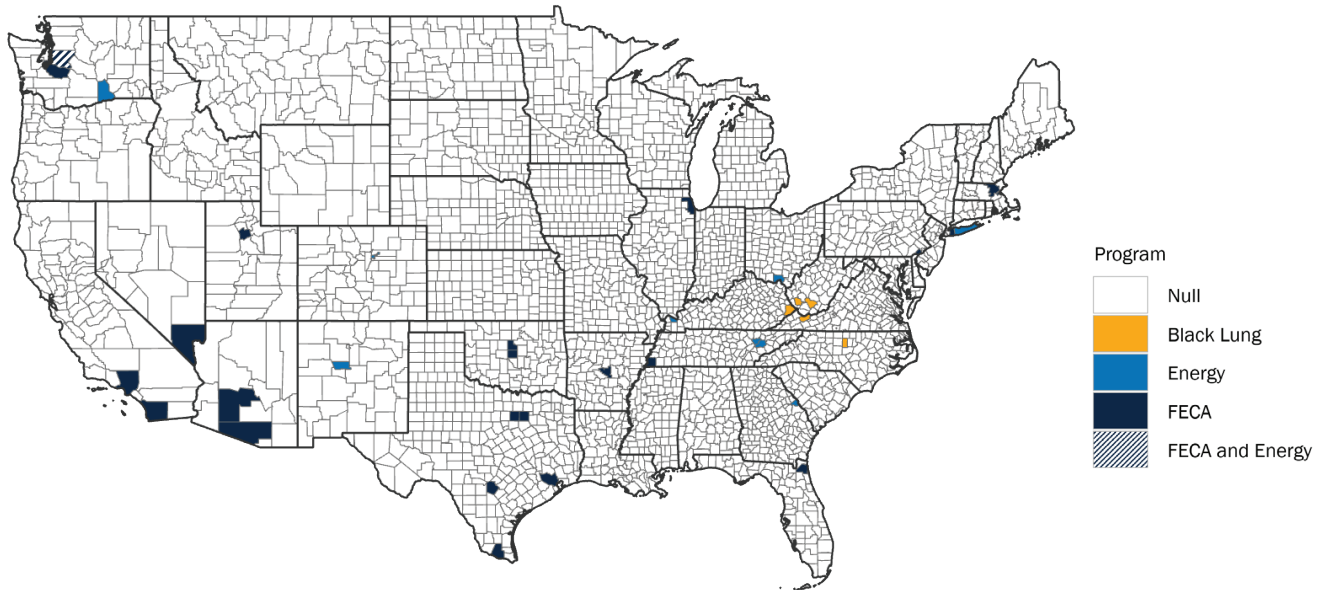
Testing in OWCP. OWCP requires medical evidence to adjudicate claims from FECA claimants who allege to have been exposed to COVID-19 in the performance of their federal job duties. Prior to accepting a FECA claim, OWCP will pay for COVID-19 testing only if a claimant was exposed to a person with a confirmed diagnosis of COVID-19 in the performance of duty or if the claimant worked in high-risk employment. If the claim is accepted, OWCP will pay for the testing through a reimbursement to the claimant. If the claim is not accepted, OWCP will not pay for the test unless the case was administratively closed.

In the Energy Workers and Black Lung Programs, OWCP will pay for COVID-19 testing when it is deemed to be associated with necessary treatment of an existing covered condition. An example of a covered condition is pneumoconiosis for Black Lung claimants.

Scope of DOL Brief. This brief provides information on COVID-19 tests administered to OWCP claimants during the time period of February 1, 2020, to August 31, 2020, that OWCP paid for or was billed for. (See [Appendix C: DOL](#) for DOL OIG's methodology.)

Exhibit 1. COVID-19 testing among OWCP claimants from February through August 2020.

DOL testing clustered in areas where people were enrolled in eligible OWCP programs.

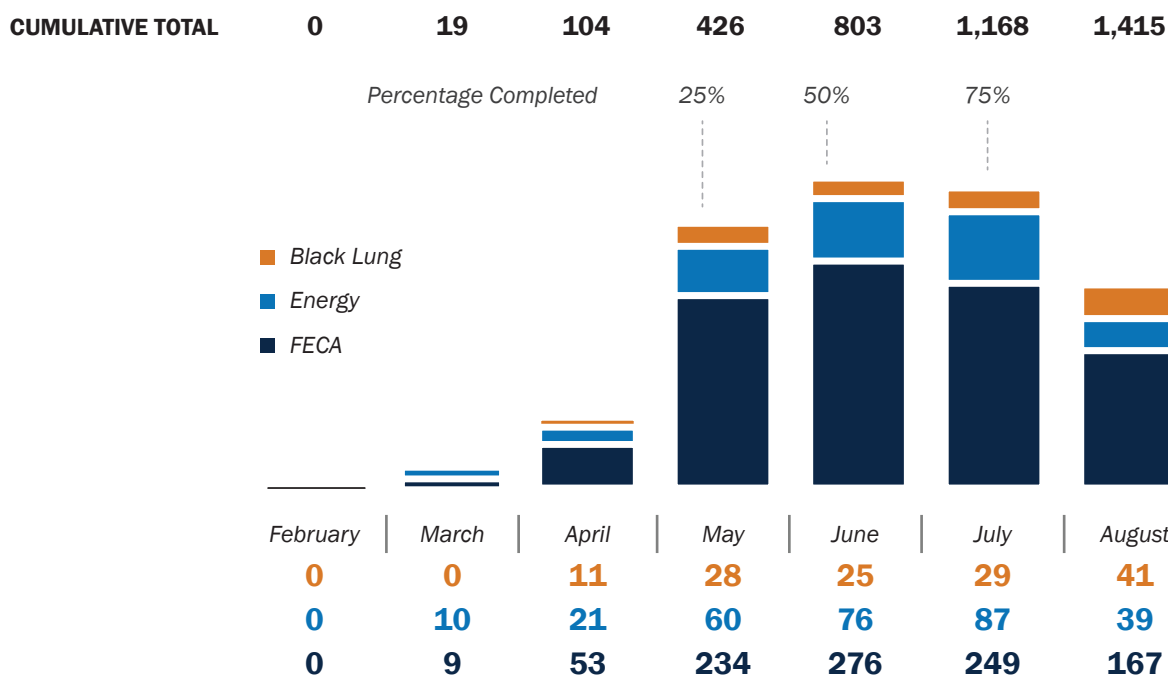


Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

HOW MANY WERE TESTS ADMINISTERED, AND WHEN?

Exhibit 2. OWCP received claims for 1,415 COVID-19 tests from February through August 2020 across three programs.

FECA claims for tests substantially increased from April to May, peaked in June, and then decreased across July and August. OWCP stated that it did not know why claims for tests increased or decreased in a given period because it did not have a mechanism in place to check the reasons. Because of the pandemic, any visit to a Health care provider potentially required a COVID-19 test to determine if treatment could be safely rendered to a claimant.



Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

Exhibit 3. FECA claims accounted for most of the 1,415 OWCP claims for COVID-19 tests from February through August 2020.

FECA received 988 claims for tests, the Energy Workers Program received 293 claims for tests, and the Black Lung Program received 134 claims for tests.

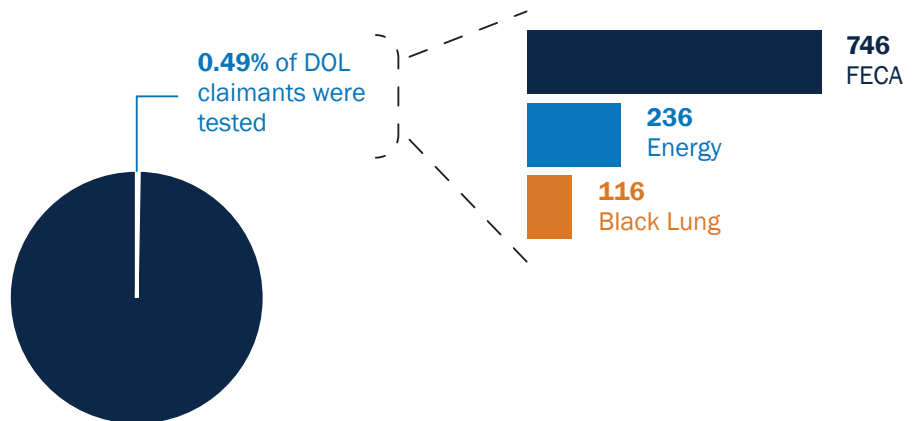


Source: DOL OIG analysis of OWCP claims data, February 1-August 31, 2020.

WHO WAS TESTED?

Exhibit 4. 1,098 claimants received at least one COVID-19 test from February through August 2020.

Of the 223,055 claimants in OWCP, less than 1% received a COVID-19 test. FECA is the largest of the three OWCP programs with 187,537 claimants. Of these, 746 claimants—or less than 1%—received a test.



Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

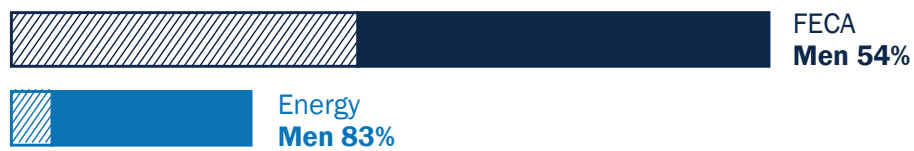
The claimants in the Energy Workers Program and Black Lung Program are particularly vulnerable to the risks of COVID-19, as these people tend to be older and have serious existing underlying conditions. The Energy Workers Program provides medical and other benefits to 22,618 claimants. About 1% of the Energy Workers Program, or 236 claimants, received at least one test.

The Black Lung Program, the smallest of the three programs, provides medical and other benefits to 12,900 claimants. Like the Energy Workers Program, the Black Lung Program had about 1% of claimants receiving at least one test.

Exhibit 5. Across the FECA and Energy Workers programs, more men were tested than women.

Of those in the FECA Program who received a COVID-19 test, 54% were men. In the FECA Program population, 57% of claimants overall were men, but the proportion of male and female claimants tested were the same.

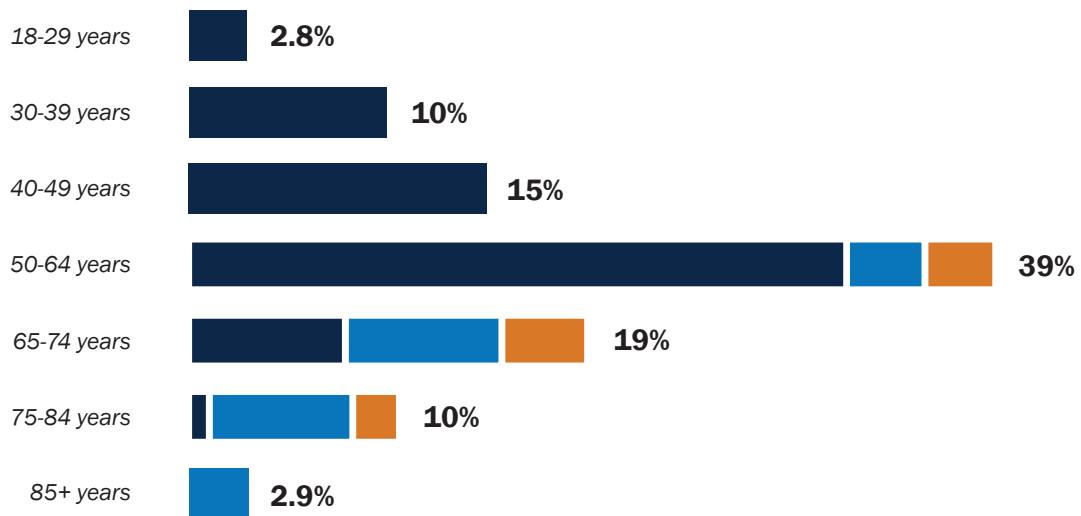
Of those in the Energy Workers Program who received a test, 83% were men. The Energy Workers Program has substantially more men enrolled (82%) than women (18%), but the proportion of female claimants (0.4%) and male claimants (0.4%) were the same.



Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

Note: The Black Lung Program was unable to provide gender information because its system does not capture that type of information.

Exhibit 6. Across all three OWCP programs, 72% of claimants who received a COVID-19 test were age 50 or older.



Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

Note: People age 0–17 years represent 0% of claimants across all three OWCP programs.

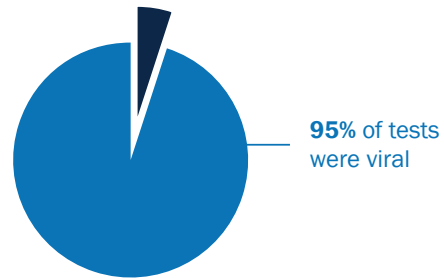
Percentages may not sum to 100% because of rounding.

This section does not include demographic information on race/ethnicity because OWCP does not collect this type of demographic information in its claims data.

WHAT TYPES OF TESTS WERE ADMINISTERED?

Exhibit 7. 1,344 COVID-19 tests billed to OWCP were viral tests.

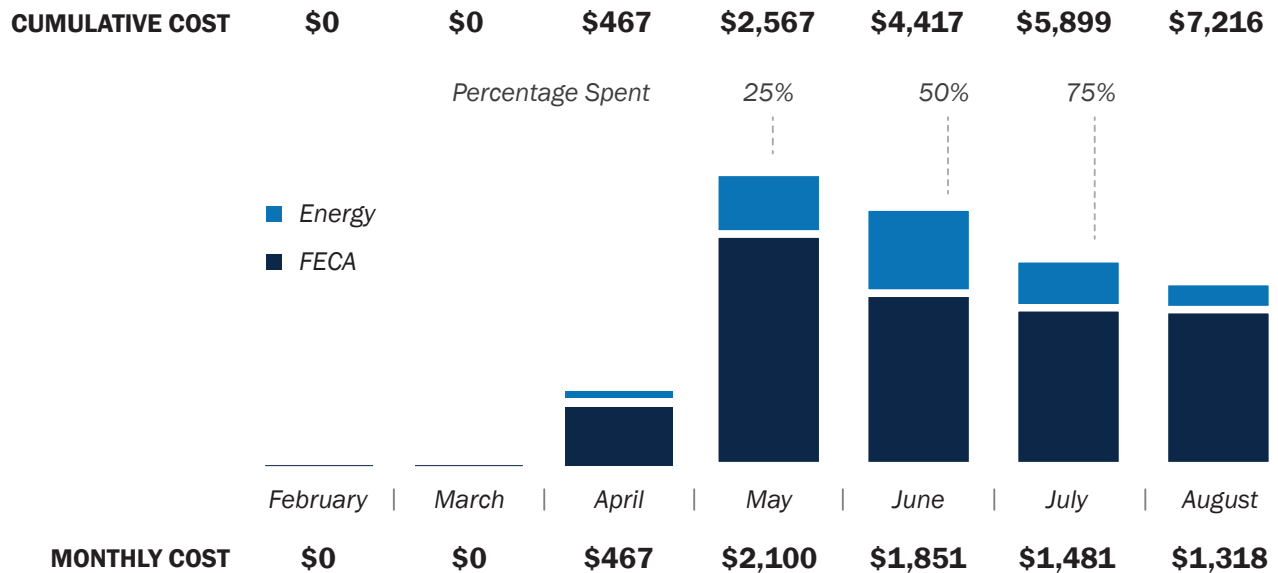
OWCP paid for 1,415 COVID-19 tests from February through August 2020. The majority of those were viral tests, which detect current COVID-19 infections. The remaining 5% were antibody tests, which detect previous COVID-19 infections.



Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

HOW MUCH DID OWCP PAY FOR TESTS?

Exhibit 8. OWCP paid just over \$7,000 for COVID-19 testing from February through August 2020.

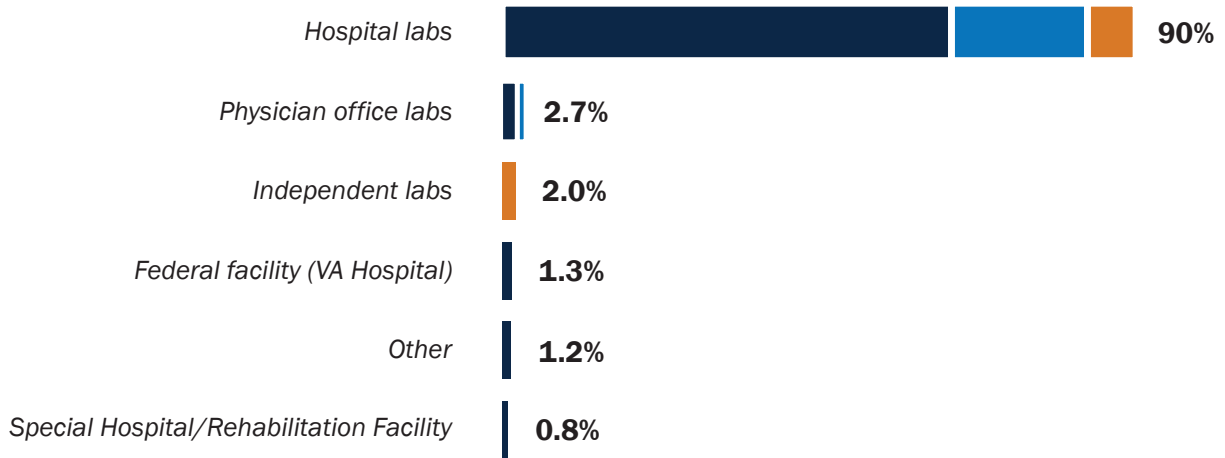


Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

Note: To provide a fuller picture of the number of tests administered to claimants, OWCP provided data on all tests billed, as well as for tests it paid for. The difference between these numbers is due to claims being denied or suspended, as well as a small number of claims to be paid in the future. The Black Lung Program received claims for COVID-19 tests but as of the time of the data collection, none of the tests had been reimbursed by DOL.

IN WHAT HEALTH CARE SETTINGS DID PEOPLE ACCESS TESTING?

Exhibit 9. 90% of COVID-19 tests billed to OWCP were performed at hospital labs.



Source: DOL OIG analysis of OWCP claims data, February 1–August 31, 2020.

Note: Percentages may not sum to 100% because of rounding.

HOW LONG DID IT TAKE TO RETURN TEST RESULTS?

OWCP claims do not include information on test turnaround times.

U.S. Department of Veterans Affairs (VA)

VA serves American veterans through its various programs, including veterans' health care provided through the Veterans Health Administration (VHA), the largest integrated health care network in the United States. As of February 1, 2020, 8.9 million veterans were enrolled in VHA health care. In addition to caring for veterans, VA's "Fourth Mission" is to support national, state, and local emergency management and public health, safety, and homeland security efforts, such as efforts in response to the COVID-19 pandemic.⁵⁹

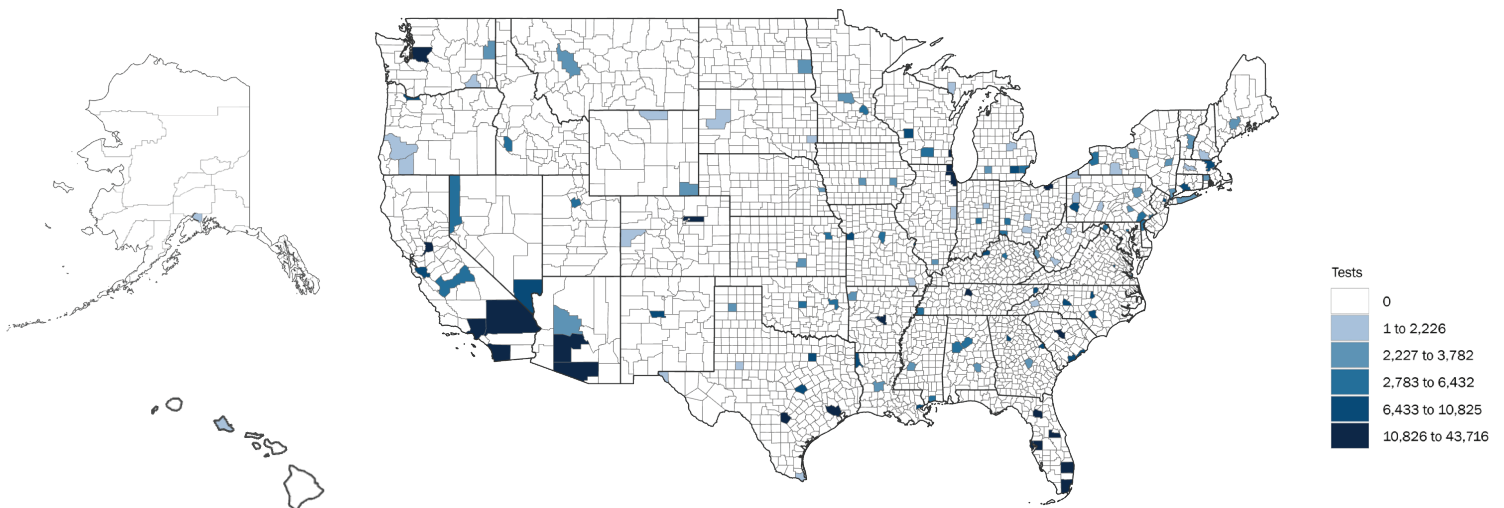
VHA developed a comprehensive response and operations plan for the COVID-19 pandemic first published March 23, 2020, to protect veterans, their families, and workforce from COVID-19. The mission of the VHA in conjunction with VA's "Fourth Mission" is to coordinate activities with HHS to:

1. Limit the spread of COVID-19 infection to veterans and staff;
2. Provide care for those infected with COVID-19;
3. Provide continuity of care for noninfected Veterans; and
4. Provide resources to HHS in support of Emergency Support Functions mission assignment tasking as requested.⁶⁰

Testing in the VHA. VHA provides COVID-19 testing for both veterans enrolled in the VHA program and nonveterans, such as VA employees and volunteers. VHA also provides testing to some active duty military and TRICARE beneficiaries. VHA provides testing on an emergency or humanitarian basis for individuals who are not eligible for VHA health care.

Scope of VA Brief. The VA OIG analysis focused on COVID-19 tests administered at VHA facilities during the time period of February 1, 2020, to August 31, 2020. (See [Appendix D: VA](#) for VA OIG's methodology.)

Exhibit 1. COVID-19 tests administered at VHA facilities from February through August 2020.

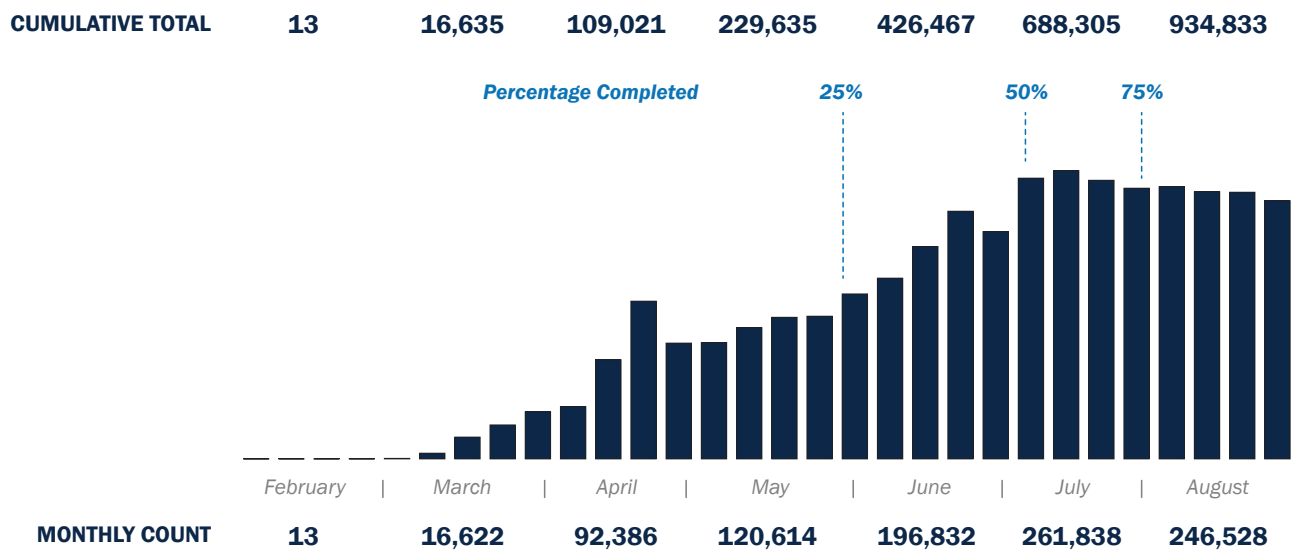


Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, February 1–August 31, 2020.

HOW MANY TESTS WERE ADMINISTERED, AND WHEN?

Exhibit 2. 934,833 tests were performed at VHA facilities from February through August 2020. The rate of testing at VHA facilities increased substantially in April and peaked in July.

As COVID-19 tests became more widely available, VHA saw an increase in the number of tests administered at VHA facilities, beginning in April. Testing at VHA facilities peaked in July, with more than 62,000 tests administered in a single week. More than half (54%) of COVID-19 tests were administered in July and August.

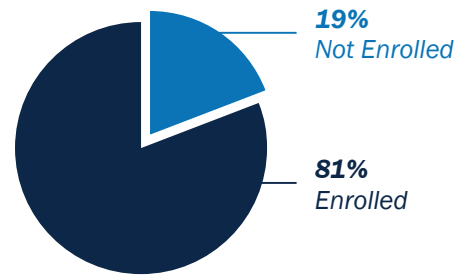


Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, February 1–August 31, 2020.

WHO WAS TESTED?

Exhibit 3. 448,352 veterans enrolled in the VHA health care program received at least one COVID-19 test at a VHA facility from February through August 2020.

VHA administers COVID-19 tests to veterans enrolled in the VHA program and VA employees, as well as to individuals in the community as part of its mission.



Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, February 1–August 31, 2020.

From February through August, 553,687 people received at least one COVID-19 test at VHA facilities. Most of those who received a test at VHA facilities were veterans or veteran VA employees. Those not enrolled in the VHA program include nonveteran VA employees and volunteers; CHAMPVA beneficiaries; TRICARE beneficiaries; active duty service members; and others who were served on a humanitarian basis.

ENROLLED IN VHA

Veteran. Individual who served in the active military, naval, or air service, and did not receive a dishonorable discharge.

Veteran Employee. Veteran who is employed at a VHA facility.

NOT ENROLLED IN VHA

Nonveteran Employee. Individual who is employed at a VHA facility.

TRICARE. Beneficiary of the DOD health care program for Uniformed Service members, retirees, and their families.

Active Duty. Individual who is on full-time duty for the Uniformed Services of the United States.

Others. Individuals receiving care while serving as volunteers at a VHA facility, as beneficiaries of the VA's Civilian Health and Medical Program (CHAMPVA—e.g., qualified spouse, surviving spouse, child of a veteran with disabilities or a veteran who has died), and individuals who were served on a humanitarian basis.

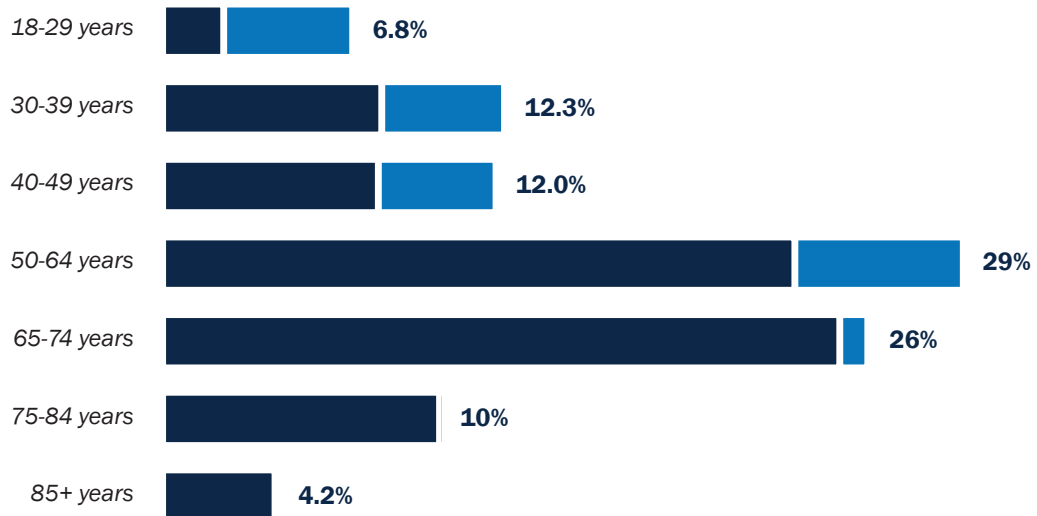
Exhibit 4. Most people who received COVID-19 tests at VHA facilities were men.

Of those not enrolled in the VHA program, more women received COVID-19 testing at VHA facilities compared to men.



Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, February 1–August 31, 2020.

Exhibit 5. 40% of people who received a COVID-19 test at a VHA facility were age 65 years and older.

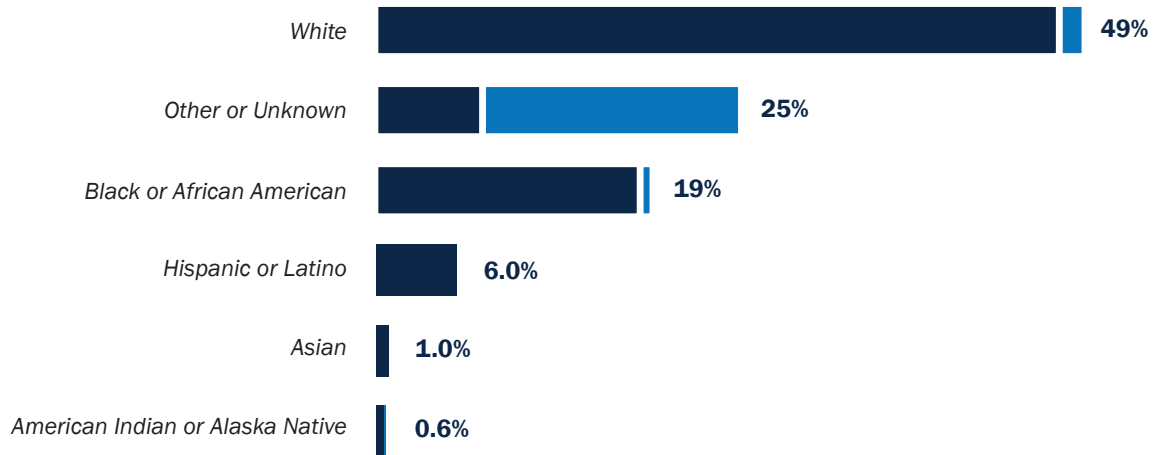


Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, February 1–August 31, 2020.

Note: People age 0-17 years represent 0% of those enrolled in VHA and 0.03% of those not enrolled who received a COVID-19 test.

Percentages may not sum to 100% because of rounding.

Exhibit 6. 49% of people who received tests at a VHA facility identified as White.

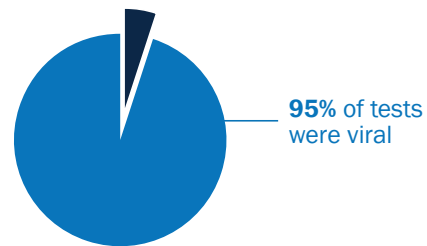


Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, from February 1–August 31, 2020.
 Note: “Non-Hispanic” has been truncated from category descriptors.
 Percentages may not sum to 100% because of rounding.

WHAT TYPES OF TESTS WERE ADMINISTERED?

Exhibit 7. VHA administered 934,833 COVID-19 tests from February through August 2020.

Almost all tests performed at VHA facilities from February through August were viral tests, which detect current COVID-19 infections. The remaining 5% were antibody tests, which can detect previous COVID-19 infections.



Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, February 1–August 31, 2020.

IN WHAT HEALTH CARE SETTINGS DID PEOPLE ACCESS TESTING?

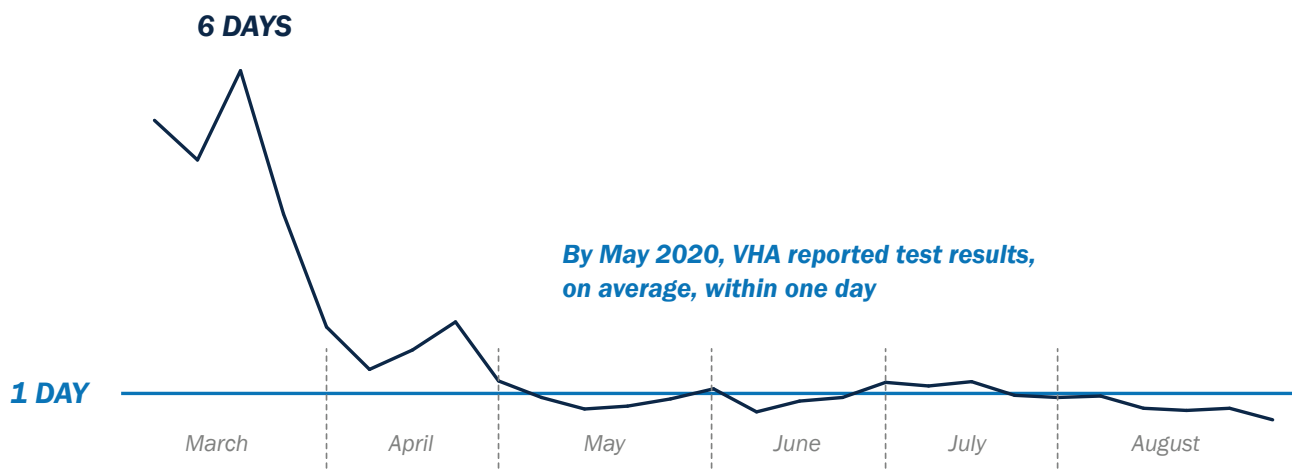
Veterans, and in some cases nonveterans, have access to more than 1,200 health care facilities across the United States, including 170 medical centers and more than 1,000 outpatient sites. While the primary mission of the VHA is to provide care and testing to veterans, VHA facilities also aim to limit COVID-19 spread and support national, state, and local efforts during a public health emergency. Almost 30% of tests were provided to VA employees, highlighting VHA’s commitment to limit the spread of infection to patients and staff.

VHA performed 934,833 COVID-19 tests at 139 VHA administrative parent facilities from February through August 2020. Most of these facilities provided testing to more enrolled veterans and veteran employees than to people who were not enrolled. In two-thirds of VHA facilities, enrolled veterans and veteran employees accounted for 80% or more of all COVID-19 testing.

One facility provided about 90% of its COVID-19 tests to people not enrolled in VHA. This facility, The Captain James A. Lovell Federal Health Care Center, is a partnership between VA and DOD. Of the tests provided to nonenrolled individuals, 93% were completed on TRICARE beneficiaries.⁶¹

HOW LONG DID IT TAKE TO RETURN TEST RESULTS?

Exhibit 8. VHA saw a decrease in the average number of days it took to return results for COVID-19 tests administered from March through August 2020.



Source: VA OIG analysis of COVID-19 tests performed at VHA facilities, February 1–August 31, 2020.

Note: Consistent reporting of test turnaround times began in March, which was also the first month of substantial testing volume at VHA facilities.

HOW MUCH DID VHA PAY FOR TESTS?

Cost to VHA for COVID-19 tests cannot be calculated at the time of this data brief because funds are allocated to medical centers on the basis of patient workload rather than for individual services. VHA is currently paying for testing through national contract buys and has not calculated the final price per test.

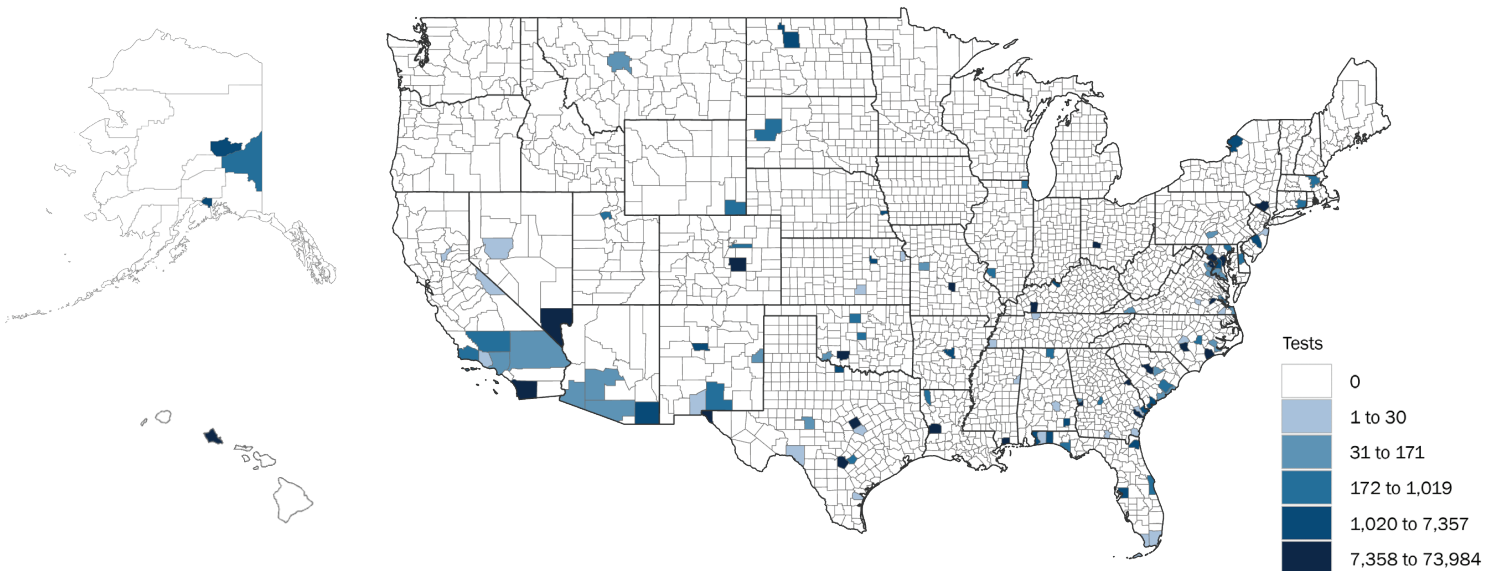
U.S. Department of Defense (DOD)

DOD provides health care coverage to military service members and their families; as well as retirees, their families, survivors, and certain former spouses through the Military Health System. This system provides health care services and support—including COVID-19 testing and medical care—through the TRICARE Health program. Health care services are available in DOD medical treatment facilities (MTFs) found at military bases and through civilian health care provider facilities.

Testing in DOD. In early February 2020, COVID-19 tests were made available to beneficiaries at MTFs or through TRICARE-authorized civilian health care providers. An MTF is a military facility established for the purpose of furnishing medical care to eligible individuals. MTFs are located on military bases and posts around the world. In fiscal year (FY) 2020, the Military Health System had about 50 inpatient hospitals and medical centers, and 425 ambulatory care and occupational health clinics, according to the Defense Health Agency’s FY 2020 Evaluation of the TRICARE Program.⁶²

Scope of DOD Brief. This data brief provides information on COVID-19 testing ordered and performed at MTFs from February 1, 2020, to August 31, 2020. This analysis does not include (1) tests ordered at MTFs and sent to outside laboratories for testing, (2) tests performed by MTFs for outside facilities, or (3) tests administered by TRICARE-authorized civilian health care providers. (See [Appendix E: DOD](#) for DOD OIG’s methodology.)

Exhibit 1. COVID-19 testing at DOD MTFs from February through August 2020.

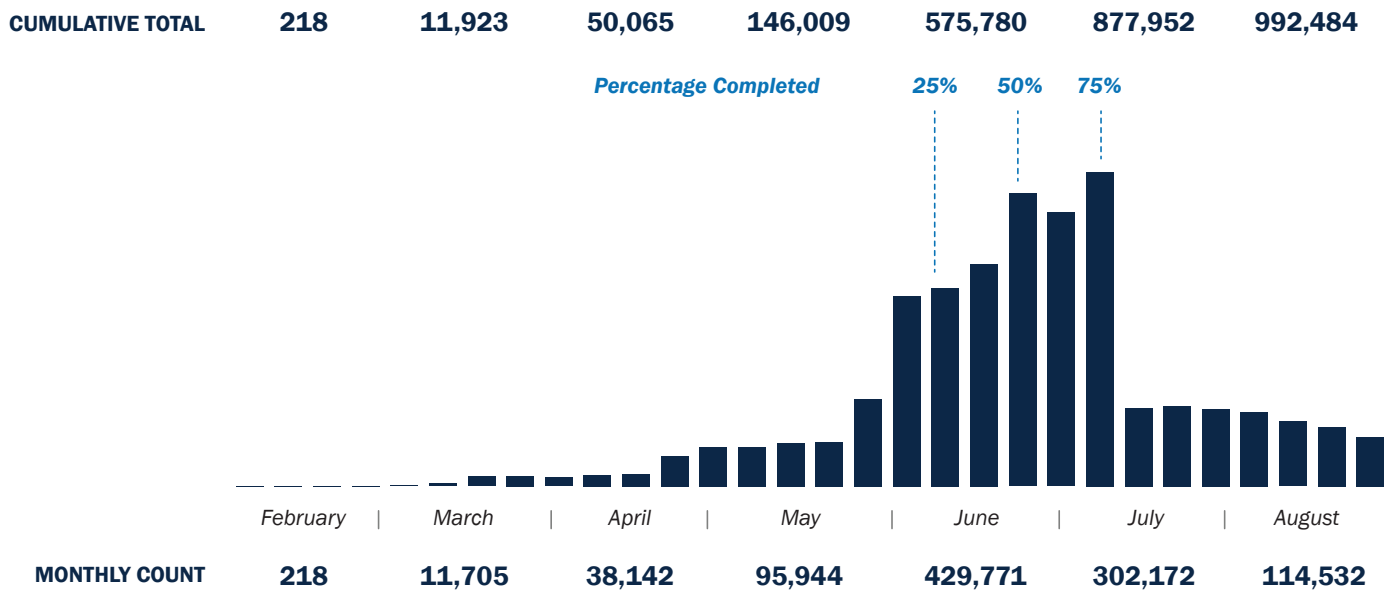


Source: DOD OIG analysis of COVID-19 tests performed at MTFs, February 1–August 31, 2020.

HOW MANY TESTS WERE ADMINISTERED, AND WHEN?

Exhibit 2. DOD MTFs provided 992,484 COVID-19 tests from February through August 2020. The number of tests increased substantially from May through June, then peaked in early July.

MTFs experienced a surge in testing during the last week of June, performing almost 125,000 tests. MTFs reached their highest peak of testing in the second week of July, with 134,116 tests administered to beneficiaries. The drop in testing in late July and August is not consistent with testing trends reported elsewhere in DOD and may be a result of a lag in available data at the time the data was pulled.

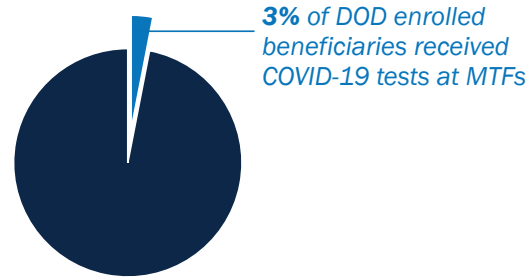


Source: DOD OIG analysis of COVID-19 tests performed at MTFs, February 1–August 31, 2020.

WHO WAS TESTED?

Exhibit 3. 319,674 beneficiaries received at least one COVID-19 test at an MTF from February through August 2020.

The DOD provides health care coverage to 9.6 million beneficiaries. Specifically, MTFs provide health care to active duty service members and their family members; retirees and their family members; survivors; certain military members not on active duty; certain foreign military members; and other individuals in special or extraordinary circumstances.



Source: DOD OIG analysis of COVID-19 tests performed at MTFs, February 1–August 31, 2020.

Active duty service members account for 204,541 of the beneficiaries who received a COVID-19 test. About 42,600 beneficiaries were dependents of military personnel, about 21,300 were retirees, and the remaining— about 51,200—were considered “Other” or their beneficiary status was not captured in data stored in the Military Health System Data Repository.

Exhibit 4. More men received COVID-19 tests at MTFs than women.

Women accounted for about half of the population covered by the Military Health System, but they accounted for less than one-third of those tested at an MTF.

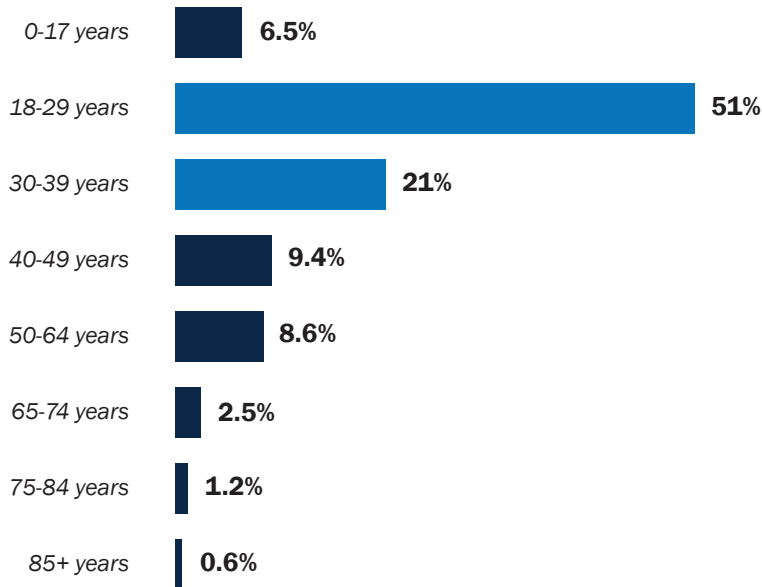


Source: DOD OIG analysis of COVID-19 tests performed at MTFs, February 1–August 31, 2020.

Note: 5% of people who received testing at MTFs were categorized as “other or unknown gender” in DOD’s data.

Exhibit 5. 71% of beneficiaries tested at MTFs were age 18 to 39 years.

227,326 beneficiaries between the ages of 18 and 39 years received at least one COVID-19 test. 81% of beneficiaries within this age group who received tests were active duty service members.



Source: DOD OIG analysis of COVID-19 tests at MTFs from February through August 2020.
 Note: Percentages may not sum to 100% because of rounding.

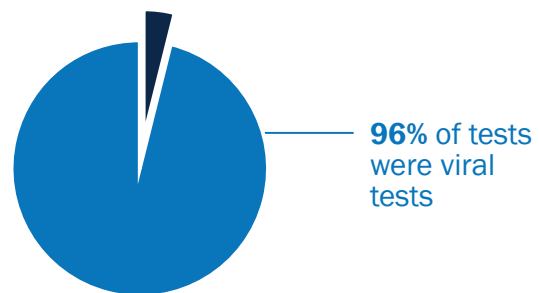
This section does not include demographic information on race/ethnicity because data about COVID-19 testing at MTFs did not include this type of demographic information.

WHAT TYPES OF TESTS WERE ADMINISTERED?

Exhibit 6. 953,333 COVID-19 tests performed at MTFs were viral tests.

Close to 1 million COVID-19 tests were administered at MTFs across the United States. Almost all of these were viral tests, which detect current COVID-19 infections. MTFs administered only a small percentage of antibody tests, which detect previous COVID-19 infections.

Laboratory test orders for viral tests included nucleic acid tests, rapid antigen tests, and respiratory pathogen panel tests that can detect multiple pathogens—including SARS-CoV-2—using one specimen.

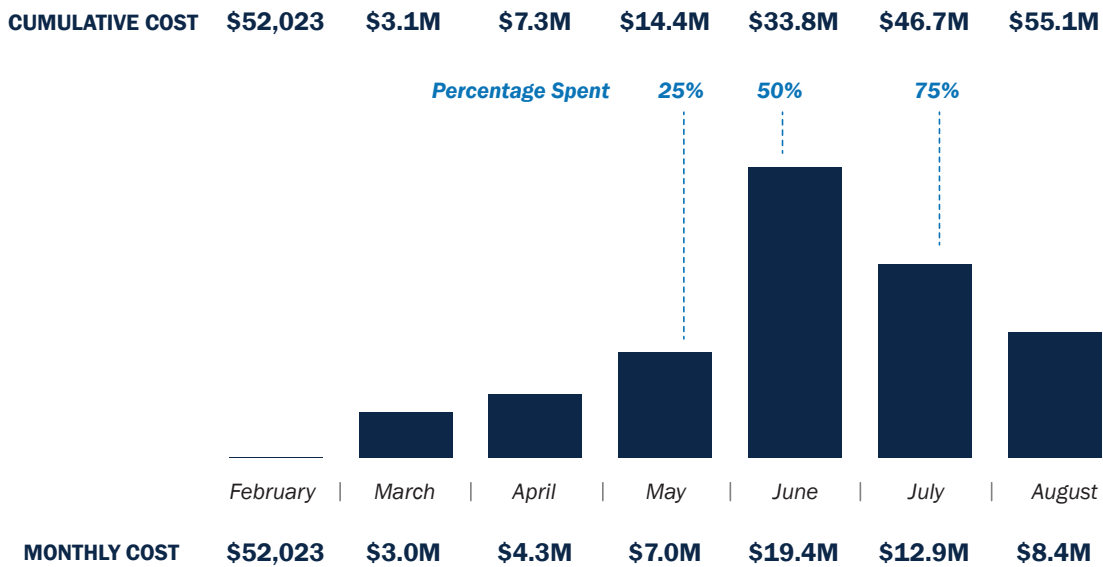


Source: DOD OIG analysis of COVID-19 tests performed at MTFs, February 1–August 2020.

HOW MUCH DID DOD PAY FOR TESTS?

Exhibit 7. DOD paid about \$55.1 million for COVID-19 testing performed at MTFs from February through August 2020.

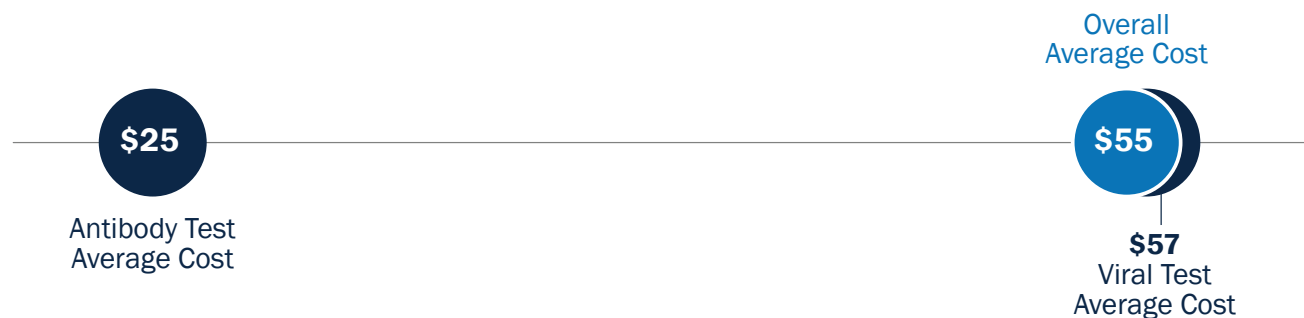
Payments for testing increased monthly from February to June, generally in line with increases in the volume of testing. DOD costs for tests performed in MTFs peaked in June at \$19.4 million.



Source: DOD OIG analysis of COVID-19 tests performed at MTFs, February 1–August 31, 2020.

Exhibit 8. DOD paid an average of \$55 for a COVID-19 test.

The average cost of testing decreased from a high of \$258 in March to a low of \$43 in July. The decrease in average cost is partly due to new DOD reimbursement rates for COVID-19 tests.



Source: DOD OIG analysis of COVID-19 tests performed at MTFs, February 1–August 31, 2020.

IN WHAT HEALTH CARE SETTINGS DID PEOPLE ACCESS TESTING?

Beneficiaries received almost 1 million COVID-19 tests at different types of MTFs, such as military medical centers, hospitals, and clinics located on military bases.⁶³ Beneficiaries may have also received tests in facilities other than MTFs, such as TRICARE-authorized civilian health care providers; tests performed at these facilities are not included in this report.

Medical Centers

- Largest type of MTF
- Offer hospitalization and outpatient services
- Multiple specialties and subspecialties
- Serve as trauma centers in the community for military and civilian patients
- Usually participate in General Medical Education and medical research programs

Hospital

- Smaller than medical centers
- Offer hospitalization and outpatient services
- Multiple specialties but not subspecialties

Clinics

- Smallest military facility
- Offer only outpatient services, with no hospitalization
- Limited number of specialties
- Some clinics limited to primary care only
- Some clinics limited to active duty service members only

Source: Defense Health Agency⁶⁴

HOW LONG DID IT TAKE TO RETURN TEST RESULTS?

The average time it took to return COVID-19 test results substantially improved in May, compared to the start of the pandemic. For example, average turnaround time in March ranged as high as 4.5 days; however, turnaround time in parts of April through July was less than a day.

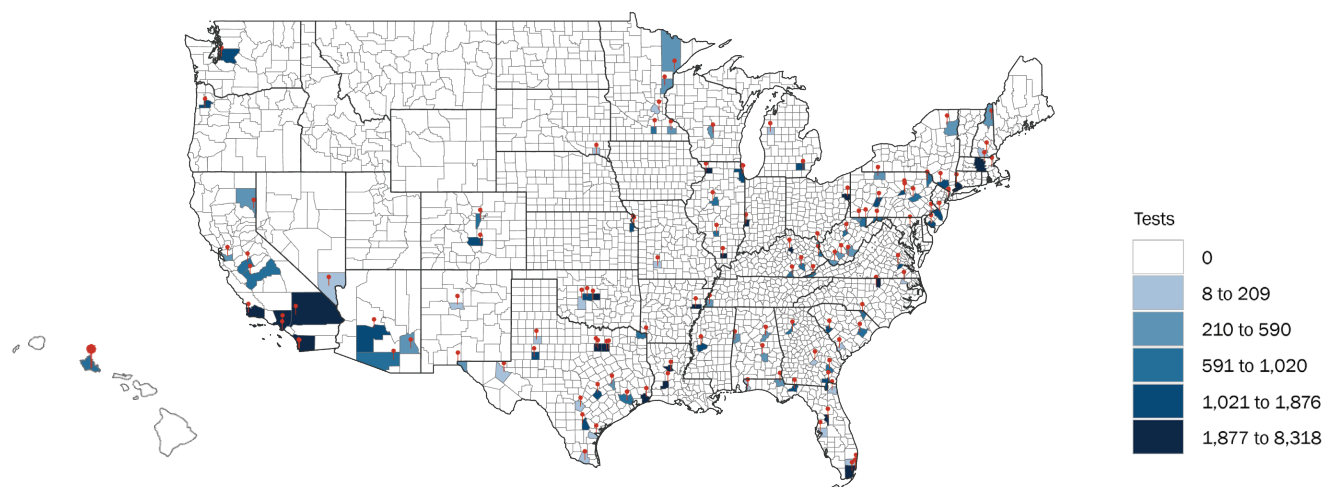
U.S. Department of Justice (DOJ)

The Federal Bureau of Prisons (BOP) is the largest component of the Department of Justice, by staffing, and is responsible for protecting society by confining federal inmates in controlled environments that are safe, cost-efficient, and secure. As part of this mission, the BOP must ensure inmates in its custody are housed in humane facilities and receive adequate health care. The BOP provides for the medical care of the inmates in its custody through medical staff inside its prisons as well as through local health care providers. Most BOP inmates are housed in BOP-operated prisons, while small subsets of the BOP inmate population are assigned to the supervision of privately operated contract prisons and privately operated Residential Reentry Centers (RRCs)—also known as halfway houses—around the country.

Testing in the BOP. Testing of BOP inmates evolved between February and August 2020, in response to CDC recommendations, the availability of tests, and the evolution of outbreaks in BOP facilities. Since March 13, the BOP’s guidance has expanded to include both symptomatic and asymptomatic inmates. If there are limitations on the number of tests that can be performed at a given location, testing prioritization is done in consultation with BOP medical officials.

Scope of DOJ Brief. This data brief provides information on a floor estimate of COVID-19 testing during the time period of February 1, 2020, to August 31, 2020, for a cumulative total of 218,406 inmates in the jurisdictional custody of BOP throughout this timeframe. The BOP acknowledged that the data provided for this snapshot report is not complete, and it is working to update its records to more fully reflect the amount of testing that occurred. (See [Appendix F: DOJ](#) for DOJ OIG’s methodology.)

Exhibit 1. COVID-19 testing for inmates in BOP facilities from February through August 2020.



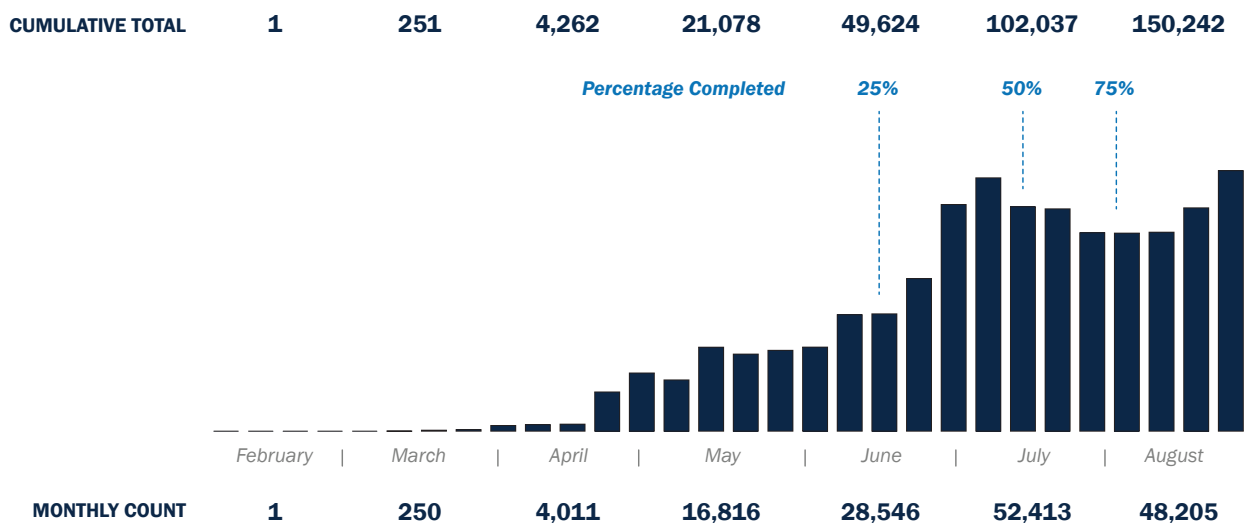
Source: DOJ OIG analysis of COVID-19 tests performed for inmates in BOP facilities, February 1–August 31, 2020.

Note: Facilities with fewer than eight tested inmates were excluded from the map to avoid disclosure issues.

HOW MANY TESTS WERE ADMINISTERED, AND WHEN?

Exhibit 2. At least 150,242 COVID-19 tests were administered for inmates in BOP facilities from February through August 2020.

Beginning in June, the volume of testing for inmates increased substantially, and two-thirds of all tests recorded since February were performed in July and August 2020. The progressive distribution of rapid testing machines out of the Strategic National Stockpile to all BOP-operated prisons contributed to this increase, as did the growing capacity of commercial laboratories and other local providers. The BOP also expanded testing as the virus progressed throughout the country.

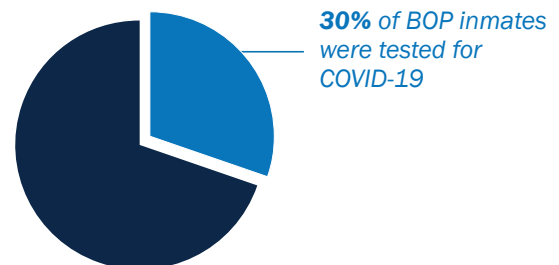


Source: DOJ OIG analysis of COVID-19 tests performed for inmates in BOP facilities, February 1–August 31, 2020.

WHO WAS TESTED?

Exhibit 3. At least 66,587 BOP inmates received at least one COVID-19 test between February and August.

Cumulatively, more than 218,000 inmates were in BOP jurisdictional custody during this time period, with 156,000 on its rosters at the end of August. More than 80% of these inmates were in BOP-operated prisons; the remaining inmate population was in privately operated contract prisons and RRCs.



Source: DOJ OIG analysis of COVID-19 tests performed for inmates in BOP facilities, February 1–August 31, 2020.

According to available records, 38% of inmates in BOP-operated prisons were tested, compared to 8% of inmates in privately operated contract prisons and 4% of inmates in contracted RRCs. Thus, 98% of the more than 150,000 reported tests were for inmates housed in BOP-operated prisons.

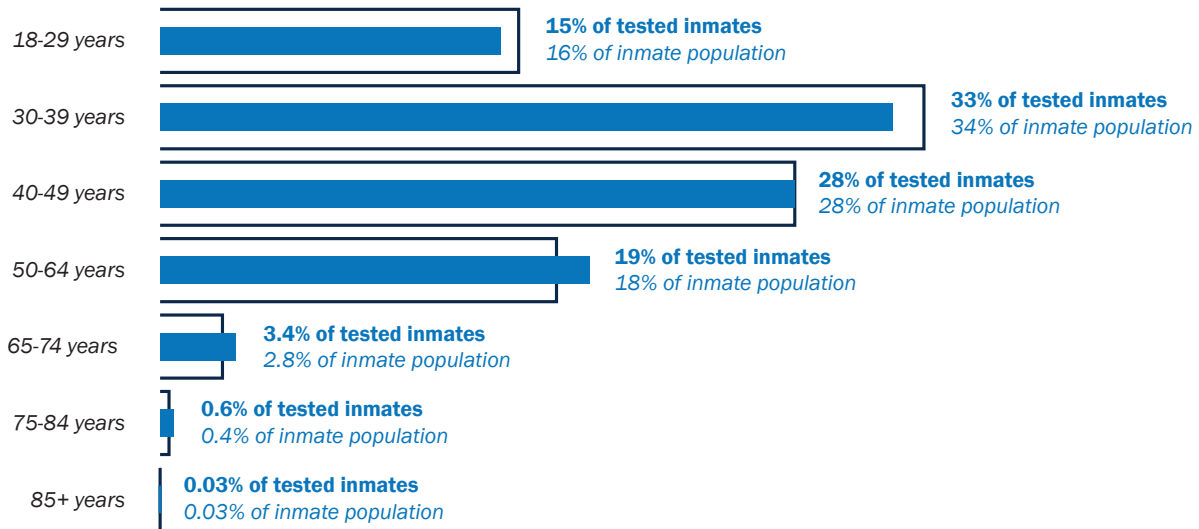
Exhibit 4. 91% of BOP inmates who received a COVID-19 test were men, which is proportional to the population of men in BOP custody.



Source: DOJ OIG analysis of COVID-19 tests performed for inmates in BOP facilities, February 1–August 31, 2020.
 Note: Gender data was unavailable for 0.6% of tested inmates.

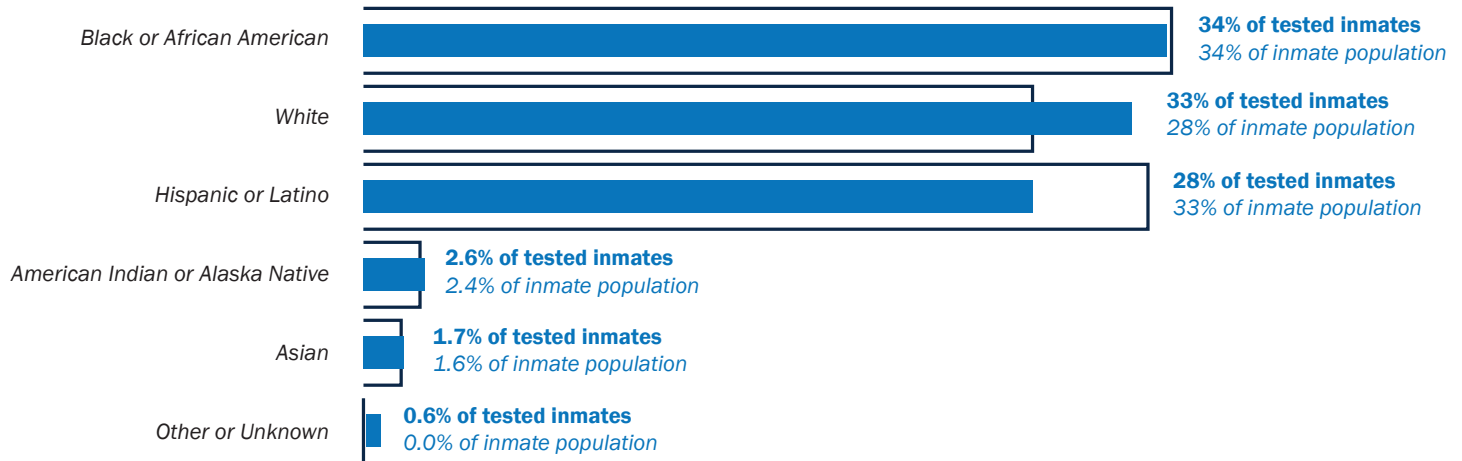
Exhibit 5. Most BOP inmates who received tests were younger adults, in line with their proportion among the inmate population.

About 4% of inmates who received tests were age 65 years and older, in line with their proportion among the inmate population. Inmates age 75 to 84 years old had the highest proportion tested; about 40% of this group were tested.



Source: DOJ OIG analysis of COVID-19 tests performed for inmates in BOP facilities, February 1–August 31, 2020.

Exhibit 6. The proportion of BOP inmates tested varied somewhat across race/ethnicity groups, with differing factors affecting testing rates.



Source: DOJ OIG analysis of COVID-19 tests performed for inmates in BOP facilities, February 1–August 31, 2020.

Note: “Non-Hispanic” has been truncated from category descriptors.

Percentages may not sum to 100% because of rounding.

A variety of factors affected the rate of testing. These factors were likely to include the following: the extent of an outbreak in a location; the underlying health conditions and ages of a facility’s inmates; the race/ethnicity mix of inmates in facilities that experienced COVID-19 outbreaks; and the localized testing strategy of facilities.

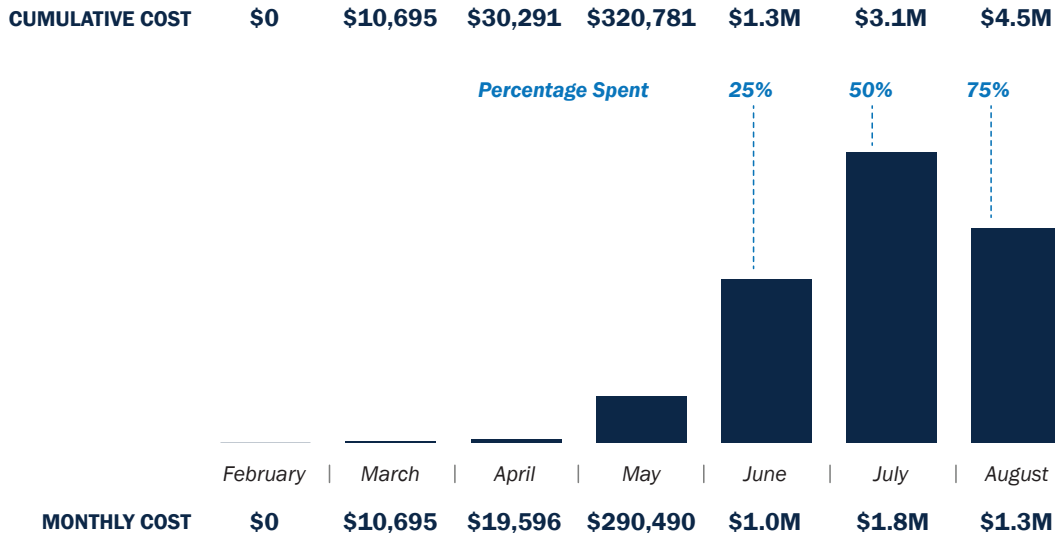
As noted previously, inmates assigned to BOP-operated prisons were more likely to receive a test than inmates assigned to contract prisons. For example, Hispanic and Latino inmates accounted for 28% of the population of BOP-operated prisons, which tested 38% of their total inmates, including 37% of their Hispanic and Latino population. In contrast, Hispanic and Latino inmates accounted for nearly 90% of inmates in contract prisons, which tested 8% of their total inmates, including 8% of their Hispanic and Latino population.

WHAT TYPES OF TESTS WERE ADMINISTERED?

All tests performed for inmates in BOP facilities were viral tests. The BOP used two types of viral tests: commercial molecular tests and rapid molecular RNA tests. Because of presumed superior sensitivity and specificity, the BOP used commercial molecular tests in certain situations, such as exit from quarantine. The BOP used rapid molecular RNA tests when the timing of results was critical, such as with symptomatic individuals.

HOW MUCH DID THE BOP PAY FOR TESTS?

Exhibit 7. The BOP paid at least \$4.5 million for COVID-19 tests administered to federal inmates from February through August 2020.



Source: DOJ OIG analysis of COVID-19 tests performed for inmates in BOP facilities, February 1–August 31, 2020.

The cost to the BOP for testing its inmates depended on the mechanism of testing. Commercial vendor nucleic acid tests accounted for more than 64,400 tests and made up the bulk of the BOP’s known testing costs. Since May 12, 2020, the cost to BOP has been \$69 per test under a national contract. From February through August 2020, commercial laboratory testing cost the BOP a total of almost \$4.5 million.

For the approximately 41,000 tests that were coordinated and administered locally, such as through hospitals and private laboratories, the BOP reported it could not determine the cost. The BOP estimated the associated costs were likely in line with the price per test that the BOP pays for its contracted commercial vendor tests. However, the overall cost of tests in this category would be reduced by the occurrence of some local initiatives for free testing, such as testing partnerships with local health departments. Estimated payments for the approximately 41,000 local tests are not included in the graph above.

Onsite rapid molecular RNA tests were of no cost to the BOP. HHS provided the BOP with rapid testing machines at no cost and resupplied the BOP with rapid testing kits, also at no cost. More than 44,500 rapid tests were performed.

IN WHAT HEALTH CARE SETTINGS DID PEOPLE ACCESS TESTING?

In general, most tested inmates received their tests at the prison facilities, with BOP or contract staff collecting samples. Inmates in BOP custody received tests via three general mechanisms:

- Rapid tests, which the BOP administered and analyzed in prisons;
- Commercial vendor tests, conducted via national contract between the BOP and a single commercial vendor; and
- Locally coordinated tests, such as those conducted by local health departments, hospitals, and private laboratories.

Rapid tests were processed and analyzed on site. Commercial vendor tests were also collected on site but then sent to national or regional labs for processing and analysis. Certain inmates received tests from other health care providers near their facilities; this was particularly true for RRC inmates, who generally receive all health care from community providers.

HOW LONG DID IT TAKE TO RETURN TEST RESULTS?

BOP officials reported that onsite rapid test results were typically available in as a little as 15 minutes. They further reported that commercial vendor test results were usually returned within 2–4 days, but that some facilities experienced 10–14 day waits for results in late July and early August because of a nationwide spike in cases and corresponding increased demand for testing.

Appendix A: HHS

Section 1. Methodology

Scope. The HHS OIG analysis focused on Medicare Part B laboratory claims for COVID-19 tests with dates of service during the time period of February 1, 2020, to August 31, 2020.

HHS OIG excluded COVID-19 tests paid for under the Medicare Part A and Part C programs. For example, services and laboratory testing associated with inpatient hospital stays and nursing home care are primarily covered by Medicare Part A; tests attributed to hospital and nursing homes in this analysis represent only a fraction of testing paid for by Medicare at these facility types. Similarly, services provided under Medicare managed care are paid through capitated payment arrangements in Medicare Part C and are not included.

Data sources. HHS OIG used Medicare Part B claims data from the National Claims History database. HHS OIG opted to use the National Claims History file, which includes only adjudicated claims. HHS OIG used two files within the National Claims History database: Physician/Supplier Part B claim files and Outpatient files. The Physician/Supplier Part B files primarily include claims from independent labs and physician office labs. The Outpatient files primarily include claims from hospital labs. HHS OIG also used Medicare Part B enrollment data as the source for demographic details and beneficiary location.

Methodology. HHS OIG analyzed Medicare Part B laboratory claims data to respond to the questions about COVID-19 testing posed by the PRAC Health care Subgroup.

Number and types of COVID-19 tests. HHS OIG used Current Procedural Terminology (CPT)⁶⁵ and Healthcare Common Procedure Coding System (HCPCS) codes to identify viral and antibody COVID-19 tests in the Medicare Part B laboratory claims. Codes for rapid antigen tests were counted as viral COVID-19 tests. Codes for combination tests—which use a single sample to test for multiple respiratory diseases, including COVID-19—were also counted as viral COVID-19 tests. The table below details the codes attributed to each test type.

<i>Viral Tests</i>	<i>Antibody Tests</i>
87635	86318
87426	86328
U0001	86769
U0002	86408
U0003	86409
U0004	86413
0202U	0224U
0223U	0226U
0225U	

HHS OIG identified the volume of all COVID-19 testing in Medicare Part B by week for the time period February 1, 2020, to August 31, 2020. HHS OIG also identified the volume of testing by type—viral or antibody. HHS OIG calculated total, monthly, and average costs associated with COVID-19 testing.

Demographics. HHS OIG used enrollment data to identify the demographic characteristics of beneficiaries with claims for COVID-19 testing. CDC analyses on the demographic categories with relatively high risks of COVID-19 hospitalization and death were used to determine demographic categories for age and race/ethnicity for analysis.^{66,67} HHS OIG used these categories to align our analysis with the current understanding of COVID-19 risk groups. For each demographic category, HHS OIG identified the number of beneficiaries who received testing and the total number of tests billed. HHS OIG then calculated the proportion of beneficiary population and testing represented by each demographic group.

Location. HHS OIG identified the facility types and geographic locations of COVID-19 testing, including both viral and antibody testing. Although hospitals and nursing homes are identified as facility types, these are different from claims paid through Medicare Part A.

To determine the geographic location of testing, HHS OIG used the provider address listed on the claim. HHS OIG used CDC's National Center for Health Statistics Urban-Rural Classification Scheme for Counties to determine the number of beneficiaries that lived in and received tests in urban and rural counties.

Cost of COVID-19 tests. HHS OIG calculated the total, monthly, and average paid amounts associated with COVID-19 testing.

Test result turnaround time. HHS OIG asked CMS if data was available for test result turnaround times for Medicare Part B beneficiaries. CMS responded that it does not collect data on test turnaround times, nor does it currently collect information necessary to calculate the data point. HHS OIG also asked CDC if it collected data on test result turnaround times for the Medicare Part B population or if it could provide such data for individuals age 65 and older. CDC responded that although it has data on test result turnaround times for the general population, it did not have turnaround time information by patient age or by insurer. While test result turnaround time was not available, antigen testing offered rapid results, so the proportion of antigen testing may offer some insight into the timing of results for that subset of testing.

Section 2. Limitations

A limitation of using the National Claims History files is that the entirety of claims that would be eventually covered for a given month, once processed, was unknown at the time of our analysis because of the potential for a lag time in adjudicating claims.

The demographic categories HHS OIG used, based on published CDC analyses, are not exhaustive and may not capture demographic detail such as how beneficiaries would identify themselves.

Section 3. Standards

HHS OIG conducted this study in accordance with the *Quality Standards for Inspections and Evaluation* issued by CIGIE.

Appendix B: OPM

Section 1. Methodology

Scope. The OPM OIG analysis focused on claims for tests administered to Federal Employee Health Benefits Program (FEHBP) participants covered by two of the larger nationwide fee-for-service carriers during the time period of February 1, 2020, to August 31, 2020.

Data sources. On a monthly basis, OPM OIG receives claims data from several, but not all, participating FEHBP carriers. Consequently, for this analysis, OPM OIG used data from two of approximately 187 carriers. These two carriers are the larger nation-wide fee-for-service carriers, which cover approximately 76% of the entire FEHBP population. OPM OIG has no reason to believe that this selected subset of the population is not representative of the total FEHBP population, although it did not project the results of to the entire population.

Methodology. OPM OIG analyzed FEHBP claims for the two selected nationwide carriers to respond to the questions about COVID-19 testing posed by the PRAC Health care Subgroup.

Number and types of COVID-19 tests. All claims incurred by these carriers for COVID-19 tests from February 1, 2020, to August 31, 2020 (by date of service) were pulled using the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes in the table below. For analysis by type of tests, OPM OIG counted both antigen tests and combination tests as viral tests. Antigen tests provide rapid results; combination tests use a single sample to test for multiple respiratory diseases, including COVID-19. For the selected carriers, OPM OIG identified the volume of all COVID-19 testing by week for the time period February 1, 2020, to August 31, 2020.

<i>Viral Tests</i>	<i>Antibody Tests</i>
87635	86318
87426	86328
U0001	86769
U0002	86408
U0003	86409
U0004	86413
0202U	0224U
0223U	0226U
G2023	
G2024	
C9803	

Demographics. OPM OIG used the claims data to identify the age and gender of FEHBP members who were tested for COVID-19. For each demographic category, OPM OIG identified the number of members who received testing and the total number of tests billed. OPM OIG then calculated the proportion of tested enrollees represented by each demographic group.

Location. OPM OIG identified COVID-19 testing by facility type. To determine the geographic locations of COVID-19 testing, OPM OIG converted the members' ZIP Code information in the data files to county locations. OPM OIG then tallied the number of enrollees in each county who received a test. Note that some enrollees could have been tested in a ZIP Code or county other than their home location.

HHS OIG used CDC's National Center for Health Statistics Urban-Rural Classification Scheme for Counties to determine the number of beneficiaries who lived in and received tests in urban and rural counties.

Cost of COVID-19 tests. OPM OIG calculated total, monthly, and average cost associated with COVID-19 testing.

Test result turnaround time. FEHBP claims do not include information on the return of test results, so test turnaround times were not readily available for analysis. OPM OIG was able to report on the proportion of viral testing that used rapid antigen testing.

Section 2. Limitations

FEHBP claims data does not include demographic detail on race/ethnicity.

Section 3. Standards

The OPM OIG conducted this study in accordance with the *Quality Standards for Inspections and Evaluation* issued by CIGIE.

Appendix C: DOL

Section 1. Methodology

Scope. The DOL OIG data includes claims for tests administered to claimants of the FECA, Black Lung, and Energy Workers Programs during the time period of February 1, 2020, to August 31, 2020. Testing data from OWCP’s Longshore Program was not available, so DOL OIG did not include this population in the analysis.

Data sources. The testing data provided by OWCP was extracted from its Workers’ Compensation Medical Bill Processing system. The dataset contained all claims billed to the FECA, Black Lung, and Energy Workers Programs, including paid claims; denied or suspended claims; and claims to be paid.

Methodology. The testing and demographic data was provided directly by OWCP in response to the questions about COVID-19 testing posed by the PRAC Health care Subgroup.

Number and types of COVID-19 tests. OWCP used the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes provided by the PRAC Health care Subgroup to identify viral and antibody COVID-19 tests in claims. The table below details the codes corresponding to each test type.

<i>Viral Tests</i>	<i>Antibody Tests</i>
87635	86318
87426	86328
U0001	86769
U0002	86408
U0003	86409
U0004	86413
G2023	0224U
G2024	0226U
0202U	
0223U	
0225U	

OWCP identified the volume of all COVID-19 testing in the FECA, Black Lung, and Energy Workers Programs using dates of service within the time period of February 1, 2020, to August 31, 2020.

Demographics. OWCP used claimant data to identify the demographic characteristics of beneficiaries with claims for COVID-19 testing. OWCP used the demographic categories for age and gender established by the PRAC Health care Subgroup, which were based on CDC materials on relative risks of COVID-19 hospitalization and death. Demographic data on race/ethnicity was not available. For each demographic category, OWCP identified the number of claimants who received testing and the total number of tests billed and paid. OWCP then calculated the proportion of the claimant population and testing represented by each demographic group.

Location. OWCP identified the facility types and geographic locations of COVID-19 testing, including both viral and antibody testing. Geographic location of testing was defined by the provider address identified on the claim.

Cost of COVID-19 tests. OWCP calculated total, monthly, and average costs associated with actual payments by FECA and Energy Workers Programs for the subset of the COVID-19 testing which had been paid at the time of data collection. OWCP did not include costs for tests it did not pay for.

Test result turnaround time. The length of time between testing and test return was not available.

Section 2. Limitations

The analysis used in this report represents claims for COVID-19 tests received by OWCP's workers compensation programs, but it does not represent all COVID-19 testing that may have been administered to the claimant populations of these programs. For example, OWCP would not have testing data for a Black Lung claimant who received a COVID-19 test that was not billed to the Black Lung Program.

OWCP does not collect data on race/ethnicity or testing turnaround times. The Black Lung Program does not collect data on gender. Data on the total number of claimants in the program by county was not obtained.

Section 3. Standards

DOL OIG conducted this study in accordance with the *Quality Standards for Inspections and Evaluation* issued by CIGIE.

Appendix D: VA

Section 1. Methodology

Scope. The VA OIG analysis focused on COVID-19 tests administered at VHA medical facilities during the time period of February 1, 2020, to August 31, 2020.

Data sources. The source for VHA COVID-19 testing data was the VHA Corporate Data Warehouse (CDW). The CDW was built and is managed by the VA Office of Information and Technology.⁶⁸ The data source for total VHA enrollment as of February 1, 2020, was the Veterans Integrated Service Network (VISN) and Medical Center Interactive Enrollment Reports by the VA Allocation Resource Center.

Methodology. The VA OIG Office of Healthcare Inspections requested assistance from the VA OIG Data Modeling Group to access required data on August 31, 2020. The first datasets were received September 7, 2020. The final data update was received October 14, 2020.

VA OIG focused the analysis on the number of COVID-19 tests conducted and the number of individuals who received COVID-19 tests at VHA medical facilities. VA OIG reported test turnaround time separately for viral and antibody tests.

Number and types of COVID-19 tests. VA OIG used CDW to obtain the number of COVID-19 tests, both viral and antibody, ordered at VHA medical facilities and that had results recorded at VHA medical facilities, as well as the number of unique individuals who were tested at VHA medical facilities during the review period.

At the time of the initial data search for COVID-19 viral and antibody testing, VA OIG found that using Logical Observation Identifiers Names and Codes (LOINC), Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) was inconsistent and undercounted testing. Therefore, VA OIG identified both viral tests and antibody tests for COVID-19 by searching the CDW by test name. VA OIG reported the number of COVID-19 viral and antibody tests and number of individuals receiving the tests by week for the review period.

Demographics. VA OIG categorized individuals tested by demographic categories for age and race/ethnicity using those presented in CDC materials on relative risks of COVID-19 hospitalization and death.⁶⁹

Enrollment Status. VHA is the largest integrated health care system in the United States. VHA serves veterans, partners with DOD, and supports its surrounding communities in times of need.⁷⁰ For this data brief, the types of patients tested for COVID-19 at VHA medical facilities are grouped into six mutually exclusive categories as described in the table below. Enrolled individuals include veterans who have enrolled in VHA health care services and enrolled veterans who are VA employees. Nonenrolled individuals include nonveteran employees and volunteers; active duty service members; TRICARE beneficiaries; CHAMPVA beneficiaries; and individuals who were provided care or services on a humanitarian basis.

<i>Patient Type</i>	<i>Description</i>
Veteran	An individual who served in the active military, naval, or air service, and did not receive a dishonorable discharge who is enrolled in VHA services and not identified as an employee of VA. ⁷¹
Veteran-Employee	A veteran enrolled in VHA services who is employed at VA.
Nonveteran Employee	An employee of VA who is not identified as a veteran enrolled in VHA services.
TRICARE	Beneficiaries of the DOD health care program for Uniformed Service members, retirees, and their families. ⁷²
Active Duty	An individual who is on full-time duty for the Uniformed Services of the United States. ⁷³
Others	This includes individuals in the following categories: CHAMPVA beneficiaries (Civilian Health and Medical Program of the Department of Veterans Affairs, which provides health care to the qualified spouse, surviving spouse or child of a veteran with disabilities or a veteran who has died), those serving as volunteers at VHA facilities, individuals who were provided care on a humanitarian basis, and those whose enrollment status is not identified or unknown. ⁷⁴

Location. VA OIG defined location as the geographic location of VHA administrative parent facilities that provided COVID-19 tests. VHA defines an administrative parent facility as a collection of all the points of services managed by a leadership group (Medical Facility Director, Deputy Medical Facility Director, Chief of Staff, Associate or Assistant Director, and Nurse Executive). The points of service can include any institution—such as a medical center, outpatient clinic, or community living center—where health care is delivered.⁷⁵ All of the data that originate from these points of service roll up to a single station number representing the administrative parent for management and programmatic activities. At the time of this data brief, VHA had 139 administrative parent facilities managed by 18 VISNs.

Cost of COVID-19 tests. VA OIG was not able to report on the cost of COVID-19 testing at the time of this data brief. VHA allocates funds to VISNs, which then allocate funds to medical centers based on patient workload. A medical center's patient workload is determined by the number and types of veterans served and the complexity of care provided. VHA currently is paying for testing through national contract buys and has not calculated the final price per test as instrument depreciation and labor time studies had not been completed at the time of this data brief.

Test result turnaround time. VA OIG calculated test turnaround time as the average number of days from the time a specimen was collected to the time the test result was reported. VA OIG summarized the findings separately for viral and antibody tests by week for the review period.

Section 2. Limitations

VA OIG was not able to report data on the point-of-care location where tests were collected at the time of this data brief. The geographical data are reported by the VHA administrative parent facility location, which includes all points of service under the umbrella of that facility. The points of service can include any institution affiliated with a VHA administrative parent facility where health care is delivered, such as medical centers, outpatient clinics, and community living centers. These affiliated institutions may be in surrounding cities, counties, and states.

This data brief focused on the number of lab tests conducted and number of individuals tested at VHA medical facilities. Tests that were ordered and performed in the community at non-VA facilities were not included. VHA may reimburse for tests at non-VA facilities; however, billing could be delayed, and billing data may not include all tests performed.

The scope of this data brief is not intended to fully address VHA's effort in implementing its Fourth Mission in support of public health and safety during the COVID-19 pandemic.⁷⁶ CDW data does not permit clear identification of tests that were conducted at a VHA facility or laboratory on behalf of state or local governments or agencies as part of the Fourth Mission. Nonetheless, the data did support that VHA provided COVID-19 tests to individuals who are not enrolled in VHA health care, such as volunteers, TRICARE enrollees, active duty members, and others served as part of VA's humanitarian efforts.

In some instances, VA OIG found inconsistencies in the reported demographic characteristics—such as enrollment status, veteran status, gender, race, and ethnicity—of patients across facilities. This was partially due to inconsistent self-reported demographic data collected at the point of service and partially due to the timeliness of updating veteran enrollment information in VHA's systems. VA OIG applied algorithms to resolve discrepancies where feasible while preserving the integrity of the source data.

Section 3. Standards

VA OIG conducted this study in accordance with the *Quality Standards for Inspections and Evaluation* issued by CIGIE.

Appendix E: DOD

Section 1. Methodology

Scope. The DOD OIG analysis focused on COVID-19 laboratory tests ordered and performed by DOD medical treatment facilities (MTFs) from February 1, 2020, to August 31, 2020.⁷⁷

Data sources. The DOD OIG obtained COVID-19 testing data from the Military Health System Data Repository. The DOD OIG used the FY 2020 Comprehensive Ancillary Data Record Extract (CADRE) Laboratory Enhanced File to identify the types of COVID-19 tests; number of individuals who received COVID-19 tests and their demographics; cost of the COVID-19 tests; and settings where COVID-19 tests were administered. The DOD OIG also used the FY 2020 CADRE Laboratory Basic Results File to calculate the average times for returning COVID-19 test results. The CADRE Laboratory Enhanced File did not include COVID-19 tests performed by a subset of MTFs, many of which were located in Washington State, that had recently switched to a different DOD system.

Methodology. The DOD OIG analyzed the CADRE Laboratory Enhanced File and CADRE Laboratory Basic Results File to respond to the questions about COVID-19 testing posed by the PRAC Health care Subgroup.

Number and types of COVID-19 tests. The DOD OIG used Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes to identify viral and antibody COVID-19 tests in the CADRE Laboratory Enhanced Files. The DOD OIG also used natural language processing to identify potentially relevant laboratory data in text-based variables with terms related to the coronavirus or COVID-19. The DOD OIG removed duplicate entries from the files to ensure that only unique tests were counted. The DOD OIG also removed irrelevant records that did not have procedural codes related to COVID-19.

The DOD OIG identified the codes that were attributed to either viral or antibody tests, as shown in the following table.

Code Type	Viral Tests		Antibody Tests		Respiratory Pathogen test	Laboratory Test Specimen Collection
CPT and HCPCS	0202U	87487	0064U	86413	0098U	G2023
	0223U	87580	0224U	86602	0099U	G2024
	0225U	87581	0226U	86635	0100U	
	87275	87582	86317	86769		
	87276	87635	86318	86794		
	87280	87804	86328			
	87400	U0001	86408			
	87426	U0002	86409			
	87485	U0003				
	87486	U0004				
LOINC	94503-0		94504-8	94564-2		
			94505-5	94661-6		
			94506-3	94720-0		
			94507-1	94761-4		
			94508-9	94762-2		
			94547-7	94768-9		
			94562-6	94769-7		
			94563-4	95125-1		

*Current Procedural Terminology (CPT) codes 0100U, 0098U, and 0099U and Healthcare Common Procedure Coding System (HCPCS) codes G2023 and G2024 were used to identify COVID-19 tests for which there were no other associated records. The DOD OIG counted these codes as unique COVID-19 tests if laboratory test data specifically identified notations related to COVID-19 in either the notes section or in the lab test name. However, if there were two records for the same beneficiary, date, and location that contained a G2023 code in one record and a viral test in the other record, then only the viral test record was counted in order to eliminate duplication.

The DOD OIG identified the volume of COVID-19 tests ordered and performed by MTFs by week for the time period of February 1, 2020, to August 31, 2020. The DOD OIG identified a significant drop in the number of tests in July and August 2020. This drop in tests is not consistent with testing trends reported elsewhere within DOD and may be a result of a lag in available data at the time of the data pull. The DOD OIG also identified the volume of testing by type—viral or antibody. The DOD OIG calculated total, monthly, and average costs associated with COVID-19 tests ordered and performed by MTFs.

Demographics. The DOD OIG used the laboratory data to identify the age and gender of beneficiaries with claims for COVID-19 tests. For each demographic category, the DOD OIG identified the number of beneficiaries who received tests and the total number of tests billed. The DOD OIG then calculated the proportion of beneficiary population and testing represented by each demographic group. The laboratory files did not include race/ethnicity of beneficiaries. DOD OIG identified the geographic locations of COVID-19 testing using the location of the MTF that ordered and performed the test.

Cost of COVID-19 tests. The DOD OIG calculated total, monthly, and average costs associated with COVID-19 testing.

Test result turnaround time. To calculate turnaround time, the DOD OIG compared the date of the results in the CADRE Laboratory Basic Results File to (1) the exam date, (2) service date, (3) certification date, or (4) laboratory order date in the CADRE Laboratory Enhanced File, based on availability of data in those fields. For example, if exam date was not available, the DOD OIG compared the service date in the CADRE Laboratory Enhanced File against the results date in the CADRE Laboratory Basic Results File.

Section 2. Limitations

To provide timely information, the DOD OIG did not conduct an independent test of the CADRE laboratory data's reliability using source documentation and determined that the data used for this project was of undetermined reliability. However, the DOD OIG took steps to test the quality of the data. See discussion in Section 4: Data Quality.

Some MTFs in certain regions, such as the State of Washington, have recently transitioned to a new electronic health system. Therefore, COVID-19 testing data was not captured in the analysis for 19 MTFs that had transitioned to the new system.

Section 3. Standards

The DOD OIG conducted this study in accordance with the *Quality Standards for Inspections and Evaluation* issued by CIGIE.

Section 4. Data Quality

The DOD OIG had not performed audits and evaluations prior to this report that involved the CADRE laboratory files and, therefore, had never previously tested the laboratory data. As a result, the DOD OIG did not have first-hand knowledge about the reliability of the data prior to the project. The DOD OIG contacted personnel from the Defense Health Agency (DHA), which has a major role in health care delivery in the DOD, to better understand the reliability of the laboratory data that the DOD OIG obtained from the CADRE laboratory files. From this discussion and the DOD OIG's testing of the laboratory data, the DOD OIG obtained limited assurance on the accuracy of the number of COVID-19 tests that were ordered and performed by MTFs. The DHA provided the number of COVID-19 tests ordered and performed within MTFs that MTFs reported to the DHA through online surveys. The DOD OIG compared the number of tests that the DHA identified with the number of tests that the DOD OIG identified through analysis of MTF laboratory data and determined the numbers were consistent.

The DOD OIG considered including in the data brief the test data for tests ordered by MTFs and sent to civilian laboratories and the test data for tests performed by MTFs for outside laboratories. However, the DHA did not provide assurance on the number of tests that the DOD OIG identified for those two categories.

The DOD OIG identified 791,392 COVID-19 tests that were ordered by DOD MTFs and sent to civilian laboratories and 714,978 COVID-19 tests that were performed by MTFs for outside laboratories. However, according to DHA personnel, the number of tests that MTFs reported to the DHA through the online surveys for the two categories of tests was inconsistent with the number of tests DOD OIG identified. In addition, DHA personnel provided conflicting statements on DHA's numbers of COVID-19 tests for the two categories, which raised questions as to which tests were included in the DHA testing numbers. As a result of the inconsistencies and conflicting statements, the DOD OIG only reported on available data for COVID-19 tests that were ordered and performed by MTFs, to include reporting of the number beneficiaries tested, testing locations, costs, and testing turnaround times.

The DOD OIG Data Analytics Team also assessed the accuracy of its analysis of COVID-19 tests by conducting a Government Accountability Office Financial Audit Manual 450 Control Test of tests ordered and performed by MTFs, ordered by MTFs and sent to civilian laboratories, and performed by MTFs for outside laboratories. The DOD OIG Data Analytics Team randomly selected 105 laboratory tests and assigned an independent analyst to determine whether laboratory data showed that the 105 laboratory tests were COVID-19-related and that the tests were performed on DOD beneficiaries. The testing found that only two of the 105 laboratory tests were potentially not related to COVID-19. The Data Analytics Team concluded with 90% confidence that the error rate of the analysis was less than 5%. However, because of the strict project timeline, the DOD OIG did not attempt to trace the computer-processed data back to source documentation to fully assess reliability.

Appendix F: DOJ

Section 1. Methodology

Scope. The DOJ OIG analysis focused on COVID-19 testing during the time period of February 1, 2020, to August 31, 2020, for individuals incarcerated within the Federal Bureau of Prisons (BOP) system, regardless of trial or conviction status or reason for incarceration (BOP inmates). Cumulatively, more than 218,000 inmates spent at least some time in one of the three BOP facility types: BOP-operated prisons, contract prisons, and contract Residential Reentry Centers (RRCs). This number includes other individuals, such as detainees from U.S. Marshals Service and Immigration and Customs Enforcement held in BOP facilities, who may not be included in official BOP inmate counts. It excludes individuals held in other (non-BOP) federal facilities.

Data sources. The BOP provided a variety of records from multiple sources to the DOJ OIG for analysis. The source of test records varied depending on the type of facility: BOP-operated prisons, contract prisons, and RRCs. Each test record file included an inmate identifier, location name or code, and one or more of the following: order, test, and/or result dates.

For *BOP-operated Prisons*, DOJ OIG received three sets of records:

1. Rapid molecular RNA tests;
2. Tests conducted by a commercial vendor under national contract with the BOP; and
3. Ordered tests tracked in the BOP's Bureau Electronic Medical Records System (BEMR), which includes tests conducted by large commercial vendor and by local medical facilities.

Contract prisons and *RRCs* are privately operated. They track their testing information separately and provide it to the BOP. We received additional files from the BOP for these populations.

1. Tests of inmates housed in contract prisons; and
2. Tests of inmates housed in RRCs.

The rapid test files, contract prison files, and RRC files do not overlap with each other or any other test files. The source of inmate demographic characteristics was obtained from BOP's SENTRY system. This dataset included inmate identifiers, demographic characteristics, and facility name. Geographic information was obtained from a variety of sources and compiled into a single geographic file that included facility name and code; complex name and code, state and county Federal Information Processing Standard (FIPS) code; and latitude and longitude.

Methodology. As mentioned above, there was overlap between the commercial vendor and BEMR files. Because the BOP considered the BEMR files to be more comprehensive, DOJ OIG used all BEMR records. DOJ OIG cross-referenced BEMR and the commercial vendor records, using the commercial vendor records only for inmates that did not appear in BEMR. Exceptions are noted in two sections below, where all of the commercial vendor records were used (and subtracted from the BEMR totals).

DOJ OIG merged the geographic file with each of the five test files listed above. This had to be done separately because each test file had a unique way of including facility information. Next, DOJ OIG constructed a master test file by standardizing common variables and concatenating the five test/geographic files. This master file was then merged with the SENTRY demographic file. The constructed files were used to respond to the questions about COVID-19 testing posed by the PRAC Health care Subgroup.

Number and types of COVID-19 tests. All tests for which DOJ OIG obtained records were viral. DOJ OIG identified the volume of all COVID-19 testing of BOP inmates by week for the time period of February 1, 2020, to August 31, 2020.

Demographics. DOJ OIG provided the number and percentage of tested inmates by demographic characteristics (age, gender, and race/ethnicity). DOJ OIG added context by providing number and percentage of the total BOP inmate population by demographic characteristics, and the percentage tested of the total population for each demographic category. DOJ OIG defined demographic categories for age and race/ethnicity by using those presented in CDC materials on relative risks of COVID-19 hospitalization and death.^{78,79}

Location. DOJ OIG compiled a geographic location (state and county) for each test, each tested inmate, and all BOP inmates. Geographic location of inmates was defined as the facility in which the inmate was confined or, in the case of inmates in home custody settings under the supervision of RRCs, the facility to which they were assigned. The only geographic location information available for tests and tested inmates was the facility housing or otherwise supervising the inmate at the time of testing. Because most test samples were collected onsite in prisons or in local medical facilities, the state and county of the inmate's assigned facility is generally an accurate depiction of the state and county where the test was conducted.

Cost of COVID-19 tests. DOJ OIG calculated total, monthly, and average costs associated with COVID-19 testing for rapid test and commercial vendor tests. This is the first instance when all commercial vendor tests were used. See Section 2: Limitations for details.

Test result turnaround time. For rapid tests and vendor tests, DOJ OIG calculated the mean turnaround time as well as number and percentage of tests for which results were received within a time that was at or below the mean. Rapid test results were always provided the same day. DOJ received confirmation that the BOP currently collects and receives the data elements needed to calculate turnaround times only for rapid tests and commercial vendor tests. The BEMR files, contract prison files, and RRC files do not include data on testing turnaround times.

Section 2. Limitations

In general, there may have been additional tests not captured in the BOP datasets, especially if the results were negative and the testing was not done via the rapid test or commercial contract mechanisms. The BOP could not provide complete, centralized records for tests that DOJ OIG categorizes as locally coordinated—such as those via local health departments, hospitals, and private

laboratories. Data for inmates assigned to contract prisons and RRCs may not reflect the full volume of tests for these populations for reasons that may include: an absence of BOP directives for widespread reporting of tests in these settings; private contractor decisions on reporting of tests; and incomplete reporting from third parties including BOP contractors, local health care providers, and inmates in nonprison settings who received tests in their communities.

Facility names, codes, and inmate identifiers were unavailable for some test records and tested inmates, so columns or rows in some tables do not sum to the total number of tests, tested inmates, or total inmates. For locations of tests and tested inmates, 65 tests and 55 tested inmates were either missing facility name or code, or the information provided did not match the BOP facility listing. While demographic information is available for all BOP inmates, some tests and tested inmates had missing or invalid identification numbers and could not be matched to the BOP demographic file. DOJ OIG used the demographic categories provided by HHS and previously published by the CDC in analyses of relative risk associated with serious adverse outcomes of COVID-19 infection. DOJ OIG used these categories to contextualize our analysis with the current understanding of COVID-19 risks. However, these categories are not mutually exclusive or exhaustive and might not capture demographic detail the way inmates might identify themselves.

The BOP could not provide cost information for the category of tests administered by local providers (e.g., hospitals, local commercial labs, health departments). There is anecdotal evidence of some local initiatives for free testing, such as testing partnerships with local health departments; however, complete data on these occurrences was not available.

Section 3. Standards

DOJ OIG conducted this study in accordance with the *Quality Standards for Inspections and Evaluation* issued by the CIGIE.

Appendix G: PRAC Health Care Subgroup Charter

The Health Care Subgroup of the Pandemic Response Accountability Committee (PRAC) comprises Offices of Inspector General (OIGs) that oversee Agencies providing or affected by the provision of health care services. The CARES Act created the PRAC as a committee of the Council of the Inspectors General on Integrity and Efficiency to promote transparency and conduct and support oversight of covered funds and the COVID-19 response. The Health care Subgroup coordinates the efforts of OIGs as they provide critical oversight and enforcement in response to the COVID-19 pandemic. The Health care Subgroup accomplishes this by sharing information, data, trends, and experiences to assist the PRAC as it strives to provide real time oversight of the COVID-19 pandemic response. By coordinating efforts and sharing data, the Health care Subgroup identifies trends and risk areas that cut across agencies and programs and promotes efficient and effective oversight of these common issues.

Who We Are. The members of the PRAC's Health care Subgroup are the U.S. Department of Defense OIG (DOD OIG), the U.S. Department of Health and Human Services Office OIG (HHS OIG), the U.S. Department of Justice OIG (DOJ OIG), the U.S. Department of Labor OIG (DOL OIG), the U.S. Department of Veterans Affairs OIG (VA OIG), and the U.S. Office of Personnel Management OIG (OPM OIG). These OIGs share a common mission of providing independent and objective oversight of the programs they oversee by promoting economy, integrity, and efficiency in those programs and protecting them from fraud, waste, and abuse. Highlights of each OIG's activities relevant to the Health care Subgroup are described below.

DOD OIG. As part of its oversight functions, the DOD OIG oversees the Military Health System that provides health care to 9.5 million beneficiaries, including active duty service members, retirees, and family members. The DOD offers health care through its military hospitals and clinics, as well as through networks of civilian providers operated by civilian managed care support contractors in the United States and abroad. The DOD OIG released a comprehensive COVID-19 Oversight Plan of the audits and evaluations that it planned to conduct of DOD programs, operations, and activities being executed in response to COVID-19. In addition to ongoing oversight projects, the DOD OIG's investigative arm continues to work with other Federal law enforcement agencies to proactively identify fraud and product substitution in DOD acquisition and health care programs related to the DOD's response to the COVID-19 crisis.

HHS OIG. A majority of HHS OIG's resources goes toward the oversight of Medicare and Medicaid—programs that represent a significant part of the Federal budget and that affect over 100 million of this country's most vulnerable citizens. HHS OIG's oversight also extends to programs under other HHS divisions, including the Centers for Disease Control and Prevention, the National Institutes of Health, and the Food and Drug Administration. HHS OIG is actively involved in the oversight of HHS' response to the COVID-19 pandemic and the funds that are being distributed to health care providers and others in order to combat the COVID-19 pandemic and its economic effects. These efforts are outlined in HHS OIG's Oversight of COVID-19 Response and Recovery strategic plan, which was released in May 2020.

DOJ OIG. Among other operational responsibilities, DOJ is responsible for the health and well-being of over 200,000 individuals in its custody. This population includes both inmates of the federal Bureau of Prisons and detainees held by the U.S. Marshals Service, housed in facilities that include federal prisons; residential reentry centers; and state, local, tribal, and contract detention centers. In general, DOJ's ability to fulfill its agency mission rests upon the health of its personnel—many of whom perform frontline, public-facing functions that include prosecution, federal law enforcement, and the operation of immigration courts. In addition, several of the programs that DOJ funds through its grant awards have a nexus to health care, with objectives that include promoting the welfare of crime victims, combating drug abuse, enhancing the health and safety of federal law enforcement officers, and supporting treatment and intervention efforts as alternatives to involvement in the criminal justice system.

DOL OIG. DOL OIG conducts audit and investigative oversight of DOL programs, including the Office of Workers' Compensation Programs (OWCP). OWCP provides wage replacement benefits, medical treatment, vocational rehabilitation, and other benefits to certain workers who experience work-related injury or occupational disease. In FY 2019, OWCP paid over \$1.8 billion in medical benefits to claimants covered by its workers compensation programs. In addition to on-going audits and investigations concerning health care issues in OWCP, DOL OIG also has been focused on DOL's response to the COVID-19 pandemic. As part of its multi-phase Pandemic Response Oversight Plan, DOL OIG is conducting audits and investigations covering many DOL programs impacted by the pandemic, including OWCP and those related to protecting the health and safety of the U.S. workforce.

VA OIG. Within VA OIG, The Office of Healthcare Inspections assesses VA's efforts to maintain a fully functional health care program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG Hotline complaints, congressional requests, and other leads. The office also performs inspections of individual medical facilities and systems. Field staff participate in Comprehensive Healthcare Inspection Program (CHIP) site visits focusing on leadership, quality management, and adherence to requirements and standards for patient care provision and documentation. This office also conducts statistically supported national reviews of topical issues and provides consultations to criminal investigators and audit staff as needed.

OPM OIG. OPM's Federal Employees Health Benefits Program (FEHBP) covers approximately eight million current and retired Federal employees and eligible family members. OPM contracts with approximately 200 health plans (health maintenance organizations and fee-for-service plans) including private sector health plans and health plans operated or sponsored by Federal employee organizations. The combined premium payments for the insurance program total over \$50 billion annually. OPM OIG is actively involved in conducting audits, evaluations, and investigations of FEHBP. Like other federal health care programs, the FEHBP and its enrollees are affected by the COVID-19 pandemic. As such, OPM OIG continues to focus on information technology and health care cost-related audits, health care fraud and patient safety investigations, and now issues specifically related to COVID-19 issues.

Endnotes.

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Appendix A.

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Appendix E.

⁷⁷ A DOD MTF is a military facility established for the purpose of furnishing medical and dental care to eligible individuals. DHA’s FY 2020 Evaluation of the TRICARE Health Program reported that in FY 2020, the military health system projected 50 inpatient hospitals and medical centers and 425 ambulatory care and occupational health clinics. Accessed at [Evaluation of the TRICARE Program: Fiscal Year 2020 Report to Congress Access, Cost, and Quality Data through Fiscal Year 2019](#) on November 20, 2020.

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