UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 16

The Honorable David R. Obey
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510-6025

Dear Mr. Chairman:

This letter is in response to the Department of Defense Appropriations Act, 2008 Conference Report (H. Rept. 110-434) that asks the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program and to make recommendations in the following areas: processes needed to verify the eligibility of health care recipients, actions necessary to develop fully compliant financial management systems, procedures to better integrate the direct care and purchased care systems, and actions which can be taken to create incentives for beneficiaries to use the least costly pharmacy programs.

The Department established a Military Health System (MHS) Senior Oversight Committee (SOC) to evaluate the recommendations of the DoD Task Force on the Future of Military Health Care and to develop an implementation plan for those recommendations accepted. While the MHS SOC was charged with responding to the DoD Task Force, it constitutes a response to those matters noted above that were identified in the Conference Report. Enclosed is the result of the evaluation that is the Department's response to the Task Force report and the Conference Report. Now that the recommendations are final we are in the process of identifying the associated costs.

Thank you for your continued support of the Defense Health Program.

Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 16

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515-6035

Dear Madam Chairwoman:

This letter is in response to the Department of Defense Appropriations Act, 2008 Conference Report (H. Rept. 110-434) that asks the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program and to make recommendations in the following areas: processes needed to verify the eligibility of health care recipients, actions necessary to develop fully compliant financial management systems, procedures to better integrate the direct care and purchased care systems, and actions which can be taken to create incentives for beneficiaries to use the least costly pharmacy programs.

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Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable Joe Wilson
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 16

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510-6028

Dear Mr. Chairman:

This letter is in response to the Department of Defense Appropriations Act, 2008 Conference Report (H. Rept. 110-434) that asks the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program and to make recommendations in the following areas: processes needed to verify the eligibility of health care recipients, actions necessary to develop fully compliant financial management systems, procedures to better integrate the direct care and purchased care systems, and actions which can be taken to create incentives for beneficiaries to use the least costly pharmacy programs.

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Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 16

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

This letter is in response to the Department of Defense Appropriations Act, 2008 Conference Report (H. Rept. 110-434) that asks the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program and to make recommendations in the following areas: processes needed to verify the eligibility of health care recipients, actions necessary to develop fully compliant financial management systems, procedures to better integrate the direct care and purchased care systems, and actions which can be taken to create incentives for beneficiaries to use the least costly pharmacy programs.

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Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 6

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515-6018

Dear Mr. Chairman:

This letter is in response to the Department of Defense Appropriations Act, 2008 Conference Report (H. Rept. 110-434) that asks the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program and to make recommendations in the following areas: processes needed to verify the eligibility of health care recipients, actions necessary to develop fully compliant financial management systems, procedures to better integrate the direct care and purchased care systems, and actions which can be taken to create incentives for beneficiaries to use the least costly pharmacy programs.

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Thank you for your continued support of the Defense Health Program.

Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable C. W. Bill Young
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 16

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

This letter is in response to the Department of Defense Appropriations Act, 2008 Conference Report (H. Rept. 110-434) that asks the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program and to make recommendations in the following areas: processes needed to verify the eligibility of health care recipients, actions necessary to develop fully compliant financial management systems, procedures to better integrate the direct care and purchased care systems, and actions which can be taken to create incentives for beneficiaries to use the least costly pharmacy programs.

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Thank you for your continued support of the Defense Health Program.

Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

JAN 16

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515-6035

Dear Mr. Chairman:

This letter is in response to the Department of Defense Appropriations Act, 2008 Conference Report (H. Rept. 110-434) that asks the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program and to make recommendations in the following areas: processes needed to verify the eligibility of health care recipients, actions necessary to develop fully compliant financial management systems, procedures to better integrate the direct care and purchased care systems, and actions which can be taken to create incentives for beneficiaries to use the least costly pharmacy programs.

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Thank you for your continued support of the Defense Health Program.

Sincerely,

David S. C. Chu

Enclosure:
As stated

cc:
The Honorable John McHugh
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE

SUBJECT: Report on Management Improvements of the Defense Health Program

The attached report will be forwarded as the Department's response to the Department of Defense (DoD) Appropriations Act, 2008 Conference Report (H. Rept. 110-434) which asked the Department to assess management improvements needed to enhance efficiency and effectiveness of the Defense Health Program. It is the report produced by the Military Health System Senior Oversight Committee (MHS SOC). The MHS SOC was established in early 2008, charged to evaluate the recommendations of the DoD Task Force on the Future of Military Health Care and to develop an implementation plan for those recommendations accepted. The Task Force, a federal advisory committee (under the Defense Health Board), had a broad charter from Congress to assess the Military Health System. The Task Force presented its final report to the Secretary of Defense in December 2007, and he forwarded it to the Committees on Armed Services.

The MHS SOC, which consisted of representatives of your Departments, carefully considered the recommendations and action items of the Task Force and developed a plan of action to implement most of the Task Force recommendations and action items. I endorse the report and request that you direct the appropriate offices and personnel in your respective Departments to give full support to execution of actions identified for implementation.

I appreciate the contributions of senior leaders of your organizations to the MHS SOC. The plan reflects a reasoned approach to improve the MHS, carrying through on the thoughtful and comprehensive analysis and advice of the Task Force. With the close involvement of the Service Secretaries, we can assure that the Military Health System will continue to perform its vital missions and functions on a sustainable basis.

David S. C. Chu

Attachment:
As stated

cc:
Service Surgeons General

The Department of Defense Military Health System Senior Oversight Committee

Response to the Recommendations of the Task Force on the Future of Military Health Care

January 2009

The Department of Defense Military Health System Senior Oversight Committee

---

Response to the Recommendations of the Task Force on the Future of Military Health Care

January 2009

At the heart of the volunteer force is a contract between the United States of America and the men and women who serve in our military: a contract that is simultaneously legal, social, and indeed sacred. That when young Americans step forward of their own free will to serve, they do so with the expectation that they and their families will be properly taken care of. . . .

Secretary of Defense Robert M. Gates
Washington, D.C.
Monday, October 20, 2008

Table of Contents

Executive Summary 1

Prologue 13

Recommendation 1
Integration Strategy for Direct and Purchased Care 24

Recommendation 2
Best Practices in Program Evaluation 34

Recommendation 3
Controllership 47

Recommendation 4
Implement Wellness and Prevention Guidelines 54

Recommendations 5, 6, and 7 69

- Recommendation 5
  Prioritize Acquisition in the TRICARE Management Activity 69

- Recommendation 6
  Implement Best Practices in Procurement 70

- Recommendation 7
  Examine Requirements in Existing Contracts 70

Recommendation 8
Improve Medical Readiness of the Reserve Component 79

Recommendation 9
The DoD Pharmacy Program 99

Recommendation 10
Retiree Cost-Sharing 107

Recommendation 11
Better Coordination of Benefits 118

Recommendation 12
Develop Metrics to Assess the Success of Military Health System Transformation 125

Appendix A: Contributors 141
Appendix B: Acronyms 142
Appendix C: Key Resources 147

Military Health System Senior Oversight Committee

Co-Chairs

LTG Eric Schoomaker, USA, Surgeon General

Dr. Stephen Jones, PDASD/Health Affairs

Members

MG David Rubenstein, USA, Deputy Surgeon General

RADM Thomas Cullison, USN, Deputy Surgeon General

Maj Gen Bruce Green, USAF, Deputy Surgeon General

RADM David Smith, USN, Joint Staff Surgeon

MG Elder Granger, USA, Deputy Director, TMA

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Dr. Joseph Kelley, DASD(HA)/Clinical and Program Policy

Mr. Allen Middleton, DASD(HA)/Health Budgets and Financial Policy

Mr. Charles Campbell, Chief Information Officer, TMA

Dr. Thomas V. Williams, Director, Health Program Analysis and Evaluation (*Ex Officio*)

CMSgt Manuel Sarmina, USAF, Senior Enlisted Advisor, TMA (*Ex Officio*)

Executive Director

Col Christine Bader, USAF, NC

Executive Summary

Introduction

The Military Health System Senior Oversight Committee (MHS-SOC) was created in March 2008 to evaluate, and, if appropriate, implement the recommendations of the Task Force on the Future of Military Health Care, which issued its final report in December 2007. [1] The MHS-SOC focused its work on the Task Force recommendations; thus, this report does not address many of the significant developments that have occurred in the MHS over the past year. The prologue to this report describes some major achievements of the MHS that reflect its deserved characterization by the Defense Health Board (DHB) as the "crown jewel" of the Department of Defense (DoD).[2] However, the Task Force, the DHB, and, indeed, MHS leadership recognize that there are many challenges to be met and areas to be improved. Thus, the MHS-SOC gave careful and serious consideration to the recommendations and action items of the Task Force and sought to develop practicable implementation plans.

The Task Force on the Future of Military Health Care was established by Section 711 of the National Defense Authorization Act (NDAA) for Fiscal Year 2007 in response to congressional concerns about the rising costs of the military health mission. Rising health care costs result from a multitude of factors that are affecting not only the DoD, but also health care in general; these factors include greater use of services, increasingly expensive technology and pharmaceuticals, growing numbers of users, and the aging of the retiree population. Considering these factors, the Task Force made recommendations to Congress on a broad range of military health care issues.

DoD's Response to the Task Force Recommendations

In response to the Task Force report, DoD determined that the MHS requires a group to evaluate, and, if appropriate, implement the Task Force recommendations. There was no existing group with the requisite composition or focus to perform this task. Active involvement of senior leadership in developing a response was deemed essential, because a wide range of functions and activities would be affected, some significantly, if Task Force proposals were to be adopted. An actionable plan must be developed, aligned with other strategic/business plans, implemented, and monitored.

In March 2008, the Principal Deputy Assistant Secretary of Defense for Health Affairs created the MHS-SOC with the following objectives:

- evaluate Task Force recommendations according to the principles adopted by the Task Force, as amended by this Committee;
- determine a strategy for implementing those Task Force recommendations deemed acceptable by the Committee;
- translate acceptable Task Force recommendations into operational terms;

[1] The Task Force's final report can be found at www.dodfuturehealthcare.net/images/103-06-2-Home-Task_Force_FINAL_REPORT_122007.pdf.
[2] See www.health.mil/dhb/downloads/DHB-Cover-letter-to-FMHC-Report-12-07.pdf.

- establish an interface with non-MHS components needed for successful implementation;
- develop an implementation plan that includes measures to assess progress;
- conduct assessments of how the recommendations are being implemented; and
- continuously coordinate with the Health Affairs Program Integration Directorate and strategic communications departments and other offices to avoid duplicative and inconsistent efforts and to engender broad support that is needed for changes.

The MHS-SOC, co-chaired by Dr. Stephen Jones, the Principal Deputy Assistant Secretary of Defense for Health Affairs, and LTG Eric Schoomaker, the Army Surgeon General, is composed of the following members:

- Army Deputy Surgeon General
- Navy Deputy Surgeon General
- Air Force Deputy Surgeon General
- Joint Staff Surgeon
- Deputy Director, TRICARE Management Activity (TMA)
- Deputy Assistant Secretary of Defense for Health Affairs/Force Health Protection and Readiness
- Deputy Assistant Secretary of Defense for Health Affairs/Clinical and Program Policy (DASD[HA]/C&PP)
- Deputy Assistant Secretary of Defense for Health Affairs/Health Budgets and Financial Policy
- MHS Chief Information Officer
- Chief, Pharmaceutical Operations
- TMA Health Program Analysis and Evaluation Representative (*Ex Officio*)
- Senior Enlisted Advisor, TMA (*Ex Officio*)

Summary of the Task Force Findings and Recommendations

As directed by the NDAA, in December 2006 the Secretary of Defense appointed 14 members to the DoD Task Force on the Future of Military Health Care, which was composed of individuals from within and outside DoD with wide expertise in issues related to health care programs and costs. In its report, the Task Force stated:

> Given the current and likely future commitments of the military, it is critical to address several persistent and new challenges facing today's current Military Health System. These include rising costs, the expansion of benefits, the increased use of benefits by military retirees and the Reserve military components, continued health care inflation, and TRICARE premiums that have been level for nearly a decade. These challenges must be considered in the contexts of the current and ongoing needs of Active Duty military personnel and their families, the critical need for medical readiness of Active Duty military personnel, the aging of the military retiree population, and the broader backdrop of the U.S. health care economy, in which the military health care system operates.

> To sustain and improve military health care benefits for the long run, actions must be taken now to adjust the system in the most cost-effective ways.[3]

As an initial step, the Task Force debated and adopted a set of guiding principles to use in assessing the desirability of recommended changes. The Task Force first adopted an overarching principle:

> All recommended changes must focus on the health and well-being of beneficiaries and be cost-effective, taking into account both short-term and long-term budgetary costs as well as the effects on the specific guiding principles noted below.[4]

The Task Force then adopted six specific guiding principles. These principles require that the changes recommended by the Task Force, when taken as a whole, must:

1. maintain or improve the health readiness of U.S. military forces and preserve the capability of military medical personnel to provide operational health care globally;
2. maintain or improve the quality of care provided to beneficiaries, taking into account health outcomes as well as access to and productivity of care;
3. result in improvements in the efficiency of military health care by, among other approaches, reflecting best health care practices in the private sector and internationally;
4. avoid any significant adverse effects on the ability of the military compensation system, including health benefits, to attract and retain the personnel needed to carry out the military mission effectively;
5. balance the need to maintain generous health care benefits in recognition of the demanding service rendered by military personnel to their country with the need to set and maintain a fair and reasonable cost-sharing arrangement between beneficiaries and DoD; and
6. align beneficiary cost-sharing measures to address fairness to taxpayers by promoting measures that enhance accountability and the judicious use of resources.[5]

The Task Force concluded that "first and foremost, DoD must maintain a health care system that meets the military's readiness needs. DoD should make changes in its business and health care practices aimed at improving the effectiveness of the military health care system."[6] The Task Force also stated that "those treated by this system—military members and retirees as well as their dependents—deserve a generous health care benefit in recognition of their important service to the Nation. However, to be fair to the American taxpayers, the military health care benefit must be reasonably consistent with broad trends in the U.S. health care system."[7]

To implement these overarching conclusions, the Task Force made 12 recommendations for change (summarized in Box ES.1). Most recommendations were expanded with action items, which are provided in this report in chapters responding to each of the 12 recommendations.

---

[3] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 7.
[4] Ibid., p. 7.
[5] Ibid., pp. 7, 8.
[6] Ibid., p. ES2.
[7] Ibid., p. ES2.

Box ES.1: Summary of Task Force Recommendations

1. Develop a Strategy for Integrating Direct and Purchased Care

2. Collaborate with Other Payers on Best Practices

3. Conduct an Audit of Financial Controls

4. Implement Wellness and Prevention Guidelines

5. Prioritize Acquisition in the TRICARE Management Activity

6. Implement Best Practices in Procurement

7. Examine Requirements in Existing Contracts

8. Improve Medical Readiness of the Reserve Component

9. Change Incentives in the Pharmacy Benefit

10. Revise Enrollment Fees and Deductibles for Retirees

11. Study and Pilot Test Programs Aimed at Coordinating TRICARE and Private Insurance Coverage

12. Develop Metrics by Which to Assess the Success of Military Health System Transformation

On December 20, 2007, the DHB endorsed the Task Force's approach and encouraged DoD and Congress to take appropriate and timely action in response to the report.[8]

The MHS-SOC's Approach to Its Task

The MHS-SOC adopted the Task Force's principles with one modification. Principle #3 was modified to be more inclusive by eliminating the specificity about the improvements in efficiency reflecting best health care practices in the private sector and internationally, because efficiency also has been achieved in some public sector settings and within DoD. Thus the amended principle reads as follows:

> 3) result in improvements in the efficiency of military health care by, among other approaches, reflecting best health care practices. ~~in the private sector and internationally~~;

Committee members agreed to apportion the workload by assigning a set or sets of recommendations and related action items to a lead member assisted by another member

[8] See www.health.mil/dhb/downloads/DHB-Cover-letter-to-FMHC-Report-12-07.pdf.

(e.g., the fourth set on wellness and prevention was assigned to DASD[HA]/C&PP, assisted by the Army Deputy Surgeon General). These teams developed proposals for consideration by the entire MHS-SOC. To assist the MHS-SOC and these teams in the analysis and development of positions, a representative of the Committee was assigned to an Integrated Process Team (working group) to gather data, provide research and analysis, and otherwise support the MHS-SOC and its members.

This report is organized around the 12 recommendations of the Task Force. It represents MHS senior leadership's consideration of the Task Force recommendations and its assessment regarding the best ways in which to plan and implement those recommendations it has accepted. Table ES.1 summarizes the recommendations and the MHS-SOC response.

Table ES.1: Summary of Task Force Recommendations and MHS-SOC Responses

Task Force Recommendation	MHS-SOC Response	Summary of Action Items (consult relevant chapters for a complete discussion of the implementation plan)	Timeframe for Implementation
Recommendation 1 DoD should develop a planning and management strategy that integrates the direct health care system with the purchased care system and promotes such integration at the level where care is provided. This strategy will permit the maintenance and enhancement of the direct care system's support of the military mission while allowing for the optimization of the delivery of health care to all DoD beneficiaries.	Accepted.	A working group will be chartered to develop a concept plan to better integrate and improve health care delivery in the selected areas. After a micro-monitoring stage, it will determine what, if any, pilot studies and/or demonstration projects are likely to yield useful information for improved integration and whether they are ready to be implemented. The working group will clearly delineate the market areas in which to conduct an inventory of Military Treatment Facilities (MTFs). The working group will determine what data should be tracked, minimizing the imposition of additional data collection requirements. The first deliverable will be a set of uniform metrics for use at the market level by which the success or failure of demonstration projects could be evaluated. Also, to the extent practicable, metrics should be linkable to enterprise metrics of the Military Health System (MHS) at the strategic level.	Open. To be determined by the working group.
Recommendation 2 DoD should charter an advisory group to enhance MHS collaboration with the private sector and other federal agencies in order to share, adopt, and promote best practices.	Accepted.	The Defense Health Board Health Care Delivery Subcommittee, serving as the best practices External Advisory Group, will assist in and oversee the implementation of this recommendation.	24 months.

Recommendation 3 DoD should request an external audit to determine the adequacy of the processes by which the military ensures 1) that only those who are eligible for health benefit coverage receive such coverage, and 2) that compliance with law and policy regarding TRICARE as a second payer is uniform.	Deferred.	Not applicable. Pending receipt of additional information on ongoing audits and implementation of new data systems, the MHS Senior Oversight Committee (MHS-SOC) has deferred making a final recommendation on an audit of Defense Enrollment Eligibility Reporting System (DEERS) and interfacing personnel systems.	Not applicable.
Recommendation 4 DoD should follow national wellness and prevention guidelines and promote the appropriate use of health care resources through standardized case management and disease management (DM) programs. These guidelines should be applied across the MHS to ensure military readiness and optimal beneficiary health.	Accepted, in part.	The MHS will maintain current wellness and prevention programs, while standardizing methods for the selection, prioritization, and implementation of new wellness and prevention programs throughout the MHS and facilitating the inclusion of such measures in performance-based reimbursement schemes. In collaboration with the Department of Veterans Affairs (VA), the MHS will continue to develop and maintain clinical practice guidelines, including those that target combat-related conditions. The MHS will continue the managed care support contractor-operated DM program with uniform MHS identification of candidates, expand the diseases included in those programs, improve integration with existing DM programs in MTFs, and pursue legislative changes, as appropriate, to allow DM services for non-TRICARE Prime beneficiaries. The current focus on case management programs for Wounded Warriors will lead to improvement in such services for all beneficiaries. The existing network of managed care support contracts in partnership with the MHS will be used to optimize the delivery of health care services in the direct care system, and attain “best	24 months or less.

Recommendation 4 (continued)		value health care" services in support of the MHS mission. Similarly, the managed care support contractors will operate quality management/quality improvement programs and comply with all aspects of the Clinical Quality Management requirements of the *TRICARE Operations Manual*, Chapter 7. Continue utilization of selected HEDIS measures related to the delivery of preventive services and the management of chronic disease to improve clinical quality in both the direct care and purchased care settings. Continue to include utilization management implementation guidelines in the next set of revisions to the *Medical Management Guide*, which is planned for release in Fiscal Year 2009.	
The MHS-SOC grouped Task Force Recommendations 5, 6, and 7 together, because they all relate to acquisition or contracting activities of the TRICARE Management Activity (TMA). **Recommendation 5** DoD should restructure TMA to place greater emphasis on its acquisition role. **Recommendation 6** DoD should aggressively look for and incorporate best practices from the public and private sectors with respect to health care purchasing.	Accepted, in part.	Several activities already are under way in response to these recommendations. The MHS: • Hired Deputy Chief, TRICARE Acquisitions. • Colocated the position with Health Plan Operations. • Will continue to conduct TMA position review. • Will continue to evaluate acquisition structure. The MHS will: • Identify interoperability standards for health information technology systems. • Identify standard quality measures. • Continue to make pricing available to beneficiaries.	12 months.

Recommendation 7 DoD should reassess requirements for purchased care contracts to determine whether more effective strategies can be implemented to obtain those services and capabilities.		The MHS has extensively reviewed and will continue to review acquisition strategies for TRICARE contracts.	
Recommendation 8 DoD should improve medical readiness for the Reserve Component, recognizing that its readiness is a critical aspect of overall Total Force readiness.	Accepted.	A detailed list of responses to this recommendation can be found in the body of the report. It includes: • conducting and reporting on surveys of Reserves with regard to medical care benefits; • improving medical benefit marketing through the managed care support contracts; • improving information dissemination about benefits; • monitoring the results of the disenrollment codes; • reviewing the results from the annual TRICARE beneficiary studies and Status of Forces Surveys to determine if there are indications for action; • planning for the integration of numerous senior level activities pertaining to DoD/VA transitions; • conducting a series of surveys addressing provider awareness and willingness to accept new Standard patients; and • publishing an RFP for the Transitional Support Program.	Activities over a 24-month period.
Recommendation 9 Congress and DoD should revise the pharmacy tier and copayment structures based on clinical and cost-effectiveness standards to promote greater incentive to use preferred medications and cost-effective points of service.	Accepted in part, rejected in part.	The MHS-SOC supports a proposal that includes the provision that future copayment increases should be indexed to the military retiree cost-of-living adjustment. The estimated savings are possible only if the current freeze on raising retail pharmacy copayments is lifted. The MHS-SOC does not concur with creating a fourth tier of more expensive, high-technology drugs, because this action in	Pending congressional action.

Recommendation 9 (continued)		effect penalizes the sickest patients. DoD's view is that it is far more equitable to identify the patients who require specialty drugs and ensure that they are using the most cost-effective venues. The MHS-SOC agrees with the inclusion of select over-the-counter (OTC) medications and recommends that all pharmacy copayments be applied toward the catastrophic cap. The MHS-SOC cannot concur with the recommendation to "carve-in" the DoD pharmacy benefits distribution function through managed care support contractor ownership of the retail networks and TRICARE Mail Order Pharmacy (TMOP).	
Recommendation 10 *The Task Force made a series of lengthy recommendations regarding cost-sharing with regard to TRICARE Prime Family, TRICARE Prime Single, TRICARE Standard Family, TRICARE Standard Single, TRICARE for Life (TFL), and indexing. See pages 102-104 of the Task Force final report or the chapter on this recommendation in this report for details.*	Accepted in part, rejected in part.	The MHS-SOC decided to deliberate on the "major" issues related to cost-sharing to develop an initial report to Congress that would outline a general plan, which, if approved, would facilitate a more detailed request for statutory and/or regulatory authority, consistent with congressional guidance/direction. This would be followed by a more refined analysis of specifics and an estimation of the budgetary impact of the proposed changes. If congressional approval to move forward is granted, a supplementary report and more specific plan will be provided for congressional consideration and approval. TRICARE Prime enrollment fees for military retirees under age 65 should be increased, but the MHS-SOC did not choose to specify the exact dollar amounts. The indexing should be designed to stabilize the beneficiary's share of costs at a level deemed appropriate by Congress. The MHS-SOC did not specify a cost-sharing target or phase-in period. It supported the recommendation that the family rate should remain twice the single rate.	Pending congressional action.

<table>
<tr><td>Recommendation 10 (continued)</td><td></td><td>Without addressing specific levels of deductibles, the MHS-SOC agreed that changes in TRICARE Prime premiums should be accompanied by changes in TRICARE Standard deductibles in order to maintain overall cost-sharing comparability (thus increasing out-of-pocket costs for TRICARE Standard).

The MHS-SOC:
• Endorsed “tiering” to mitigate the escalation of fees on those less able to pay the higher costs.
• Did not concur with the Task Force recommendation for the initiation of a modest enrollment fee for TFL.
• Agreed that enrollment fees should not count against the catastrophic cap and that the cap should be reduced from its current level of $3,000 as recommended by the Task Force.

DoD will continue to ask for congressional authority to change fees and copays in an effort to maintain both a generous health care benefit and a fair and reasonable cost-sharing arrangement between beneficiaries and DoD. All other actions are dependent upon this congressional approval.

Once authority is granted, the Office of the Assistant Secretary of Defense for Health Affairs will form a team to develop a proposed fee structure and an implementation timeline that will be provided to Congress for consideration and approval.

In the meantime, TMA will review its contracts to determine what modifications are needed to accommodate the changes in enrollment fees, copayments, deductibles, and catastrophic caps in order to assure the appropriate collection, payment, and accounting of funds and costs.</td><td></td></tr>
</table>

Recommendation 11 DoD should commission a study, and then possibly a pilot program, aimed at better coordinating insurance practices among those retirees who are eligible for private health care insurance as well as TRICARE.	Rejected.	Not applicable. The Task Force's overarching principle was that "all recommended changes must focus on the health and well-being of beneficiaries and be cost-effective, taking into account both short- and long-term budgetary costs." The above analyses by the Quadrennial Review of Military Compensation and the Institute for Defense Analyses predict that under the Task Force's proposals, DoD costs would increase, and the more recent analysis by Kennell and Associates concludes such a proposal is highly risky. The MHS-SOC concluded that DoD should not commission a study or a pilot program aimed at better coordinating insurance practices among those retirees who are eligible for both private health care insurance and TRICARE. If the TRICARE fee or benefit structure changes, and depending on the impact of expected national health care reform at the national level that might affect the availability and cost of other health insurance, reevaluation may be warranted.	Not applicable.
Recommendation 12 DoD should develop metrics by which to measure the success of any planned transformation of the command and control structure of the MHS, taking into consideration its costs and benefits.	Accepted.	Teams (with representatives from the Services and Health Affairs/TMA) will use the MHS value measures as a foundation, and then develop linked measures (if necessary) that will apply more specifically to changes likely to occur with the implementation of the structural changes specified above. Because significant progress has already been achieved in establishing the Joint Task Force Medical Capital Region, the development of measures of medical market performance will be the first area of emphasis for implementation. An analogous approach will be used to identify the optimal set of measures to be used to assess the effect of the other structural and governance changes such as the implementation of the Military Education and Training Center and the colocated medical headquarters.	End of Fiscal Year 2009.

Prologue

Over the past year, Military Health System (MHS) senior leaders have carefully evaluated the findings and recommendations of the Task Force on the Future of Military Health Care. The thoughtful and comprehensive analysis of the Task Force is greatly appreciated, and this report addresses the challenges described by the Task Force and proposes plans for implementing many of its recommendations. The purpose of this prologue is to provide a summary of the many ongoing successes and innovative efforts in military medicine.

Strategy Management

In addition to meeting the challenges involved in providing outpatient care and transition services to the wounded, ill, and injured, MHS leaders (including the Assistant Secretary of Defense for Health Affairs, the Principal Deputy, Deputy Assistant Secretaries, the Service Surgeons General, and others) have refocused the MHS mission and vision statements and strengthened the customer value propositions that serve the MHS across the continuum of care. The first value proposition, *service-oriented culture*, requires the MHS to address competency in the patient-provider relationship, which increases patient satisfaction, improves health care quality, and lowers health care costs. The second value proposition, *product leadership*, requires the MHS to address competency in innovation and research, which defines its unique mission on and off the battlefield.

The MHS uses the Balanced Scorecard approach to improve patient satisfaction, enhance staff engagement, and incorporate medical innovation in its performance management effort. The MHS has developed key performance indicators based on value propositions and an overarching measure of financial performance. In addition, the MHS has selected mission success outcomes for each of its mission elements and performance measures to drive these outcomes. On July 31, 2008, the MHS Office of Strategy Management unveiled the first MHS Values Dashboard, which is supported by approximately 50 performance measures. The MHS Strategic Plan outlines these performance management efforts.[1]

This performance-based management effort supports Executive Order 13410,[2] which calls for measurement and transparency of the quality of health care delivery and for the availability of price information on health care items and services. The MHS is working toward making the new measures of performance available to the public.

[1] The Military Health System Strategic Plan. Available at http://health.mil/StrategicPlan/2008%20Strat%20Plan%20Final%20-lowres.pdf.
[2] Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs. August 22, 2006. Available at www.whitehouse.gov/news/releases/2006/08/20060822-2.html.

MHS Governance

According to a strategic planner at a *Fortune* 20 company, "You can have the best processes in the world, but if your governance processes don't provide the direction and course correction required to achieve your goals, success is a matter of luck."[3] The MHS believes that effective governance creates a chain of reporting relationships that will drive improvement based on MHS performance metrics. At the leadership level, the MHS will colocate its medical headquarters and consolidate common functions and policy development.

In the National Capital Region (NCR) at the Joint Task Force National Capital Region Medical (JTF CapMed) and in San Antonio at the San Antonio Military Medical Center, leaders continue to share best practices across the Services. In these test-bed regions, leadership is focused on achievements that drive MHS enterprise-wide objectives. As the MHS hypothesized, and has shown in the NCR and San Antonio regions, consolidating hospital functions in each of the major markets means the market leaders will be able to distribute resources across hospitals and clinics within a defined market to meet the needs of the entire population of eligible beneficiaries. Through this consolidation, the MHS anticipates achieving improved continuity of care and better coordination of safety and quality programs.

The MHS will benefit from the joint Medical Education and Training Campus (METC) in San Antonio, which will enable more streamlined and integrated training for enlisted medics and corpsman—the lifesavers who make the greatest difference in survival on the battlefield. In San Antonio, the Uniformed Services Health Education Consortium has fully integrated 28 of 30 graduate medical education programs, reducing duplication. These programs are nationally recognized, and they generally exceed national board certification rates.

The MHS strategic destination includes the creation of a joint medical research and development effort to encourage collaboration and coordination. Military medical leaders publish approximately 2,500 articles annually in peer-reviewed journals, and in Fiscal Year 2009, the MHS will begin a Pay for Publication initiative to support medical innovation. To encourage research collaboration across the Services, Pay for Publication will include extra payment for articles authored by researchers from more than one Service. To improve the visibility of research projects, there is a Research and Publications navigation site at www.health.mil.

Combat Casualty Care

When Warfighters are ill or injured, the MHS provides a wrap-around system of medical care and support for them and their families, and does so always with a view toward rehabilitation and continued service.

Major upgrades to vehicle and individual protection devices, such as body armor, Kevlar helmets, rapid clotting agents, and advanced tourniquets, have protected our fighting forces more effectively than at any time in the past. As a result, severely wounded patients who otherwise would have died on the battlefield now survive to reach medical facilities.

[3] Robert Kaplan, David Norton. The Execution Premium. Harvard Business School Publishing Corporation. 2008.

The Army, Air Force, and Navy operate jointly to provide the most effective casualty care and management system in military history. Combat medics from all services deliver life-saving care to injured Warfighters on the battlefield. Military medics and nurses continue care during rapid ground or air evacuation from point of injury to forward trauma facilities, and then to hospitals in Europe or the United States.

Today, patient movement from the battlefield to stateside care takes on average less than three days. This is in stark contrast to the 10 to 14 days that were required during the Gulf War or the 21 days it took during the Vietnam conflict. This swift movement is even more remarkable, given the severity and complexity of the wounds our forces are sustaining today.

Excellence in trauma care is a critical component of the casualty care mission. Military trauma outcomes exceed those of the best hospitals in America. The combination of the excellent performance of first responders, the use of novel medical technologies, and the best in trauma care and en route care has led to the lowest rate of Service members dying of wounds in history.

A specific example of trauma innovation is the treatment of massive blood loss. For trauma patients who require massive transfusions, mortality rates in the best civilian hospitals range from 20 to 50 percent. Currently, approximately 5 percent of all patients admitted to U.S. combat support hospitals in Iraq require massive transfusions, and the mortality rate has averaged 20 percent over the last four years.

The MHS casualty care mission extends beyond acute care. A coordinated system of care is vital to help our wounded, ill, and injured. Effective rehabilitation requires coordinated care between the MHS, the Department of Veterans Affairs (VA), and civilian medical centers. Key to this is the provision of seamless case management for medical issues and assistance with financial, educational, and family needs.

Psychological Health Initiatives

Precision medicine is based on accurate diagnoses for which accepted treatments address the causes rather than the symptoms of an illness.[4] Much of psychological health, however, falls under the heading of "intuitive medicine," which is not supported by precise diagnoses. This makes the treatment of psychological health conditions difficult and varied.

The MHS is a leader in research devoted to the diagnosis and treatment of psychological health conditions and is creating a center for neuroscience and regenerative medicine at the Uniformed Services University of the Health Sciences (USUHS). Additionally, the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury is overseeing $45 million of research for 49 studies related to the study of psychological health and traumatic brain injury (TBI) conditions. This is a portion of the $454 million that Congress generously provided in Fiscal Year 2007-2008 to advance psychological health initiatives to help meet the needs of military personnel and their families.

[4] Jerome Grossman. Disruptive Innovation in Health Care: Challenges for Engineering. The Bridge. National Academy of Engineering Vol. 38, No. 1.

USUHS has established a consortium among Walter Reed National Military Medical Center (WRNMMC), the National Institutes of Health (NIH), DCoE, the Army Medical Research and Materiel Command laboratories, and Navy laboratories. This network will work with USUHS as the coordinating center to accelerate regenerative medicine programs across these institutions so that fundamental studies are moved to translational laboratories. In turn, this science will migrate to clinical settings to advance development.

The National Intrepid Center of Excellence (NICoE) will be situated adjacent to WRNMMC in Bethesda, Maryland, with close access to USUHS and NIH. The NICoE, scheduled to open in late 2009, will provide advanced diagnostics, initial treatment planning, family education, and referral and reintegration support for warriors with TBI, post-traumatic stress disorder (PTSD), and other complex psychological conditions. The NICoE concept features a holistic approach to patient care, led by an interdisciplinary team that can harness the latest advances in science, resilience, therapy, rehabilitation, education, research, and technology, while providing compassionate family-centered care for Wounded Warriors and their loved ones throughout recovery. The NICoE will conduct research, test new protocols, provide training and education, and strive to be a knowledge leader for TBI, PTSD, and other related psychological health conditions. In short, the NICoE will serve as a treatment and resource center for warriors and families with challenging psychological health and TBI problems that are not responding to care being provided through their local providers. Developing a comprehensive treatment plan for implementation by their local provider allows the warriors and their families to have the very best evidence-based evaluation and treatment in their home environment.

As Service members transition in and out of MHS care, some lose sight of how to get the care they need for psychological health and other conditions. The MHS is using the services of the Armed Forces Health Surveillance Center to help address this issue. Additionally, DCoE is establishing a 24-hour call center where Service members, their families, and providers can get the information they need to get care for psychological health conditions. In a late 2008 MHS web-based questionnaire, the most frequent comment made by family members concerned mental health issues. The MHS will continue efforts to reach out to Service members and their families.

DCoE also has been at the forefront of leveraging computer-based technologies to enhance resilience, treatment, and rehabilitation. During the coming year, DCoE will explore the use of relatively inexpensive console-based videogame technologies, such as those found in the Wii, PlayStation 3, and Xbox, to improve the access and effectiveness of cognitive/motor rehabilitation for patients with TBI.

DCoE also is exploring the use of PC-based voice interactive technologies linked to artificial intelligence systems to provide educational services, while working to destigmatize the psychological health treatment process. Furthermore, DCoE is currently fostering new efforts to leverage virtual reality technologies to improve outcomes in the treatment of PTSD and has established the TeleHealth and Technology (T2) Center at Madigan Army Medical Center to validate and improve these technologies. The T2 Center also is exploring the use of such social networking tools as Second Life to provide new types of outreach to the current generation of Warfighters who are accustomed to interacting with these types of tools.

The center will continue to explore new approaches to working with the entertainment industry in order to provide family outreach, using such tools as the highly acclaimed Sesame Workshop "Talk, Listen, and Connect" program, which is helping families cope with deployments and injured parents. In 2009, DCoE will work with the Sesame Workshop to create a program to help children cope with the death of a parent.

On the research front, DCoE will monitor the outcomes of research funded in Fiscal Year 2008 and examine the use of complementary and alternative medicine approaches such as yoga, meditation, acupuncture, and other commonly used approaches to assess their effectiveness in improving outcomes for both TBI and psychological health issues.

Through the component called the Center for Deployment Psychology, DCoE is providing training on state-of-the-art evidence-based treatment for PTSD and mild TBI (mTBI, or concussion) to MHS and network providers, ensuring that Warriors and families receive effective treatment whenever and wherever needed. DCoE is also working with others to study the current barriers to such treatment. In addition, DCoE is working with the existing DoD/VA Evidence Based Practice Workgroup to continue to refine and improve the existing clinical practice guidelines for the treatment of mental health and TBI issues.[5]

DCoE also is focused on the wellness of families, the members of which are susceptible to combat/operational stress and are also at the same time affected by the mental health and TBI issues of the Service member. To this end, DCoE is developing a family advisory council and is working with Military Community and Family programs to sponsor an upcoming conference that will address the needs of military families and identify the gaps in meeting those needs.

Prevention is a key part of any comprehensive psychological health effort. To that end, DCoE has launched the "Real Warriors. Real Battles. Real Strength" proresilience campaign designed to reduce stigma and increase knowledge of the psychological health issues facing Warriors and their families. This campaign includes an interactive website, www.afterdeployment.org, with a variety of resources, and a significant public education campaign that features inspiring stories of leaders and others who have had the courage to seek mental health care when needed. In addition, a recent three-day conference on resilience was very well attended and brought together line and medical leaders to disseminate current information and identify the way forward.

The military Services also are working to improve the psychological health of the Armed Forces. The Army's Battlemind program is provided predeployment and postdeployment and appears to show promise. In addition, the annual Mental Health Assessment Team studies have provided invaluable insight into the issues facing our Warriors in Afghanistan and Iraq and have helped leaders identify strategies to effectively address these issues. RESPECT-MIL is providing training on mental health issues to primary care providers, improving their ability to identify and address psychological health issues, with the goal of increasing access and decreasing stigma. The Army is pilot testing several initiatives, such as the Soldier Wellness Assessment Program and mental health screenings at Fort Lewis. The Marines Operational Stress Control and Readiness program, which embeds mental health providers in line units and empowers line leaders to intervene early with Marines who may have stress issues, is another example of a

[5] The guideline for treating mTBI has been developed and should be released by February 2009.

Service-led initiative to improve the psychological health of Warriors. The Navy and Air Force both are working to increase the number of embedded mental health providers in primary care settings, again with the goal of addressing both access and stigma. The Services, working with DCoE in many cases, are working to assess the effectiveness of these programs to ensure that those that are the most effective are supported across the Services.

The DCoE, coordinating with the Services, other DoD agencies, VA, civilian experts, and family and community organizations, serves as DoD's "front door" for psychological health and TBI issues. Through the efforts of DCoE and many others, the MHS is working to ensure that the needs of Warriors and their families are being met using the best evidence-based techniques available, while also sponsoring research and pilot programs to develop even more effective approaches in the future. All of these efforts are focused on a single goal: serving the Warriors and families who serve their country.

Healing Environments

> MHS clinics and hospitals must be healing environments that lift the spirit by their bright colors and views of nature, and by the sight and sound of falling water. They must be quiet, clean and clean-smelling, and have features that promote independence, patient control, and welcome family participation. MHS facilities must have the latest technology, such as imaging and electronics, and the latest features that promote safety, such as HEPA-filtered air, carpeting, design that reduces the risk of falls, and informatics safeguards that reduce the risks of medical errors and breaches of privacy.
>
> Honorable S. Ward Casscells[6]

In the November 2008 issue of *Healthcare Design*, editors featured the MHS in an article titled "Healing Environments for America's Heroes."[7] The article demonstrates the commitment needed to transform the military's health infrastructure to meet the unique challenges of caring for the Nation's heroes and their families, when more than 40 percent of that infrastructure is more than 50 years old. The MHS is grateful to Congress for the unprecedented opportunity to modernize many of its key facilities through the Base Realignment and Closure (BRAC) program. As the MHS modernizes its buildings, it will ensure that hospital designs promote integrity during the clinical encounter, empower patients and families, relieve suffering, and promote long-term health and wellness.

The MHS is defining the elements of a world-class health care facility. In November 2008, MHS staff began conducting site visits to civilian hospitals regarded as world class by their patients.

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[6] Statement on the Future of the Military Health System by the Honorable S. Ward Casscells, MD, Assistant Secretary of Defense for Health Affairs, before the Subcommittee on Military Personnel, Armed Services Committee, United States House of Representatives. March 12, 2008.

[7] Michelle Ossmann, Clay Boenecke, Barbara A. Dellinger. Healing Environments for America's Heroes. Healthcare Design. November 2008. Available at www.healthcaredesignmagazine.com/ME2/dirmod.asp?sid=&nm=&type=Publishing&mod=Publications%3A%3AArticle&mid=8F3A7027421841978F18BE895F87F791&tier=4&id=D2C6E7066F1745F8B35002C855C2ED5C.

From these site visits, a team will develop the first-ever MHS definition of a world-class health care facility.

Peace Through Medicine/Humanitarian Assistance and Disaster Response

The MHS cares for families at home, responds to the Nation's call to support its warriors, and provides humanitarian assistance through military-to-military support to countries around the world. To execute these broad missions, the Services must work interoperatively and interdependently. Success depends on MHS partnerships with other federal agencies, domestic and foreign nongovernment organizations (NGOs), host nations, academic institutions, and industry.

Army Activities

The Army Medical Department (AMEDD) helps promote national strategic and security interests through its extensive involvement in medical missions extending well beyond support for the Global War on Terrorism. The AMEDD extends the Army's footprint into the global and joint environment, through participation in Humanitarian and Civic Assistance (HCA) activities and through joint operations across the Services and Combatant Commands. HCA activities are necessary to maintain a forward U.S. military presence, ensure operational readiness to respond to crises, and prepare Reserve Components for their wartime missions.

The most common HCA activities for the AMEDD are through Medical Readiness Training Exercises (MEDRETEs). In Fiscal Year 2008, Army Medicine HCA activities logged more than 198,000 encounters, providing medical, surgical, ophthalmologic, veterinary, preventive medicine, and dental care in Central and South America, the Caribbean, Pacific, South Asia, and Oceania. In addition, Army veterinarians participated in numerous joint missions, deploying on Naval Vessels (e.g., *USNS Comfort*, *USNS Mercy*, *USS Boxer, USS Kearsarge*) to provide veterinary care and treatment for more than 31,000 animals in 2007 and 2008.

Air Force Activities

Through AE, Air Force medicine has the capability to provide a responsive and flexible medical platform to support local, state, national, and international contingency operations and disaster response. The Air Force and Air National Guard were key components in the successful operation to evacuate more than 3,000 people from the Gulf Coast in anticipation of Hurricane Gustav's landfall. Among the evacuees were 833 patients who required specialized medical evacuation from the area. In the storm's aftermath, these forces continued to support the region by providing further medical evacuation and humanitarian aid. These capabilities have been employed successfully worldwide in response to events such as typhoons, tsunamis, and earthquakes.

The Air Force Medical Service conducts humanitarian mission and medical training through MEDRETE. Over the past year, the Air Force has provided medical, surgical, and dental care to more than 110,000 patients in 17 countries in Africa, Asia, Latin and South America, and Eastern Europe. At the same time, medical seminars were conducted in these countries to

facilitate professional development and build international health care partnerships. The Defense Institute for Medical Operations provided instruction in Disaster Planning, Critical Lifesaving for First Responders, and Mobile Contingency Hospital Training. Theater Contact Teams also provided training in Aviation and Space Medicine, Laboratory Skills, and Public Health and Emergency Operations.

Navy Activities

During summer 2007, the *USNS Comfort* visited 12 Central American, South American, and Caribbean countries, conducting 1,170 surgeries and providing immunizations, pharmaceuticals, and eyeglasses. Veterinary staff treated 17,772 animals, providing a critical health care service that helps prevent diseases that could be passed from animals and livestock to people. Dental care also was a major mission priority, with treatment provided to more than 25,000 patients. Operation Smile, an international medical charity that in developing countries provides free surgeries to children with facial deformities, working alongside *Comfort*'s dental staff in Nicaragua and Peru performed more than 50 surgeries. Members of the ship's medical staff partnered with Project Hope to conduct more than 1,000 training sessions for approximately 28,628 students, including preventive medicine training for patients and health procedures training for medical providers.

The *USNS Mercy*, Pacific Partnership for 2008, conducted missions to the Philippines, Vietnam, Timor Leste, Papua New Guinea, and Micronesia. Training was provided to 2,293 students in Vietnam, with nearly 23,000 patient encounters.

The *USS Kearsarge*, Continuing Promise 2008 Atlantic Phase (August - November), conducted missions to Nicaragua, Colombia, Dominican Republic, Trinidad and Tobago, and Guyana. From September 7 to September 26, 2008, *USS Kearsarge*, LHD 3, was diverted from Continuing Promise operations to support international relief operations in Haiti. During its deployments, medical staff treated 47,000 patients and provided veterinary care to 5,600 animals.

The *USS Boxer*, Continuing Promise 2008 Pacific Phase (April - June), conducted missions to El Salvador, Guatemala, and Peru. The ship's team of more than 150 military medical and dental professionals and NGOs worked with partner nation officials to provide treatment to 14,000 patients, repair biomedical equipment in clinics and hospitals, provide veterinary treatments to 2,900 animals, and conduct valuable training on basic life support, nutrition, basic sanitation techniques, and first aid to 18,000 students in 123 classes.

Quality Improvement

The MHS is embracing the Patient-Centered Medical Home concept, which is a recommended practice of the National Committee for Quality Assurance and is endorsed by a number of medical associations, several large third-party payers, and many employers and health plans. The Patient-Centered Medical Home improves patient satisfaction through its emphasis on appropriate access, continuity and quality, and effective communication.

The seven core features of the Medical Home are:

- Personal Primary Care Provider (primary care manager/team)
- Primary Care Provider Directed Medical Practice (the primary care manager is team leader)
- Whole Person Orientation (patient centered, not disease or provider centered)
- Care Is Coordinated and/or Integrated (across all levels of care)
- Quality and Safety (evidenced-based, safe medical care)
- Enhanced Access (meets access standards from the patient perspective)
- Payment Reform (incentivizes the development and maintenance of the medical home)

The MHS already has begun its Pay for Performance program at Military Treatment Facilities that are meeting performance targets that ensure patients get needed care and that are promoting effective patient-provider communication.

The MHS developed Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) to improve the culture of patient safety in hospitals and other health care settings. In November 2006, the MHS teamed up with the Agency for Healthcare Research and Quality to release the program to civilian health care providers. TeamSTEPPS is a research-based system that presents tools for team training, coaching, and change management to effectively improve communication, reduce medical error, and create a culture of safety within the MHS.

DoD/VA Partnerships

The DoD and VA partnership in interagency health data sharing is robust. The partnership is developing information technology solutions that support the secure sharing of appropriate electronic health information, the continuity of health care, and the quality of health care provided. Over the last decade, the two departments have greatly increased health data sharing and interoperability activities, and this has resulted in more complete, accurate, and secure health information sharing. DoD and VA are working on ongoing data exchanges that will form the foundation for enhanced interoperability in Fiscal Year 2009 and beyond.

For the most seriously injured and wounded Service members and veterans, the departments support a medical record scanning and image transfer capability. In addition, DoD sends deployment health assessments to VA weekly for individuals referred for VA care or evaluation. As of October 2008, DoD has sent VA more than 2.4 million Pre-and Post-Deployment Health Assessment and Post-Deployment Health Reassessment forms on more than 972,000 individuals. These numbers include monthly data transmissions of deployment health assessments for National Guard and Reserve members who have been deployed and are now demobilized.

For VA patients treated in DoD facilities, as of October 2008, DoD has transmitted to VA more than 3.2 million patient messages (laboratory results, radiology reports, pharmacy data, and consults).

Thousands of each other's patients are being treated by both DoD and VA. As a result, the departments maintain the jointly developed Bidirectional Health Information Exchange (BHIE)

system. Using BHIE, DoD and VA clinicians are able to access health data bi-directionally and in real time. As of October 2008, the BHIE system had 3.2 million unique correlated patients, including more than 90,200 theater patients.

Through a common desire to develop "joint" health care ventures between the systems that are focused on improving health care delivery, the departments have created eight joint venture medical facilities. The latest and most advanced of these is the Federal Health Care Center, North Chicago, Illinois. The center represents a major milestone in the development of a comprehensive integrated health care delivery system for treatment of DoD and VA beneficiaries in the North Chicago area. Another recent example of integration between the DoD and VA systems occurred in August 2008, with the opening of the Joint Ambulatory Care Center next to the Naval Hospital at the Naval Air Station in Pensacola, Florida. In addition, under the direction of the Joint Executive Council (JEC), a joint DoD/VA assessment team is conducting a full study of other joint market opportunities around the country. The results of that study will be reported to the Office of Management and Budget in late 2009.

Pay for Performance

In Fiscal Year 2008, the MHS put $58 million toward Pay for Performance in the direct care system (military hospitals and clinics) to reward the facilities in which staff members are improving health care and providing a home for patients who use the MHS. This Pay for Performance initiative is linked to the areas of the Medical Home in which the MHS would like to see improved performance (access to care and effective patient-provider relationships).

Pay for Performance also supports Executive Order 13410, which directs the alignment of incentives, so that payers, providers, and patients benefit when health care delivery is focused on achieving the best value at the lowest cost. In the coming years, the MHS will extend Pay for Performance to research, education, and force health readiness improvements. In addition, military leaders are looking at innovative benefit reform to reward patients and providers for their prevention efforts and healthy lifestyles. For Fiscal Year 2009, the MHS is backing future Pay for Performance efforts, with $80 million in potential performance rewards.

Drug Safety

The TRICARE database is proving to be a useful tool for providing information about U.S. public health regarding drug safety. Over the past two years, several medications have had their safety/benefits questioned in both professional journals and the lay press. TRICARE Management Activity staff members conducted analyses on DoD's extensive claims databases to assess the risk in the covered patient population. Results of the analyses did not support the claims made in the literature and allowed for the studied medications to be maintained in the DoD formulary. The MHS is working to publish its findings in peer-reviewed journals to share the wealth of knowledge derived through its unique databases. In the future, the MHS intends to collaborate more with the U.S. Food and Drug Administration on drug safety issues.

The depth of analysis possible through the TRICARE database is substantial. In the future, the MHS could use it regularly for quality, drug safety, and food safety surveillance and to mine for unknown but clinically important associations.

Future Benefit Structure

Given the challenges involved in lowering the cost of health care for the Uniformed Services, leaders of the MHS recommended conducting a reassessment of the health care benefit. These efforts have been validated by the Task Force on the Future of Military Health Care and the Quadrennial Review of Military Compensation.

Up to this point, leaders have focused on adjusting fees within the context of the basic triple-option benefit (Prime, Standard, Extra) in order to rebalance the beneficiary cost-share. The triple option was formulated in the early 1990s and has served the military well; however, since that time, health benefits delivery has continued to evolve, and new paradigms have entered the market place. (One such model is the introduction of Health Savings Accounts; another is High-Deductible Health Plans.)

DoD should take a broader view and examine other models for delivering health benefits to evaluate whether it can better manage costs and also provide an improved benefit to the beneficiary in terms of lower cost, higher quality, increased access, and better health. Such a shift would require extensive study and might best be addressed in the context of the Quadrennial Review, which would allow DoD leaders to fully consider all options, unconstrained by short timelines and current policies and contracts.

Conclusion

Our future strategic environment is extremely complex, dynamic, and uncertain. Therefore, we will not rest on our successes. MHS leaders recognize that there are gaps that must be filled in health care services, access, care coordination, safety, accounting, and cost controls, as well as other areas that are in need of improvement. MHS leaders are committed to addressing these challenges. The Task Force has provided invaluable insights on how to move forward, and MHS leadership thanks the members of the Task Force for their dedication and superb contributions. The MHS is already using Task Force assessments in its efforts to improve the health care services that are so essential to the men and women in uniform, their families, those who have served in the past, and the Nation. The people of the MHS want to become part of a model health care system, and they stand ready to participate in health care reform—a major national concern—as directed by national leadership.

Recommendation 1
Integration Strategy for Direct and Purchased Care

Task Force Recommendation

DoD should develop a planning and management strategy that integrates the direct health care system with the purchased care system and promotes such integration at the level where care is provided. This strategy will permit the maintenance and enhancement of the direct care system's support of the military mission while allowing for the optimization of the delivery of health care to all DoD beneficiaries.

Action Items

- *The Office of the Secretary of Defense, the Joint Staff, and the military departments should develop a strategy for health care delivery that integrates the direct and the purchased care systems.*

- *DoD should:*

    - *provide incentives that optimize the best practices of direct care and private sector care;*
    - *fiscally empower the individuals managing the provision of integrated health care and hold the same individuals appropriately accountable;*
    - *draft legislative language to create a fiscal policy that facilitates an integrated approach to military health care; and*
    - *develop metrics to measure whether the planning and management strategy produces the desired outcomes.*

Task Force Assessment

Shaping the future requires planning, and strategic planning is particularly important for the future of military health care because of the resource-constrained environment and the rapidly increasing costs of health care, which is driven by many factors beyond the control of DoD and its components. The same level of planning that occurs when military forces are deployed—with a focus on optimizing the performance of the mission, including the integration of units, regardless of the military service that provides them— also needs to occur within the Military Health System (MHS). It is particularly critical at the intersection between direct care and purchased care systems, as well as at the intersection of the different military services, where more focus is needed on both strategic planning and integration.[1]

This recommendation is overarching and relates to several other Task Force recommendations. For example:

[1] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 19.

- The Task Force's second recommendation calls for DoD to increase collaboration with the private sector and other federal agencies "to share, adopt, and promote best practices."[2]
- An action item under the third recommendation said that DoD should "establish a common cost accounting system that provides true and accurate accounting for management."[3] The Task Force also said the "most significant challenge to the MHS continues to be the existence of financial, cost accounting, and information systems that do not interface well with one another."[4]
- As part of the fourth recommendation, DoD should "implement and resource standardized case management and care coordination…across the spectrum of care."[5]
- Recommendation 6 stated that DoD should "aggressively look for and incorporate best practices…with respect to health care purchasing."[6]
- Recommendation 7 asked DoD to reassess requirements for purchased care contracts "to determine if more effective strategies can be implemented" to obtain services and capabilities.[7]
- Recommendation 12 emphasized the development of metrics by which changes in command and control can be measured.[8]

The Task Force noted some of the effects of the lack of integration:

- diffused accountability for fiscal management;
- misalignment of incentives;
- limitation on continuous improvement in quality of care for beneficiaries; and
- lack of a single point of accountability for costs for services provided or for health care outcomes in major markets with more than one Service, such as the National Capital Region and San Antonio, Texas.[9]

The Task Force further described some of the factors that contribute to the lack of an integrated strategy:

- An organizational structure that causes fragmentation of the Military Health System (MHS), because resources flow through different branches of the system, "resulting in a

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[2] Ibid., p. 27. Action items under Recommendation 2 include efforts to "strengthen incentives to providers and health insurers to achieve high-quality and high-value performance" and to "implement a systematic strategy of pilot and demonstration projects to evaluate changes in MHS practices and identify successful practices for more widespread implementation."
[3] Ibid., p. 31.
[4] Ibid., p. 32.
[5] Ibid., p. 41.
[6] Ibid., p. 53. Action items under this recommendation encouraged the use of health information technology systems and products that meet recognized interoperability standards and making quality of care and price information more "transparent" to providers and beneficiaries.
[7] Ibid. An action item focused on practices for "accomplishing referrals" and "need for authorizations" and other aspects of "contracting strategy."
[8] Ibid., p. 116.
[9] Ibid., p. 23.

cumbersome, disintegrated system certain to have an adverse effect at the operational level."[10]

- The "absence of a common accounting system…is an example of deficient integrative focus, which impedes decision making regarding the best allocation and use of health care resources."[11]
- "[F]ragmentation of funds [that] begins with Congress and its restrictions on budget flexibility."[12]

Accordingly, at the local level, there is limited flexibility to make the most cost-effective and beneficial health care delivery decisions for beneficiaries.[13]

The Task Force acknowledged that the MHS engages in strategic planning. The strategic plan, in effect at the time of the Task Force review, was based on "three pillars": 1) providing a medically ready and protected force and medical protection for communities; 2) creating a deployable medical capability that can go anywhere, anytime with flexibility; and 3) managing and delivering a superb health benefit.[14] The Task Force recognized the importance of the first two pillars by explaining its recommendation: "This strategy will permit the maintenance and enhancement of the direct care system's support of the military mission…."[15] The Task Force stated that better business practices for the delivery of health care were evolving, but that "greater emphasis" is needed for "addressing the problems of integration at the 'market,' or MTF level, between direct care and purchased care, and among the service components."[16]

Background

The Task Force noted that the problems and possible solutions for better integration at the local level were "not new concerns." For example, it reviewed the analyses and recommendations of the Local Authorities Working Group, a group chartered by the MHS Executive Review to "improve operational efficiency and effectiveness while ensuring force health protection and quality beneficiary care."[17,18]

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[10] Ibid., p. 20.
[11] Ibid.
[12] Ibid., p. 21.
[13] Ibid., p. 23.
[14] Ibid., p. 22. This MHS Strategic Plan (2006) was updated in 2008. In 2008, senior leaders of the MHS crafted new mission and vision statements, refined descriptions of core values, and developed 10 strategic priorities. See the Prologue and Chapter 12 for more information. See also www.health.mil/StrategicPlan. The plan illustrates the complexity of meeting many missions, far more than a civilian health plan must meet, and includes elements that directly bear on the Task Force's first recommendation. It reflects a shift in thinking about a provider-centered model to a patient-centered system and from a direct care system of MTFs and network of civilian providers to an integrated health delivery team with shared accountability.
[15] Ibid., p. 23.
[16] Ibid., p. 22.
[17] Ibid., p. 22. See also The Military Health System Executive Review. Local Authorities Working Group Final Report. January 2005.
[18] The working group identified six major actions that must occur to improve MTF efficiency and effectiveness, summarized as follows: 1) the dual mission of force health protection and beneficiary health care must be managed as a comprehensive whole; 2) the MTFs must be given performance and cost objectives for both health care and force health protection; 3) the system must accurately and transparently measure and communicate performance and cost information; 4) current regulatory-based controls must be replaced by performance-based incentive systems and

The Task Force acknowledged that there were substantial changes in the management and oversight of TRICARE purchased care and direct care systems during the evolution of TRICARE, to include a regional governance structure adopted in 2004: TRICARE Regional Offices (TROs) were given management responsibilities over their respective TRICARE regions, to include responsibility for integrating single Military Treatment Facility (MTF) and Multi-Service Market business plans with the TRO non-MTF business plan and developing regional business plans for health care delivery.[19] The Task Force observed, as did the working group, that in the "maturing business planning process," shortcomings existed in large part because of the complexity in the chain of responsibility: Some MTFs are subject to two or three entities providing oversight of planning and performance processes.[20,21]

To understand fiscal constraints, it may be helpful to provide a brief explanation of the appropriations process. The MHS receives funding from numerous appropriations sources with different timeframes and restrictions. A significant source is the Defense Health Program (DHP) Operations and Maintenance (O&M) appropriation. This must be obligated within one fiscal year and with limited carryover to the succeeding fiscal year. This funding is used to cover day-to-day operations across a wide variety of medical, dental, and veterinary services, and to cover readiness, to the extent it is not already funded through Service line appropriations, including functional areas such as education and training, occupational health, and industrial health; facilities; and information technology. Some funds within the DHP are not O&M funds, such as research and development (two-year) money or procurement (three-year) money. The DHP does not fund military personnel working at an MTF; that funding is through the Services.[22] Military construction funds support the MHS, but they are not part of the DHP.[23] Also, supplemental

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accountability processes that guide and control MTF operations; 5) MTFs must be developed and prepared to operate in a performance-based environment; and 6) these five actions are a precondition for the sixth—MTFs must be provided with flexibility to manage and allocate resources.

[19] Under Secretary of Defense for Personnel and Readiness. TRICARE Governance Plan (Cover letter October 22, 2003, signed by David S.C. Chu). 2003.

[20] Task Force on the Future of Military Health Care, op. cit., p. 23

[21] Under Secretary of Defense for Personnel and Readiness. TRICARE Governance Plan (Cover letter October 22, 2003, signed by David S.C. Chu). 2003, p. 12. The TRICARE Governance Plan established advisory committees at the regional and headquarters level to identify and resolve issues. The TRICARE Regional Advisory Committee (TRAC) reviews annual business plans and periodically assesses business plan performance. The TRICARE Advisory Committee (TAC) is the next level to approve and periodically evaluate regional health plans and is available to identify and resolve issues. Issues not resolved by the TRAC or TAC are presented for review by the Senior Military Medical Advisory Council and resolution by the Assistant Secretary of Defense for Health Affairs as program manager for all medical resources.

[22] Department of Defense Inspector General, Audit Report: Military Health System Optimization Plan, D-2002-034, December 31, 2001, p.1, pointed out the need for a systemwide methodology for allocating military personnel during peacetime, regardless of Military Department affiliation, to achieve maximum efficiency and productivity in the MTFs. In Appendix B of that report are listed some specific initiatives at the regional level for optimizing productivity in the direct care system, intended to reduce work being transferred to purchased care. For example, there was a "circuit rider" program of sharing military physicians at different MTFs within a region, regardless of military affiliation of the facility or physician. Other initiatives included efforts to have civilian primary care providers increase referrals to specialists in the MTF rather than the civilian network and to use a registered nurse triage program (a registered nurse to answer phone calls and help patients decide what should be done at home and whether a visit is needed).

[23] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 10.

funding supports the MHS—that is, funding that is restricted for specific purposes related to the Global War on Terrorism.

Within the DHP O&M appropriation there are seven activities, of which two are directly relevant to this topic. One covers direct care (called Budget Activity Group 1, or "BAG 1"), and the second is for purchased care (called "BAG 2"). The MHS cannot transfer money from BAG 1 to BAG 2 without use of "prior approval reprogramming procedures."[24] In a statement to Congress in 2006, the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs said that more flexibility is needed in moving funds between direct to purchased care so that the MHS could manage its funds "as an integrated system, which will allow funds to flow on a timely basis to where care is delivered."[25] Under the existing constraints, the MHS must ensure that BAG 2 is sufficient to pay the purchased care bill at the end of the year, and, as that time approaches and forecasts become more certain, additional funds can be provided to the Services for direct care. Because the transfer of funds from BAG 1 to BAG 2 is highly restricted, in one sense, BAG 2 operates as a reserve account for BAG 1.

Budgets for the MTFs are based in large part on business plans that project workload outputs, rather than historical spending levels, using a prospective payment system.[26] Adjustments during the budget execution year are made on the actual reported workload, and typically funds are released to the Services for their respective MTFs. Time delays in this process sometimes undermine best business or investment decisions because of funding delays or uncertainty. The Services may have to use funds to sustain "unprofitable" MTFs at the expense of "profitable" MTFs that otherwise should be rewarded for superior performance and efficiency in executing their business plans. Also, the relatively short duration of funds may inhibit longer-term investments in order to avoid the risk of violating the Antideficiency Act,[27] or it may simply impede the hiring of contractor staff in the MTF to solve staffing problems that are adversely affecting capacity or productivity.

MHS-Senior Oversight Committee (MHS-SOC) Review and Comments

Of all the Task Force recommendations, Recommendation 1 resulted in the most extensive discussion by MHS-SOC members. Much discussion centered on the issues of the appropriate form of governance and the adequacy of transparency and exchange of information between the direct care and purchased care components. There is concern about the declining workload in direct care and the increasing workload and costs of purchased care.

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[24] Ibid., p. 21.
[25] Ibid., p. 22, citing testimony by Dr. Chu and Dr. Winkenwerder to a personnel subcommittee. April 4, 2006.
[26] Ibid. The prospective payment system is used to justify budgets for the MTFs, based on outputs, not inputs, and is used to provide a basis for the distribution of funds. Not all workloads have outputs that are measured, for example, ancillary services, dental, or some readiness-related activity that cannot be captured in inpatient or outpatient codes. Inpatient workload is translated to relative weighted products (RWPs) and mental health bed days, and outpatient workload is translated to relative value units (RVUs). Obviously, inaccurate coding can undermine data quality. Values given to workload are based on values (rates for purchasing) rather than MTF costs (resources consumed to produce the outputs).
[27] The Antideficiency Act (P.L. 97-258) is one of the major laws through which Congress exercises its constitutional control of the public purse.

Members of the Committee questioned whether existing mechanisms and incentives were sufficient to optimize the delivery of health care and to optimize utilization of MTFs. The Deputy Surgeons, in particular, noted the difficulty in recapturing workload that is referred to the contractor-managed civilian network of providers. There also was discussion about the funding processes arising from segregated budgeting accounts (BAGs 1 and 2). However, perceived fiscal problems may be more attributable to the fact that the MHS operates in a resource-constrained environment in which there is often not enough to go around, exacerbated by the lack of a common cost accounting system across the enterprise, than to the rules related to BAG 1 and BAG 2 funding.

One clear area of agreement was that all efforts toward improved integration should focus on a patient-centered model. Integration is not simply about decreasing health care costs. Improved integration should improve the quality and access of health care delivery and health outcomes without undermining the performance of other mission areas, goals, and objectives of the MHS.

Governance

The TRICARE Management Activity (TMA) supports the 2004 directive[28] directing execution of the existing governance plan, which outlines roles of the TROs, emphasizes integrated business planning, and provides a dispute resolution system for elevation of unresolved issues.[29] However, the Navy offered a regionalized governance plan with a Flag Officer/General Officer providing oversight for direct and purchased care services and incorporating the TRO Director within the leadership structure as the Deputy Regional Commander; for example, the Navy would have the lead in one region (West), the Army in another (North), and the Air Force in a third (South).[30,31] The TROs would provide oversight and management of the "white spaces" (areas outside of a one-hour drive time from an MTF) and contract and private sector care. Local MTF Commanders would be responsible for the oversight and management of direct and purchased care services within the one-hour drive time of the MTF. This model would provide the tools at the local level to integrate direct and private sector care with an emphasis on purchased care optimizing care within the MTF.[32]

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[28] Deputy Secretary of Defense for the Assistant Secretary of Defense for Health Affairs memorandum entitled TRICARE Governance Plan, dated January 20, 2004, directing immediate execution of the TRICARE Governance Plan, approved by the Under Secretary of Defense for Personnel and Readiness, dated October 22, 2003, to the Secretaries of the Army, Navy, and Air Force. See footnotes 19 and 21, above.

[29] Under Secretary of Defense for Personnel and Readiness. TRICARE Governance Plan (Cover letter October 22, 2003, signed by David S.C. Chu). 2003.

[30] Minutes of MHS-SOC meeting. August 18, 2008.

[31] Ibid. A local Commander would be in charge of his or her facility, and the Regional Commander would have a consultative role. The business plans would be coordinated through the regional headquarters that would have responsibility for the funds allocated to the region. It was further explained at the November 24, 2008, meeting that a senior Uniformed Service Commander would be responsible for implementation of a plan in a market area, and the managed care support contractor would be responsible for those areas outside of a one-hour drive from MTFs in the designated area. There must be a clear definition of responsibility for the area to be covered, because there may be places where an MTF is not readily accessible within a designated area.

[32] Minutes of MHS-SOC meeting. August 18, 2008.

The Army and Air Force agreed with the concept.[33] TMA leadership did not agree, saying that this concept had been tried before (Catchment Area Management in 1989-1992) and incorporated into the managed care principles employed by TRICARE today. TMA strongly believes the tenets of the approved DEPSECDEF (2004) plan[34] should be reviewed, improved, and consistently applied. Additionally, the Services advocated a realignment of the Services Medical Regions with TRICARE regions, with the goals of better-defined scope of geographic responsibilities, enhanced communications at all levels, and improved fiscal and health care partnerships in all local markets.

Fiscal Matters

Governance issues are intertwined with fiscal issues. A change in governance presumably would lead to some changes in the allocation and management of resources at the local or regional level. For example, more flexible funding at the local level could mitigate barriers and risks that may inhibit MTF commanders from investing in projects designed to improve the integration of the delivery of health care services. More flexibility also could allow faster responses to contingencies (e.g., deployments) that adversely affect performance under a business plan. Also, more directed and timely financial incentives could be devised to encourage MTF commanders to focus on maximizing care provided within the MTF. Finally, incentives could increase attention to healthy behavior, preventive care, better care coordination, and improved disease management. Rewards could be shifted toward outcomes, not just outputs.

The MHS-SOC members agreed on the need for more transparency in purchased and direct care fiscal data elements. They acknowledged that the limitations of cost accounting systems preclude valid comparisons between direct and purchased care at the patient level and that a near-term solution was not likely. No consensus was reached on what, if any, changes should be recommended regarding the BAG 1/BAG 2 rules. Any such changes would require congressional action. Fewer restrictions could be viewed as a diminution in Congress' oversight and control over the "purse strings." The Deputy Assistant Secretary for Health Budgets and Financial Policy indicated that the restrictions serve as a safeguard to assure adequate funds for the "must-pay" bill for purchased care at the end of the fiscal year.

Other Issues Involving Integration

The MHS-SOC addressed other integration issues, such as the greater need for transparency of health data, and discussed a possible demonstration or pilot project that would give network providers access to electronic health records. Much discussion was focused on the objectives of such studies and potential sites. Possible health care delivery elements proposed for possible study include improvements in urgent care, improved information sharing, improved consultation and authorization processes, better after-hours access to direct care providers, improved communications on consultations, and improved referral processes.[35]

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[33] See also Minutes of MHS-SOC meetings. October 27, 2008, and November 24, 2008.
[34] Deputy Secretary of Defense for the Assistant Secretary of Defense for Health Affairs. Memorandum entitled TRICARE Governance Plan. January 20, 2004. See footnote 28 above.
[35] Minutes of MHS-SOC meetings. August 18, October 27, and November 24, 2008.

The members agreed that reform should focus on enhanced business planning at the "market" level. But the members decided that, before directing a pilot program for changing management responsibilities, they would test their assumptions by "micro-monitoring" targeted market areas. During this period, MHS leadership would gather baseline data to define the objectives and requirements for a demonstration project or pilot before implementing any significant changes in governance. This would help provide more clarity on what data should be tracked, for example, measurement of workload and its impact on manpower determinations. Standardized metrics would be developed to replace Service-specific or local metrics.

Four markets were identified for micro-monitoring. The single-Service market of San Diego includes various sizes of MTFs, and as a single-Service region or market, it provides an opportunity to gain better insight into how integration may be adversely affected by disparate systems and approaches of the different Services in multi-Service markets. Fewer challenges in the areas of interoperability, resource sharing, and reallocation would be expected.

Two multi-Service mega-markets would be included: the National Capital Region and San Antonio. These two markets have a head start in integration planning because of major actions currently under way. Including these markets takes advantage of initial lessons learned and other efforts relevant to development of an integration strategy—that is, the metrics are in a more advanced stage of development. Because these markets may not be representative of other multi-Service markets where successful results could be replicated, the MHS-SOC decided to examine the Colorado Springs market as well (Air Force and Army).[36] Micro-monitoring these four market areas should accelerate the analysis at a more granular level before deciding upon, and developing, a demonstration project or projects with new overall governance structure focused on the integration of the direct and purchased care systems.

Implementation Plan

A working group will be established, composed of representatives to be appointed by each member of the MHS-SOC, and augmented by others as necessary to accomplish its objectives. To the extent possible, representatives should include members of the Integrated Process Team, which provided support to the MHS-SOC. The Integrated Process Team is familiar with concerns and issues related to Recommendation 1 and related action items, as well as other aspects of the Task Force report critical to developing a strategy for better integrating health care delivery at the operational level (i.e., direct care/purchased care, inter-Service). The working group will develop a charter to be submitted to the Principal Deputy Assistant Secretary of Defense for Health Affairs consistent with guidance in this implementation plan. The working group will develop further details on the project scope, other deliverables, and milestones consistent with this implementation plan.

Objectives

1. The initial objective of the working group is to develop a concept plan to better integrate and improve health care delivery in the selected areas. After the micro-monitoring stage, it should be determined what, if any, pilot studies and/or demonstration projects are likely to yield

[36] Ibid.

useful information for improved integration and whether they are ready to be implemented. Readiness for implementation means that at the market level, sufficient management information and management tools are available to carry out such studies or projects in a manner that allows for the evaluation of what works in improving the integration of health care delivery at the market level. Before a study or demonstration project is undertaken, an operation plan must be developed with the participation of personnel at the respective market level.

Preliminary Tasks

2. At the outset, the working group will clearly delineate the market areas identified above, to include an inventory of the MTFs within such market areas. Such delineation must define and delineate "white spaces" within a market area. It also should include information on the TRICARE beneficiary population in those markets, particularly in terms of health care needs.

3. The working group will determine what data should be tracked, minimizing the imposition of additional data collection requirements. The data gathered should be broad enough to cover the following action items under Recommendation 1:

- *activities that provide incentives that optimize the best practices of direct care and private sector care;*
- *activities that fiscally empower the individuals managing the provision of integrated health care and holding them appropriately accountable;*
- *fiscal policy changes that would facilitate an integrated approach to military health care; and*
- *the development of metrics that can be used to measure whether the planning and management strategy produces the desired outcomes.*

Importance of Metrics

4. Management metrics should include those that assess management data at different levels and that measure the performance of the MTFs and managed care support contractors for the respective markets, for example, MTF level, higher headquarters (including Service Surgeons General), TROs, TMA, and Health Affairs.

5. The first deliverable will be a set of uniform metrics for use at the market level by which the success or failure of demonstration projects could be evaluated. Also, to the extent practicable, metrics should be linkable to enterprise metrics of the MHS at the strategic level.[37]

Evaluation of Business Plans

6. The working group should assess business plans used in the respective market areas.

[37] See discussion of metrics for Recommendation 12.

Other Tasks and Considerations for the Working Group

7. Determine what education and training is needed at the local/market level to assure consistency and quality data—for example, if workload is measured, then accurate coding is required for comparative analysis.

8. Determine what additional authorities and management tools are needed for managers to be able to act upon management information that can yield improved integration.

9. Identify barriers to integration and areas for improvement in transparency in quality and cost, interfaces for information exchange that can improve health outcomes, workload balancing, quality of care, supply and demand, resource sharing, patient satisfaction, access, provider satisfaction, and costs. The examination of barriers should include an effort to identify all policies, directives, and regulatory issues that require amendment, modification, or discontinuation.

10. Examine how the prospective payment system operates in the different markets, identify areas for improvement, and seek to identify how all areas of workload related to mission accomplishment are measured, for example, readiness, education, and training.

11. Evaluate the coordination of referral and preauthorization processes across the spectrum in the market areas and the level of follow-up consultation.

12. Gather information on the potential for consolidating health care and support services, which could result in savings from economies of scale. Assess the current level of collaboration at the market level along different functional lines and across the overall infrastructure of health care entities supporting the MHS mission. This assessment should cover the delivery of health care, including facilities, systems, installations, supply chain management, the procurement process, vendor performance, services, and the staff necessary for the functioning and delivery of health care services provided within the health care continuum.

13. Determine liaison relationships for working group development within the market areas and/or its components.

14. Identify options for changes in governance, both near term and long term, ensuring that such options optimize accountability and responsibility. Take into account what is pragmatic, but consider options that may go beyond current paradigms.

15. The evaluation, while focused, must be performed in the context of patient-centered care, the advancement of values in the MHS Strategic Plan, and the promotion of best practice initiatives, such as the Patient-Centered Medical Home concept and pay for performance.

Recommendation 2
Best Practices in Program Evaluation

Task Force Recommendation 2

DoD should charter an advisory group to enhance Military Health System (MHS) collaboration with the private sector and other federal agencies in order to share, adopt, and promote best practices.[1]

Action Items

DoD should:

- *align with the Departments of Health and Human Services and Veterans Affairs, the Office of Personnel Management, and private sector organizations to make health care quality and costs more transparent and easily accessible by all beneficiaries;*
- *use performance-based clinical reporting by managed care support contractors and the direct care system;*
- *strengthen incentives to providers and health insurers to achieve high-quality and high-value performance; and*
- *implement a systematic strategy of pilot and demonstration projects to evaluate changes in Military Health System practices and identify successful practices for more widespread implementation.*

Task Force Assessment

The Task Force identified a cross-cutting theme in its review of various reports and studies delineating recommendations for best practices: DoD had not adequately considered systems outside DoD to include other federal agencies as well as the private sector in its efforts to examine and possibly adopt health care best practices. While recognizing the unique characteristics and capabilities of the MHS, the Task Force stated that commonalities regarding the purchase and delivery of health care services pervade disparate health care systems and concluded that the MHS would benefit from active engagement in broad-based discussions within national conferences and forums. Consequently, the Task Force emphasized that DoD should significantly enhance and maintain its efforts in this area. The Task Force stated that such collaboration also would give the MHS an opportunity to assist and influence the larger civilian health care community through the contribution of knowledge and experiences.

The Task Force recognized that DoD has been working to establish relationships and collaboration with major purchasers, including the Centers for Medicare & Medicaid Services (CMS), and with other agencies, including the Department of Health and Human Services (HHS), the Department of Veterans Affairs (VA), and the Office of Personnel Management (OPM), particularly in conducting initiatives outlined in Executive Order 13410 (Promoting

[1] Task Force on the Future of Military Health Care. Final Report, December 2007, p. 27.

Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs). The Task Force urged the MHS to continue to improve its collaboration efforts.

Related Task Force Recommendations on Collaboration

In addition to Recommendation 2, other recommendations of the Task Force promote improved collaboration with different departments and agencies to meet DoD beneficiary needs.

Recommendation 8 states that "DoD should improve medical readiness for the Reserve Component, recognizing that its readiness is a critical aspect of overall Total Force readiness."[2] One of its action items recommends that "DoD should harmonize and leverage the work of other review groups to streamline processes to promote better 'hand offs' from the DoD to the Veterans Affairs health system, and reduce administrative 'seams' in the Military Health System to ensure beneficiaries receive adequate service."

Recommendation 6 states that "DoD should aggressively look for and incorporate best practices from the public and private sectors with respect to health care purchasing," and one of its action items suggests "compliance with the principles of value-driven health care consistent with Executive Order 13410…."[3]

Recommendation 4 states, in part, that "DoD should follow national wellness and prevention guidelines and promote the appropriate use of health care resources through standardized case management and disease management programs." [4] One of the related action items states that "DoD should implement and resource standardized case management and care coordination that extends beyond the Wounded Warrior to other beneficiary groups across the spectrum of care."

MHS Senior Oversight Committee (MHS-SOC) Review and Comments

Accepted.

The MHS-SOC accepted the Defense Health Board's (DHB's) offer to spearhead the development of an implementation plan for Recommendation 2. MHS-SOC members discussed ongoing collaboration with non-DoD entities, such as work with VA on various issues, and day-to-day interaction of the TRICARE Management Activity with industry and CMS. The MHS-SOC agreed that collaboration with others should be expanded at the strategic level and decided to conduct an inventory of existing collaborative efforts in order to identify areas for improvement. An abbreviated description of its review follows.

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[2] Ibid., pp. 65, 66.
[3] Ibid., p. 53.
[4] Ibid., p. 41.

Veterans Health Administration (VHA)

VA operates nationwide programs for health care, financial assistance, education, and burial benefits. These benefits help veterans and their family members and survivors. VHA operates the nation's largest integrated health care system, divided into 21 Veterans Integrated Service Networks.[5] It generally is a direct service provider rather than a health care insurer or payer, and it makes its services available to honorably discharged veterans under a priority enrollment system—that is, groupings based on Service-connectedness conditions/disabilities and income.[6] VA health care has grown to serve approximately 5.5 million people (as of 2006).[7] Although VA health care once was reputed as suboptimal, more recent studies show that through system-wide re-engineering, there has been a dramatic improvement in the quality of care. A review of this system can help identify some attributes that may be relevant to improving the quality of care in the broader health system.[8]

The importance of DoD/VA collaboration can be seen when viewing the DoD/VA Program Coordination website.[9] This website lists many shared plans, resources, and projects, and it provides access to the VHA Handbook 1660.04, *VA-DoD Direct Sharing Agreements*, which provides guidance on sharing agreements for health care resources.

In 2009, the Under Secretary of Defense for Personnel and Readiness and the VA Deputy Secretary approved a VA/DoD Joint Executive Council (JEC) Strategic Plan for Fiscal Years 2009-2011.[10] This is part of a continuing joint effort toward improved collaboration.[11] The VA/DoD Joint Strategic Plan for Fiscal Years 2009-2011 is the single comprehensive record for all VA/DoD sharing, including all joint wounded, ill, and injured initiatives. For more information on the level of collaboration, the full extent of which is beyond the scope of this report, see discussions related to Action Item 3 (Recommendation 8) and Action Item 2 (Recommendation 4). Those discussions elaborate on the work of the VA/DoD SOC[12] and the Wounded Warrior Project.[13]

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[5] Congressional Research Service Report for Congress. Veterans' Health Care Issues in the 109th Congress. Sidath Viranga Panangala, Analyst in Social Legislation, Domestic Social Policy Division. Updated October 26, 2006, p. 3. Available at www.fas.org/sgp/crs/misc/RL32961.pdf.
[6] Ibid., pp. 1-2.
[7] See the Department of Veterans Affairs website at www1.va.gov/opa/fact/vafacts.asp.
[8] Congressional Research Service Report for Congress, op. cit., pp. 37-38; for example, its Barcode Medication Administration System for dispensing pharmaceuticals, use of wireless applications to reduce medication errors, electronic health records, and patient safety measures.
[9] DoD/VA Program Coordination at www.tricare.mil/DVPCO/tri-va.cfm.
[10] VA/DoD Joint Executive Council Strategic Plan for Fiscal Years 2009-2011. Available at www.tricare.mil/DVPCO/downloads/JSP.pdf.
[11] VA/DoD Joint Initiatives at www1.va.gov/op3/page.cfm?pg=16.
[12] Statements of Lynda C. Davis, Deputy Assistant Secretary of the Navy for Military Personnel Policy, Department of Defense, and Kristin Day, Chief Consultant, Care Management and Social Work, Department of Veterans Affairs, before the U.S. Senate Committee on Veterans' Affairs. March 10, 2008. Available at http://senate.gov/~veterans/public/index.cfm?pageid=16&release_id=11536&sub_release_id=11593&view=all.
[13] Improving Care for America's Wounded Warriors. House Committee on Veterans' Affairs. June 11, 2008. Available at http://veterans.house.gov/news/PRArticle.aspx?NewsID=262.

One of the many important VA/DoD partnerships is the sharing of electronic health records (EHRs), an endeavor that supports Action Item 1 of Recommendation 2 as well as Recommendation 8. Such sharing can eliminate the unnecessary duplication of medical tests on the same patient at different medical facilities, improve quality, and reduce costs. A DoD/VA Interagency Program Office was created to facilitate this project and to act as a single point of communication for Congress on this project.[14] Although many records are currently being shared, one concern is the need for further interoperability, particularly in the case of wounded soldiers from Afghanistan and Iraq who are transitioning to the VA system.[15] DoD and VA have committed to have fully shared EHRs by September 2009.[16]

Although the comprehensive health care systems of DoD and VA have different missions, there is overlap. Many military retirees eligible for TRICARE also are enrolled in VA medical care. As the demographics of the TRICARE beneficiary base have changed, including greater numbers of retirees, patient populations increasingly are becoming similar to those of VA. These emerging similarities present opportunities for increased cooperation and collaboration, which could include the buying and selling of services, supplies, and products; shared staffing; the development and use of advanced technology; increased education and training; and the development of joint facility agreements.[17]

Health and Human Services (HHS)

HHS includes more than 300 programs related to health, health care, and social programs. Its agencies include the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Indian Health Service, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality (AHRQ), and CMS.

Like VA, HHS is collaborating with DoD on EHRs. The American Health Information Community (AHIC), which began as a federal advisory body, but which has become a public-private partnership,[18] is advising the Secretary of HHS on health information technology. The Assistant Secretary of Defense for Health Affairs is a member of AHIC. An AHIC priority is the EHR, and the agency has formed a workgroup that includes representatives from VA and DoD. AHRQ is an HHS agency that works specifically in the areas of health care quality, accessibility, cost, and best practices. An example of collaboration is DoD working with AHRQ on the Team STEPPS™ initiative. This project has developed training for creating more effective medical teams for better patient outcomes. The training is now being offered through university medical centers.[19]

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[14] Brian Robinson. DoD-VA Office Plots Health Record Sharing. Government Health IT. July 4, 2008.
[15] Ibid.
[16] Jason Miller. DoD, VA Sharing More Medical Data than Ever. Federal News Radio. September 25, 2008.
[17] Executive Office of the President, Office of Management and Budget. The President's Management Agenda, FY 2002, p. 69, regarding Initiative 14, "Coordination of VA and DoD Programs and Systems." Available at www.whitehouse.gov/omb/budget/fy2002/mgmt.pdf.
[18] AHIC information at www.hhs.gov/healthit/community/background.
[19] Implementation of Team STEPPS™ at Duke Medicine. Karen Frush, BSN, MD, Chief Patient Safety Officer, Duke University Health System. June 14, 2008. Available at www.ama-assn.org/ama1/pub/upload/mm/44/kfrush_a08.pdf.

Office of Personnel Management (OPM)

OPM is the human resources agency for the federal government and is responsible for ensuring it has an effective civilian workforce. It administers the Federal Employees Health Benefits Program (FEHBP), the largest single employer-sponsored health insurance program in the world, with 8 million covered individuals.[20] OPM has made information technology and cost transparency key provisions of FEHBP, for example, by requiring insurance carriers to report on their information technology progress (such as personal health record adoption) and their cost and quality transparency initiatives. OPM then publishes the ratings on its website and encourages employees to consider the ratings when choosing a health plan.[21] The combined purchasing power of OPM and the MHS, with sufficient coordination, has the potential to accelerate the development and adoption of best practices and transparency initiatives that are designed to better inform consumers about health care services. The MHS-SOC believes that more collaboration with OPM is needed.

The Task Force stated that "[t]ransparency in quality reporting is frequently an initial step prior to implementation of incentive programs that reward high-quality, high-value care delivery."[22] Further collaboration with OPM should facilitate the implementation of Action Item 3 (of Recommendation 2) that asks DoD to "[s]trengthen incentives to providers and health insurers to achieve high-quality and high-value performance." One way to do this is through *transparency of quality and costs.* HHS also states that transparency is key for "Value Driven Health Care."[23] OPM, DoD, HHS, and VA all have transparency websites that communicate information about quality and value to beneficiaries and providers.[24] The TRICARE website posts TRICARE allowable charges and links beneficiaries to allied websites.[25] Among other information, CMS offers a Physician Fee Schedule.[26] The VA transparency website provides data on quality of care, including reports on five quality measures used at different VA hospitals.[27]

Nongovernmental Organizations (NGOs)

Nongovernmental organizations (NGOs) also are involved in collaborations with DoD. The President and Chief Executive Officer of the National Quality Forum, an organization dedicated to health care quality and reporting, improved patient outcomes, and reduced health care costs, is on the board of directors of AHIC.[28] The Leapfrog Group, a voluntary program aimed at mobilizing employers to purchase the best health care possible and to help health care providers make "big leaps" in improvement, has board member liaisons with DoD, CMS, and OPM.[29] These NGOs are setting quality benchmarks that can support Action Item 2 of Recommendation

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[20] OPM 2007 Performance and Accountability Report. Available at www.opm.gov/account/gpra/opmgpra/par2007/OPM_PAR2007.pdf.
[21] Mary Mosquera. OPM puts weight behind e-health. Federal Computer Week. September 29, 2008.
[22] Task Force on the Future of Military Health Care, op. cit., p. 26.
[23] See www.hhs.gov/valuedriven.
[24] Mary Mosquera, op. cit.
[25] See www.tricare.mil/transparency.
[26] See www.cms.hhs.gov/pfslookup.
[27] See www.qualityofcare.va.gov/home.cfm.
[28] See www.qualityforum.org/news/releases/news_release_092408.asp.
[29] See www.leapfroggroup.org/about_us/leapfrog_group_board.

2: “Use performance-based clinical reporting by managed care support contractors and the direct care system.” DoD should continue to contribute to and take greater advantage of these programs, in an effort to improve MHS and health care delivery at large. Also, DoD regularly obtains advice from a variety of consultants and contractors, such as the Advisory Board Company, which surveys and analyzes best demonstrated practices in the private sector of health care delivery. It is anticipated that this practice of using consultants will continue and is one that furthers the objectives sought through the broader public-private collaboration encompassed in the Task Force recommendation.

Pilot Projects

To successfully test and disseminate best practices, Action Item 4 of Recommendation 2 calls for DoD to “[i]mplement a systematic strategy of pilot and demonstration projects to evaluate changes in MHS practices.” A successful collaborative pilot project with VA involved shared EHR information between Walter Reed Medical Center and the Polytrauma Unit at the Tampa, Florida, VA Medical Center. The next step will be sharing EHR information among VA’s four polytrauma centers in Tampa, Florida, Richmond, Virginia, Minneapolis, Minnesota, Palo Alto, California, and all Army Military Treatment Facilities (MTFs).[30]

Another example of a successful pilot program involves the Disability Evaluation System. This pilot allows VA and DoD to share data to determine if an injured Service member is fit to return to duty and provides his or her Service-connection rating and medical status.[31] To the Service member, it means a single examination, rather than two separate disability examinations from different departments, to receive benefits. Current plans are to expand this program to MTFs beyond the National Capital Region.[32]

Advisory Group to Enhance Collaboration

The DHB is a chartered federal advisory committee tasked with providing independent advice and recommendations to the Secretary of Defense, through the Assistant Secretary of Defense for Health Affairs. The DHB provides independent advice and recommendations on matters regarding the treatment and prevention of disease and injury, the promotion of health, and the delivery of efficient, effective, and high-quality health care services to DoD beneficiaries. The mission of the DHB’s Health Care Delivery Subcommittee focuses on ensuring optimal health care and health care delivery across the MHS (see Box 2.1 for membership).

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[30] VA Press Release. VA, DoD Electronically “Hand Off” Records of Wounded Patients. September 25, 2008. Available at www1.va.gov/opa/pressrel/pressrelease.cfm?id=1587.
[31] Washington DC VA Medical Center Pilots New VA/DoD Disability Evaluation Examination. Available at www.washingtondc.va.gov/news/disability_evaluation_system.asp.
[32] North Atlantic Regional Medical Command (NARMC), NARMC News and Events. Disability Evaluation Pilot Program Expands to Dewitt and Kimbrough. September 30, 2008.

Box 2.1: Characteristics and Composition of the DHB Subcommittee on Health Care Delivery

The DHB Health Care Delivery Subcommittee focuses on ensuring the optimal delivery of health care across the MHS. Its members have subject matter expertise on issues encompassing preventive medicine and health care quality and delivery and have extensive experience serving within health services leadership roles.

Current positions held by subcommittee members include Senior Fellow at Project HOPE, Special Assistant to the Assistant Secretary of Defense for Health Affairs, President of the American College of Preventive Medicine, Co-Founder of The Leapfrog Group, President and Chief Financial Officer of the Institute for Healthcare Improvement, Associate Vice President for Academic Affairs at Clarian Health Partners, Endowed Professor in Nursing Education and Dean at the University of California San Francisco School of Nursing, Distinguished University Health Professor and Associate Dean for Research and Doctoral Study at the University of South Florida, Co-Founder of the Massachusetts Health Quality Partnership and of the Massachusetts Healthcare Purchaser Group, Global Chief Medical Officer and Director of Integrated Health Services for E.I. DuPont de Nemours and Company, Director of Global Health Care at General Electric, Vice-President and Chief Information Officer of Partners HealthCare System, Inc., Mayo Professor of Public Health at the University of Minnesota, and Executive Director of the Association of Military Surgeons of the United States.

Previous professional and academic experience of the subcommittee members include serving as the Chair of the Medicare Payment Advisory Commission, Administrator of the Health Care Financing Administration, Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy, Chairman of the Massachusetts Business Roundtable Health Care Task Force, Executive Vice-President and Chief Health and Medical Officer of Lumenos, Vice-President of Information Systems at Brigham and Women's Hospital, member of the National Advisory Committee of the Robert Wood Johnson Foundation Health Care Purchasing Institute, Chairperson and Acting Associate Dean for Research at the University of California Los Angeles School of Nursing, and faculty member for the Robert Wood Johnson Foundation "Aligning Forces for Quality" project.

In keeping with this mission, the subcommittee serves as an external advisory group with two conceptual methods for achieving this mission: 1) by developing and implementing the methodology and science of innovation to achieve transformational changes in military health care delivery and 2) by facilitating the adoption of the most clinically effective and operationally efficient best practices in direct or purchased care for military Service members, retirees, and their families with the goal of optimizing health and military readiness. The subcommittee believes that the MHS can serve as the national model for innovative transformation in health care delivery and health care delivery best practices, provide standards based on a population health optimization construct, and serve as an example for existing best practices in the private and government sectors.

This implementation plan focuses on the Task Force's Recommendation 2:

> *DoD should charter an advisory group to enhance MHS collaboration with the private sector and other federal agencies in order to share, adopt, and promote best practices.*

As a result of this sharing process, the MHS can assist and influence the larger civilian health care community through the contribution of knowledge and experiences. The DHB Health Care Delivery Subcommittee, serving as the best practices External Advisory Group (EAG), will incorporate and expand as necessary the recommendations of the Task Force on the Future of Military Health Care in order to 1) achieve optimal health of MHS beneficiaries and 2) create and sustain the most effective and efficient MHS.

Scope and Vision

The EAG believes the MHS can represent a national model for health and health care transformation informed by, but not limited to, what may be current best practices in the private or non-DoD governmental health- and health care-related systems. The DHB and DHB Subcommittee on Health Care Delivery will utilize an evidence-based approach in the evaluation of best practices. The methodology employed for this evaluation will take into account various guiding principles set forth in the final report of the Task Force, including the impact on the cost-effectiveness and efficiency of the military health care system, improvement of health outcomes, and access to and productivity of care. In addition, the methodologies will take into consideration whether evidence exists to validate the impact of the best practice and whether it is executable within DoD.

Goals and Objectives

The goal of the EAG is to optimize the health and performance of MHS beneficiaries through enhancing and sustaining an effective and efficient MHS, both in direct and purchased care, by 1) facilitating MHS collaboration with the private sector and other federal agencies in order to share, adopt, and promote best practices; 2) conducting evidence-based reviews of health care planning and delivery best practice approaches in order to provide recommendations on business and health care delivery best practices for adoption within the MHS; and 3) identifying innovation and transformation opportunities for continuously improving health, health care delivery, and outcomes within the MHS.

Membership

EAG members initially have been appointed by the Assistant Secretary of Defense for Health Affairs. It is likely that the EAG will identify additional individuals, agencies, and organizations, and these groups will provide the subject matter expertise, information, and insights needed to fulfill the broad and transformational vision and mission of the EAG.

EAG Content and Process Approach

To ensure both a comprehensive and integrated approach to conducting its work and meeting its mission, the EAG will systematically review core functions along two “axes” that are known to be necessary to address optimal health and an effective and efficient health care system: 1) health and health care continuum and 2) health system infrastructure continuum.

1) Health and Health Care Continuum (see Table 2.1, below)

The health[33] and health care continuum[34] is defined here as an extensive and all-encompassing array of health care services, such as individual and community-based health promotion activities, prevention activities, well-being visits, acute care services, skilled care, home health care, outpatient care, community services, and other health care services that are meant to address a broad spectrum of health care needs that an individual may encounter at any stage of the health continuum. The continuum includes health promotion, disease prevention, and clinical preventive services; emergent, acute, and chronic disease care; surgical decision support and shared decisionmaking; transitional and rehabilitative care; and hospice and end-of-life issues.

Table 2.1: Health and Health Care Continuum Components

Health Care Continuum Element Under Study	Existing MHS/Service Quality Improvement Approach (Metrics, Benchmarks, Milestones, Dissemination)	External Benchmarking Practices and Source	Emerging Best Practices
HEALTH PROMOTION			
Health Behaviors and Wellness Programs			
Physical – Individual			
Mental – Individual			
Physical – Family/ Military Unit/Community			
Mental – Family/ Military Unit/Community			
Preventive Care			
Clinical preventive services (screening tests, counseling, immunizations, chemoprophylaxis)			
MEDICAL CARE			
Primary Care			
Acute, Episodic Care/ Self-Care			
Chronic Disease/Condition Management/Self-Care			
Specialty Care			
Inpatient Care			
Surgical Decision Support			
Rehabilitative Care			
Hospice Care			

[33] Michael O'Donnell. Definition of Health Promotion. American Journal of Health Promotion. 1986;1(1):4.
[34] John L. Deffenbaugh. Health-Care Continuum. Health Manpower Management. 1994;20(3):37-39. The EAG also will address dental care.

Key to Table 2.1:

Health Promotion Element: Includes the processes that are involved in enabling individuals to acquire and enhance control and management of their health. This health and health care continuum component includes **health behaviors and wellness programs,** which address both physical and mental health concerns and issues, within both individual and family/military unit contexts, as well as **preventive care,** such as clinical preventive services, across the full health spectrum, from optimal health to premature death. Provider skills and resourcing need to produce sustainable behavior change, and adoption will be tracked.

Medical Care Element: Consists of the various types of medical care required along an individual's health continuum, varying according to illness severity and duration, and includes **primary care** (advanced medical home, whole patient/family, linkage to population-based resources/programs); **acute, episodic care models and alternatives**; **chronic disease/condition management,** including both behavioral and medical technology aspects using evidence-based approaches with demonstrated impacts, such as remote, virtual support, and maximal "self-help" decision support; **specialty care; inpatient care; surgical decision support; rehabilitative care; and hospice care,** sustaining quality-of-life functions and end-of-life alternatives.

2) Health System Infrastructure Continuum (see Table 2.2, below)

The health system infrastructure continuum is delineated here as the basic, underlying framework and processes that are involved, including facilities, systems, installations, supply chain management, the procurement process, vendor performance, services, and the staff necessary for the functioning and delivery of health care services provided within the health care continuum. A key element is creating and sustaining a continuous quality improvement process that becomes the culture of the MHS.

Each EAG recommendation will be evaluated for how well it supports the MHS goals in this project and the relationship/impact of a recommendation on the remainder of the operation of an improved MHS.

Table 2.2: Health System Infrastructure Continuum Components

Health System Infrastructure Element Under Study	Existing MHS/Service Quality Improvement Approach (Metrics, Benchmarks, Milestones, Dissemination)	External Benchmarking Practices and Source	Emerging Best Practices
FACILITIES			
Medical centers, hospitals, clinics, stand-alone or "drive thru" pharmacies, pharmaco-economic centers, logistics/supply centers and supporting agencies			
SYSTEMS			

Health Information Technology (electronic medical record, personal health record, consumer-information technology portals, web-based consultations, e-visits; provider/system accreditation, licensure, credentialing, request/receipt of specialist consultation; remote technologies and imaging, "telemonitoring and medicine," health care system logistics, patient self-scheduling, through-put patient flow management, use of data warehouses, scorecarding of institution and provider performance and its use in consumer education and engagement)			
Integration of Direct and Contracted Care			
Health and Productivity Integration of Related Benefit Programs (disability, employee assistance program, worker's compensation)			
SERVICES			
Benefits Design and innovations including account-based and value-based plans including beneficiary and provider incentives			
Evolving Private Sector Delivery Alternatives (retail reduced price pharmacies, retail and workplace onsite health clinics, international medical services)			
Environmental/Community Integration and Alignment			
STAFF			
Personnel and Training Requirements (including Graduate Medical Education [GME])			

Procurement Processes			
RESOURCES			
Resourcing, operations, and infrastructure necessary to efficiently and effectively deliver the highest quality of health and health care			
Existing and Emerging **Technology/Pharmaceutical Comparative Cost-Effectiveness** Evaluation and Alternatives			

Timeline

The EAG will be a sustained commitment of the MHS. The goal is to achieve a comprehensive MHS review of both the health/health care and health system infrastructure continuum components over the course of two years. The schedule will be built in consultation with MHS leadership to ensure that it meets near-term needs while preserving the strategic and transformational focus of the EAG.

Health Care Element and Infrastructure Functional Area Standardized Review Approach

The subcommittee views the implementation plan for MHS best practices as one utilizing a comprehensive approach—provided by the health and health care continuum model—as well as the health care services necessary at each step. This model is interspersed with the consideration of cross-cutting and supporting health system infrastructure issues that taken together will help ensure consistency, effectiveness, and efficiency within military health care delivery. Each major topic area to be brought before the EAG for review, external benchmarking, study, and recommendations should follow a consistent operational process supported by the most knowledgeable and relevant MHS office or individual source for the topic area in question (from the MHS, DoD, Surgeon General, Command, or MTF level), and what should be conducted before, during, and after EAG meetings:

1. Review existing MHS/Service performance and metrics (quantitative assessments of the health care system and their interpretation), as well as the existing practices and policies for the specific health/health care or infrastructure element under study.
2. Review external benchmarking practices for that health/health care component or infrastructure element (metrics, practices, and policies) obtained from publicly available sources on relevant national organizations and companies and government agencies. Information on these practices should be collected by staff and EAG members before EAG in-person meetings, to the extent possible. External benchmarking involves the evaluation of various aspects of an organization's processes in relation to established best practices, and consequently, it involves the identification of areas for improvement and

strategies to increase or advance performance. This organizational surveillance is a required component of the health/health care and infrastructure continuum model. It solicits best practices and emerging, transformational models for the EAG's consideration.

3. Examine other promising best practices models that are emerging or investigational or that represent original, transformational approaches through direct solicitation of the relevant information from EAG members or outside individuals or groups.
4. Identify opportunities for innovation and transformation for pilot projects within the MHS.
5. Make presentations to the EAG during a day-long meeting.
6. Submit preliminary findings and reports for each health/health care continuum element or infrastructure component to MHS staff to be reviewed for consistency with earlier EAG recommendations.
7. Provide recommendations from the EAG to the MHS via the DHB.
8. Report on MHS progress toward implementing EAG recommendations periodically. This should be a routine EAG meeting agenda item.

Frequency of Meetings

If the meetings to be held are day-long, and if one or two health and health care or health system infrastructure continuum components or elements (e.g., health promotion, staff, health information technology, or benefits design) are addressed during each meeting, it would be possible to systematically review the MHS over the course of two years. It is anticipated that the EAG would meet approximately six times each year.

Recommendation 3
Controllership

Task Force Recommendation 3

DoD should request an external audit to determine the adequacy of the processes by which the military ensures 1) that only those who are eligible for health benefit coverage receive such coverage, and 2) that compliance with law and policy regarding TRICARE as a second payer is uniform.

Action Items

DoD should:

- *charge the auditor with assessing the most efficacious and cost-effective approach, for example, fraud identification and prevention and system changes to the Defense Management Data Center and/or Defense Enrollment Eligibility Reporting System;*[1]
- *ensure that audit recommendations are implemented and include follow-up; and*
- *establish a common cost accounting system that provides true and accurate accounting for management and supports compliance with law that TRICARE be a second payer when there is other health insurance.*

Task Force Assessment

External Audit

Controllership, in this context, means a commitment to compliance, effectiveness, and integrity, and how each is to be achieved. It presents unique challenges for the Military Health System's (MHS's) financial sustainability.[2]

The Task Force believed that MHS policies, practices, and procedures for the oversight of enrollment and eligibility data appeared to be of fairly high quality. However, weaknesses in the system can arise with respect to the oversight of health plan financial controls and the coordination of benefits. Just as weaknesses can occur in the private sector regarding oversight of health plan financial controls, weaknesses also can arise in DoD's controls pertaining to expenditures for those ineligible for care.

The last comprehensive audit of the Defense Enrollment Eligibility Reporting System (DEERS) by the DoD Inspector General occurred in 2001, and its purpose was to assess the reliability and completeness of the demographic data used to calculate the DoD military retirement health benefits liability. The audit resulted in a recommendation to develop and implement a

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[1] DMDC, the Defense Management Data Center, is responsible to the Under Secretary of Defense for Personnel and Readiness and is responsible for DEERS, the Defense Enrollment Eligibility Reporting System, the designated automated information system designed to provide timely and accurate information on those eligible for medical and dental benefits and entitlements.

[2] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 27.

comprehensive data quality assurance program to verify the completeness, existence, and accuracy of new and existing data in the DEERS database.[3]

The Task Force opined that weaknesses were apparent between the personnel offices of the Uniformed Services and the Defense Manpower Data Center (DMDC). These weaknesses can lead to DoD DEERS database errors that can affect eligibility determinations in different medical settings (e.g., Military Treatment Facility [MTF], network, private care). Although DEERS requires more substantiating documentation for eligibility than what may be required in the private sector and has automated systems to enhance the quality assurance of information, the system still is not immune from faulty eligibility data. Advances in technology and systems may make it easier and faster to detect and correct erroneous eligibility data. However, the Task Force noted that the sheer number and frequency of events affecting eligibility, such as mobilizations and demobilizations, and changes in family/dependent status, such as births, adoptions, divorces, and remarriages, suggest that an audit would identify areas for improvement and could yield considerable cost savings.[4]

Cost Accounting

The Task Force stated that MHS financial accounting and reporting and cost accounting systems are "in need of significant improvement or even a complete overhaul."[5] The deficiencies preclude accurate reporting of financial and cost accounting information. For many years, the MHS has relied on the Medical Expense and Performance Reporting System (MEPRS) as its cost accounting system—a complex system that relies on multiple systems that feed into each other and that are "prone to user errors even at the lowest level."[6] Reported workload and coding effectiveness "often are unreliable."[7]

MHS-Senior Oversight Committee (MHS-SOC) Review and Comments

Pending receipt of additional information on ongoing audits and implementation of new data systems, the MHS-SOC has deferred making a final recommendation on an audit of DEERS and interfacing personnel systems.

After accepting the recommendation for the audit at one of its early meetings (March 18, 2008), the MHS-SOC asked the Deputy Assistant Secretary of Defense for Health Budgets and Fiscal Policy to start a staffing action to elicit participation by necessary parties (e.g., DMDC, the Inspector General, and personnel communities) in the audit.

DMDC questioned the necessity of an audit, and the MHS-SOC reconsidered its original decision and analyzed the matter in greater detail. This reevaluation included a review of the DMDC response to the Task Force's interim report, which also had recommended the audit.[8]

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[3] DoD Inspector General Audit Report, Beneficiary Data Supporting the DoD Military Retirement Health Benefits Liability Estimate, D-2001-154, July 5, 2001, cited by the Task Force on the Future of Military Health Care, p. 29.
[4] Task Force on the Future of Military Health Care, op. cit., p. 29.
[5] Ibid., p. 34.
[6] Ibid., p. 33.
[7] Ibid.
[8] DMDC Response to the Task Force on the Future of Military Health Care Interim Report. October 10, 2007.

DMDC's Viewpoint

DMDC stated that the "level of identity verification, verification of source documents, and validation of family relationships is much more stringent than in the commercial healthcare arena."[9] Regarding the 85 percent reliability noted in the previously cited Inspector General audit, DMDC's review of the "problem" 100 cases that led to that conclusion indicated, in actuality, that there were only 3 problem cases (1 was a duplicated dependent, and 2 were unreported changes in family relationships). Hence, statistical reliability was 99 percent and not 85 percent.[10]

The DMDC response, however, did acknowledge the following viable areas for improvement:

- reconciliation of duplicate persons in DEERS;
- communication, coordination, and the level of quality assurance between DMDC/DEERS and the Military Liaisons/Service Personnel Centers;
- control of "unverified" sponsor records in DEERS;
- internal quality assurance of DEERS data; and
- verification of source documents for adding persons to DEERS.[11]

A full reconciliation of identified duplicate persons was accomplished in 2003, and the process to capture and reconcile duplicates is performed weekly. Communications with Military Liaisons and their Personnel Centers have improved, and efforts are ongoing to achieve full reconciliation between Service Master Files and the DEERS database. This includes reconciliation of data related to contingencies and deployments. DMDC has collaborated with the Uniformed Services and Defense Human Resources Activity to channel the addition of sponsor records only through authorized data sources (no longer allowing verifying officials at RAPIDS sites to do this).[12] DMDC continues to perform periodic audits of RAPIDS sites to determine if they are following prescribed procedures for verifying documentation.[13] It has enhanced its quality assurance programs and engaged in more frequent data matching with the Centers for Medicare & Medicaid Services. It described various other business and system improvements, including a major initiative of the DMDC Director to improve data quality across the DMDC enterprise.[14]

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[9] Ibid., p. 4.
[10] Ibid., p. 5.
[11] Ibid.
[12] Ibid. RAPIDS stands for Real Time Automated Personnel System. This system and the Common Access Card (CAC) program are interrelated and interdependent with DEERS. DEERS is DoD's personnel data repository; the CAC uses the DEERS database for authentication and personnel information, and RAPIDS is the system that supports the Uniformed Services Identification card program, provides online updates to DEERS, and issues the CAC. DEERS contains personnel data on more than 26 million people with current or past employment or a benefits relationship with DoD. It is DoD's only centralized repository for all Service members, retirees, family members, DoD civilians, and selected contractors. It provides more than 22 applications and 25 interfaces to hundreds of systems supporting the MHS (such as eligibility, enrollments, fees, catastrophic caps, deductibles, and other health insurance). Fiscal Year 2007 Budget Estimates, Defense Human Resources Activity. February 2006, pp. 7-11.
[13] Ibid.
[14] Memorandum of DEERS Division Chief to Executive Director, MHS-SOC. "Issues Identified in the Task Force on the Future of Military Health Care Report of December 2007–Updates as of October 17, 2008."

DMDC recently performed an internal audit, having contracted with former government auditors.[15] It also underwent a recent external audit relating to DEERS data used by the DoD Medicare-Eligible Retiree Health Care Fund.[16] Pending receipt of additional information on these audits, the MHS-SOC has decided to defer making a final recommendation on an audit of DEERS and interfacing personnel systems.

Furthermore, the implementation of the Defense Integrated Military Human Resources System (DIMHRS) is imminent and provides another reason to delay a DEERS-related beneficiary eligibility audit.[17] DIMHRS is scheduled for a roll-out in the Army in the near future—early 2009—and is expected to be expanded as an enterprise solution to the Navy and Air Force. Retiree pay will remain the responsibility of the Defense Finance and Accounting Service.[18] The MHS-SOC believes that a sample, or focused, audit of the DIMHRS-DEERS interface would be prudent after a testing period that addresses synchronization of the systems.

Thus, at present, the lack of apparent value, utility, cost, and impact of a comprehensive external audit does not justify the immediate implementation of this Task Force recommendation. After a focused audit of DIMHRS-DEERS, a series of sample audits—or focused audits on situations posing a higher risk of erroneous data—can be planned.

Other Factors Considered

The MHS-SOC considered that "dependent eligibility audits" have become more common and financially rewarding for many companies as an attempt to contain rising health care costs. The number of such audits has exploded, and they typically reveal that up to 15 percent of those who are claimed as dependents are not entitled to coverage. One employer survey released in March 2008 indicated that 55 percent of large employer plans would conduct a dependent audit in 2008, and 74 percent said they planned one in 2009.[19] Ineligible dependents often are ex-spouses and children who have become ineligible by "aging out" or by dropping out of college.[20]

Apart from dependent eligibility audits, "coordination of benefits" audits are common. During these audits, auditors seek to identify situations in which a primary party was responsible for a claim that was paid by another payer. These audits are increasing as a cost-containment strategy

[15] Memorandum for the Record, Telephone conversation, October 17, 2008, between Janine Groth, DEERS Division Chief, and Col Christine Bader, Executive Director, MHS-SOC.
[16] The DoD Medicare-Eligible Health Care Board of Actuaries is required to review the actuarial status of the fund and to provide an annual audited financial statement.
[17] DIMHRS is a congressionally mandated enterprise solution, with its initial focus on the Army's personnel and pay functionality. It addresses major deficiencies in the delivery of personnel and pay services that are caused by myriad systems with complex interfaces. The system is designed to enhance real-time accuracy of personnel data, among other things, and will provide data to DEERS. It will include the Army Reserve and Army National Guard.
[18] See www.hrc.army.mil/site/Army DIMHRS/faq/faq_general.htm.
[19] Judy Greenwald. Dependent Health Care Audits Become "a Hot Topic." August 18, 2008. Available at www.workforce.com/section/00/article/25/71/51.php; You've Got Dependents? Prove It. November 28, 2007. Available at www.businessweek.com/print/magazine/content/07_48/b4060082.htm.
[20] Greenwald, op. cit.

for government health care programs—for example, secondary payer recovery audits for Medicaid and Medicare.[21]

The Task Force's recommendation takes into consideration this type of audit by stating as part of its rationale that an audit should be designed to assure "compliance with law and policy regarding TRICARE as a second payer."

The DoD Inspector General and the U.S. Army Audit Agency recently conducted an audit of the outpatient third-party collection program. This program involves billing third-party payers on behalf of beneficiaries for treatment provided by or through MTFs, which entails identifying other health insurance that may be in force, billing those insurers, and following up for collections. The audit focused on MTFs in six geographic regions, using samples representing 41 percent of DoD patient encounters for outpatient visits and pharmacy prescriptions. It concluded that, for Fiscal Year 2005, DoD could have collected an additional $9.4 million. The report recommended that the business operations manual covering this subject be made an auditable item. The Assistant Secretary of Defense for Health Affairs agreed.[22]

Proper coding of patient encounters is necessary for computing bills for third-party collections (and to accurately measure workload for budgeting of MTF activities). In 2007, the TRICARE Management Activity contracted for an external audit of coding, using samples from six MTFs (two Army, two Navy, and two Air Force). Overall accuracy for all Services was 85.56 percent for inpatient records, 26.67 percent for outpatient records, and 45 percent for ambulatory procedure visits.[23] In short, there is a high error rate that provides challenges for measuring, evaluating, and analyzing health care delivery in the MHS and for executing an effective "coordination of benefits" program involving other health insurance.

The managed care support contractors use claims processing systems designed to minimize improper payments, including payments that should be paid by a primary payer other than TRICARE, for example, Medicare (for dual-eligible beneficiaries) and other health insurance with respect to the broader range of TRICARE beneficiaries (not Medicare eligible). The managed care support contractors are required to use specialized software containing specific auditing logic and to conduct prepayment reviews designed to minimize the risk for overpayments. The claims processing systems use various prepayment and postpayment controls. Managed care support contractors are subject to quarterly audits of their claims processing, and an annual audit is used to determine whether they will be penalized for erroneous overpayments.

Claims related to TRICARE for Life are processed under a separate contract (not by the managed care support contractors); this is the TRICARE Dual Eligible Fiscal Intermediary Contract. That contractor also processes Medicare claims. The contractor is audited on a quarterly and annual basis and is penalized if erroneous payments are excessive (more than 2

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[21] HMS Holdings Corporation at JPMorgan Healthcare Conference. October 17, 2008. See www.insurancenewsnet.com/print.asp?neid=20080122560.2_7aac026d9aa3f67a.

[22] DoD Inspector General and U.S. Army Audit Agency Report, Report No. D-20070108, Outpatient Third Party Collection Program. July 18, 2007, p. i.

[23] Final Report, Coding Audit, Military Health System, prepared for TMA/Health Program Analysis and Evaluation Directorate (HPA&E) by Standard Technology, Inc. July 27, 2007.

percent—the contract standard). The contractors have incentives to perfect claims processing because of the policy of zero tolerance for overpayments: The risk of overpayment is shifted to the contractor. If audits detect overpayments, the contractor is liable and is charged for the overpayment.[24]

A Common Cost Accounting System

The MHS-SOC agrees with the Task Force on the need for a common cost accounting system for the reasons it stated.

Each Service has separate Enterprise Resource Planning (ERP) under various levels of development in order to enhance transparency and financial controls. A request in January 2008 from the Defense Medical Logistics Standard Support for Defense Business Transformation certification of an interface between the MHS and the Army's program (General Fund Enterprise Business System [GFEBS]) triggered a request by the Under Secretary of Defense for Personnel and Readiness for a Tri-Service review of ERP solutions for the MHS. The team evaluating options determined that the Defense Health Program would never achieve true financial visibility and audit control without a single unified management system across the MHS with a common set of business rules. In response to this observation, the Deputy Under Secretary of Defense for Financial Management, DoD Comptroller, and Director for Information Management under the Under Secretary for Defense for Personnel and Readiness asked for a feasibility study of a single MHS ERP system. The study currently is under way (through a contractor) and has not been completed. The task order for the study outlines a number of issues that must be addressed; however, a detailed discussion is beyond the scope of this report.

Implementation Plan

A focused audit of the DIMHRS-DEERS interface should be directed after implementation and initial testing of DIMHRS.

A decision on additional focused or sample audits of DEERS has been deferred pending receipt of information on recent audits of DMDC/DEERS (release of the report by the DoD Inspector General is expected in the near future).

The TMA Health Program Analysis & Evaluation Division will be tasked to develop a follow-up plan to the coding audit mentioned earlier in coordination with the Services, consistent with the Task Force action item to "ensure that audit recommendations are implemented and include follow-up."

The Deputy Assistant Secretary of Defense for Health Budgets and Financial Policy will be tasked to obtain a feasibility study on an MHS-wide ERP system, to include a comparative analysis of the following systems:

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[24] Fiscal Year 2007 Medicare-Eligible Retiree Health Care Fund Audited Financial Statements. November 30, 2007, pp. 8-10.

- the Defense Agency Initiative;
- the Navy's ERP;
- the Army's GFEBS;
- the Air Force's Defense Enterprise Accounting and Management System; and
- other alternatives, as deemed appropriate.

The main objective of the study is to determine what ERP would provide the optimal solution for financial visibility and auditability for the Defense Health Program appropriation and provide an effective and seamless exchange of required information among the Services' military medicine organizations and their parent Services themselves. First, a framework for high-level analysis and completing data collection and analysis would be developed. The initial deliverable of the study should be to provide an array of options, with information regarding the pros and cons of each, and to estimate the most significant differences between the two most favorable options.

Recommendation 4
Implement Wellness and Prevention Guidelines

Task Force Recommendation 4

DoD should follow national wellness and prevention guidelines and promote the appropriate use of health care resources through standardized case management and disease management programs. These guidelines should be applied across the Military Health System (MHS) to ensure military readiness and optimal beneficiary health.

Action Items

To promote accountability and transparency in fiscal management and quality of services, DoD should:

- *continue to prioritize prevention programs in accordance with the National Commission on Prevention Priorities;*
- *implement and resource standardized case management and care coordination that extends beyond the Wounded Warrior to other beneficiary groups across the spectrum of care;*
- *ensure timely performance feedback to clinical providers, managers, and the chain of command through a timely and easily accessible reporting system such as a provider score card; and*
- *maintain high-level visibility of business and clinical performance for the entire enterprise via the Tri-Service Business Planning Process and the MHS Balanced Score Card Metric Panel.*

Military Health System Senior Oversight Committee (MHS-SOC) Position

Accepted, in part.

The wellness and prevention measures presently chosen for use by DoD are based on their applicability to the population and the level of evidence supporting their use.

National wellness guidelines, including those of the U.S. Preventive Services Task Force (USPSTF), currently are used to support DoD health promotion and disease prevention activities. Evaluation of wellness activities is standardized through the use of HEDIS (Healthcare Effectiveness Data and Information Set) national commercial technical specifications for data pulls and by the use of national commercial percentiles for benchmarks.

Prevention guidelines are prioritized according to evidence. DoD's selection of measures for prevention activities is based on USPSTF recommendations, National Committee for Quality Assurance (NCQA) and HEDIS guidance, current research, and expert opinion. There is little evidence that the National Commission on Prevention Priorities (NCPP) scale has ever played a role in the choice of DoD's prevention measures.

Current Status

Evidence-Based Practice Guidelines

National wellness guidelines, including those of the USPSTF, currently are used to support DoD health promotion and disease prevention activities. Furthermore, DoD and the Department of Veterans Affairs (VA) develop and maintain clinical practice guidelines (CPGs) that serve as the foundation for interagency population-based health promotion and disease prevention and management initiatives. DoD/VA CPGs are collaboratively developed through rigorous evidence-based review of best medical evidence and differ from other national and specialty guidelines, in that they only use evidence collected by unbiased third parties. VA and DoD develop and revise these CPGs for use by both departments' health care practitioners. With the expanded use of CPGs, improvements in the quality, utilization, and value of health care resources are anticipated.[1]

Guidelines available for use throughout the DoD Military Health System (MHS) and VA include those pertaining to:

- Asthma
- Congestive Heart Failure
- Hypertension
- Ischemic Heart Disease
- Dyslipidemia
- Medically Unexplained Symptoms: Chronic Pain and Fatigue
- Post-Deployment Health Evaluation and Management
- Diabetes Mellitus
- Chronic Renal Disease
- Dysuria
- Major Depressive Disorder
- Post-Traumatic Stress Disorder
- Psychoses
- Substance Use Disorder
- Low Back Pain
- Amputation
- Uncomplicated Pregnancy
- Opioid Therapy for Chronic Pain
- Post-Operative Pain
- Obesity
- Chronic Obstructive Pulmonary Disease
- Stroke Rehabilitation
- Gastroesophageal Reflux Disease
- Management of Tobacco Use
- Health Promotion and Disease Prevention (adopted from USPSTF)
    - Breast Cancer Screening
    - Cervical Cancer Screening
    - Colorectal Cancer Screening
    - Prostate Cancer Screening
    - Abdominal Aortic Aneurysm Screening
    - Osteoporosis Screening
    - Adult Immunizations

The Army serves as the DoD lead for the CPG initiative and maintains a website[2] to ensure easy access to CPG information and CPG toolkits for DoD practitioners and facility staff.

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[1] The Joint Commission. 2007 Comprehensive Accreditation Manual for Hospitals: The Official Handbook. Rationale for Standard LD.5.10. 2007.

[2] See www.qmo.amedd.army.mil.

Population Health and Disease Management

Originally developed by the Air Force, and now used by all three Services in the direct care system (DCS), the MHS Population Health Portal (MHSPHP) methodology[3] has been adapted to identify target populations for care throughout the MHS, including those beneficiaries in the managed care support contractor disease management (DM) programs. The MHSPHP methodologies are based on HEDIS, which is developed and maintained by NCQA.[4] Performance measures for both the direct and purchased care systems also use national benchmarks, such as the HEDIS targets. Moreover, the MHSPHP contains data from the electronic health record for beneficiaries enrolled in a Military Treatment Facility (MTF). This enables the Services to use the MHSPHP "Action Lists" as their systemwide population health tool.

Currently, the TRICARE Management Activity (TMA) identifies beneficiaries who are diagnosed with congestive heart failure (CHF), chronic asthma, or diabetes using selection criteria derived from the MHSPHP and HEDIS methodologies. Once identified, the population is risk stratified. Risk stratification involves sorting those beneficiaries identified as having CHF, chronic asthma, or diabetes into groups or levels using data on their health care utilization (e.g., emergency department visits, hospitalizations, prescriptions filled). In the TMA model, these levels range from 1 to 4, with 1 being lowest risk and 4 being highest risk.[5] The managed care support contractors then develop and implement targeted DM strategies for beneficiaries identified as being level 3 or 4.

The use of central patient identification and risk-stratification methodologies may create overlap between patients already identified locally for DM programs by MTFs and the managed care support contractor lead DM programs. TMA encourages increased communication between the managed care support contractors and individual MTFs to limit duplication of effort to the extent possible and to ensure the alignment of specific DM recommendations through the use of nationally recognized CPGs. TMA is looking at ways to further improve collaboration between the managed care support contractors and MTFs, but further integration between the direct and purchased care systems could be helpful in dealing with this overlap.

Language in the next round of managed care support contracts (currently in acquisition) specifies that the DM conditions will be asthma, CHF, diabetes, chronic obstructive pulmonary disease (COPD), cancer screening, and depression and anxiety disorders. The managed care support contractors must submit individual DM program plans that demonstrate the implementation of DM interventions that use the VA/DoD CPGs, when such guidelines are available. The managed care support contractors' DM programs must meet national accreditation standards for DM and

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[3] The MHSPHP uses a Tri-Service, centralized web-based population health management system that includes TRICARE Prime and TRICARE Plus beneficiaries.
[4] See http://web.ncqa.org/tabid/59/Default.aspx.
[5] Research shows that the opportunity to improve health and reduce cost is primarily related to reducing hospitalizations. Secondary to that is reduction in emergency room visits. (Ariel Linden. What will it take for disease management to demonstrate a return on investment? New perspectives on an old theme. American Journal of Managed Care. 2006;12(4):217-222.) Hospitalization is an indicator of both advanced disease and lessened quality of life and is far and away the largest cost factor associated with treating chronic disease. Thus, analysis of utilization is a good approach for identifying DM and chronic care management opportunities.

chronic care management within 18 months of the start of health care delivery. However, TMA will continue to identify the population and risk stratify beneficiaries for inclusion in the managed care support contractors' DM programs.

Collaborative Practice Models

DM programs are a relatively recent approach to medical care. Having first attained currency in the 1990s, DM conceptually de-emphasizes the system in which physicians deliver care in isolation and emphasizes a collaborative approach in which all team members, including the patient and his or her family, work together using evidence-based best-practice approaches. Coordination among levels of care, sites of care, and among care providers is critical to the success of disease and chronic condition management efforts. To bring these components together, a well-designed program requires input and commitment from each member.

On the other hand, case management (CM) dates back to the early 1900s, when nurses and social workers formed connections to help patients receive social services in the community. However, like DM, CM has only come into the mainstream of health care in the past 20 years, and also like DM, CM relies on the identification of not only the patients in need of services, but also on their need for resources available to the patients within the context of the medical setting and the community. The difference between the two is one of intensity of management. With DM, much of the focus is on patient education and subsequent self-management to improve outcomes, while with CM there is greater focus on collaborative assessment, planning, facilitation, and advocacy on the part of the CM providers. Even so, experts comment that the lines between DM and CM are often blurred.

The Chronic Care Model[6] (CCM) is the framework that has been chosen by the MHS to guide the provision of population-based disease and condition management programs. The CCM identifies the unique components required to effectively manage chronic illnesses and includes the following characteristics:

1. Community: Collaboration with governmental and professional organizations that share the goal of enhancing chronic care management.
2. Health care system: A culture organized to provide safe, quality care to those with chronic illnesses.
3. Self-management: The empowerment of patients with the knowledge, skills, and competency to participate in the active management of their own health care needs.
4. Delivery system design: Identification of providers' roles and access to clinical data to ensure quality, culturally sensitive management, and follow-up of care.
5. Decision support: Use of evidence-based guidelines as a foundation for clinical management decisions.
6. Clinical information system: A tracking system that supports care coordination and that monitors the care of individuals and populations.

[6] The CCM was developed by Ed Wagner, M.D., M.P.H., Director of the MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound, and colleagues of the Improving Chronic Illness Care program, with support from the Robert Wood Johnson Foundation.

The *Medical Management Guide* (published by TMA in 2006) utilizes the above concepts to tie together DM, CM, utilization management (UM), and population health. The guide emphasizes two elements of DM: 1) self-care/self-management of disease and 2) the use of CPGs. The general MHS DM philosophy is that the patient must be responsible for a substantial part of his or her own care, but that this responsibility is shared with health care providers who must use evidence-based standards of practice to deliver that care. The *Medical Management Guide* expanded the usual definition of CM to place it under the umbrella of population health and to recognize it as part of the continuum of care that includes primary care and DM. In the MHS, medical management (MM) is expected to encompass the entire spectrum of health, from wellness to chronic disease, from primary care to DM prevention and treatment programs, and to CM, as illustrated in Figure 4-1. It should be understood that neither DM nor CM has a primary goal of following wellness guidelines, although some individuals participating in these programs may do so.

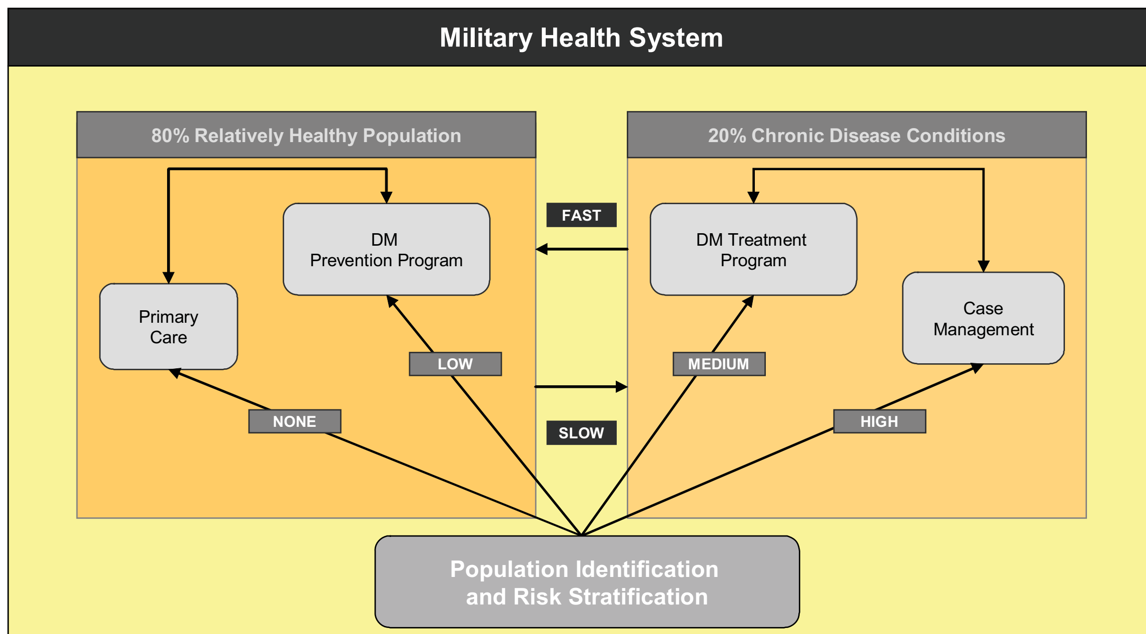

Figure 4-1. Conceptual Model of Integrated MM in the MHS

MHS Disease and CCM Opportunities

Knowledge of changes in prevalence and costs over time are vital to developing an effective implementation plan for the disease and CCM program. Data on these changes are needed for all MHS beneficiaries with chronic diseases (for those enrolled in both direct care and purchased care, and for those both diagnosed and as yet undiagnosed). Unfortunately, MHS administrative data cannot identify undiagnosed beneficiaries.

For those who have been diagnosed, however, the MHS centralized administrative data repository has been used to estimate the current and immediate future burden of the following diseases and conditions throughout the MHS:

- diabetes;
- CHF;
- asthma;
- COPD/emphysema; and
- depression/anxiety.

These estimates used Fiscal Year 2004, Fiscal Year 2005, and Fiscal Year 2006 data to develop prevalence rates and costs among those patients already diagnosed and utilizing the MHS for treatment and to further forecast future disease burdens. TMA currently uses these estimates to develop the algorithms it is using to identify which beneficiaries to target for focused DM interventions. The prevalence and cost of chronic disease presented by disease and by region are useful indicators of the health status of TRICARE beneficiaries and their demand for services and therefore provide an informative picture of DM opportunities throughout the MHS.

Process and Outcome Measurement, Evaluation, and Management

The MHS measures, evaluates, and manages DM services using national performance process and outcome measures such as HEDIS. Each of the Services monitors its DM programs using Service-level dashboards, and TMA is conducting a comprehensive review of the managed care support contractor DM programs across all three regions. The results of these evaluations will provide the MHS with an objective analysis of the success of each component of the program at multiple levels of the organization (e.g., regional, Service, and MHS). In addition to measuring the processes of the managed care support contractor programs (e.g., engagement rates), TMA is also assessing clinical, utilization, humanistic (e.g., patient satisfaction), and financial outcomes consistently across the three regions. Moreover, TMA, in collaboration with the Services and the TRICARE Regional Offices, conducts a comprehensive review of the health status of the MHS population with identified disease states and preventive service needs (e.g., breast, cervical, and colorectal cancer screening) through the MHS Clinical Quality Forum.

As mentioned above, DM programs also exist separately within some MTFs, particularly the larger hospitals and medical centers. These programs often pre-date and remain separate from the contractually required managed care support contractor programs. The interface between the MTF and managed care support contractor programs varies, depending primarily on the interest of the MTF in utilizing the managed care support contractor DM services to augment what the MTF has in place or is able to offer. Another key factor in the interface between programs is the patient, who has the option of participating in the TMA-directed, managed care support contractor-implemented DM program and the MTF program, just one of the two programs, or neither. And although the managed care support contractors' DM programs are standardized within each region, the primary standardization that exists across MTFs is that which comes from the utilization of CPGs and following accepted standards of care. Thus, a greater amount of variability exists within the DCS than within the purchased care system with respect to DM programs.

Strategies for All Beneficiaries

Although there are many similarities between TRICARE Standard and TRICARE Prime regarding the preventive health care services that may be provided in the current benefit, there are services *that are expressly excluded* under TRICARE Standard *that may be offered under* TRICARE Prime (see Table 4.1, below). The excluded services for TRICARE Standard beneficiaries are, unfortunately, what make up the essence of a DM program.

Table 4.1: Current Legal Authorities Addressing DM Services

10 U.S.C. 1079(a)(13) - TRICARE may cost-share only services or supplies that are medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction as assessed or diagnosed by an authorized provider.
10 U.S.C. 1074(d) - Members and former members of the Uniformed Services are entitled to preventive health care services, including cervical cancer screening, breast cancer screening, and screening for colon and prostate cancer. (These same services are available to them and all dependents in MTFs under **10 U.S.C. 1077(a)(14)** and to all covered beneficiaries under TRICARE under **10 U.S.C. 1079(a)(2)**).
10 U.S.C. 1079(a)(2)(B) - Other health promotion and disease prevention visits for those over 6 years of age are authorized under TRICARE Standard *only* when done in connection with immunizations or with diagnostic or preventive cancer screening tests.
10 U.S.C. 1097–1099 - The TRICARE Prime program is authorized to provide services not covered by TRICARE Standard, and the Secretary shall prescribe regulations to carry out this authority.
32 C.F.R. 199.18(b)(2) - The following services are available under TRICARE Prime that are not authorized under TRICARE Standard: (1) “Periodic health promotion and disease prevention exams; (2) Appropriate education and counseling services. The exact services offered shall be established under uniform standards established by the Assistant Secretary of Defense (Health Affairs). (3) In addition to preventive care services provided pursuant to paragraph (b)(2) of this section, other benefit enhancements may be added and other benefit restrictions may be waived or relaxed in connection with health care services provided to include the Uniform HMO Benefit. Any such other enhancements or changes must be approved by the Assistant Secretary of Defense (Health Affairs) based on uniform standards.”
32 C.F.R. 199.4(g)(39) - Under TRICARE Standard, education and counseling services are expressly excluded.

Because of these current exclusions, TMA found it necessary to conduct a demonstration project[7] to offer TRICARE Standard beneficiaries the same benefits that TRICARE Prime beneficiaries receive under the DM program. The purpose of this demonstration will be to evaluate DM program applicability for TRICARE Standard beneficiaries, in terms of the same

[7] Notice of a DM demonstration project for TRICARE Standard beneficiaries. [FR Doc. E7–4924 Filed 3–16–07; 8:45 am].

clinical, utilization, satisfaction, and financial outcomes. The formal evaluation of the TRICARE Standard beneficiaries in the demonstration project will enable the MHS to determine whether recommendations should be made to change the current statutes that exclude the provision of these services.

Although beneficiaries over the age of 65 may receive disease and chronic care management services through direct care if they are enrolled at an MTF and those services are available, there is no provision for providing DM services to beneficiaries over age 65 in the existing managed care support contractor DM program. TMA and Medicare are collaborating to determine the best mechanism available to offer DM services to those beneficiaries over age 65 who are in need of such services. Currently, any patient who is identified by TMA as a candidate for managed care support contractor-provided DM services matriculates from the program upon reaching age 65.

For example, in April 2007, TMA began coordinating benefits with Medicare to make it easier for beneficiaries with end-stage renal disease to participate in three Medicare demonstrations in multiple counties in Alabama, Arizona, California, Connecticut, Georgia, Massachusetts, Pennsylvania, Tennessee, and Texas.[8] TRICARE acts as the second payer for TRICARE-covered services for beneficiaries participating in these demonstrations.

In summary, as of June 1, 2007, TMA had established a consistent approach to identifying and evaluating DM services for TRICARE beneficiaries less than 65 years old who had a diagnosis of chronic asthma and CHF (effective in September 2006) and/or diabetes (effective in June 2007), to include both TRICARE Prime and non-Prime beneficiaries residing in the West, South, and North regions. Lessons learned from the current DM efforts will be carried forward as the MHS expands to include the additional diseases and condition states listed in Section 734 (Disease and Chronic Care Management) of the National Defense Authorization Act of 2007 (COPD, depression and anxiety disorders, and cancer). The results of the ongoing evaluation will help determine the effectiveness of the program in facilitating improvement in health status and in ensuring the availability of effective health care services for individuals with these chronic conditions.

Case Management

Language in the next round of managed care support contracts (currently in acquisition) specifies that the managed care support contractors must operate CM programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which evidence-based clinical management programs exist. These programs must be available to TRICARE-eligible beneficiaries authorized to receive reimbursement for civilian health care per 32 C.F.R. 199 and Active Duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. However, these programs will continue to exclude beneficiaries who are dually eligible for both TRICARE and Medicare. When care occurs outside an MTF, the managed care support contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers. Unlike DM, for which clinical conditions have been specified by Congress, the managed care support contractors will propose MM programs and

[8] See www.tricare.mil/pressroom/news.aspx?fid=278.

patient selection criteria for review and concurrence by TMA prior to implementation and annually thereafter.

Although the *Medical Management Guide* envisions CM as part of population health, interfaces between CM and other preventive functions, such as health promotion, military readiness, and community health, are not currently well defined. Neither is the responsibility nor accountability for patient wellness clearly delineated beyond that expected of the primary care managers (PCMs). Therefore, CM structures, functions, and policies vary widely across MTFs.

When the Army first developed Medical Retention Processing Units (MRPUs), in 2003, it identified case managers as critical for managing patient care plans and for navigating medical board processes for wounded, ill, or injured Reserve Component Soldiers mobilized in support of Operation Enduring Freedom and Operation Iraqi Freedom. Using MRPUs proved to be a highly successful management strategy—so successful that the Army retooled them in 2007 to become Warrior Transition Units (WTUs), more formal, robust units designed and staffed to provide comprehensive administrative and health care management for Active Duty as well as Reserve Component Soldiers. As with the MRPUs, WTU CM was recognized as key to successful patient recovery. Nurse case managers became part of the “triad of care,” coordinating with PCMs and WTU squad leaders daily to design, manage, and support an individualized comprehensive transition plan for each assigned warrior in transition. Many of the principles of CM developed for these Army WTUs have found new roots in sister Service programs, and concepts for Tri-Service Wounded Warrior programs are now being discussed and developed.

The Wounded Warrior initiative called for uniform standards and programs for:

- early screening and ongoing surveillance for risk of accidental harm or suicide;
- daily contact/interaction with a “triad” member;
- patient tracking and patient appointment notifications;
- the development of comprehensive recovery plans;
- the assignment of Recovery Care Coordinators;
- the assignment of Medical Care Case Managers;
- the assignment of Non-Medical Care Managers;
- timely access to urgent and nonurgent medical care;
- assignment to a location of care;
- transportation and subsistence;
- work and duty assignments;
- educational and vocational training and rehabilitation;
- managing patient referrals; and
- support of family members.

The separate DoD/VA SOC—tasked with addressing the care, management, and transition of recovering Service members—worked closely with DoD and VA health care leaders caring for WTU soldiers to develop a comprehensive CM policy for Wounded Warriors. This CM policy focused on the care and management of recovering Service members, medical evaluation and disability evaluation, returning recovered Service members to Active Duty when appropriate, and transitioning Service members from DoD to receipt of care and services in VA.

The DoD/VA SOC released its "Report to Congress on the Comprehensive Policy Improvements to the Care, Management and Transition of Recovering Service Members" on September 16, 2008. This policy document formalizes the recommendations developed for the Wounded Warrior Initiative, and together with a supporting document, "The Foundations of Care, Management and Transition Support for Recovering Service Members and Their Families," it establishes a system of care coordination that ensures oversight of and assistance to recovering Service members and their families from recovery, through rehabilitation, to reintegration.

Response and Implementation Plan

Scope

Guidelines pertain to strengthening the effectiveness of health care delivered to beneficiaries throughout the MHS. CM and DM programs are specific to individual beneficiaries with targeted illnesses, injuries, or conditions. However, these programs are to be implemented throughout the MHS, giving them a broad scope as well.

Goals and Objectives

- Maintain current wellness and prevention programs, while standardizing methods for the selection, prioritization, and implementation of new wellness and prevention programs throughout the MHS, and facilitate the inclusion of such measures in performance-based reimbursement schemes.
- In collaboration with VA, continue to develop and maintain CPGs, serving as a foundation for interagency population health prevention and disease and condition management initiatives. This will include CPGs that target combat-related conditions.
- Continue the managed care support contractor-operated DM program with uniform MHS identification of candidates, expand the diseases included in those programs, improve integration with existing DM programs in MTFs, and pursue legislative changes, as appropriate, to allow DM services for non-TRICARE Prime beneficiaries. The current DM conditions are asthma, CHF, and diabetes. The expanded program, under the T3 contract, will add COPD, depression/anxiety disorder(s), and cancer screening. The current demonstration authorization for standard beneficiaries to receive DM benefits expires March 31, 2009.
- The current focus on CM programs for Wounded Warriors will lead to improvement in such services for all beneficiaries.
- The existing network of managed care support contracts in partnership with the MHS will be used to optimize the delivery of health care services in the DCS and to attain "best value health care" services (in accordance with the *TRICARE Operations Manual*, Appendix B) in support of the MHS mission. Similarly, the managed care support contractors will operate quality management/quality improvement programs and comply with all aspects of the Clinical Quality Management requirements of the *TRICARE Operations Manual*, Chapter 7.
- Continue utilization of selected HEDIS measures related to the delivery of preventive services and the management of chronic disease to improve clinical quality in both the direct care and purchased care settings.

- Continue to include UM implementation guidelines in the next set of revisions to the *Medical Management Guide*, which is planned for release in Fiscal Year 2009.

Stakeholders

Broadly speaking, population health and wellness initiatives are relevant to all MHS stakeholders, from patients to providers to program managers to bill payers. More specifically, the key stakeholders are patients enrolled in DM and CM programs, providers caring for those patients, administrators overseeing the DM, CM, and UM programs under the MM umbrella, and those who finance the MHS (Congress and the taxpayers).

Vision and Strategy

The MHS should follow national wellness guidelines, which should be used in all MHS locations. However, there are pre-existing limitations on data utilization, and further standardization of the selection and implementation of these measures is needed.

Prevention guidelines should be used and prioritized according to evidence. At present, the NCPP recommendations do not play a role in DoD's choice of prevention measures. Rather, the selection of measures has been based on USPSTF recommendations, NCQA and HEDIS guidance, current research, and expert opinion. National wellness guidelines, including those of the USPSTF, are used to support DoD health promotion and disease prevention activities. DOD currently selects measures based on their applicability to the population and the level of evidence supporting them. Evaluation activities are standardized through the use of HEDIS national commercial technical specifications for data pulls and by the use of national commercial percentiles in all three Services.

Metrics reflecting the state of health of the DoD population are valuable tools to support decisionmaking in all facets of organizational functioning. For example, current and historical data on diabetes care, breast cancer screening, cervical cancer screening, colon cancer screening, and chlamydia screening are available to DoD. Some measures are included in a Service's pay-for-performance reimbursement system. However, the quality of the data is limited by the accuracy of clinical coding, validity, and reliability of enrollment information, and the inability to use Armed Forces Health Longitudinal Technology Application (AHLTA) systems for data pulls. Valid and reliable data must be made available, including network care data, VA care data for MTF-enrolled beneficiaries, accurate Defense Enrollment Eligibility Reporting System data, AHLTA immunization module data, and AHLTA wellness reminder data. In addition, the accuracy of clinical coding must improve in order to track deficiencies in wellness measures and compliance in Active Duty and beneficiary populations in CONUS and OCONUS.

On the other hand, utilization of integrated CM and DM services will not achieve the recommendation's stated goal of following national wellness and prevention guidelines. Population health is not the sole responsibility of CM or DM professionals. An integrated MM program, including CM and DM functions, is an important tool within a system-based effort to improve population health. Although there is a professional responsibility for providing prevention services and referrals for patients to CM, roles regarding CM functions in preventive

services are not defined at this time. Furthermore, not all beneficiaries need or receive CM services.

Currently, DM services are available only to TRICARE Standard beneficiaries through a demonstration project, because there are services *that are expressly excluded* under TRICARE Standard *that may be offered* under TRICARE Prime. In order to achieve a truly integrated DM program within the MHS, it will be necessary to pursue the legislative changes needed to allow DM services for non-TRICARE Prime beneficiaries.

The MHS will continue to promote the appropriate use of health care resources. Proper stewardship of health care resources is necessary in today's economic and health care environments. An integrated MM program, including CM and DM functions, is an important tool within a system-based effort to optimize the utilization of health care resources. However, resource management is not the sole responsibility of CM or DM professionals.

UM is the facet of an integrated MM program that is involved with the appropriate use of health care resources. Integrated MM programs, as promulgated by the TMA *Medical Management Guide*, including UM, are not yet operationalized at all sites, and UM is not standardized across MTFs and the Services. The MHS intends to continue including UM for the next set of revisions to the *Medical Management Guide*.

The MHS is working to implement and resource standardized CM and care coordination services. Multiple configurations of CM and similar services are duplicative and a barrier to optimal patient care. CM and related services should be unified in all MTFs, with policies and procedures and documentation systems standardized. However, another SOC is specifically addressing the CM issue with respect to Wounded Warrior care. Rather than duplicate their implementation proposals here, it is specifically proposed that the current focus on CM programs for Wounded Warriors will lead to improvement in CM services for all beneficiaries.

Although it is necessary that DoD ensure timely performance feedback in order to promote accountability and transparency, obstacles exist. Current systems are not satisfactory with respect to the previously described validity and reliability of health care data. Performance-based reimbursement in the Army has been effective in raising awareness about clinical measurement, but data difficulties have raised concerns. Provider-level data reporting is being piloted in some of the Services. However, the quality of the data currently is limited, as described above.

Implementation Specifics

Action Item 4.1

> *To promote accountability and transparency in fiscal management and quality of services, DoD should continue to prioritize prevention programs in accordance with the National Commission Prevention Priorities.*

Tasks/Requirements

- Designate a single body responsible for the prioritization, selection, and implementation of new wellness and prevention measures for use in assessing, monitoring, and managing population health within DoD.
- Grant authority to and resource this body to effectively manage the prescribed tasks.
- Further define the role of DoD and outside advisory bodies in the selection and approval of metrics and the associated data challenges.
- Develop a standardized evidence-based approach for choosing prevention measures to be utilized within DoD that makes use of the NCPP recommendations as well as other nationally recognized standards.
- Establish procedures to support decisions concerning the use of wellness and prevention measures in performance-based reimbursement schemes, and begin step-wise implementation of new measures on a planned timeline utilizing new procedures.
- Allocate resources to support primary prevention efforts related to community outreach/marketing for childhood immunizations, tobacco prevention/cessation, and influenza vaccination. Focusing on these primary prevention issues is in accordance with NCPP and is beneficial to the DoD population.[9]
- Convene an MHS task force to discuss policy interventions related to tobacco prevention/cessation.

Timeline

The above tasks and requirements will be accomplished within 24 months of the acceptance of this implementation plan.

Action Item 4.2

> *To promote accountability and transparency in fiscal management and quality of services, DoD should implement and resource standardized case management and care coordination that extends beyond the Wounded Warrior to other beneficiary groups across the spectrum of care.*

Tasks/Requirements

- DoD Clinical CM Policy directive (required by 2008 NDAA, Section1611(a)), currently under development and aligned with care and CM reform for Wounded Warriors, will be released in early Fiscal Year 2009.
- Tri-Service implementation plans will be developed under the auspices of the above DoD Clinical CM Policy directive.
- DoD Health Affairs will then undertake to study the most efficient means to expand the CM programs and mitigate barriers to unified practice, policy, and documentation.
- DoD will ensure that resourcing for CM programs includes adequate staffing.

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[9] See www.prevent.org/content/view/43/71/.

Timeline

The above tasks and requirements will be accomplished within 18 months of the acceptance of this implementation plan.

Action Item 4.3

> *To promote accountability and transparency in fiscal management and quality of services, DoD should ensure timely performance feedback to clinical providers, managers, and the chain of command through a timely and easily accessible reporting system such as a provider score card.*

Tasks/Requirements

- Convene a group of current authorities on data systems and current users from the field, as part of the data integration efforts required in response to Task Force Recommendation 1.
- Ensure that data requirements in support of DM, CM, and MM in general are addressed in developing the systems needed to support timely feedback to clinical providers and populations of a provider score card.
- Develop the means to expand the MHS Population Health Portal to include patients and providers within the purchased care system.
- Have the above group of data system authorities propose solutions to each identified data deficiency, and delegate responsibility to the appropriate authority to address the deficiencies and resource the necessary solutions.

Timeline

The above tasks and requirements will be accomplished within 24 months of the acceptance of this implementation plan. However, actual implementation of any newly required data systems will take longer.

Action Item 4.4

> *To promote accountability and transparency in fiscal management and quality of services, DoD should maintain high-level visibility of business and clinical performance for the entire enterprise via the Tri-Service Business Planning Process and the MHS Balanced Score Card Metric Panel.*

Tasks/Requirements

- Analyze information concerning data needs to support the Tri-Service Business Planning Process and the Balanced Score Card Metric Panel.
- Propose population health, DM, and CM metrics for inclusion in the Tri-Service Business Planning Process and the MHS Balanced Score Card Metric Panel.

- Develop the means to expand the MHS Population Health Portal to include patients and providers within the purchased care system.
- Adopt the chosen metrics.

Timeline

The identification and adoption of metrics supported by currently available data systems will be accomplished within 12 months of the acceptance of this implementation plan. The adoption and implementation of metrics requiring new data systems will be dependent on the development of those supporting systems.

Additional Related Action Item

To promote accountability and transparency in fiscal management and quality of services, include UM implementation guidelines in the next set of revisions to the Medical Management Guide*, which is planned for release in Fiscal Year 2009.*

Tasks/Requirements

- Ensure UM systems, requirements, and standard operating procedures are included in the *Medical Management Guide*, which is currently undergoing revision.

Timeline

This task should be completed before the end of Fiscal Year 2009.

Recommendations 5, 6, and 7
Prioritize Acquisition in the TRICARE Management Activity
Implement Best Practices in Procurement
Examine Requirements in Existing Contracts

Overview

The Military Health System Senior Oversight Committee (MHS-SOC) grouped Task Force Recommendations 5, 6, and 7 together, because they all relate to acquisition or contracting activities of the TRICARE Management Activity (TMA). This chapter describes the Task Force assessments underlying Recommendations 5, 6, and 7 as a whole, rather than as three separate parts, after setting forth specific recommendations and action items. Recommendation 5 and its associated action items focus on the TMA management structure and workforce in order to emphasize TMA's acquisition role. Recommendation 6 and its action items are designed to promote the use of best practices in health care purchasing. Recommendation 7 and its action items call for TMA to reassess requirements in its contracts to determine if TMA is using the most effective strategies to buy services and capabilities.

Task Force Recommendation 5

DoD should restructure the TMA to place greater emphasis on its acquisition role.

Action Items

DoD should:

- *elevate the level of the Head of Contracting Activity (e.g., to the level of the Military Deputy Director of TMA);*
- *ensure acquisition personnel are certified according to the Defense Acquisition Workforce Improvement Act (DAWIA) and have strong competencies in health care procurement;*
- *ensure the management of acquisition programs is consistent with the Defense Acquisition System Process;*
- *clearly delineate program managers and program executive offices;*
- *ensure compliance with DoD Directive 5000.1, The Defense Acquisition System, and DoD Instruction 5000.2, Operation of the Defense Acquisition System;*
- *create a system of checks and balances by separating the acquisition functions from the requirements/operations and the budget/finance functions and placing them under the Chief Acquisition Officer-equivalent who operates independently and is on the same level in the organization as the Chief of Health Plan Operations and Chief Financial Officer; and*
- *implement a study to determine if it is in the best interests of the government to colocate the TRICARE Deputy Chief TRICARE Acquisitions organization (located in Aurora, Colorado) and its acquisition counterparts (located in the National Capital Region).*

Task Force Recommendation 6

DoD should aggressively look for and incorporate best practices from the public and private sectors with respect to health care purchasing.

Action Items

DoD should:

- *examine and implement strategies to ensure compliance with the principles of value-driven health care consistent with Executive Order 13410, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs."*[1]

    - *Health Information Technology: Require in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it should use, where available, health information technology systems and products that meet recognized interoperability standards.*
    - *Transparency of Quality Measurements: Implement programs measuring the quality of services supplied by health care providers to the beneficiaries or enrollees of the TRICARE health care programs.*
    - *Transparency of Pricing Information: Make available to the beneficiaries the prices that TMA pays for procedures to providers in the health care program with which the agency, issuer, or plan contracts.*

Task Force Recommendation 7

DoD should reassess requirements for purchased care contracts to determine whether more effective strategies can be implemented to obtain those services and capabilities.

Action Items

DoD should:

- *examine whether the benefits from waiving cost accounting standards outweigh the risks associated with the waiver;*[2]

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[1] Executive Order (E.O.) 13410, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," is a priority for DoD. See also the discussion of Recommendation 2, Implementation Plan, for additional details on the use of information technology and best practices and collaboration that are taking place in compliance with E.O. 13410.

[2] This issue arose at the Task Force meeting of April 18, 2007. A contractor, in explaining why it did not intend to submit a proposal on a DoD contract, mentioned that it was burdensome to change accounting systems to meet the requirements of DoD's cost accounting system and stated that its existing accounting system complied with Generally Accepted Accounting Practices (p. 81, Slide 8). The Task Force saw this rule as a possible obstacle to receiving a larger number of bids. See www.dodfuturehealthcare.net/images/103-06-9-Meetings_April_18_2007_Transcript_.pdf.

- *examine the current requirements for the delivery of health care services, including the contractor's role in accomplishing referrals, the need for authorizations, and whether enrollment could be accomplished by DoD with registration performed by managed care support contractors;*
- *test and evaluate through pilot or demonstration projects the effectiveness of carved out chronic disease management programs; and*
- *examine the overarching contracting strategy for purchased care to consider whether certain functions should be:*
    - *added to managed care support contracts (e.g., marketing/education and TRICARE for Life claim processing), and/or*
    - *carved out from managed care support contracts (e.g., specialized contracts to enhance disease management or other innovative pilot programs).*

Task Force Assessment

In its report, the Task Force noted the uniqueness of the MHS as a direct care provider that increasingly relies on purchased health care. Many factors contribute to the shift toward more purchased care, including fewer Military Treatment Facilities (MTFs), resulting from downsizing, realignments, base closures, and the effects of the activation of reservists and the deployment of medical personnel. At the same time, civilian managed care support contracts are intended to optimize delivery of health care in the MTFs.[3] The Task Force noted the magnitude of change, citing a Government Accountability Office (GAO) report that states that DoD's obligation for medical service contracts of $1.6 billion in 1996 had grown to $8.0 billion by 2005.[4] Thus, for DoD, buying health care is big business—and getting bigger. Effective procurement is essential.

The Task Force accepted four pillars as providing a framework for an efficient, effective acquisition function: 1) organizational alignment and leadership; 2) policies and processes; 3) human capital; and 4) knowledge and information management.[5] The Task Force's Recommendation 5 evinces a concern expressed in a GAO report on federal acquisitions, in which the GAO cautioned against a situation in which "there is no chief acquisition officer, or the officer has other significant responsibilities and may not have management of acquisitions as his or her primary responsibility."[6]

The Task Force examined the evolution of TMA procurement of contractor managed care. In 1994, TMA had 7 managed care contracts for 11 health care regions, and in the next generation of contracts, those contracts were consolidated under 3 contracts for 3 regions. The second generation of managed care contracts included other changes that evoked some criticism of the

[3] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 43.
[4] GAO. Defense Acquisitions: Tailored Approach Needed to Improve Service Acquisition Outcomes. GAO-07-20. November 2006, p. 5. Available at www.gao.gov/new.items/d0720.pdf. Note: The General Accounting Office changed its name to the Government Accountability Office on July 7, 2004. GAO is used throughout this document to refer to either entity.
[5] GAO. Framework for Assessing the Acquisition Function at Federal Agencies. GAO-05-218G. September 2005, p. vii. See www.gao.gov/new.items/d05218g.pdf.
[6] Ibid., p. 8.

TMA approach to purchasing care. These contracts differed from typical integrated health plan offerings (e.g., in the making of MTF appointments and the segregation of marketing and education services). Some provisions were criticized as "dis-integrating" to the provision of health care or as deviating from "best practices."[7] Such views may help to explain why the Task Force stated (as part of Recommendation 7)[8] that DoD should consider conducting pilot studies and demonstration projects to determine if more effective strategies would lead to better health care delivery.

The Task Force was aware of many of the steps taken by TMA in planning the next generation of managed care contracts (Third Generation of TRICARE contracts [T3]) designed to streamline procurement and stimulate competition. For example, TMA used FedBizOpps.gov and other means to advertise its contracts[9] and to solicit industry input. It met with potential prime contractors and subcontractors in Request for Information meetings. The Task Force, in making its proposals, recognized the long duration and detailed planning required for an acquisition activity of such scope and complexity. Pilot studies and demonstration projects were favored over more sweeping and immediate changes.

The Task Force noted a more fundamental point of view that previously was expressed by GAO: "The challenge for DoD, in other words, is to decide whether to continue to use fewer large and complex contracts versus managing smaller and potentially simpler contracts, each of which has unique management challenges."[10] Size, complexity, and prescriptive requirements could limit competition among contractors, thus reducing the acquisition choices for TMA.[11] The Task Force's proposal to reassess contract requirements through pilots or demonstration projects was intended to provide targeted, evidence-based opportunities for improvement.

MHS-SOC Review

Accepted, in part. Several activities already are under way in response to these recommendations.

Vision and Strategy for Recommendation 5

After completing a review of TMA's organizational structure supporting acquisitions in December 2007, the Acquisition Directorate was restructured to put in place appropriate authorities and responsibilities for contracting activities. This reorganization of the Health Plan Operations (HPO) Directorate appears to address the concerns underlying the Task Force recommendation to place greater emphasis on acquisition management, but the structure will be subject to continuing review to ensure compliance with acquisition laws, regulations, and

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[7] Task Force on the Future of Military Health Care, op. cit., p. 46.
[8] HealthNet. Brief to the Task Force. March 28, 2007, p. 47. See www.dodfuturehealthcare.net/images/103-06-9-Meetings-March_28_2007_Transcript.pdf.
[9] FedBizOpps.gov is the single government point of entry for federal government procurement opportunities over $25,000. Government buyers are able to publicize their business opportunities by posting information directly to FedBizOpps via the Internet.
[10] GAO. Defense Health Care, Lessons Learned from TRICARE Contracts and Implications for the Future. GAO-01-742T. May 17, 2001, pp. 10, 11. See www.gao.gov/new.items/d01742t.pdf.
[11] Ibid., pp. 5, 6.

policies. The HPO reorganization improved the delineation of missions and functions. Program policy/operations and acquisitions were separated into two separate and distinct directorates. The previous directorate, which included the acquisitions function, was led by a Senior Executive Service (SES) program official (301 series[12]), who performed both program management and acquisition functions. The contracting office was under this individual. The reorganized Acquisitions Directorate is led by an SES contracting official (1102 series[13]) with strong competencies in contracting and health care procurement. Also, a newly established Deputy Director (YC-1102-03) position is designed to increase oversight and integration of the agency's acquisition activities. The TRICARE Operations Directorate, which supports the development of all TRICARE policies and programs, was filled by another senior executive; however, a replacement senior executive position has not yet been allocated to replace this individual upon retirement. An out-of-cycle SES request has been initiated.

The recommendation to elevate the Head of Contracting (HCA) to the Military Deputy Director of TMA was considered, but has not been implemented. Given the reorganization noted above, after some additional time for observation of its effect, the issue of elevation of the HCA to the Deputy Director level will be revisited. The Deputy Director, TMA, did take action to raise the HCA to the SES level as Deputy Chief, TRICARE Acquisitions, reporting to the Chief, HPO.

The TMA 1102 job series (contracting) staff is currently at or above the required level of Defense Acquisition Workforce Improvement Act (DAWIA) certification. DAWIA was signed into law in November 1990. It requires DoD to establish education and training standards, requirements, and courses for the civilian and military workforce. To further strengthen its acquisition role, TMA is conducting a comprehensive assessment of current TMA acquisition processes, an audit to determine what TMA positions qualify for certification under DAWIA, a proposed structural improvement model, a training deficiency remediation plan, and a sustainment and improvement efficiencies plan. In short, the goal is to evaluate and quantify current acquisition processes across TMA and provide operational business process improvement methods and strategies in the areas of professional certification, education, and training for appropriate staff and improved methods and processes for operational transactions for the government, vendors, and internal customers. In addition, TMA has implemented a comprehensive acquisition career management program. The program is designed to assure that acquisition positions are properly coded so that persons in those positions will be qualified and meet all DoD certification requirements. If gaps are found, individual development plans will be developed to ensure proper training. The TMA Human Resource Office will manage the program, and the senior acquisition official will oversee the program in order to provide greater assurance of compliance with standards.

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[12] This series includes positions that perform, supervise, or manage nonprofessional, two-grade interval work for which no other series is appropriate. The work requires analytical ability, judgment, discretion, and knowledge of a substantial body of administrative or program principles, concepts, policies, and objectives.

[13] This series includes positions that manage, supervise, perform, or develop policies and procedures for professional work involving the procurement of supplies, services, construction, or research and development using formal advertising or negotiation procedures; the evaluation of contract price proposals; and the administration or termination and close out of contracts. The work requires knowledge of the legislation, regulations, and methods used in contracting and knowledge of business and industry practices, sources of supply, cost factors, and requirements characteristics.

The TRICARE Regional Offices manage and oversee the regional contractors and run an integrated health care delivery system in the three U.S.-based TRICARE regions. Under the TRICARE Governance Plan, each region is led by the Regional Director, who is the health plan manager. The Regional Director position is filled by a military flag officer or SES civilian who has at least 10 years of experience, or equivalent expertise or training, in the military health care system, managed care, and health care policy and administration. The Regional Director has knowledge of both the contract and direct care assets, including management of the TRICARE contracts for all eligible MHS beneficiaries in the region. This responsibility includes ensuring network quality, monitoring customer satisfaction, coordinating referral and appointment policies, addressing enrollment issues, overseeing contractor credentialing, ensuring contract support for MTF optimization, approving Memorandums of Understanding with the contractor, reviewing regional marketing and educational material, conducting oversight of regional business plans, serving as Chair of the TRICARE Regional Advisory Committee, and other delegated functions. The Regional Director reports to the Deputy Director, TMA, and is supported by a staff of military, civilian, and contractor personnel.

During the Task Force evaluation, the Deputy Chief, TRICARE Acquisitions, performed the role of project officer and was in charge of the contracting activity and the HCA. Although TMA had a business model that had been approved by the Component Acquisition Executive and the Assistant Secretary of Defense for Health Affairs, the new structure of TRICARE acquisitions is expected to emphasize and strengthen acquisition management and reduce the risk of a conflict of interest or insufficient independence of contracting officers in performance of their responsibilities. In short, the current Program Management business model used by TMA, combined with the recent reorganization elevating the level of the HCA and creating a separate SES-level Acquisition Chief, should provide greater assurance of compliance with DoD 5000 series directives and provide sufficient checks and balances among operations, finance, and acquisition. Furthermore, the decision to colocate the Deputy Chief, TRICARE Acquisitions, and his or her Deputy with the HPO in Falls Church, Virginia, should serve to enhance performance of acquisition functions by improving the opportunity for coordination and consultation with the rest of the TMA senior executives. Also, the creation of an acquisition policy office in Falls Church, near other senior leaders of the MHS, is under active consideration.

Table 5.1: Implementation Plan for Recommendation 5

Tasks	Requirements	Lead	Milestone
Hire SES-level Deputy Chief, TRICARE Acquisitions Colocate the position with the HPO in Falls Church, Virginia	The Deputy Director was hired in June 2008	Deputy Director, TMA	Completed
TMA position review	Designate positions, identify training, and recruit for backfill	Chief, HPO	Ongoing
Acquisition structure evaluation	Conduct evaluation of acquisition coded positions	Chief, HPO	Ongoing

Vision and Strategy for Recommendation 6

In an effort to incorporate best practices from the public and private sectors with respect to health care purchasing, TMA held a one-on-one industry forum meeting in June 2006. Engaging industry in the development process was very positive. The forum was a two-way exchange of information attended by more than 35 participants, and it validated that performance-based contracting with the use of incentives and guarantees is a leading-edge approach and the right approach. Key recommendations included the following:

- address barriers identified by potential new offerors;
- award longer-term contracts to promote competition;
- build requirements to drive implementation of new technologies and practices through partnerships with industry;
- align incentives to cost reduction and quality; and
- focus on accuracy in setting standards with only a few key performance guarantees.

Industry input contributed to TMA's thorough review of acquisition strategies in formal T3 Program Management Requirements Development Integrated Product Team (IPT) meetings chaired by the Program Manager and concluded with formal decisions by the Program Executive Officer and the Assistant Secretary of Defense for Health Affairs.

TMA also developed a TRICARE Transparency website specifically designed to support the Executive Order. The site empowers beneficiaries to research TRICARE's health plan options to select the best option, know the quality of doctors and hospitals, and know how much money they will pay out of pocket for the care they need. The information on this site is designed to help beneficiaries decide how to spend their health care dollars more wisely.

The Task Force recommended that TMA require language in contracts or agreements with health care providers, health plans, and health insurance issuers to the effect that as each provider, plan, or issuer implements, acquires, and upgrades health information technology systems and products, those systems meet recognized interoperability standards. TMA does require the managed care support contractor to establish, maintain, and monitor an automated information system to ensure that claims are processed in an accurate and timely manner and that they meet functional system requirements as set forth in the *TRICARE Operations Manual* and the *TRICARE Systems Manual*. The claims processing system is a single database and is Health Insurance Portability and Accountability Act of 1996 compliant. It also interfaces with the Defense Enrollment Eligibility and Reporting System (DEERS) to accurately determine eligibility and enrollment status.

In compliance with the Executive Order, the Task Force also recommended that TMA implement programs measuring the quality of services supplied by health care providers to the beneficiaries or enrollees of the TRICARE health care programs. TMA is currently evaluating Centers for Medicare & Medicaid Services measures to develop and refine appropriate quality measures and share information about the quality of services provided by doctors, hospitals, and other health care providers on the TRICARE Transparency website.

Under T3 contracts, monetary performance incentives are available to the managed care support contractor. The managed care support contractor may receive a positive performance incentive payment by either exceeding a minimum standard or for performance above a fully satisfactory level in any of three areas: clinical quality, program integrity, and electronic claims, as defined for each respective option period. Clinical quality will be measured on a regionwide basis using seven performance metrics that are similar to Healthcare Effectiveness Data and Information Set (HEDIS) "Effectiveness of Care" measures.

HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. To calculate the performance incentive, DoD will measure cervical cancer screening, breast cancer screening, use of asthma medication, colorectal cancer screening, diabetes management A1c testing, diabetes management lipid testing, and diabetes management retinal screening. These seven HEDIS-like measures will be calculated by DoD from administrative data using current technical specifications for all TRICARE Prime network-enrolled patients in the relevant region. For program integrity, DoD will evaluate the referral of fraud and abuse cases referred during each respective option period and determine whether the contractor satisfactorily met all minimum requirements contained in the *TRICARE Operations Manual*, Chapter 14.[14]

TMA also uses an award fee process in the T3 contracts. The award fee process is a subjective evaluation by DoD that rewards contractor performance that exceeds contract requirements. The fee is based on the results of DoD-designed and -performed Beneficiary, Commander, and Provider Satisfaction Surveys, which are conducted every six months. DoD also will assess the contractor's performance related to accessibility at all levels, responsiveness in resolving program problems and issues, support with data and information requirements, integration of contractor processes with the MTFs, contract management capability and performance, responsiveness to patient concerns and issues, and overall management cooperation and integrity. Other pertinent performance factors included under the contract, such as contract and subcontract management, were compliance with contract terms, conditions, clauses, and Contracting Officer directions; change order management; and general factors bearing on overall performance, and these may be considered as the facts and circumstances of each performance period may require.

Finally, the Task Force recommended that TMA make available to the beneficiaries the prices that TMA pays for procedures to providers in the health care program with which the agency, issuer, or plan contracts. On the TRICARE Transparency website, TRICARE Maximum Allowable Charges for the most frequently used procedures or services were posted within 24 hours of Executive Order issuance. These charges are the maximum amounts TRICARE is allowed to pay for each procedure or service and are tied by law to Medicare's allowable charges.

[14] See http://manuals.tricare.osd.mil/.

Table 6.1: Implementation Plan for Recommendation 6

Tasks	Requirements	Lead	Milestone
Identify interoperability standards for health information technology systems	Incorporate in contracts or agreements with health care providers	Deputy Director, TMA	Ongoing
Identify standard quality measures	Post quality measures on TRICARE website	Deputy Director, TMA	Ongoing
Make pricing available to beneficiaries	Post CHAMPUS Maximum Allowable Charge (CMAC) rate prices on TRICARE website	Deputy Director, TMA	Completed

Vision and Strategy for Recommendation 7

In early 2006, TMA executive leadership formulated a program structure to plan and implement T3. The Under Secretary of Defense for Personnel and Readiness is the Milestone Decision Authority, the Assistant Secretary of Defense for Health Affairs is the TRICARE Acquisition Executive, and the Deputy Director, TMA, is the Program Executive Officer. The T3 procurement was guided by a T3 Executive Council to develop policy and was centrally managed by the Chief, HPO, as the Program Manager. A Procurement Workgroup developed a Concept of Operations, which formed the basis for contract requirements.

TMA completed a thorough review of acquisition strategies during formal T3 Program Management Requirements Development IPT meetings that were chaired by the Program Manager and that resulted in formal decisions by the Program Executive Officer. A full analysis of carve-ins and carve-outs was conducted during the development of the Request for Proposals (RFPs). Requirements for the delivery of health care services have been debated by MHS senior leadership. The final set of requirements under which the current solicitation was opened was approved by the Assistant Secretary of Defense for Health Affairs and the Under Secretary of Defense for Personnel and Readiness. Necessary changes have been incorporated into the RFPs. Contractor proposals from the resulting solicitation were received on June 30, 2008, and source selection is now under way. If further changes are defined, they can be incorporated into the new contracts.

During TMA's thorough review, most requirements that are not commercial in nature have been determined to be necessary. The IPT determined that the contractor's role in health plan enrollment activity utilizing DEERS is proven and mutually beneficial. DoD implemented a web-based enrollment tool adding further efficiencies to the current process. In addition, analysis determined that waiving cost accounting standards was not in the best interest of DoD for T3 contracts.

Also, the T3 contracts require the contractor to operate a disease management (DM) program that meets national accreditation standards for DM and chronic care management. DM conditions will be asthma, congestive heart failure, diabetes, chronic obstructive pulmonary

disease, cancer, depression, and anxiety disorder. DoD will identify the population and risk stratify beneficiaries for inclusion in the contractor's DM program. The contractor will submit a DM program plan that demonstrates implementation of the DM intervention(s) that use the Department of Veterans Affairs/DoD clinical practice guidelines, when available.

Table 7.1: Implementation Plan for Recommendation 7

Tasks	Requirements	Lead	Milestone
Review acquisition strategies for T3 contracts	Incorporation of requirements in RFP completed	Deputy Director, TMA	Review of acquisition strategies is ongoing.

Recommendation 8
Improve Medical Readiness of the Reserve Component

Task Force Recommendation 8

DoD should improve medical readiness for the Reserve Component, recognizing that its readiness is a critical aspect of overall Total Force readiness.

Action Items

DoD should:

- *after three to five years, assess the impact of recent changes in TRICARE Reserve Select eligibility on readiness issues. This assessment should include examining the adequacy of the provider network to absorb the additional workload and to provide sufficient geographic coverage for the dispersed beneficiary population;*
- *improve information dissemination about the health benefit program to both the Service member and his/her family members, particularly at times not associated with mobilization/demobilization;*
- *harmonize and leverage the work of other review groups to streamline processes to promote better "hand offs" from the DoD to the Veterans Affairs health system, and reduce administrative "seams" in the Military Health System to ensure beneficiaries receive adequate service; and*
- *expand efforts to promote provider participation in the network in nonprime service areas to improve access.*

The Task Force noted that the roles and missions of the Reserve Component have changed dramatically when comparing the last 18 years with the preceding 44 years. During the latter period, reservists were called to Active Duty an average of less than once per decade. Since 1990, however, reservists have been mobilized an average of nearly once every three years. Such an operational tempo highlights the need to ensure that reservists are medically ready to serve and deploy.

DoD and the Services have undertaken several initiatives to enhance medical readiness:

- The Army implemented a First Term Dental Readiness initiative to address dental readiness during initial entry training.
- DoD established a policy that requires an annual dental exam for all Reserve Component members and approved the use of a standard dental screening form to be completed by a reservist's civilian dentist and to be used by DoD to assist in tracking the dental readiness of members.
- DoD developed a concept of operations and a cost estimate to provide Reserve Component medical element access to AHLTA (Armed Forces Health Longitudinal Technology Application).
- DoD established and enhanced TRICARE Reserve Select (TRS).

- DoD, in partnership with the Department of Health and Human Services, developed the Federal Strategic Health Alliance (Feds_HEAL) program, which was replaced by DoD's Reserve Health Readiness Program (RHRP).

The RHRP expanded beyond what the Task Force had reported about the Feds_HEAL program. There are now 45,000 points of service available to Reserve Component members so that they can receive required medical examinations (including laboratory work and vision and audiology screening), dental examinations, limited dental treatment, immunizations, and periodic health assessments. Results from these services are subsequently entered into the respective Service Component databases. All Reserve Components use the RHRP—approximately 90,000 Service members received more than 369,000 of these readiness-oriented services between January 1, 2008, and July 31, 2008.[1]

A slow but steady improvement has been evident in Reserve Component medical readiness. The Under Secretary of Defense for Personnel and Readiness medical readiness metrics showed that, between July 2006 and July 2008, the percentage of members who were deemed "medically ready" increased from 74 to 76 percent, and those with "unknown status" decreased from 35 to 29 percent. However, more work is required to improve Reserve Component medical readiness.

The Task Force recommended four action items to further increase Reserve Component medical readiness.

Action Item 8.1

The Task Force recommended:

> *DoD should, after three to five years, assess the impact of recent changes in TRICARE Reserve Select eligibility on readiness issues. This assessment should include examining the adequacy of the provider network to absorb the additional workload and to provide sufficient geographic coverage for the dispersed beneficiary population.*

Military Health System Senior Oversight Committee (MHS-SOC) Review and Comments

Accepted.

TRS is based, in part, on an underlying assumption that it will be effective in improving Individual Medical Readiness (IMR). Some evidence indicates that enrollment in insurance programs does not affect medical and dental readiness. For example, a 2002 study by the Uniformed Services University Tri-Service Center for Oral Health Studies showed no significant statistical difference in dental readiness among Service members with no insurance, TRICARE Dental Program (TDP) insurance, other insurance, and both TDP and other insurance.

Medical readiness is a shared responsibility among commanders, supervisors, the Military Health System (MHS), and the individual Service member. Although the MHS can establish programs

[1]Logistics Health Incorporated. August 7, 2008.

and benefits such as TRS, commanders cannot order Service members to enroll in TRS (pay premiums) or to use it (pay copays) in order to obtain the services that are necessary to improve readiness. Although TRS is premium based, a large portion of the cost is borne by the government. Further study is indicated to determine if this benefit to the Service member can be leveraged by the commander to improve IMR. One return on investment of this program that should be explored may be that it could be used as an incentive for recruitment and retention. In summary, an assessment of TRS should examine the underlying assumptions that it improves IMR and enhances retention and recruitment.

8.1 Overview

This action item contains two major components:

1. How does the change in TRS eligibility impact readiness?
2. How does the change in TRS eligibility affect provider workload and the dispersed population that uses TRS?

TRS eligibility criteria changed on October 1, 2007. Before that, the program, which began in Fiscal Year 2005, based eligibility on a three-tier enrollment system with different eligibility criteria, deadlines for enrollment, and fee schedules.[2]

The October 1, 2007, change eliminated the three tiers, which simplified the eligibility criteria and rules and the fee schedule. TRS has a monthly premium of $81 for a single member and $253 for a family, closely aligning with the Tier 1 level in the old TRS. Per the 2009 National Defense Authorization Act (NDAA), on January 1, 2009, the monthly premium for a single member was lowered to $49, and for a family, it is now $189.

TRS is intended to be similar to TRICARE Standard and TRICARE Extra. It provides coverage for emergency and urgent care, immunizations and health screenings, maternity care, behavioral health care, annual eye exams, and prescription drugs. TRS uses TRICARE-authorized providers and Military Treatment Facilities (MTFs) on a space-available basis.

8.1 Assessing the Effect of TRS on Medical Readiness

Medical readiness is measured by IMR metrics. IMR is, per DoD Directive 6200.04 and DoD Instruction 6025.19, a shared responsibility among commanders, supervisors, individual Service members, and the MHS. There are six key elements required for determining IMR:

1. no dental problems that will cause problems if a Service member is deployed;
2. current immunizations;
3. current laboratory tests;
4. current health assessments;
5. necessary medical equipment (e.g., gas mask inserts, medical warning tags); and
6. no deployment-limiting medical conditions (e.g., pregnancy, bipolar disorder).

[2] Task Force on the Future of Military Health Care. Final Report. December 2007, Appendix H.

The medical benefits available through TRS may also improve medical readiness through medical treatment for conditions that can be treated and reversed. The TRS medical benefits do not, however, have a one-to-one correlation with the key IMR elements—for example, predeployment Hepatitis B vaccination is an IMR requirement—but it would not ordinarily be something requested or authorized in TRS.

To examine the effect of TRS on medical readiness, a study will be conducted that will compare IMR statistics among three groups of reservists:

- those enrolled in TRS;
- those who have other health insurance; and
- those who have no insurance.

8.1 Assessing the Effect of TRS on Recruitment and Retention

Past studies have not indicated that providing medical care for a Service member or his or her family has been of major importance in terms of the retention or recruitment of Reserve Component members.[3] The November 2004 Status of Forces Survey of Reserve Component Members asked reservists about military and civilian health care. Reservists who had been activated in the past 24 months were asked to select from 17 programs or to identify the top 3 programs that would be the most important in their decision to continue participating in the Guard or Reserve. Health care was not among the top issues selected.

A roundtable discussion among federal agency, private sector, congressional, and beneficiary representatives convened by the U.S. Medicine Institute for Health Studies on May 24, 2004, in Washington, D.C., noted that 80 percent of reservists already had health care insurance. The other 20 percent were mostly young, healthy individuals who declined to spend money on health premiums and who would be unlikely to be swayed by a richer, premium-based federal health benefit.[4] These findings are consistent with a GAO study in 2002 that found that 80 percent of Reserve Component members had health care insurance and that the majority of those members continued their civilian health care insurance during mobilization.[5]

The Defense Manpower Data Center's (DMDC's) recent June 2007 Status of Forces Survey of Reserve Component members indicated that concerns about redeployment upon return, financial stability, problems for the spouse while being deployed, and readjustment to family life and work were all significantly more important to the Reserve Component member than health care coverage for the member and his or her family. These findings suggest that other concerns have more influence on the decision to continue or discontinue participation in the Reserve Component than the availability of health care coverage.

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[3] RAND and National Defense Research Institute Analysis prepared for the Under Secretary of Defense for Personnel and Readiness, 2005, and Status of Forces Survey, 2004.
[4] COL Gaye George, OASD Reserve Affairs. Personal communication. July 10, 2008.
[5] GAO. Defense Health Care: Most Reservists Have Civilian Health Coverage but More Assistance Is Needed When TRICARE Is Used. GAO-02-829. September 6, 2002.

DMDC conducts the Status of Forces Surveys of Reserve Component members biannually. The survey could include specific questions about the effect of TRS on a Service member's intention to remain in the Reserve Component as well as the effect it had on the decision to join initially. Because circumstances may have changed over the past several years, a future Status of Forces Survey will take another look at this issue. TRICARE Management Activity (TMA) also conducts beneficiary satisfaction surveys, which could include questions on retention.

8.1 TRS Workload and Participation and the Adequacy of the Number of Health Care Providers

One measure of TRS's effect is the proportion of eligible beneficiaries participating in the program. On May 31, 2008, 3.2 percent of the eligible population (26,821 of 836,256 Selected Reserve Component members) had signed up for TRS (compared to 19,081 on December 31, 2007, and 10,571 on September 30, 2007).[6]

When compared to the total TRICARE beneficiary population of more than nine million individuals, the additional TRS population resulting from the change in eligibility is very small and is not expected to require that providers be added to the TRICARE provider network. The geographic dispersion of Reserve Component members, however, requires an examination of whether there are adequate numbers of providers in nonprime areas. Nonprime services areas are identified as those that are not TRICARE Prime Service Areas (PSAs) and as geographical areas that are outside a 40-mile radius from an MTF or Base Realignment and Closure (BRAC) installation. PSAs also have been developed in some other areas by managed care support contractors.

Three TRICARE Regional Offices (TROs) provide reports, as required by law, that assess the adequacy of numbers of providers and their level of participation in TRICARE. DoD health care beneficiaries are surveyed to obtain their perspectives on the benefit and the care they receive. Health care providers are surveyed on their awareness and acceptance of TRICARE Standard. These surveys are conducted annually by the Health Programs Analysis and Evaluation Directorate, and the results are incorporated into an annual report to Congress. Useful feedback is derived from other sources, such as direct correspondence from beneficiaries, health benefits counselors, and coordinators. Managed care support contractors perform assessments of the adequacy of access.

Success in identifying and meeting any needs for additional providers is directly related to Action Item 8.4, "expand efforts to promote provider participation in the network in nonprime service areas to improve access."

8.1 Implementation Plans and Timelines

- The Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA), Force Health Protection and Readiness (FHP&R) will:

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[6] DMDC. July 11, 2008.

- brief the proposed study examining the effect of the TRS eligibility change to the Force Health Protection Council by four months after the response to the Task Force has been submitted to Congress;
    - write the Performance Work Statement for additional needed staff to conduct the study by six months after submission of the response to Congress, and bring the additional staff on by five months thereafter;
    - request needed information from DMDC to be received by 14 months after the response submission;
    - request IMR data on the three groups (TRS enrollees, those with other health insurance, and those with no insurance) from the Services to be received by 17 months after response submission; and
    - conduct an analysis and provide a report to the Deputy Secretary of Defense and subordinate project-affiliated offices—for example, Assistant Secretary of Defense for Reserve Affairs, Assistant Secretary of Defense for Health Affairs, and Under Secretary of Defense for Personnel and Readiness—by 24 months after response submission.
- Legislative or policy requirements: None.

TRS Effect on Recruitment and Retention

- The Office of the Assistant Secretary of Defense for Reserve Affairs (OASD/RA) will work with DMDC to include questions in the earliest Status of Forces Survey possible regarding the effect of TRS and medical care for the Reserve Component member and family on the decision to enter and intent to remain in the Reserve Component. OASD/RA will contact DMDC by three months after submission of the response to Congress regarding a set of questions on this topic and will settle on a final set of questions by four months.
- DMDC's report will be complete within one year of the survey and will be submitted to the Deputy Secretary of Defense and subordinate project-affiliated offices—for example, the Assistant Secretary of Defense for Reserve Affairs, the Assistant Secretary of Defense for Health Affairs, and the Assistant Secretary of Defense, Manpower and Reserve Affairs, for review and action.
- Legislative or policy requirements: None.

TRS Workload and Participation and the Adequacy of the Number of TRS Health Care Providers

- TMA will continue to send its mandated reports to Congress about the TROs' activities to monitor, oversee, and improve the access to TRICARE Standard. The report includes information from surveys of both beneficiaries and providers. The Fiscal Year 2008 report will be sent to Congress by April 30, 2009. Subsequent annual reports will be sent in similar timeframes.
- TMA will include in the next annual beneficiary survey questions regarding reasons for enrolling or not enrolling in TRS, whether the change in eligibility for TRS influenced an enrollment decision, and why Service members either dropped or failed to purchase TRS.

- TMA and its TROs will, on an ongoing basis, monitor the findings of the beneficiary and provider surveys and take appropriate actions to ensure the adequacy of the provider pool resulting from changes in beneficiary eligibility or benefit. Follow-up actions by TMA, the TROs, and managed care support contractors will be documented in the annual report to Congress noted above.
- TMA will, by six months after submission of the response to Congress, set internal trigger points in its feedback mechanisms (beneficiary surveys and complaints) that will lead to TRO efforts that will go beyond the norm to examine the adequacy of the provider pool in that particular area.
- Legislative or policy requirements: None.

Action Item 8.2

The Task Force recommended:

> *DoD should improve information dissemination about the health benefit program to both the Service member and his/her family members, particularly at times not associated with mobilization/ demobilization.*

MHS-SOC Review and Comments

Accepted.

To ensure the maximum utilization of TRS, information dissemination about the health benefit program is critical, because it will lead to effective program execution and meaningful evaluation and assessment of the program. It is important to identify best marketing practices to improve education.

8.2 Overview

The enrollment rate of TRS is relatively low, as noted above (only slightly more than 3 percent). One reason for this may be inadequate marketing. To maximize enrollment, however, other reasons for nonenrollment must be examined. These other reasons may include:

- enrollment barriers, such as complexity or timing in the deployment cycle;
- cost; and
- comfort with current other health insurance coverage, due to factors such as perceived accessibility and availability of providers, related administrative requirements, and quality of care.

The first section addressing this action item will cover the current methods of information dissemination and the measurement of the effectiveness of those methods. The second section will address previous studies of why TRS enrollment is so low. A final portion will address an implementation plan to use "best practices" to disseminate information to both the Service member and his or her family and to maintain continued awareness of and develop responses to reasons for nonenrollment.

8.2 Dissemination of Information About the Health Care Benefit Program

TMA's Communications and Customer Service Directorate (C&CS) conducted a TRICARE Standard outreach campaign to TRICARE beneficiaries during Fiscal Year 2007 and Fiscal Year 2008.

- TMA mailed letters to all Reserve Component members enrolled in the Fiscal Year 2006 three-tiered TRS health care program. The letter explained the qualification requirements and procedures needed to migrate to the Enhanced TRS. TMA has used the Reserve Component members' Leave and Earnings Statements to educate members about TRS and other TRICARE programs.
- The C&CS TRICARE Beneficiary Publications Division wrote and produced approximately 200,000 Standard Handbooks that were distributed to managed care support contractors, who provided them to TRICARE Standard beneficiaries upon request. Downloads of the Standard Handbook from the C&CS SMART website totaled approximately 12,000. Since the launch of the MHS's user-friendly "My Benefit" web portal in July 2007, the Standard Handbook web page was accessed approximately 35,000 times through September 2007.
- In February 2007, the Publications Division sent out its annual TRICARE Standard newsletter via direct mail to more than 1.4 million TRICARE Standard beneficiaries. "Health Matters" is a 12-page color newsletter with information on eligibility; the savings that can be obtained by using TRICARE Extra in the network; cancer prevention and screening; what to do if a Service member would soon be leaving TRICARE Standard for TRICARE for Life; how to contact the program; how to find the Standard Handbook and get e-mail updates; how to get care; TRICARE Standard survey results; how to use the TRICARE pharmacy benefit; the deductible and catastrophic caps; how other health insurance interfaces with TRICARE; and dental benefits.
- The C&CS Public Affairs Division produced more than 30 news releases targeting TRICARE Standard beneficiaries, including one to promote the new Standard Handbook. Additional news release topics covered the mail-order pharmacy benefit and other pharmacy initiatives, the TRS benefit, the improved TRICARE website, the availability of TRICARE Standard information, and various health and benefit feature topics.
- C&CS coordinated monthly meetings with the TRICARE Beneficiary Panel, comprising members of the Military Coalition and Alliance, which has the mission of advocating for its members' health care priorities.
- The TRICARE.mil website has been redesigned to make it easier for beneficiaries, including those among the Reserve Component community, to find information targeted specifically to them. Monthly online surveys of the website's users indicate that customer satisfaction is growing. Recently added to the website is the GovDelivery listserv, which allows beneficiaries to sign up for new information about benefit changes that may be of interest.
- OASD/HA and TMA have recently started to use videos, podcasts, blogs, online radio, and websites, such as Facebook, YouTube, and others, to reach those who cannot be reached through traditional outreach efforts. In May 2008, C&CS launched a weekly BlogTalkRadio program entitled "DotMilDoc," which periodically features information about TRICARE benefits. Other social media programs include monitoring social

websites for comments and questions from TRICARE beneficiaries and engaging with beneficiaries in order to guide them to the TRICARE resources that may be of the most interest to them.
- C&CS also manages toll-free telephone numbers, including 1-800-TRICARE, which allow beneficiaries to obtain general information about the TRICARE benefit and provides the toll-free telephone numbers of contractors that can answer specific issues and address specific concerns.

TMA also has worked with the Reserve Component to increase awareness. Service input and collaboration is important to facilitate consistent and effective information dissemination. Each TRO and its respective managed care support contractor conduct their own regional outreach and educational programs.

- TMA held TRS conferences in 2006 and 2007 for the Reserve Component personnel community, as well as TRICARE and MHS customer service staff, to educate them about the TRS health plan. Approximately 500 personnel attended each year. C&CS also hosts an annual customer service training conference, during which Reserve Component unit representatives and family support staff are invited and their issues are addressed. Reserve Component issues also have been addressed at the annual MHS conference held each winter in the Washington D.C., area, with approximately 3,000 attendees from DoD and the Service Component medical headquarters and field activities. C&CS also attends the annual National Guard and Reserve Public Affairs Conference and provides information and products to these key Reserve Component communicators.
- TRO-South and its managed care support contractor conducted outreach visits with the majority of National Guard Adjutants General in the South, Naval Reserve Forces Command, Army Reserve Command, and Marine Forces Reserve Command to provide Reserve Component leadership with information on health care issues.
- In calendar year 2007, the South managed care support contractor provided 311 TRICARE briefings to Reserve and National Guard units. From January to May 2008, it conducted 224 TRICARE program briefings attended by 31,348 Reserve Component Service members and their families. Also, during this same time, the managed care support contractor attended 16 family day activities and 16 officer and enlisted conferences.
- TRO South held the first TRICARE Region South Guard/Reserve Leadership Advisory Committee meeting. All 10 Adjutants General either attended or were represented by members of their staffs. The Army, Navy, Marine, and Air Force Reserve leadership also participated. Agenda items included TRICARE program updates, access standards, provider issues, and educational opportunities. A second meeting was held in September 2008.
- TRO North enhanced its Reserve and National Guard Briefing program through the use of a web-based request form that would allow all units to have one central place to request briefings. There were 546 Reserve and National Guard briefings held over the 12 months before June 2008, and a total of 56,784 Reserve and Guard Service members and family members were briefed.

- The North managed care support contractor has established Field Operations Teams in the four subregions and has been conducting follow-up meetings with the Guard and Reserve senior leadership and their key staff.
- The West managed care support contractor has briefed more than 1 million TRICARE beneficiaries since June 2004, including more than 215,000 Reserve Component members. As of June 2008, the managed care support contractor had held an average of 154 Reserve Component briefings, reaching 7,615 Reserve Component beneficiaries monthly.
- The West managed care support contractor places full-page, color educational advertisements in Reserve and National Guard, Reserve Officer, Military Officer, and Military Spouse magazines monthly. It also writes and distributes 2 articles each month that are distributed to nearly 70 base, post, and National Guard and Reserve Component newspapers, newsletters, and websites.

8.2 Effectiveness of Dissemination Methods

The results of C&CS surveys for 2005 reveal that 96 percent of Reserve Component beneficiaries were aware of TRICARE toll-free telephone numbers, 96 percent were aware of printed materials, 93 percent were aware of the availability of beneficiary advisors, and 93 percent were aware of TRICARE Internet sites. Furthermore, 88 percent of Reserve Component beneficiaries had looked for TRICARE information in the previous 12 months, and the top 3 sources used were TRICARE Internet sites (64 percent), TRICARE printed materials (62 percent), and TRICARE toll-free telephone numbers (57 percent). Although TRICARE Internet sites were cited as the primary source of information for Reserve Component beneficiaries, the most preferred method for receiving answers was by telephone (30 percent). The second most preferred method was face-to-face communication (27 percent), followed by Internet sites (21 percent). The least preferred method for receiving answers was by mail (45 percent).

DMDC, as part of its Human Resources Strategic Assessment Program, conducted surveys from November 21, 2005, through June 1, 2006, of Reserve Component spouses regarding their perceptions of deployment support practices. The relevant findings were that the spouses valued newsletters and packets of information as well as informational phone calls. They requested more information on managing their insurance options before deployment and viewed the Internet as a good medium for obtaining information.[7]

Measuring the effectiveness of the various methods of health benefit program information dissemination has traditionally focused on enrollment rates and research, but not on marketing best practices. The annual TMA-sponsored beneficiary surveys mentioned above have not addressed evaluations of the benefit information. Contracts for those surveys for Fiscal Year 2009 have been let and do not include that focus. Efforts to derive best marketing practices can, however, be made after the award to the new TRICARE managed care support contractors is made and the transition to the new contract is complete.

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[7] DMDC Survey Note No. 2008-010. May 30, 2008.

Similarly, the biannual Status of Forces Surveys have not addressed evaluations of the efficacy of various dissemination methods. Health care typically is a focus of surveys completed in the fall of even years, but DMDC does ensure there is space on all surveys for additional items of interest. Therefore, questions on this topic could be added to the Status of Forces Survey slated for spring 2009.

8.2 Reasons for Low Enrollment in TRS

Information about why potential beneficiaries fail to enroll in TRS or why they disenroll from TRS can be found in surveys such as the TMA annual beneficiary survey and the DMDC biannual Status of Forces Survey.

Findings presented at the June 2008 Academy Health Annual Research Meeting in Washington, D.C., indicated that in the old program, the highest enrollment rates were for those individuals who had previously higher inpatient, outpatient, and pharmacy costs, as well as for those with previously diagnosed chronic conditions and larger families; thus, there was some evidence of adverse selection. There is insufficient history and data to determine if the change in TRS eligibility has modified any of those findings.

The Status of Forces Survey of Reserve Component members for which data were collected from November 20, 2006, to January 11, 2007 (before changes in TRS eligibility), addressed some Reserve Component member perceptions of TRICARE as they relate to family members. Approximately 80 percent of respondents had family members currently enrolled in a civilian health care plan. Of those with family members who had TRICARE benefits but who did not use them in the preceding 24 months, the most common reason for not using TRICARE was "preferred to use civilian health care plan," as noted by 58 percent of respondents. The next most frequently reported items were "comfort/familiarity with doctor outside of TRICARE" (40 percent), "no need for medical care" (38 percent), and "complexity of TRICARE process" (38 percent).

When comparing dependents' TRICARE medical coverage with the coverage available in the private sector, the most common response was "no difference." There were several items for which at least 15 percent of the respondents perceived civilian plans to be better than TRICARE. Those items included the availability of providers (47 percent rated this as "much better" or "better" in civilian plans versus 13 percent as "much better" or "better" in TRICARE), administrative requirements (39 percent "better" in civilian plans versus 17 percent in TRICARE), understanding the benefits (37 percent "better" in civilian plans versus 21 percent in TRICARE), and obtaining assistance when questions or problems arise (37 percent "better" in civilian plans versus 21 percent in TRICARE). None of these relate to the perceptions of overall medical coverage, which were essentially the same (24 percent viewed the civilian plans as "better" or "much better"; 27 percent viewed TRICARE as "better" or "much better").

The reason codes for termination/disenrollment from TRS are general—for example, "personnel action" (such as going from Selected Reserve to Individual Ready Reserve), voluntary disenrollment by sponsor, obtaining other health coverage, failure to pay enrollment fees/premium, and dissatisfied with the program. Before the TRS eligibility criteria changed, the primary disenrollment codes were return to Active Duty (27 percent), failure to pay premium (26

percent), voluntary disenrollment by sponsor (18 percent), and loss of eligibility (16 percent). All other termination codes were reported less than 10 percent of the time. Since the change in TRS eligibility criteria, the three termination codes at or above 10 percent have been failure to pay premium (39 percent), return to Active Duty (36 percent), and loss of eligibility (10 percent).

These data suggest that people are unlikely to move from one health care plan that they are comfortable with and see as easily accessible to one they are unfamiliar with and do not understand as well, unless they believe they will see a significant savings. The increase in TRS disenrollment because of failure to pay the premium requires additional study.

8.2 Implementation Plans and Timelines

- TMA will meet with the three new managed care support contractors by six months after contract award to extract best practices in the marketing of health benefit programs.
    - The findings of these meetings will be disseminated to the TROs and managed care support contractors by nine months after contract award in order to share information on best practices.
    - The findings of these meetings and subsequent activities also will be included in TMA's Fiscal Year 2010 report and subsequent annual reports to Congress regarding TRO activities in monitoring, overseeing, and improving the TRICARE Standard activities.
- TMA will lead a joint effort with OASD/RA and the Reserve Components to examine the TRICARE health benefit information dissemination at various stages of the deployment cycle in order to determine where improvements can be made to make dissemination more effective. Findings will be provided and recommendations made to the Senior Military Medical Advisory Council by six months after submission of the response to Congress.
- TMA will include items regarding the effectiveness of its information and the information dissemination practices in beneficiary surveys to be completed in Fiscal Year 2010.The surveys will focus on the dissemination of information at key transition points in the Reserve Component deployment cycle. TMA will evaluate the findings of those surveys, and by December 31, 2010, it will determine any necessary modifications to the information provided and its dissemination.
- TMA will monitor the results of the disenrollment codes every six months for the two years following submission of the response to Congress to determine if there are any trends indicating a need for action.
- TMA Program and Policy Operations will review the results from the annual TRICARE beneficiary studies within 90 days of their publication to determine if there are indications for action on its part or legislatively.
- TMA Program and Policy Operations will review the results from the Status of Forces Surveys within 90 days of their publication to determine if there are indications for action on its part or legislatively.
- In preparing future surveys of eligible beneficiaries, TMA and OASD/RA will coordinate to achieve coverage of key items of interest while avoiding redundancy. TMA and OASD/RA also will directly share their findings with each other, starting immediately.

- Legislative or policy requirements: Only if TMA finds that legislative action is required to implement needed changes in TRICARE benefits. No legislative or policy requirements will be needed regarding the improvement of health benefit program information.

Action Item 8.3

The Task Force recommended:

> *Harmonize and leverage the work of other review groups to streamline processes to promote better "hand offs" from the DoD to the Veterans Affairs (VA) health system, and reduce administrative "seams" in the Military Health System to ensure beneficiaries receive adequate service.*

MHS-SOC Review and Comments

Accepted.

Multiple task forces/study groups have identified opportunities for improvements at care transition points—MTF-to-MTF, MTF-to-Department of Veteran Affairs (VA)/Network Provider, MTF-to-outpatient care, and outpatient care-to-reintegration/retirement. No further evaluation is required, and work should continue within the current Overarching Integrated Product Team (OIPT) of the DoD/VA Senior Oversight Committee as well as the DoD/VA Strategic Plan developed and monitored by the Joint Executive Council of VA and DoD.

8.3 Overview

The Task Force noted that a number of recent task forces, working groups, and commissions have examined the "hand offs" between the DoD and VA health systems and across the administrative seams in the MHS. Major efforts have included the following:

- Task Force on Returning Global War on Terror Heroes[8];
- Inspectors General DoD and VA Care Transition Process for Service Members Injured in Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF)[9];
- DoD Task Force on Mental Health[10];
- President's Commission on Care for America's Returning Wounded Warriors;[11] and
- Scott/Veterans Disability Benefits Commission.[12]

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[8] See www1.va.gov/taskforce/page.cfm?pg=4.

[9] See www.dodig.osd.mil/IGInformation/IGInformationReleases/DoD%20VA%20Care%20Transition%20Process%20Service%20Members%20Injured%20OIF%20OEF%20508%20tagged%20version.pdf.

[10] Department of Defense Task Force on Mental Health. An Achievable Vision: Report of the Department of Defense Task Force on Mental Health. Falls Church, VA: Defense Health Board. 2007.

[11] The President's Commission on Care for America's Returning Wounded Warriors. Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors. July 2007. Subcommittee Reports and Survey Findings.

Each group provided recommendations, in addition to those initiatives included in the 2008 NDAA. In total, more than 500 task force/commission/NDAA initiatives and recommendations were offered.

As with the other action items, there first will be a discussion of what already has been done to accomplish this specific action item, followed by an implementation plan that moves the action item forward.

8.3 Integration of and Action on Task Force/Commission/NDAA Recommendations and Requirements

The Joint Executive Council (JEC) of VA and DoD has been in existence since 2002, when it was established to engage senior leadership in coordination and resource sharing between the two departments. The JEC is co-chaired by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense for Personnel and Readiness. It submits annual reports to Congress and the Secretaries of Defense and Veterans Affairs as required by Public Laws 97-174 and 108-136. In July 2006, the JEC approved a proposal to establish a VA/DoD Joint Coordinated Transition Work Group to achieve a more integrated approach to a coordinated transition to the VA health care system for injured and ill Service members and their families.

On May 8, 2007, however, the DoD/VA SOC was created to serve as the single point of contact for the oversight, strategy, and integration of efforts designed to improve support throughout an injured Service member's recovery and rehabilitation. At that juncture, the JEC's Joint Coordinated Transition Work Group was put on hold and the SOC and its OIPT took the overall lead in addressing the Task Force recommendations. The SOC is co-chaired by the Deputy Secretary of Defense and the Deputy Secretary of VA. The OIPT is co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and VA Under Secretary for Benefits.

In examining the previously mentioned recommendations and initiatives, the DoD/VA SOC determined that eight Lines of Action (LOAs) needed to be established to address those recommendations/initiatives and create a seamless continuum that is efficient and effective in meeting the needs of Service members and their families. Significant progress has been accomplished in each of these LOAs. Examples of their efforts include:

- The Office of the Secretary of Defense (OSD) implemented a Disability Evaluation System pilot (beginning in November 2007 and extending to June 2009), featuring a single physical exam and a single disability rating by VA. Each was designed to eliminate the often confusing elements of the two current disability processes and reduce by half the time required to transition a Service member to veteran status. This effort was a result of the NDAA 2008, Section 1644.
- LOA 2 (traumatic brain injury [TBI]/post-traumatic stress disorder [PTSD]), led by OASD/HA FHP&R and VA, established the Defense Centers of Excellence for

[12] Veterans Disability Commission. Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century. October 2007. See www.vetscommission.org/reports.asp.

Psychological Health and Traumatic Brain Injury to facilitate coordination and collaboration for psychological health and TBI-related services among the military Services and VA. The ground breaking of the National Intrepid Center of Excellence occurred in June 2008. The anticipated opening will be fall 2009. This initiative was in response to the NDAA 2008, Section 1621.

- LOA 2 representatives and the Defense Centers of Excellence collaborated with the Department of Labor to increase employer awareness of TBI and PTSD.
- Under LOA 2 and in response to the Task Force on Mental Health (established by the NDAA 2006, Section 723) concerns about continuity of mental health care while Service members are transitioning between health care systems or providers, OASD/HA FHP&R is readying an RFP for a Transitional Support Program. The RFP should be released early in 2009, with the goal of bridging such potential gaps in services by proactively coaching, offering information, providing patient support and education, and otherwise encouraging the utilization of behavioral health services.
- On August 1, 2008, following recommendations from the Mental Health Task Force, Section 5.2.2.6, VA established a policy to allow 24-hour triage and 14-day appointment access for OIF/OEF veterans and those with mental health concerns.
- LOA 3 (Case/Care Management) implemented a Dole/Shalala President's Commission on Care for America's Returning Wounded Warriors 2007 recommendation. The Federal Recovery Coordination Program (FRCP) and its Federal Recovery Coordinators (FRCs) was established to supplement newly deployed Service case/care management teams across the continuum of care. The FRCs advocate for the wounded, injured, or ill Service member with high-severity wounds, injuries, illnesses, high-risk wounds, injuries, illnesses, and/or the potential for long-term care needs. They also advocate for families regarding all clinical and nonclinical aspects of recovery, while participating in the development of the Federal Individual Recovery Plan (FIRP).
- Representatives from LOA 3 developed the prototype automated FIRP to complement the FRCP. The FIRP is created using input from the Service member or veteran's multidisciplinary health care team, the Service member or veteran, and his or her family or caregiver. The plan tracks care, management, and transition through recovery, rehabilitation, and reintegration. For each of these care phases, goals are identified, responsibilities are assigned, and timelines are created. The FRCs work with existing resources to include DoD and VA personnel, as well as other federal, state, and private entities, to implement the plan.
- Representatives from LOA 4 (Data Sharing) made DoD theater clinical data available to both DoD and VA providers. This action was completed in October 2007 and sprang from a Bi-directional Health Information Exchange (BHIE) requirement in the Independent Review Group Report of 2007. Although not specifically called for, theater data were added to the requirements for BHIE development.
- Representatives from LOA 4 completed plans for the eBenefits Web Portal to support the needs of the wounded, ill, or injured in August 2007. Although the portal already exists, it is being further refined before its expected public rollout by the end of calendar year 2008. This portal was recommended by the President's Commission on Care for America's Returning Wounded Warriors 2007.
- Representatives from LOA 5 (Facilities) established inspection standards for the housing of military personnel receiving medical care at MTFs before their release to their home

stations. Service representatives completed inspection of all 475 associated MTFs. The following documents outline the legislation for MTFs: inspection standards NDAA 2008, Section 1648; facilities inspections NDAA 2008, Section 1662; and the Army Medical Action Plan (Walter Reed Army Medical Center deficiencies) NDAA 2008, Section 1649.

- To implement the Dole/Shalala report recommendations, the Secretaries of Defense and Veterans Affairs signed and submitted a legislative proposal titled "America's Wounded Warriors Act" to the Senate on October 16, 2007. The proposal was subsequently sponsored by Senator Burr (S. 2674) and Congressman Buyer (H.R. 5509). The bills were referred to committee.
- OASD/HA standardized and reduced the premium for TRS. This was self-initiated by DoD and was recommended in the Dole/Shalala report after the fact. The standardization and reduction of TRS premiums became effective as of October 2007. Information about TRS is located on the TRICARE website under the Reserve and Guard tab.
- Representatives of LOA 8 (Pay, Personnel, and Benefits) secured legislation (NDAA 2008, Section 1633) for a respite care benefit for Service members. On August 20, 2008, Dr. Casscells, Assistant Secretary of Defense for Health Affairs, signed a memorandum implementing this benefit.
- Representatives of LOA 8 secured legislation for continuation of certain specialty pays that increased the availability of needed health care providers. Dr. Chu, the Under Secretary of Defense for Personnel and Readiness, signed a Directive Type Memo in May 2008 to authorize this benefit.
- Stemming from the NDAA 2008, Section 1616, DoD's Military and Community and Family Policy established a Wounded Warrior Resource Center (WWRC) to provide Wounded Warriors, their families, and their primary caregivers with a single point of contact. Military OneSource has a 24/7 toll-free number that is used for all incoming inquiries and that triages Wounded Warrior-specific calls to the WWRC. The WWRC number is manned from 8 am to 9 pm, Monday through Saturday, and callers can leave messages after hours. The Military OneSource website is the portal to the WWRC web page.
- VA initiated a national program to screen all OIF/OEF veterans for TBI, PTSD, and psychological health at their first clinic visit. This is a Veterans Health Administration Directive, 2007-2013, expiring April 30, 2012.
- The DoD/VA SOC leadership and OIPT staff provided oversight for the Services' expansion of their Wounded Warrior programs in response to the many reports and legislative actions cited earlier.

Although the SOC has made fundamental changes in integrating the VA and DoD approaches to addressing psychological health and TBI, and care and support for outpatients, a number of challenges remain:

- A firm plan for the hand off of responsibilities needs to be established.
- Metrics and a "sensor suite" need to be created to ensure that the new systems are operating as intended.

- Challenges in communication with the geographically dispersed Reserve Component members who are not seen daily—as their Active Component counterparts are—need to be addressed.
- Actions necessary for the sharing of medical information between DoD (including its Reserve Component) and VA need to be completed.
- The changing approach to psychological health and customer care needs to be emphasized.
- Agreements on DoD/VA roles and responsibilities as outlined in the Dole/Shalala report need to be completed.

8.3 Implementation Plans and Timelines

- The JEC and SOC are integrating the SOC/LOA efforts into a structure under the auspices of the JEC. Decisions on that structure have been reached, enabling it to be incorporated into the VA/DoD Joint Strategic Plan for Fiscal Years 2009-2011. The plan was signed by the JEC on January 8, 2009.
- Between now and December 31, 2009, the SOC, the OIPT, full-time staff and personnel dedicated to the SOC, and the LOA working groups will continue to focus on a smooth transition to and integration with the JEC. They also will continue their work on accomplishing the remaining unfinished recommendations and will report on their progress to Congress as requested.
- After January 1, 2010, the JEC will drive further action on the unfinished fulfillment of recommendations and report to Congress as requested and will also do so in the required annual report.
- Legislative or policy requirements: The SOC and JEC will propose legislative action as needed to implement recommendations, just as the SOC has done in the past.

Action Item 8.4

The Task Force recommended:

> *Expand efforts to promote provider participation in the network in nonprime service areas to improve access.*

MHS-SOC Review and Comments

Accepted.

Access to MHS health care in nonprime service areas can be a challenge. To be truly accessible, health care should be local, timely, and affordable. A large percentage of Reserve Component members live in remote areas where the availability of providers is perceived to be low, and others are in areas where providers demand payment up front. These factors are often cited as reasons for low participation in TRS. Priority needs to be given to identifying the scope and demographics of the population in nonprime areas and to expanding capabilities in those areas.

8.4 Overview

Accessibility to providers is key to beneficiaries enrolling in and being satisfied with any health care program, TRICARE included. Reservists, much more than Active Duty members, live and work in areas that are outside prime service areas (PSAs), where the number of providers may preclude access. The following section discusses how nonprime service areas are defined and the overall populations of beneficiaries and providers in prime and nonprime service areas. Current TMA activities to increase provider participation in nonprime service areas are addressed, and provider perspectives about TRICARE are examined. Finally, implementation plans for future efforts to promote provider participation in nonprime service areas are addressed.

8.4 Defining Nonprime Service Areas

Nonprime service areas are geographical areas (Zip Codes) more than 40 miles from an MTF or BRAC installation. Although TRICARE Prime is offered only inside the PSAs, TRICARE Standard is available to beneficiaries both inside and outside the PSAs. As such, there is no true "network" of providers outside the PSAs.

8.4 Beneficiary and Provider Population Inside Prime and Standard Service Areas

The overall TRICARE beneficiary population is distributed, with 91 percent inside a PSA and 9 percent inside a nonprime service area. Because there is no true network of providers outside the PSAs, the best estimate of number of providers outside the PSAs that are willing to see TRICARE patients can be determined by examining the number of individual providers that have submitted a claim over a certain period. For the three months ending on March 30, 2008, 2.91 providers inside the PSAs were submitting claims for every 1 provider outside the PSAs, and 5.74 beneficiary visits inside the PSAs for every 1 visit outside the PSAs. Similar ratios of hospitals and hospitalizations exist—2.61 hospitals inside the PSAs to 1 outside the PSAs, and 5.91 hospitalizations inside the PSAs to 1 outside the PSAs.

8.4 Actions to Promote Provider Participation in the Standard Option

During Fiscal Year 2008, FHP&R began the process of instituting the Transitional Support Program to coach and educate both Active Duty and Reserve Component members with behavioral health problems as they move from one health care system to another—for example, from an MTF provider to TRICARE or to VA and back again. A transitional support facilitator (TSF) provides patient education, expert information, and support group information until the Service member has completed the transition to a new provider. During that transition, the TSF also would provide advice about the types of clinicians available and direction in obtaining assistance and resources in the immediate area, whether it be a PSA or a nonprime service area.

The NDAA 2006, Section 716, outlines the responsibilities of the TRO, including identifying health care providers who will participate in TRICARE and provide the TRICARE Standard option, communicating with beneficiaries who receive TRICARE Standard, conducting outreach to community providers to encourage participation in the TRICARE program, and publishing information that identifies health care providers that provide TRICARE Standard. Each TRO

has employed a full-time health system specialist to monitor, oversee, and improve the provision of TRICARE Standard. Examples of TRO actions during Fiscal Year 2007 to promote provider participation include:

- TRO North incorporated TRICARE Standard monitoring and improvement requirements in its formal business plan. The execution of those TRICARE Standard elements in the business plan resulted in identifying the locations and beneficiary categories of beneficiaries in remote areas of the North Region. Seventy-seven cities in this category with populations of more than 1,000 Standard-eligible beneficiaries were identified and targeted for potential provider awareness and/or beneficiary information outreach efforts.
- TRO North developed a TRICARE Standard Communications Plan focused on reaching out to providers in areas where TRICARE Prime is not available. The plan was designed to increase providers' knowledge of TRICARE and refer them to the managed care support contractor to become TRICARE-authorized providers.
- The managed care support contractor in the South Region went beyond the contractual requirements (e.g., identifying PSAs by proximity to an MTF or BRAC installation) and determined that the entire region would be a PSA. TRO South monitored compliance of the South Region managed care support contractor with its commitment to establish provider networks for the delivery of Prime and Extra (Standard members using the Prime providers) services throughout 100 percent of the South Region. More than 73,000 providers, almost one-third of the total providers in the South Region, are in the network, enhancing access to care for TRICARE Standard beneficiaries who wish to use the Extra option. This was an increase of 9,742 network providers and 127 hospitals/facilities when compared to the prior year.
- TRO South monitored its managed care support contractor as it conducted non-network (TRICARE Standard) provider and network provider seminars in the South Region PSAs. The managed care support contractor conducted 250 provider seminars, of which 72 were targeted to non-network providers. At the seminars, the managed care support contractor provided marketing materials to TRICARE Standard providers.
- The TRO West managed care support contractor published an electronic newsletter every 2 to 3 weeks and distributed it to more than 40,000 providers. The newsletters contained numerous topics applicable to provision of the TRICARE Standard benefit.
- Both the Assistant Secretary of Defense for Health Affairs and the Deputy Director for TMA have encouraged providers to support TRICARE and Service members. The Deputy Director for TMA signed hundreds of letters to governors, the Adjutants General, state medical officers, the American and state medical associations, and other medical professionals and associations, asking them to urge providers to accept TRICARE patients.

8.4 Provider Perspectives on TRICARE

DoD conducts surveys in TRICARE market areas to assess the willingness of civilian health care providers to accept TRICARE Standard beneficiaries as new patients. In Fiscal Year 2007, TMA completed the third year of an Office of Management and Budget-approved 3-year survey of civilian physicians and administered the required survey in 10 statewide market areas, supplemented with random samples of physicians in 53 hospital service areas (HSAs), including

Washington, D.C. The TROs and TRICARE beneficiary organizations selected the majority of the HSAs to be sampled from the survey. The survey revealed that of those responding, 91 percent of physicians surveyed in HSAs and states were aware of the TRICARE health plan, 96 percent accepted new patients, and 83 percent of those accepting any new patients accepted new TRICARE Standard patients. Results varied by HSA and state. Awareness of the TRICARE health program among the survey sites ranged from 76 percent to 100 percent. From 87 to 100 percent of the physicians were taking new patients, and, of those, between 37 and 100 percent were accepting TRICARE Standard patients, again depending on the location.

The 2007 survey supplemented surveys conducted within the other 40 states during the previous 2 years. Results totaled over the three years indicate that there appears to be a high level of physician awareness, with approximately 90 percent of physicians reporting awareness of the TRICARE program in general. Approximately 80 percent of physicians accepted new TRICARE Standard patients if they accepted any new patients at all. Of the remaining 20 percent who did not accept new TRICARE Standard patients, the most commonly cited reason was "reimbursement," as reflected in one-fourth of all comments received.

8.4 Implementation Plans and Timelines

- TMA Program and Policy Operations will review the results from the annual TRICARE beneficiary studies within 90 days of their publication to determine if there are indications for action on its part or legislatively regarding provider participation and the program as a whole.
- TMA Program and Policy Operations will review the results from the Status of Forces Surveys within 90 days of their publication to determine if there are indications for action on its part or legislatively regarding provider participation and the program as a whole.
- TMA Program and Policy Operations will evaluate the activities in each of its TROs regarding their monitoring, oversight, and improving Standard access by November 15 of each year and will disseminate their findings and best practices to all the TROs by December 31 of each year. Emphasis on implementing these best practices when appropriate will continue in TMA communications to the TROs.
- The TMA Health Program Analysis and Evaluation Division will begin another series of surveys addressing provider awareness and willingness to accept new TRICARE Standard patients in Fiscal Year 2010. The results of these surveys will help focus initiatives to drive increased provider participation.
- FHP&R will publish an RFP for the Transitional Support Program by November 30, 2009, and will make a source selection by March 30, 2010.
- Legislative or policy requirements: Only if TMA finds that legislative action is required to implement needed changes in activities of the TROs.

Recommendation 9
The DoD Pharmacy Program

Task Force Recommendation 9

Congress and DoD should revise the pharmacy tier and copayment structures based on clinical and cost-effectiveness standards to promote greater incentive to use preferred medications and cost-effective points of service (see Table).

Table: Proposed Pharmacy Copayment Structure

	DoD Current		**Task Force Recommendation**	
	Retail Network 30 Days	Mail 90 Days	Retail Network 30 Days	Mail 90 Days
Tier 1: Preferred[1]	\$3 (~\$36/year)	\$3 (~\$12/year)	\$15 (~\$180/year)	\$0 (~\$0/year)
Tier 2: Other	\$9 (~\$108/year)	\$9 (~\$36/year)	\$25 (~\$300/year)	\$15 (~\$60/year)
Tier 3: Nonformulary Brand	\$22 (~\$264/year)	\$22 (~\$88/year)	\$45 (~\$540/year)	\$45 (~\$180/year)

Action Items

- *The tier structure should be as follows:*
    - *Tier 1: Preferred—preferred medications, to include selected OTCs, cost-effective brand products, generics.*
    - *Tier 2: Other formulary medications.*
    - *Tier 3: Nonformulary medications.*
    - *Tier 4: Special Category Medications—very expensive, specialty, and/or biotechnology drugs with a mandated point of service. The DoD PEC would specify the tier for establishing the copayment and point of service for the most cost-effective delivery for the special medication.*

Copayments for Tier 1 and 2 drugs only should be applied against the catastrophic cap in order to drive beneficiary behavior toward the most cost-effective medications. For example, the copayment for a Tier 2 drug using the retail point of service would result in yearly copayments totaling \$300, which can be used against the catastrophic cap.

[1] The Task Force recommended "preferred," because Tier 1 then could include select over-the-counter and some brand names.

- *Congress should:*
  - *Grant authority to DoD to selectively include OTC medications in the formulary based on clinical effectiveness and cost-effectiveness as evaluated and recommended by the Pharmacoeconomic Center (PEC).*
  - *Grant authority to DoD to mandate the point of service for certain carefully selected medications (Special Category Medications) based on prior established criteria that take into consideration high clinical risk, short supply, or extreme cost, as recommended by the PEC.*

- *DoD should conduct a pilot program integrating the Pharmacy Benefit Management function within the managed care support contract in one of the three service regions to assess and evaluate the impact on total spend and outcomes. This pilot should test and evaluate alternative approaches, successfully implemented in the private sector, that would seek to reduce the total health care spend; increase mail order use; better integrate pharmacy programs and clinical care; and maintain or improve beneficiary satisfaction. The goal of such a pilot program would be to achieve better total financial and health outcomes in the MHS as a result of an integrated pharmacy service. The overall results in total costs and health outcomes in this one region should eventually be compared with those in the other regions to determine the best approach for the MHS in terms of total spend and outcomes.*

Overview

DoD, through TRICARE, provides a pharmacy benefit to all eligible Uniformed Services members, their family members, and all retirees and their family members, including beneficiaries ages 65 and above.[2] The benefit covers 9.3 million individuals through 3 outpatient venues of distribution: 1) Military Treatment Facility (MTF) pharmacies; 2) a 54,000 TRICARE Retail Pharmacy (TRRx) network; and 3) a TRICARE Mail Order Pharmacy (TMOP) program. In Fiscal Year 2007, 71 percent of eligible beneficiaries (6.6 million) used the benefit. In that year, more than 119 million prescriptions were filled at an expense of $6.5 billion.

Legislative Framework

The National Defense Authorization Act (NDAA) for Fiscal Year 2000 established the parameters for the DoD Pharmacy Benefits program. This federal law requires the Secretary of Defense to establish an effective, efficient, and integrated pharmacy benefits program. Under this program, the Secretary must ensure the availability of pharmaceutical agents for all therapeutic classes, establish a Uniform Formulary based on clinical effectiveness and cost-effectiveness, and assure the availability of clinically appropriate pharmaceutical agents to members and retired members of the Uniformed Services and their family members. By law, the Uniform Formulary may not exclude access to any medication used in the ambulatory care setting and must make all medications available to beneficiaries at a nominal copayment, even those medications designated as “nonformulary,” a key difference from civilian pharmacy benefit plans.

[2] See 69 Fed. Reg. 17035 (April 1, 2004) (final rule effective May 3, 2004).

The Secretary of Defense implemented the current TRICARE pharmacy benefits program, a key component of the TRICARE program, effective May 3, 2004.

Benefit Structure

The law stipulated a three-tier cost-sharing structure and limits the amount of the highest copayment category—the nonformulary or third-tier category—to 20 or 25 percent of the costs of drugs in the third tier. Although the law allows established copayments to be adjusted periodically based on experience with the uniform formulary, changes in economic circumstances, and other appropriate factors, the copayment structure has not changed since 2001. Legislation in Fiscal Year 2007 and renewed in Fiscal Year 2008 has placed a freeze on raising all TRICARE copayments in the retail pharmacy network.[3]

Expenditures

DoD's pharmacy benefits program expenditures have grown significantly over the last seven years, primarily in the retail venue. In Fiscal Year 2000, DoD's retail pharmacy expenditures approximated $450 million; by Fiscal Year 2007, retail pharmacy expenditures exceeded $4 billion.

The primary driver for DoD's increase in pharmacy expenditures was the implementation of the TRICARE Senior Pharmacy Program as promulgated in the NDAA of 2001.[4] This legislation expanded pharmacy coverage for beneficiaries age 65 and over, providing them access to the retail pharmacy network and TMOP. Prior to the enactment of this legislation, this beneficiary category had only limited access to MTF pharmacies. With the maturation of the TRICARE Senior Pharmacy Program for DoD's 1.5 million Medicare-eligible population, retail costs have risen dramatically. This escalation in pharmacy expenditures is further compounded by other cost drivers, such as inflation and increased utilization that affect pharmacy spending in commercial health plans as well. An increased number of beneficiaries overall, coupled with an increased number of users of the benefit, has furthered the increase in overall costs.[5]

An additional critical factor in understanding DoD pharmacy costs is that before the Fiscal Year 2008 NDAA, DoD had very limited discounts available for medications dispensed through the retail venue.[6] Although military pharmacies and TMOP both had access to significant federal pricing discounts, the retail venue did not. With the passage of the Fiscal Year 2008 legislation, the TRICARE retail venue soon will enjoy discounts valued at approximately $400 million in reduced spending in the Defense Health Plan in Fiscal Year 2009.[7]

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[3] National Defense Authorization Act for Fiscal Years 2007.
[4] National Defense Authorization Act for Fiscal Year 2001, P.L. 106-398, §711.
[5] RADM Thomas McGinnis, Chief, Pharmaceutical Operations Directorate. Unique User Trends – Number of Users. Brief to the Task Force. February 6, 2007.
[6] National Defense Authorization Act for Fiscal Year 2009, §703.
[7] See Volume 73, Fed. Reg. 144, July 25, 2008, proposed rule.

Pharmacy Benefit Management Tools

Pharmacy benefit management in the commercial arena uses a number of tools to control costs.[8] Among them are the use of formulary management—which provides the ability to drive utilization to formulary medications by restricting access to more expensive medications that are not proven to be more clinically effective; implementing timely adjustments to cost-shares; and forcing the use of less expensive venues, such as mail order, by restricting access to more expensive venues. In addition, commercial pharmacy benefit managers' ability to restrict access to nonformulary medications or render some medications unavailable to beneficiaries is a powerful leveraging tool with the pharmaceutical industry.

DoD likewise uses formulary placement decisions to obtain discounts. However, because legislation stipulates that all medications must be available, even if placed on the third "nonformulary" tier at $22, this leveraging tool is not an effective incentive for manufacturers, who are fully aware that regardless of the prices they offer, DoD must continue to provide their products.[9] At the time of the final rule (2004), $22 represented 20 percent of the average cost of single-source brand name drugs.

Although DoD has a longstanding mandatory generic substitution policy, this policy does not mitigate the use of brand name products that have no generic equivalent and that remain available at low copayment differentials ($3 for generics versus $9 for brand names).

Management of the DoD pharmacy benefit has many other unique challenges resulting from the legislated framework for benefit delivery. DoD may not, for example, forcibly drive utilization to the less expensive mail order venue, but instead must focus its efforts on marketing the convenience and cost savings of mail order to encourage beneficiaries to use it. These efforts have had unprecedented success, and TMOP use has continued to increase; however, further increases in TMOP use could be realized through regulatory changes.

Although the TRICARE retail copayments are currently three times greater than the TMOP copayments, the extremely low copayments for all three tiers have little effect on influencing beneficiary choices. DoD must provide even the most expensive, but no more effective, medications at very nominal copayments, currently $22 for a 30-day supply in retail and a 90-day supply in mail order. The current law removes the ability to create meaningful differences between retail and mail order copayments, resulting in little financial incentive to beneficiaries to use mail order.

[8] Academy of Managed Care Pharmacy. How Managed Care Organizations Secure Price Concessions from Pharmaceutical Manufacturers. Available at www.amcp.org.
[9] 10 U.S.C. 1074(g) (2004).

Task Force Evaluation and Recommendations and Military Health System Senior Oversight Committee (MHS-SOC) Response

Accepted in part, rejected in part.

DoD firmly adheres to pharmacy benefit management best business practices to the maximum extent possible under the current legislative and regulatory guidance. The Task Force evaluation and subsequent recommendations provide an insightful and valid framework for regulatory changes that will enhance the tools available to DoD for pharmacy benefit management.

The Task Force concluded that the current DoD copayment tier structure does not create effective incentives to stimulate compliance with clinical best practices or the use of the most cost-effective point of service. The Task Force recommended significant rises in the retail copayment and the creation of a fourth tier with a mandated point of service for "specialty" medications defined as "very expensive, specialty, and/or biotechnology drugs."

The MHS-SOC responded to the retail copayment recommendation by noting that raising copayments at the retail point of service has been blocked by Congress for three consecutive years and has most recently been blocked for Fiscal Year 2009. Attempts to increase retail copayments in recent years have been opposed by powerful lobbying groups, including chain drugstore coalitions, the pharmaceutical industry, and DoD beneficiary groups. Thus, the MHS-SOC fully concurs with the Task Force recommendation that increasing retail copayments is critical to controlling the escalating growth in the retail venue.

The following copayment proposal (Table 9.1, below) has been reviewed and approved by the MHS-SOC, which believes this proposal best aligns the interest of beneficiaries with those of DoD. This proposal includes the provision that future copayment increases should be indexed to the military retiree cost-of-living adjustment. The estimated savings are possible only if the current freeze on raising retail pharmacy copayments is lifted.

Table 9.1: Proposed Copayments

	TMOP (90 days)	**TRRx (30 days)**	**TRRx (90 days)**
Preferred	$0	$4	$12
Brand	$0	$20	$60
Nonformulary	$10	$30	$90

In addition, this proposal includes a provision to treat TRICARE Prime Remote Active Duty family members the same as Active Duty members regarding pharmacy copayments. This means that Active Duty family members would have no copayments for Tier 1 and Tier 2 drugs in retail pharmacies and in TMOP, and Active Duty family members would not be eligible for Tier 3 drugs unless they are medically necessary. This policy mirrors the policy at MTFs for Active Duty members and their families.

Savings from this modified proposal are estimated in Table 9.2, below:

Table 9.2: Estimated Savings

Year	**FY09**	**FY10**	**FY11**	**FY12**	**FY13**	**FY14**	**FY15**
Estimated government savings	$361M	$524M	$676M	$749M	$826M	$982M	$1084M

Justification

The source of the largest increase in DoD's pharmacy costs over the past five years has been in the retail pharmacy venue, the most costly venue to both DoD and beneficiaries. MTF pharmacies remain the most cost-effective point of service, with TMOP very close behind. It is DoD's intent to reduce retail costs through maximizing the use of the MTF and TMOP points of service through retail copayment increases.

After careful review of several proposed scenarios, the MHS-SOC believes that this proposal provides the best option for moving forward to meet the goal of promoting a cost-effective benefit while meeting the clinical needs of patients. It incentivizes the use of mail order and MTF pharmacies, while controlling the growth in the use of retail pharmacies in order to sustain a robust pharmacy benefit. The zero copayment at TMOP facilitates transfers from MTFs to TMOP, freeing personnel to handle the workload that will return to the MTFs from the retail network as a result of the proposed retail copayment increases.[10]

As a result of the increased retail copayments, it is estimated that in Fiscal Year 2011—the first full year in which behavioral impacts will be seen—1.9 million prescriptions would be shifted from retail to MTF pharmacies. This would represent an increase in MTF prescriptions of approximately 5 percent. DoD estimates that for Fiscal Year 2009 through Fiscal Year 2015, it will save $5.2 billion from these proposed copayment adjustments.

The MHS-SOC does not concur with creating a fourth tier of more expensive, high-technology drugs, because this action in effect penalizes the sickest patients. DoD's view is that it is far more equitable to identify the patients who require specialty drugs and ensure that they are using the most cost-effective venues.

In addition to the copayment recommendations, the Task Force recommended the inclusion of coverage of selected over-the-counter (OTC) medications, restricting certain medications to a designated point of service, and applying the Tier 1 and Tier 2 copayments to the catastrophic cap. The MHS-SOC agrees with the inclusion of select OTC medications and recommends that all pharmacy copayments be applied toward the catastrophic cap.

In its final report, the Task Force suggested that DoD conduct a pilot program to reintegrate the management and distribution function of the pharmacy benefit into one of the managed care support contracts in one of three TRICARE service regions to evaluate the impact on costs and

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[10] There will be a need to expedite the System Change Request to facilitate MTF-to-TMOP transfer at the provider level.

health outcomes. This action would reverse the action DoD took in 2004 of "carving-out" the pharmacy benefit from the managed care support contracts. DoD took this action to place the management of the benefit under a single entity and to create a structure compatible with the legal parameters for accessing federal discounts in the retail pharmacy venue. In addition, a major factor in the decision to centralize pharmacy benefit delivery was beneficiary dissatisfaction with the lack of portability from one TRICARE regional contract to another. The current program removed all portability issues and significantly increased beneficiary satisfaction.

Regarding costs, after the Task Force's final report was released, legislation was passed giving DoD access to federal discounts for all covered drugs dispensed in its retail network pharmacies, thus bringing the price structure more in line with TMOP and MTF pharmacies.[11] The impact of this legislation significantly changed the dynamics of DoD pharmacy benefit management. By law, DoD (and other certain federal agencies) must receive discounts that are not available to nonfederal, commercial entities. Therefore, placing the pharmacy benefit back under a managed care support contract—even on a pilot basis—would not only lose a portion of the estimated $400 million annual savings to DoD, but also could jeopardize DoD's access to even greater federal discounts in the other two venues as well, because of the resulting fragmented market share.

Regarding health outcomes, the MHS-SOC fully agrees that disease management (DM) and appropriate polypharmacy[12] management are the ultimate goals of successful managed health care and pharmacy benefit management to improve health outcomes. These goals are achievable independent of the distribution processes involved.

DoD has started to share pharmacy data with the TRICARE managed care support contractors and welcomes the opportunity to continue to work with them to ensure the accurate and timely flow of data.[13] In addition, DoD has included requirements in the next generation of TRICARE contracts and the newly awarded T-Pharm contract to formalize the processes of pharmacy data sharing and DM.[14] The contracts require a formal Memorandum of Understanding (MOU) between the managed care support contractors and the TRICARE pharmacy contractor for the purpose of establishing the necessary cooperation for data exchange, coordination of care for patients receiving specialty pharmacy services, third-party liability, and claims issues. The MOU

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[11] Ibid.

[12] Polypharmacy—the simultaneous use of multiple prescription medications over the same time period—has been repeatedly identified as an area of concern, particularly among our Nation's seniors. Increased polypharmacy has been significantly associated with an exponential increase in the risk of an adverse drug-related event; higher likelihood of inappropriate drug use; noncompliance with critical medications; increased potential for adverse side effects; increased health care utilization; and higher overall health care expenditures for both the patient and the insurer. LCDR Mathew Garber, Pharmaceutical Operations Directorate, TRICARE Management Activity. Outpatient Polypharmacy Among 65+ Department of Defense Health Care Beneficiaries, Research paper. January 2007.

[13] RADM Thomas McGinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity. Brief presented at Managed Care Support Contractor Summit. December 14, 2007.

[14] T-Pharm contract awarded June 27, 2008, contracting officer TRICARE Management Activity West, Aurora, Colorado.

will specifically address the frequency and format of pharmacy data that will be provided to the managed care support contractors by the pharmacy contractor.

It is for these reasons that the MHS-SOC cannot concur with the recommendation to "carve-in" the DoD pharmacy benefits distribution function through managed care support contractor ownership of the retail networks and TMOP. Carving the pharmacy benefit back into the managed care support contracts adds no value to those contracts or to DoD's DM process requirements or to the pursuit of more effective management of polypharmacy patients. These practices are based entirely on prescription data sharing, not on who is responsible for administering the benefit and dispensing the medication. Additionally, the fragmentation of services and the confusion imposed on beneficiaries regarding the delivery of the benefit, including the degradation of the portability of the benefit, were significant concerns that had to be factored into the decisionmaking process. Finally, the loss of millions of dollars in savings resulting from the 2008 legislation and the potential of decreasing federal discounts render implementation of this recommendation imprudent.

Implementation Plan

DoD Strategy: Amend 32 C.F.R. Part 199.21, Pharmacy Benefits Program, to incorporate the MHS-SOC recommendations.

Responsibilities: Consistent with clear congressional direction, DoD remains committed to administering a generous pharmacy benefits program that fully meets the needs of MHS beneficiaries, while seeking to moderate the uncontrolled growth in costs. These proposed program improvements maintain that commitment.

Recommendation 10
Retiree Cost-Sharing

Task Force Recommendation 10

With regard to TRICARE Prime Family:

- *The average enrollment fee paid by an under-65 retiree should rise gradually from the current level of $460 per year to an average of $1,100 per year.*
- *The enrollment and other fees should vary depending on the level of retired pay. Those in the higher ranges should pay a higher enrollment fee, but not a proportionally higher one. Specifically, the Task Force recommends "half-proportional tiering." DoD should propose and Congress should approve indexing the retired pay ranges each year based on the percent change in retired pay.*
- *Changes in enrollment fees should be phased in over a period of four years to permit retirees time to plan. After year one of the phase-in period, enrollment fees should include an adjustment for the previous year's growth in per capita military health care costs. The adjustment should be such that, after the four years of phase-in, the fee would equal the level proposed by the Task Force, as adjusted for all growth in per capita military medical costs.*
- *The catastrophic cap should be set at the level of $2,500. The enrollment fee—which currently counts toward meeting the cap—would not count toward meeting the cap under the Task Force recommendation, but copayments for Tier 1 and 2 drugs would count.*
- *The Task Force does not recommend annual indexing of the catastrophic cap. However, DoD should assess the level of the cap at least every five years in light of trends in the public and private sectors. After a review, Congress should grant DoD the authority to adjust the cap, so long as the adjustment does not exceed growth in the cost index.*
- *There should be a one-time adjustment in the copayment levels, which should be increased in the same manner as the Prime Enrollment Fee, with changes delayed two years. The Task Force does not recommend annual indexing of copayments; however, there should be a periodic reassessment of these copayments at least every five years. Congress should grant DoD the authority to make changes in the copayment levels, so long as those changes do not exceed the growth in the cost index.*

With regard to TRICARE Prime Single:

- *Retain the current relationship between the enrollment fees for Prime Family and Single—that is, the Single fee should be half the Family fee.*
- *All other aspects of the Prime Single program should be changed to match the Task Force recommendations for Prime Family. Tiering would use the same approach, and the phase-in approach would be identical. The catastrophic cap would be set at the same level and follow the same rules as Prime Family, as would copayments.*

With regard to TRICARE Standard Family:

The Task Force recommends changes in Standard Family that are comparable to those for Prime Family. Specifically, the Task Force seeks changes in Standard that would be similar in dollar value to those in Prime.

- *A modest enrollment fee of $120 per year should be implemented. This fee should not be tiered, but should be indexed using the method noted below. Those beneficiaries wishing to use pharmacy benefits only would be required to enroll and pay the enrollment fee.*
- *The deductible should be increased to an average of $600 per year before tiering. The deductible should be tiered using the same approach as the one recommended for Prime Family.*
- *To promote the use of preventive care, DoD should create a list of preventive care procedures that would be paid under Standard Family and that would not be subject to the new deductible.*
- *The deductible should not be automatically indexed each year; however, at least once every five years, DoD should reassess the level of the deductible, taking into account not only trends in military health care costs but also the relationship of costs and cost-sharing in Prime and Standard. After a review, Congress should grant DoD the authority to modify the deductible, so long as the change does not exceed growth in the cost index proposed below.*

With regard to TRICARE Standard Single:

- *A modest enrollment fee of $60 per year should be implemented.*
- *This fee should not be tiered, but should be indexed using the method noted below. Those beneficiaries wishing to use pharmacy benefits only would be required to enroll and pay the modest enrollment fee.*
- *Increase the deductible to an average of $300 per year before tiering. The deductible should be tiered using the same approach as the one recommended for Prime Family.*
- *To promote the use of preventive care, DoD should create a list of preventive care procedures that would be paid under Standard Single, even if a beneficiary had not met the new deductible.*
- *The deductible should not be automatically indexed each year; however, at least once every five years, DoD should reassess the level of the deductible, taking into account not only trends in military health care costs, but also the relationship of costs and cost-sharing in Prime and Standard. Congress should grant DoD the authority to modify the deductible periodically, so long as the change does not exceed growth in the cost index proposed below.*

With regard to TRICARE for Life:

- *Implement a modest enrollment fee of $120 per person per year. Because of its small size, the fee would not be tiered, but would be indexed. The fee should be phased in over four years using the same approach proposed above for under-65 retirees.*

- *DoD should be permitted to waive part or all of the enrollment fee for those retirees who take steps specified by DoD to improve their health or reduce costs.*

With regard to indexing:

- *DoD should propose and Congress should accept a method for indexing that is annual and automatic. Indexing should be based on changes in per capita military health care costs. Indexing should be applied to enrollment fees.*
- *The Secretary of Defense should direct the creation of a cost-sharing index based on changes in per capita civilian care costs under TRICARE Prime. Prime civilian care costs should be used as a basis for the index, rather than total Prime costs (including both civilian and the MTF costs for Prime beneficiaries).*
- *Once DoD has designed an index, the indexing method should be reviewed by GAO to establish the legitimacy of the indexing method.*

Action Items

- *DoD should implement, and Congress should accept, all the cost-sharing recommendations listed above.*
- *Congress would need to make specific changes in the law as follows:*
  - *modify existing law to change the enrollment fee with tiering based on retiree pay for Prime Family and Prime Single;*
  - *establish a fee for TRICARE Standard with tiered deductibles for Family and Single; and*
  - *adjust the catastrophic cap.*
- *In addition, Congress would have to authorize the Secretary of Defense, or his designee, to make changes to the enrollment fees and tiered salary ranges annually based on the newly developed DoD index and make changes to copayments, deductibles, and the catastrophic cap as necessary at least every five years, making certain to stay within the DoD-approved index.*
- *DoD should examine the feasibility of establishing other TRICARE options so that all retirees can be assured of having comparable choices among TRICARE options such as Prime and Standard.*

Analysis of Task Force Recommendations

The DoD Task Force on the Future of Military Health Care provided a number of assessments, recommendations, and action items addressing two issues in its congressional charge:

- alternative health care initiatives to manage patient behavior and costs, including options, costs, and benefits of a universal enrollment system for all TRICARE users; and
- the beneficiary and government cost-sharing structure required to sustain military health benefits over the long term.

Highlights of Task Force Assessments, Analyses, Recommendations, and Action Items on Retiree Cost-Sharing (Except for the Pharmacy Benefit)

The Task Force said that TRICARE's cost-sharing provisions—that is, the portion of costs borne by retiree beneficiaries and the government—are not always conducive to providing the best health care for military retirees and are rapidly becoming an anachronism. Because costs borne by retirees under age 65 have been fixed in dollar terms since 1996, when TRICARE was being established, the portion of medical care costs assumed by these military retirees has declined by a factor of two to three, and, unless action is taken, that portion will continue to fall. According to the Task Force report, this decline in the share of costs paid by the under-65 retiree has resulted in higher costs for DoD.

However, the cost pressures should not be the only reason for change. The Task Force stated that cost-sharing provisions for retirees should be altered because, in some cases, the changes may help improve retiree health care, rationalize the use of care resources, and improve accountability. It noted that the current cost-sharing provisions run so counter to broad trends in U.S. health care that they increasingly burden U.S. taxpayers. Finally, the Task Force found that current TRICARE plans for retirees do not provide sufficient choices among TRICARE options.

TRICARE Premiums

The Task Force stated that the cost-sharing relationship, at least as far as TRICARE Prime premiums are concerned, should be restored through phasing to what existed at the time that TRICARE was implemented in 1996. It recommended correlative changes to TRICARE Standard affecting out-of-pocket costs for military retirees, mainly by adjusting the deductibles. Since TRICARE's inception, the TRICARE Prime annual premiums have been $230 for an individual and $460 for a family. The Task Force believed that its proposed increase in premiums would not undermine TRICARE's reputation as a generous program when its costs are compared to those of almost all private health care plans. It also believed that the cost change would be consistent with other metrics of growth in health care costs during the relevant period (e.g., per capita Medicare costs or premium increases for the Federal Employees Health Benefit Plan [FEHBP]).

For TRICARE Standard, the Task Force recommended a modest enrollment fee ($120 annually for family coverage). Currently, there is no enrollment fee, although there is a high out-of-pocket cost, which is attributed to the combined effect of the deductible and copayments.

The Task Force also recommended the initiation of a modest fee for TRICARE for Life (TFL), with provisions for waivers in whole or part for those retirees "who take steps specified by DoD to improve their health or reduce costs."

Tiering

The Task Force recommended that enrollment and other fees should vary depending on retired pay—that is, fees should be tiered. Military retirees earning more military retired pay would pay more than those earning less. It recommended a schedule of fees and deductibles based on three

ranges of retired pay (which would be indexed to cost-of-living adjustments [COLAs] that would be made to military retired pay in order to avoid "tier creep"). It considered, but rejected as inherently inequitable, a tiering structure based on retired grade, which had been proposed in an earlier legislative proposal. Under the Task Force scenario, the TRICARE Standard and TFL fees would not be tiered.

Gradual Increase

To permit retirees time to plan, the Task Force recommended that increased fees and deductibles be phased in over four years (with adjustments over that period for ongoing changes in per capita health care costs). Health care costs were not expected to remain static during the phase-in period.

Catastrophic Cap

The Task Force recommended that the enrollment fee not count against the catastrophic cap, as is currently the case, but rather recommended to reduce the cap from $3,000 to $2,500. The cap on total out-of-pocket costs is "particularly important for those retirees who are most vulnerable because of substantial health care costs."[1] It believed that this cap is generous by private sector standards. It did not recommend that the cap be subject to annual indexing; however, it did recommend that the cap should be periodically reviewed by DoD (i.e., every five years) for possible adjustment within the limits of a DoD index. The cap would be the same for family or single coverage (as is currently the case).

Copayments

The Task Force recommended a one-time but delayed increase in copayments for TRICARE Prime. Such copayments have not changed since their inception. The Task Force recommended that any further increases should be periodically reviewed rather than automatically indexed annually. The Task Force also recommended that to encourage the use of preventive care services, such services should be exempt from copayments. No changes in copayments (coinsurance) for TRICARE Standard were recommended.

Family Versus Single Premiums

The relationship between enrollment fees for family versus single coverage should remain the same—that is, a two-to-one ratio (e.g., $460 versus $230).

Indexing of Selected Retiree Cost-Shares

The Task Force stated the following: "Indexing represents the single most important step that can be taken if DoD and Congress wish to reverse some of the trends in military health care cost-sharing of the past decade."[2] It strongly recommended a method for indexing that is both annual and automatic.

[1] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 95.
[2] Ibid., p. 101.

The Task Force recommended that the Secretary of Defense, with the approval of Congress, direct the creation of an index, to be validated by a review of GAO based on per capita changes in civilian care costs under TRICARE Prime (excluding Military Treatment Facility [MTF] costs, because those data were not deemed to be as reliable over the relevant period).

Deductibles

Under the Task Force proposal, deductibles under TRICARE Standard would be increased, phased in, tiered, and periodically reassessed for change, subject to index ceilings.

Military Health System Senior Oversight Committee (MHS-SOC) Review and Comments

The MHS-SOC accepted most of the Task Force recommendations on cost-sharing and agreed that the retiree (non-Medicare-eligible) beneficiary's share of costs should be increased.

To avert the erosion of the beneficiary's share of costs, the retiree's cost must be indexed in a manner that increases at a rate comparable to that of the MHS health care costs. An index tied to annual COLA increases of retired pay, for example, would continue to cause a disproportionate share of costs to be borne by the government and would be increasingly asynchronous with the health care cost-sharing trends across the Nation. More detailed discussion of the MHS-SOC position on the Task Force's recommendations follows a discussion of some aspects of the Tenth Quadrennial Review of Military Compensation (QRMC).[3]

The MHS-SOC considered the Task Force recommendations in light of the recommendations put forth by the QRMC relating to the military health care benefit. The Task Force acknowledged the uniqueness of the entire military compensation system, as contrasted with a typical civilian "salary" system, stating that changes in "the health care benefit must be examined in the context of this unique system and its compensation laws, policies, and programs."[4]

Highlights of the Tenth QRMC on the Health Care Benefit

In considering program reform, the QRMC stated its set of principles "designed to enhance equity and cost-effectiveness" related to the military health care benefit:

- TRICARE's first priority is the care of Active Duty personnel and their families.
- All retiree fees should relate to the value of the plan selected.
- Fees should be fair to all retiree populations.
- Fees should reflect a beneficiary's ability to pay.
- The TRICARE system should be biased toward preventive care rather than treatment.[5]

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[3] See www.defenselink.mil/prhome/docs/Tenth_QRMC_Feb2008_Vol%20I.pdf.
[4] Task Force on the Future of Military Health Care, op. cit., p. 1.
[5] QRMC, p. 53.

Premiums

The QRMC noted the trend of increasing premiums for private sector employees as well as Medicare participants. It recommended increasing TRICARE Prime enrollment fees for military retirees and linking them to Medicare Part B premiums. It also recommended an enrollment fee for TRICARE Standard that should be linked to Part B premiums. The participant's Part B premium, by law, is set to maintain a constant cost-sharing arrangement with the government (the constant for determining the premium depends on the income bracket of the participant).

To participate in TFL, military retirees age 65 and over must pay Medicare Part B premiums. Those premiums have increased considerably—for example, single rates of $600 in 2001 have increased to a minimum of $1,157 in 2008 (assuming the lowest bracket rate; beginning in 2007, persons with higher levels of modified adjusted gross income pay higher premiums based on graduated brackets). Consequently, older military retirees (those 65 years of age and over) who participate in TFL are paying more than pre-65 military retirees, even though the older group is likely to have higher expenses and lower income than the younger retirees (a higher percentage of whom are employed).

The QRMC believed that TRICARE fees should be "fair to all retiree populations—consistent with trends in Medicare—and should cover a larger portion of health care costs and reflect beneficiaries' ability to pay."[6]

The QRMC stated that when the TRICARE Prime fee schedule was established, the premium for TRICARE Prime was 41.6 percent of the single Medicare Part B premium, but it has since eroded to 21.7 percent (2008). In recommending that TRICARE Prime fees be increased and linked to Medicare Part B, the effect would be to restore the price-relationship between Medicare Part B and TRICARE when TRICARE Prime fees were set in 1996.

Based on this rationale, the QRMC recommended to set TRICARE Prime fees at 40 percent of the Part B premium for the single rate and at 80 percent for the family rate (and 15 and 30 percent, respectively, for TRICARE Standard single and family rates). It elaborated as follows:

> [B]asing TRICARE premiums for younger retirees on the fees charged to TRICARE-for-Life beneficiaries would inject an element of equity into the health care system by treating all military retirees more consistently. Maintaining higher premiums for TRICARE-for-Life coverage reflects the relatively more generous nature of that program compared to TRICARE Prime, but tying the two premiums together ensures that the rate-setting systems are consistent and based on the same cost-sharing and income-based policies.[7]

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[6] Tenth Quadrennial Review of Military Compensation. February 2008, pp. 56, 59. Available at www.defenselink.mil/prhome/docs/Tenth_QRMC_Feb2008_Vol%20I.pdf.
[7] Ibid., p. 56.

Phase-In

The QRMC recommended that new fees be phased in over a four-year period (the Task Force also recommended a four-year phase-in period).

Tiering

The QRMC adopted tiering, tying rates to total income (more specifically, modified adjusted gross income), not simply to military retirement pay, stating that retiree pay is not necessarily a good indicator of a retiree's ability to pay. The QRMC cited a DoD precedent for using family income (versus the income of the member alone) as the basis for the fee structure for child development centers. The Medicare Part B premiums are tiered based on modified adjusted gross income, with different ranges for singles and couples.

Copayments, Deductibles, and the Catastrophic Cap

The QRMC recommended tying TRICARE deductibles to Medicare deductibles and eliminating copayments for preventive care. TRICARE deductibles for singles would be equal to the Medicare deductible ($135 per person in 2008 and $270 for family). Copayments would stay the same but be reevaluated after the transition to the new premium rate is complete. The catastrophic cap of $3,000 would remain the same, but premium contributions would not be counted against it.

Cost Containment Initiatives

The QRMC evaluated a number of policy changes designed to encourage MHS users to select more cost-efficient options, such as a high-deductible health plan combined with a health savings account, an "other health insurance" subsidy for military retirees choosing a plan other than TRICARE, or a "buy-out" option for retirees under age 65.[8] The QRMC rejected these options, and except for the "other health insurance" subsidy, these potential reforms were not examined by the MHS-SOC. (See the discussion of the Task Force's Recommendation 11 on coordination of benefits.)

Enrollment Changes

Currently, a retiree wishing to use TRICARE can do so at any time. The QRMC recommended that military retirees and dependents wishing to participate in TRICARE be required to enroll during a designated open enrollment period. The QRMC reasoned that this change is consistent with civilian practice and would result in improved identification of patient populations and increased premium contributions. It would encourage more retirees and dependents to obtain ongoing health coverage and care instead of relying on episodic coverage. Enrollment eligibility would be flexible to address events such as marriage, the birth of a child, or the loss of private insurance.[9]

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[8] Ibid., pp. 53-55.
[9] Ibid., p. 60.

MHS-SOC Evaluation

The MHS-SOC decided to deliberate on the "major" issues related to cost-sharing to develop an initial report to Congress that would outline a general plan, which, if approved, would facilitate a more detailed request for statutory and/or regulatory authority, consistent with congressional guidance/direction. This would be followed by a more refined analysis of specifics and an estimation of the budgetary impact of the proposed changes. If congressional approval to move forward is granted, a supplementary report and more specific plan will be provided for congressional consideration and approval.

The MHS-SOC agreed that TRICARE Prime enrollment fees for military retirees under age 65 should be increased, but it did not choose to specify the exact dollar amounts. The timing of congressional approval will affect the fee amounts proposed, because health care costs will not remain static. Fees should be phased in gradually in order to mitigate the impact on beneficiaries. Clearly, fees must be indexed to adjust for expected increases in health care costs, which have exceeded increases in retired pay through COLA adjustments. The indexing should be designed to stabilize the beneficiary's share of costs at a level deemed appropriate by Congress. The MHS-SOC did not specify a cost-sharing target or phase-in period. It supported the recommendation that the family rate should remain twice the single rate.

Copayments (for Prime) in the near term should be increased, not adjusted automatically on an annual basis, and should be periodically reassessed (after five years). The copayment structure should be examined more fully for possible modification to discourage potential instances of inappropriate utilization of health care services (such as unnecessary emergency room visits) and to encourage preventive measures by waiving copayments for specified activities. Eliminating some copayments for TRICARE Prime for certain purchased care could add "equity" to the benefit for those beneficiaries that had no control over their need to access purchased care for a medical visit/treatment where there was no MTF, or if a needed service was not available at the MTF.

Without addressing specific levels of deductibles, the MHS-SOC agreed that changes in TRICARE Prime premiums should be accompanied by changes in TRICARE Standard deductibles in order to maintain overall cost-sharing comparability (thus increasing out-of-pocket costs for TRICARE Standard).

The MHS-SOC endorsed "tiering" for the reasons stated by the Task Force and the QRMC, namely to mitigate the escalation of fees on those less able to pay the higher costs. The tiers should be adjusted annually to avoid "bracket creep." The MHS-SOC preferred the QRMC approach to tiering over that of the Task Force, recognizing that legislation probably would be required to access "modified gross income" as used for tiering of Medicare Part B premiums, because reliance on self-reporting would be insufficient. The MHS-SOC was persuaded by the QRMC's view that adjusted gross income (as opposed to military retired pay) may be a better measure of a retiree's ability to pay for TRICARE coverage. This approach would provide more "equity" between younger and older retirees (age 65 and older), who must pay Part B premiums to be able to participate in TFL. The older retirees are likely to have lower income than younger

retirees (more of whom have other employment), yet they may pay more for their health care coverage.

The QRMC approach to tiering and indexing would use the Medicare Part B index and would relieve DoD of the administrative and cost burden of computing its own index. However, adjustments or modifications because of demographic differences (older populations typically have higher medical costs than younger populations) or for other reasons might still be required. Even if retirement pay were used, there may be a need for refinements based on type of retirement—for example, Reserve, regular, or disability, or situations in which such pay has been awarded or granted to a former spouse by a court or under a property settlement agreement. Of note is the Task Force's rejection of the use of FEHBP premium indexing that DoD had used in its "Sustain the Benefit" legislative proposal in 2006. The Task Force had not found a sufficient nexus between the FEHBP premium growth to cost growth in the MHS, and thus recommended the creation of an index more clearly tied to MHS costs for the relevant population affected (retirees under age 65). The Task Force did not consider the Medicare Part B premium changes for an index, but its basis for rejecting the FEHBP premium index appears to be applicable to rejecting the Medicare Part B premium changes as an index. It has no relationship to MHS cost increases. Of the indices reviewed by the MHS-SOC, the Medicare Part B index was one with a higher cumulative increase over the period reviewed.[10]

The MHS-SOC did not concur with the Task Force recommendation for the initiation of a modest enrollment fee for TFL. The QRMC made no such recommendation regarding the TFL fee. It was questioned whether the imposition of a fee on TFL would have a cost exceeding its value or whether it otherwise would be efficacious in promoting wellness or preventive health services (through fee waivers for specified behavior or for using certain health care services).

The MHS-SOC agreed that enrollment fees should not count against the catastrophic cap and that the cap should be reduced from its current level of $3,000 as recommended by the Task Force.

The MHS-SOC wanted to ensure that a new fee structure would be designed in such a manner that it does not undermine sound military personnel management policies—for example, by adversely affecting the retention of personnel, including those who would be eligible to retire based on years of service.

Implementation Plan

- DoD will continue to ask for congressional authority to change fees and copays in an effort to maintain both a generous health care benefit and a fair and reasonable cost-sharing arrangement between beneficiaries and DoD. All other actions are dependant upon this congressional approval.
- Once authority is granted, the Office of the Assistant Secretary of Defense for Health Affairs, will form a team to develop a proposed fee structure and an implementation timeline that will be provided to Congress for consideration and approval.

[10] Robert Opsut, Health Benefits and Financial Planning, Office of the Assistant Secretary of Defense for Health Affairs. Response to Task Force for Request for Information. August 16, 2007.

- In the meantime, TRICARE Management Activity will review its contracts to determine what modifications are needed to accommodate the changes in enrollment fees, copayments, deductibles, and catastrophic caps in order to assure the appropriate collection, payment, and accounting of funds and costs.

Recommendation 11
Better Coordination of Benefits

Task Force Recommendation 11

DoD should commission a study, and then possibly a pilot program, aimed at better coordinating insurance practices among those retirees who are eligible for private health care insurance as well as TRICARE.

Task Force Assessment

The Task Force believed that improved coordination of benefits between private health insurance and TRICARE offers the potential to provide retirees with better health care while helping to control growth in DoD's medical costs. The issue of coordination of benefits does not apply to the nearly one-fourth of retirees who do not have access to private employer insurance.[1] For these retirees, TRICARE is their main and only insurance.[2]

Some retirees with access to both private employer insurance and TRICARE use both TRICARE and other health insurance (OHI) on an episodic basis. Some retirees with access to both options choose to drop their OHI and use TRICARE exclusively (approximately 60 percent).[3] This practice is unlikely to change significantly, despite Congress' recent prohibition against employers' use of incentives to encourage employees to use TRICARE in lieu of their employer plans (because of the relative generosity and favorable cost-sharing of TRICARE compared to most private plans).[4]

When a retiree has both OHI and TRICARE and uses both, OHI is supposed to be the primary payer and TRICARE is the secondary payer. DoD generally cannot pay for a benefit that is covered by both OHI and TRICARE.[5]

The Task Force believed that, if a retiree has access to TRICARE and private employer insurance, it would be better for the employee to select one plan and hence one set of providers. Presumably, this would improve the coordination of care. If OHI is chosen as the one plan, TRICARE at most would be the second payer.

To promote the selection of one plan, whether OHI or TRICARE, the Task Force identified two general approaches.[6]

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[1] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 104, citing Louis T. Mariano, Sheila Nataraj Kirby, Christine Eibner, Scott Naftel. Civilian Health Insurance Options of Military Retirees: Findings from a Pilot Survey. National Defense Research Institute and RAND Health, 2007, p. 57. Available at www.rand.org/pubs/monographs/2007/RAND_MG583.sum.pdf.
[2] Ibid.
[3] Ibid., p. 105
[4] Ibid.
[5] Ibid., pp. 30, 31. The Task Force recommended an audit to ensure compliance with law and policy that TRICARE act as the second payer.
[6] Ibid., pp. 105, 106.

First, some retirees prefer to use their employer's private insurance—perhaps because they prefer the available providers or because those providers offer care that is more convenient. But some may elect not to use it because their out-of-pocket costs are substantially higher than their out-of-pocket costs for TRICARE. The Task Force suggested that DoD could offer these retirees the option of using their employer's private insurance with the government paying part or all of their contribution, or even, perhaps, a portion of the employer's premiums.

Second, some retirees prefer to use TRICARE because it offers them more convenience or makes available trusted health care providers. In this case, to be symmetric with the first approach, the Task Force suggested that employers would not have to pay the premium under their plans to cover such employees, but would be required to pay part or all of the TRICARE enrollment fee, and, perhaps, a portion of the government's TRICARE costs.

Because of limited time and complexity of the issue, the Task Force could not adequately assess the effect on coordination and quality of care for retirees and DoD's medical costs. Thus, further study was recommended.

The Task Force emphasized that the choice of a plan by retirees should be "strictly voluntary," allowing them periodically to change their selection, for example, through annual open seasons enrollments.[7] The Task Force favored providing choices, but not without some restrictions. It stated the following:

> Along with the enrollment plan for the Standard program, the Task Force recommends new rules regarding changes between plans. The Task Force recommends that retirees be permitted to switch from Standard to Prime, or vice versa, only during a designated annual open season period. Retirees who are enrolled in a TRICARE program would also be able to leave the program only during this open season. Limits on the ability to switch among plans are necessary to prevent retirees from choosing a plan based on its generosity with regard to a particular episode of military health care.[8]

The Task Force suggested that DoD evaluate the feasibility of additional TRICARE options, because not all retirees have a choice between TRICARE Prime and Standard. Some have no access to TRICARE Prime because they reside outside a prime service area. For these retirees, TRICARE Standard is their only option.[9]

Other Studies

Before undertaking a new study, the Military Health System Senior Oversight Committee (MHS-SOC) conducted a review of relevant studies, reports, and analyses. A summary is provided below.

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[7] Ibid., p. 106.
[8] Ibid., p. 99.
[9] Ibid., pp. 98, 104.

Report of the Tenth Quadrennial Review of Military Compensation

The Tenth Quadrennial Review of Military Compensation (QRMC) made some findings and recommendations that are relevant to coordination of benefits.[10] It evaluated some possible policy changes that might encourage those in the MHS to use more cost-efficient options such as a high-deductible health plan (HDHP), coupled with a health savings account (HSA), an OHI subsidy for military retirees choosing a plan other than TRICARE, or a "lump sum buy-out" for retirees under age 65.[11]

The QRMC rejected the high-deductible health plan HDHP/HSA option. The notion underlying this type of plan is that employees have incentives to use health care more wisely and sparingly. Dollars in the employer-funded HSA, if not used currently for health care, are carried over from year to year, and eventually they can be used in retirement.[12] The QRMC determined that the decline in the government's health care costs resulting from lower utilization of health care services would be less than the increase in the government's overall costs for its contribution to the HSAs.[13]

The QRMC considered the OHI subsidy and determined it would cause an increase in DoD's costs regardless of the level of subsidy. It opined that many beneficiaries not using TRICARE would claim the subsidy—thus, a cost increase would occur without a commensurate decrease in TRICARE costs.[14]

The QRMC evaluated the possibility of offering a "lump-sum buyout" to military retirees under age 65 who would agree to use OHI other than TRICARE until they reached age 65. It determined that the funds that would be required to make this option attractive, however, did not justify the selection of this initiative. Also, some retirees would not have continuous access to employer-provided OHI until age 65, and those with lowest incomes would be most at risk for health care costs.[15]

The QRMC recommended more restrictive enrollment policies for TRICARE. Military retirees and dependents wishing to participate in TRICARE should be required to enroll during a designated open enrollment period, rather than being allowed to switch at anytime. The QRMC said that this change comports with civilian practice and would improve the identification of patient populations and increase premium contributions. It also said it would encourage more retirees and dependents to obtain ongoing health coverage and care, rather than just episodic coverage. Enrollment eligibility would be flexible to address events such as marriage, the birth of a child, or the loss of private insurance.[16]

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[10] Report of the Tenth Quadrennial Review of Military Compensation. Cash Compensation. Vol. I. February 2008. Available at www.defenselink.mil/prhome/docs/Tenth_QRMC_Feb2008_Vol%20I.pdf. See also Recommendation 10 in this document regarding cost-sharing.
[11] Ibid., pp. 53-55.
[12] Ibid., p. 53.
[13] Ibid., pp. 53, 54.
[14] Ibid., p. 54.
[15] Ibid.
[16] Ibid., p. 60.

Pilot Survey on Civilian Health Insurance Options of Military Retirees

DoD commissioned a prior study that concluded that many military DoD retirees under age 65 have second careers and access to non-DoD health insurance. The study reported that the growing gap between civilian health insurance premiums and TRICARE enrollment fees has made TRICARE an increasingly attractive option for them.[17]

The study was based on a survey fielded in early 2006. It asked retirees about their employment status, eligibility for and enrollment in civilian health insurance plans, reasons for enrolling or not enrolling, their use of TRICARE for medical care and prescription drug coverage, and other, related matters. It provides useful information on retirees' health care status, enrollment in civilian health care plans, the use of TRICARE, and sensitivity to changes in the price of civilian plans. It contains estimates of the percentages of retirees who are eligible for civilian health insurance, either through their own or their spouse's employment or through a union or a professional association, the percentage of retirees enrolled in civilian plans (and information on their reasons for enrolling or not enrolling in civilian plans), premium costs that retirees pay to enroll in their civilian health plans, how changes in civilian premiums would affect participation, and information on the mix of TRICARE and civilian services used by those covered by civilian plans.

Overall, 80 percent of the survey population was employed (decreasing to 53 percent of those over age 60). More than half worked for large employers (500 or more employees), which are likely to sponsor health plans. Excluding eligibility through working spouses, unions, and professional associations, about 65 percent of the survey population was eligible to enroll in an employer plan. Of those with working spouses, most had access to an employer plan allowing family coverage. Counting all sources of coverage for retirees or their families (including working spouses with access to insurance and access to insurance through unions or professional associations), 78 percent of the survey population had access to some other form of health insurance for themselves and/or their families.[18]

About half of those who were eligible for a civilian plan chose not to enroll in those plans. About half of those enrolled in a civilian plan mentioned that they preferred the network of doctors/hospitals in those plans, and about half noted inconvenient locations of Military Treatment Facilities (MTFs) as the reason for enrollment. Thirty percent said they had free coverage through their employer or other non-TRICARE source. One-quarter reported a lack of TRICARE coverage for needed medical care and the administrative burden and reimbursement delays associated with TRICARE as reasons for their enrollment in a civilian plan. Twenty percent said that their civilian coverage was less costly than TRICARE.[19]

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[17] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 104, citing Louis T. Mariano, Sheila Nataraj Kirby, Christine Eibner, Scott Naftel. Civilian Health Insurance Options of Military Retirees: Findings from a Pilot Survey. National Defense Research Institute and RAND Health, 2007. Available at http://www.rand.org/pubs/monographs/2007/RAND_MG583.sum.pdf.
[18] Ibid., pp. xiv, xv.
[19] Ibid., pp. xv, xvi.

Those choosing not to enroll in civilian plans stated the premium cost as the predominant reason for not doing so (mentioned by about 80 percent of the nonenrollees). Other reasons included high copayments or high deductibles, and about half said that they preferred doctors in MTFs or TRICARE.[20]

In survey responses of retirees enrolled in a civilian health plan, about half of those paying a premium said they would give up their civilian plan if their premiums rose by 25 percent. Of those retirees eligible for but not enrolled in a civilian plan (about half), very few said they would switch to a civilian plan if the civilian premium was reduced by 25 percent.[21]

In 2005, 39 percent of all retired enlisted personnel and 45 percent of all retired officers received care at a civilian facility only, and another 12 percent and 16 percent, respectively, chose to go to a military facility only. Some—between 15 and 18 percent—received care at two types of facilities, most commonly at a civilian facility and an MTF. There is a similar pattern among families of military retirees. Retirees who were enrolled in a civilian plan relied on a mix of both TRICARE and civilian plans for medical treatment. For example, only 38 percent of this group said they relied exclusively on the civilian plan, while 36 percent said they used both TRICARE and the non-TRICARE plan. Overall, about half reported that they used TRICARE for all or some of their medical care. Military retirees enrolled in a civilian plan relied heavily on TRICARE for coverage of prescription drugs. Overall, 56 percent of retirees enrolled in a civilian plan reported relying on TRICARE to some extent for their prescription drug coverage.[22]

This study, while providing important insights, was a pilot study based on a small sample size. For better understanding of the potential impact of an increase in TRICARE premiums, more complete and comprehensive information would be needed.

Controlling TRICARE Cost Growth

The Institute for Defense Analyses (IDA) prepared a study for use by the QRMC that included analysis of a subsidy for OHI.[23] The study noted a rapid growth rate in purchased care for military retirees and attributed part of that to the use of less OHI, prompted in part by an increase in real premiums for OHI and a decline in TRICARE real premiums and copayments.[24] The study included data on what affects a retiree's choice and used a simulation model to project effects on total government and beneficiary costs.[25] For the OHI subsidy (using a range from $500 to $4,000 per family), the study concluded that total subsidy payments are always greater than the savings from reduced utilization of TRICARE.[26]

[20] Ibid., p. xvii.
[21] Ibid.
[22] Ibid., p. xviii.
[23] Lawrence Goldberg, et al. Institute for Defense Analyses. Controlling TRICARE Cost Growth: An Evaluation of Three Policies. January 2008.
[24] Ibid., p. 4. From Fiscal Year 2000 to Fiscal Year 2006, OHI coverage for retirees fell from 48.7 to 26.8 percent, while TRICARE Prime increased from 27.0 to 45.7 percent. In year 2000 dollars, OHI premiums increased from $1,570 in Fiscal Year 2000 to $2,454 in Fiscal Year 2006 (56.3 percent), and the TRICARE Prime premium, in inflation-adjusted terms, declined by 14.9 percent during that period.
[25] Ibid., p. 11.
[26] Ibid., pp. 16, 17, 21, 22.

Most Recent Cost Analysis Study

The most recent cost analysis study, conducted by Kennell and Associates, addressed Task Force Recommendation 11.[27]

In considering the OHI premium subsidy, this study was based on the average premium amounts paid for OHI.[28] Four categories of retirees (and their families) were considered:

- Some retirees who would have used OHI exclusively even without a subsidy. A subsidy for this group would be "found money" and would provide no cost savings for TRICARE.
- Some retirees who would have used OHI as the first payer and TRICARE as the second payer. They probably would take the subsidy if it was considered higher than the expected value of TRICARE as a second payer.
- Some retirees with OHI who could switch to TRICARE in the future, but would elect not to because of the OHI subsidy.
- Some retirees who use TRICARE as their primary coverage and might switch out of TRICARE in order to take the OHI subsidy.[29]

Using a range of assumptions to estimate percentages of different categories of retirees who would take the OHI subsidy and opt out of TRICARE—a "lock-out" similar to those who are enrolled in the Uniformed Services Family Health Plan—it appeared that the OHI subsidy poses a large degree of uncertainty and risk. The cost impact through Fiscal Year 2015 could range from savings of $4.4 billion to a cost increase of $4.7 billion. All four scenarios present a very large initial cost increase to DoD and a substantial risk in achieving any net savings. To be beneficial to DoD, some existing TRICARE users would need to take the OHI subsidy.[30]

Requiring employers to pay employees' TRICARE enrollment fees would not be helpful to DoD, according to the Kennell and Associates analysis. This option would make TRICARE more attractive to retirees and more reliant on TRICARE. DoD previously cited concerns about this practice, and the National Defense Authorization Act of 2007 prohibited it. Requiring employers to pay a share of DoD's costs for employees who use TRICARE would constitute a fundamental change from a prevailing view of TRICARE as an entitlement earned by retirees.[31]

MHS-SOC Evaluation and Conclusion

Rejected.

The Task Force's overarching principle is that "all recommended changes must focus on the health and well-being of beneficiaries and be cost-effective, taking into account both short- and

[27] Kennell and Associates, Inc. Analysis of Two of the Task Force's Recommendations. October 24, 2008.
[28] Ibid., pp. 2-4. The average premium amount paid for OHI, in Fiscal Year 2009 dollars, was projected at $797 for singles and $3,751 for families.
[29] Ibid., pp. 4, 5.
[30] Ibid., p. 6.
[31] Ibid., p. 7.

long-term budgetary costs."[32] The above analyses by the QRMC and IDA predict that under the Task Force's proposals, DoD costs would most likely increase, and the more recent analysis by Kennell and Associates concludes such a proposal is highly risky.

Therefore, the MHS-SOC concludes that DoD should not commission a study or a pilot program aimed at better coordinating insurance practices among those retirees under the age of 65 who are eligible for both private health care insurance and TRICARE. If the TRICARE fee or benefit structure changes, and, depending on the impact of expected national health care reform at the national level that might affect the availability and cost of OHI, reevaluation may be warranted.

Implementation Plan

None at this time.

[32] Task Force on the Future of Military Health Care. Final Report. December 2007, p. 7.

Recommendation 12
Develop Metrics to Assess the Success of Military Health System Transformation

Task Force Recommendation 12

DoD should develop metrics by which to measure the success of any planned transformation of the command and control structure of the MHS, taking into consideration its costs and benefits.

Introduction

The Task Force on the Future of Military Health Care was charged to address "[t]he appropriate command and control structure within the Department of Defense and the Armed Forces to manage the military health system." After reviewing the current status of efforts to improve governance, the Task Force concluded that it was premature to make additional recommendations regarding command and control, but believed that it was appropriate to monitor and assess the effects of changes in Military Health System (MHS) governance already under way. Furthermore, consistent with an October 2007 GAO report,[1] the Task Force suggested that any additional options for changes in MHS governance be assessed in terms of the costs and benefits to be derived from each of the options under consideration.

On November 27, 2006, Deputy Secretary of Defense Gordon England approved an action memorandum for incrementally improving the governance of the MHS. It specified seven specific initiatives and called for "smaller operating headquarters, lower personnel and operating overhead, consolidation of shared and common service functions …, and joint and combined medical requirements development."[2]

In approving this memorandum, Deputy Secretary of Defense Gordon England directed that reorganization must enhance DoD operational capabilities and remove redundancy and unnecessary costs. Conservative estimates of the savings to be realized from the reorganization as outlined were projected to be approaching $200 million per year.[3]

GAO studied the process used to determine the course of action for improving governance and concluded that DoD "did not perform a comprehensive cost-benefit analysis of all potential options."[4]

Consequently, GAO recommended that "DOD address the expected benefits, costs, and risks for implementing the fourth option (as specified in the November 2006 Decision memo) and provide

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[1] GAO. Defense Health Care: DoD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure. GAO-08-122. Available at www.gao.gov/new.items/d08122.pdf.
[2] Action Memorandum for Deputy Secretary of Defense. Joint/Unified Medical Command Way Ahead. November 27, 2006, Tab B. pp. 1, 2.
[3] E. Christensen, D. Farr, J. Grefer, E. Schaefer. Cost Implications of a Unified Medical Command, Center for Naval Analysis. April 6, 2006.
[4] GAO, op. cit., p. 4.

Congress the results of its assessment."[5] The Task Force on the Future of Military Health Care also recommended that DoD develop performance measures to monitor the progress of its chosen plan for improving governance through better system integration.

As part of its analysis, the Task Force reviewed the types of improvements that could be expected as a result of improved governance. These benefits included greater accountability, increased integration for all elements of medical command and control, better integrated health care delivery, enhanced peacetime effectiveness and ability to quickly transition to war, and a more rapidly deployable and flexible medical capability.

In addition, the Task Force's first recommendation includes an action item specifying that the MHS should develop metrics to measure whether the planning and management strategy to improve integrating direct and purchased care produces the desired outcomes (see the discussion of this recommendation earlier in this report). Because the efforts to improve integration coincide with the efforts to improve governance, especially in large medical markets, the metrics developed in response to Task Force Recommendation 12 could meet the intent of that portion of Recommendation 1.

The MHS Senior Oversight Committee (MHS-SOC) agrees with this recommendation; it is entirely consistent with the MHS Strategic Plan published in June 2008, which includes the following paragraph:

> You have to know the score to win the game. We know that the best information leads to the best decisions, so we are committed to creating a comprehensive performance dashboard freely accessible to leaders and decision-makers at all levels of the enterprise. We know that sharing our results freely builds knowledge and creates wisdom to better serve the people who trust us with their lives.[6]

As a performance-based organization, the MHS understands that all stakeholders deserve to see evidence that the organization is dedicated to quality outcomes and to creating optimal value. The MHS mission is complex, and measuring success is not easy. In 2008, the MHS developed a set of enterprise measures of value creation that will serve as the foundation for implementing Recommendation 12. To fully implement the recommendation, however, the MHS must translate the strategic measures into a set of operational measures with sufficient sensitivity to discern changes that affect only a part of the organization. To achieve success, the MHS will have to reconcile differences among the Service medical departments regarding the way that data are captured, processed, and displayed, so that measures can be used to compare performance across the enterprise.

The MHS-SOC also noted that the ability to discern changes in performance that can be attributed to changes in governance will be complicated by the fact that other major changes have occurred over the past several years. Some of these changes include the implementation of

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[5] Ibid., p. 5.
[6] The Military Health System Strategic Plan. Available at www.health.mil/StrategicPlan/2008%20Strat%20Plan%20Final%20-lowres.pdf, p. 4.

Base Realignment and Closure (BRAC), Operation Iraqi Freedom and Operation Enduring Freedom, military-to-civilian conversions, and transformation activities specified in the Quadrennial Defense Review's road map for medical transformation.[7] Because these factors may make it difficult to establish true baseline performance, where possible, measures of performance should be obtained from 2001 and later, so that the effects of the war effort and other externally driven changes on performance can be discerned.

In addition, over the past eight years, the MHS has instituted changes in the way that workload and expense data are captured and reported, and the quality of data has continuously improved. Any perceived changes in clinical efficiency over time will therefore need to be interpreted with care to avoid reaching unwarranted conclusions. Given these caveats, the MHS-SOC agreed that the MHS should proceed to develop metrics that will assess the impact of changes in governance.

Scope and Approach

Recommendation accepted.

The intent of this initiative is to measure MHS performance before and after changes in governance (command and control) to determine whether the changes have had the anticipated positive effect. Successful performance is defined as MHS meeting its designated mission in a cost-effective manner. The metrics will not measure the effectiveness of governance directly; they will measure the effectiveness of the MHS changes when changes in governance are implemented. A key assumption is that it is not possible to predict which aspects of performance will be significantly affected by changes in governance. Therefore, measures must be designed to enable comparisons over time of performance across the entire spectrum of MHS mission outcomes.

A comprehensive metrics set must include measures that address the four elements of the MHS mission: Casualty Care and Humanitarian Assistance; Fit, Healthy and Protected Force; Healthy & Resilient Individuals, Families & Communities; and Education, Research and Performance Improvement. The four MHS mission elements are defined in the 2008 MHS Strategic Plan as follows:

- Casualty Care and Humanitarian Assistance: We maintain an agile, fully deployable medical force and a health care delivery system so that we can provide state-of-the-art health services anywhere, any time. We use this medical capability to treat casualties and restore function and to support humanitarian assistance and disaster relief, building bridges to peace around the world.
- Fit, Healthy and Protected Force: We help the Services' commanders create and sustain the most healthy and medically prepared fighting force anywhere.
- Healthy and Resilient Individuals Families and Communities: The MHS provides long-term health coaching and health care for 9.2 million DoD beneficiaries. Our goal is a sustained partnership that promotes health and creates the resilience to recover quickly from illness, injury or disease.

[7] Quadrennial Defense Review Report, Department of Defense. February 6, 2006.

> Education, Research and Performance Improvement: Sustaining our mission success relies on our ability to adapt and grow in the face of a rapidly changing health and national security environment. To do this we must be a learning organization that values both personal and professional growth and supports innovation.[8]

Using this description of the MHS mission, leadership developed a comprehensive list of enterprise-level measures in the following manner:

- First, objective descriptions of mission success were developed for each mission element. (The mission success statements and descriptions are included as Appendix R12A to this chapter.)
- Next, a group of subject matter experts developed the MHS Value Measures Dashboard, consisting of over 50 measures linked to the mission outcomes. This dashboard was approved by MHS leadership June 2, 2008. (The MHS dashboard is included as Appendix R12B of this chapter.)

The MHS Value Measures Dashboard is a strategic enterprise-level dashboard; it is not intended to identify the effect of changes that affect a relatively small part of the enterprise. To assess the impact of changes in governance at the regional or market level, or changes that affect a specific function such as education, the enterprise measures will need to be developed further, and more granular measures will need to be added.

In addition, because the focus for the MHS dashboard was on value creation and not on the cost of doing business, additional financial measures will be needed to specifically address the costs and benefits of changes in governance. Changes in governance that are likely to affect MHS performance are occurring in several functional areas and in several geographic areas. The major changes were specified in the framework for achieving increased jointness and unity of command that was approved by the Deputy Secretary of Defense on November 27, 2006. The approved framework consists of incremental and achievable steps that are designed to yield efficiencies throughout the MHS. Economies of scale are achieved by combining common functions. Structural changes include the following:

- establishment of a joint command for the National Capital Region (NCR);
- establishment of a joint command for the Medical Education and Training Campus in San Antonio;
- establishment of a joint command for all medical research and development assets;
- creation of an MHS Support Directorate within the TRICARE Management Activity (TMA) to consolidate shared MHS services, such as human capital, finance, information management/information technology (IM/IT), logistics, and force health sustainment;
- creation of a TRICARE Health Plan Management Directorate within TMA; and
- colocation of medical headquarters, with consolidation of common functions, operations, practices, and cultures.

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[8] DoD. The Military Health System Strategic Plan. Available at http://health.mil/StrategicPlan/2008%20Strat%20Plan%20Final%20-lowres.pdf.

To implement Recommendation 12, teams (with representatives from Health Affairs, TMA, and the Services) will use the MHS value measures as a foundation and then develop linked measures (if necessary) that will apply more specifically to changes likely to occur with the implementation of the structural changes specified above. Because significant progress already has been achieved in establishing the Joint Task Force National Capital Region Medical (JTF CapMed), the development of measures of medical market performance will be the first area of emphasis for implementation.

The teams will identify measures currently in use at the local level in a market and then compare these to the enterprise-level measures in the MHS dashboard. A gap analysis will identify where additional measures need to be developed. The team will then compare the measures in use in the NCR to other major markets (San Antonio, San Diego, and Colorado Springs), perform a second gap analysis, and then reconcile any differences. The goal will be to have a set of measures that will allow for a before-and-after comparison of performance in the NCR and a side-by-side comparison of performance across major markets. Even at this early stage of development, it is important to note that comparisons across markets will need to be made, based on the understanding that significant environmental and operational differences (e.g., demographics of the population served, mission requirements) could affect the interpretation of performance across markets.

An analogous approach will be used to identify the optimal set of measures to be used to assess the effect of the other structural and governance changes that may occur, such as the implementation of the Medical Education and Training Center (METC) and the colocated medical headquarters. These approaches are specified below.

Goals and Objectives

Goal 1: Develop metrics to measure the success of the transformation of the command and control structure of the NCR, taking into consideration its costs and benefits.

Objective 1: Convene a work group from NCR and Health Affairs to develop a draft set of measures that:

- assess the success of the Military Medical Market Leadership (i.e., JTF CapMed) in accomplishing its assigned mission in a cost-effective manner;
- link to the MHS Value Measures Dashboard:
- include financial measures; and
- include measures linked specifically to BRAC outcomes (e.g., Full-Time Equivalents [FTEs], Graduate Medical Education support).

Objective 2: Compare to measures being used in San Antonio, San Diego, and Colorado Springs, and reconcile differences.

Objective 3: Propose standard market-level measures to leadership for approval.

Objective 4: Resolve any differences in how data are captured, how measures are calculated, and how data are displayed in the three markets of interest (San Antonio, San Diego, and Colorado Springs).

Objective 5: Populate measures in a standard dashboard that is accessible to all in the MHS with a need to know.

Objective 6: Monitor and report on performance.

Goal 2: Develop metrics to measure the success of the transformation of the command and control structure of the METC, taking into consideration its costs and benefits.

Objective 1: Convene a work group from Health Affairs and the METC to develop a draft set of measures that:

- assess the success of the combined education and training assets in San Antonio in meeting the education and training mission both within and across the Services;
- link to the MHS Value Measures Dashboard;
- include the appropriate financial measures; and
- link specifically to BRAC outcomes (e.g., changes in total FTEs).

Objective 2: Propose draft measures to leadership for approval.

Objective 3: Resolve any issues concerning how data are captured, how measures are calculated, and how data are displayed.

Objective 4: Populate measures in a standard dashboard that is accessible to all in MHS with a need to know.

Objective 5: Monitor and report on performance.

Goal 3: Develop metrics to measure the success of the transformation of the command and control structure of the MHS headquarters' functions, taking into consideration its costs and benefits.

Objective 1: Convene a work group from Health Affairs, TMA, and the Services to develop a draft set of measures that:

- assess the success of MHS in using headquarters' assets most effectively to support the MHS mission;
- link to the MHS Value Measures Dashboard;
- include the appropriate financial measures; and
- link specifically to BRAC outcomes (e.g., changes in total FTEs).

Objectives 2-5: Same as for Goal 2.

Goal 4: Develop metrics to measure the success of the transformation of the command and control structure of MHS research and development activities, taking into consideration its costs and benefits.

Objective 1: Convene a work group from Health Affairs, TMA, and the Services to develop a draft set of measures that:

- assess the success of the MHS in deriving value from the research and development investment;
- link to the MHS Value Measures Dashboard;
- include the appropriate financial measures; and
- link specifically to BRAC outcomes (e.g., changes in total FTEs).

Objectives 2-5: Same as for Goal 2.

Goal 5: Develop metrics to measure the success of the transformation of the command and control structure of the MHS Health Plan Management Directorate, taking into consideration its costs and benefits.

Objective 1: Convene a work group from Health Affairs, TMA, and the Services to develop a draft set of measures that:

- assess the success of TMA in managing the Health Plan;
- link to the MHS Value Measures Dashboard, where appropriate; and
- include the appropriate financial measures.

Objectives 2-5: Same as for Goal 2.

Goal 6: Develop metrics to measure the success of the transformation of the command and control structure of MHS support functions (e.g., IM/IT, logistics, financial services, Human Capital Support), taking into consideration costs and benefits.

Objective 1: Convene a work group from Health Affairs, TMA, and the Services to develop a draft set of measures that:

- assess the success of the MHS in deriving value from the shared services (e.g., IM/IT, logistics, financial services, Human Capital Support);
- are linked to the MHS Value Measures Dashboard; and
- include the appropriate financial measures.

Objectives 2-5: Same as for Goal 2.

Stakeholders

The stakeholders for this initiative are the stakeholders for the MHS. As described in the MHS Strategic Plan, the MHS must ensure that three stakeholder groups are served by the enterprise: external customers, employees, and investors. Having measures of performance that demonstrate the effects of changes in governance would be of interest to all three stakeholder groups.

The specific stakeholders within each of the three subgroups are as follows:

- External Customers:
  - DoD Beneficiaries
  - Combatant Commanders
  - Other Military Commanders and Service members (Active, Guard, and Reserve)
- Employees:
  - Active Duty MHS Employees
  - Guard and Reserve MHS Employees
  - Civilian MHS Employees
  - Contracted MHS Employees
- Investors (those who ensure the availability of adequate resources):
  - Secretary of Defense
  - Under Secretary of Defense for Personnel and Readiness
  - Service Secretaries
  - Service Chiefs
  - Congress

Timeline

Goal 1: Develop metrics to measure the success of the transformation of the command and control structure of the NCR.

Estimated Completion: Fiscal Year 2009 3rd Quarter

Goal 2: Develop metrics to measure the success of the transformation of the command and control structure of the METC.

Estimated Completion: Fiscal Year 2009 4th Quarter

Goal 3: Develop metrics to measure the success of the transformation of the command and control structure of the MHS headquarters functions.

Estimated Completion: Fiscal Year 2009 4th Quarter

Goal 4: Develop metrics to measure the success of the transformation of the command and control structure of MHS research and development activities.

Estimated Completion: Fiscal Year 2009 4th Quarter

Goal 5 and Goal 6: At this time, changes in the governance of health plan management and MHS support services have been deferred. Completion of these goals will depend on a decision regarding changes in the structure of TMA.

Appendix R12A
Definitions of Mission Elements and Mission Outcomes[9]

Mission Element 1: Casualty Care and Humanitarian Assistance

We maintain an agile, fully deployable medical force and a health care delivery system so that we can provide state-of-the-art health services anywhere, any time. We use this medical capability to treat casualties and restore function and to support humanitarian assistance and disaster relief, building bridges to peace around the world.

Mission Outcomes:

A. Reduce Combat Losses (consequences of wounds)
Service members know if they are injured they will be rescued immediately and afforded all the care needed to recover as quickly and completely as possible. Reducing combat losses requires a system of coordinated activities and interventions that happen from the time a Service member is wounded until he or she returns to duty or enters a more extended period of rehabilitation. This system includes buddy care, stabilization, medical evacuation, acute care and initial rehabilitation.

B. Effective Medical Transition from Service and Seamless Transition from Battlefield to VA or Other Rehabilitation
We achieve success when Service members and their families tell us we have been fair, compassionate and competent in delivering fully integrated services between military, VA and civilian hospitals during the transition. For those Service members with severe injury or illness, the MHS must enable a fair disability evaluation and carefully coordinated care that facilitates transition to the next phase of life. Family participation and education is critical to success.

C. Improved Rehabilitation and Reintegration
Service members who have suffered severe physical and emotional trauma or illness deserve our commitment to compassionate, coordinated care and their full recovery whenever possible. The goal of rehabilitation is for a wounded Service member to return to his or her highest achievable level of function. Our care system must address the most complex problems, but in a way that is simple to understand and communicate, compassionate and permits the patient to take charge of his or her recovery.

D. Increased Interoperability with Allies, Other Government Agencies and NGOs
We will maintain and improve existing relationships with other governmental agencies, non-governmental organizations (e.g. , CARE, etc.) and international partners, which will better enable us to come together to accomplish our missions. These relationships will act as force multipliers to enhance MHS mission effectiveness.

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[9] The Military Health System Strategic Plan. Available at www.health.mil/StrategicPlan/2008%20Strat%20Plan%20Final%20-lowres.pdf.

E. Reconstitution of Host Nation Medical Capability
We will provide assistance to rebuild medical capabilities that are damaged or consumed in a conflict. Our success will be measured in improved public health outcomes for the region, population or country we serve.

F. Strategic Deterrence for Warfare
As the world's 9-1-1 emergency service, people around the globe look to the MHS in a catastrophe. Humanitarian assistance plays a critical role in winning hearts and minds. MHS success is when the people we assist say the U.S. military cares, protects, builds, teaches, and trusts enough to help. By building this "medical bridge to peace," the people in countries that could otherwise become hostile will be more likely to become our friends. Our success will mean less violence against Americans, fewer terrorist attacks, and avoidance of armed conflict, and will be reflected in more positive public opinion of the United States in the countries where we provided health services.

Mission Element 2: Fit, Healthy and Protected Force

We help the Services' commanders create and sustain the most healthy and medically prepared fighting force anywhere.

Mission Outcomes:

A. Reduce Medical Non-Combat Loss
We reflect our success in reduced rates of preventable injury and disease. Service members maintain their health in partnership with the MHS. They participate in preventive activities and stress training to achieve optimal physical and psychological fitness. Commanders are active partners in creating and sustaining a medically fit and protected force.

B. Improve Mission Readiness
We reflect our success in increased rates of individual deployability and mission readiness. We partner with Service members to ensure they are medically ready at all times. Throughout their military career, they participate in health assessment and improvement. Combatant Commanders have full visibility of the readiness status of their troops at all times.

C. Optimize Human Performance
We reflect our success in the measureable medical resilience of the force. We leverage medical research, technology and our understanding of optimal human performance to enable our warfighters to think clearly, move more rapidly, withstand emotional challenges and return to operations more quickly than the enemy. Our people will feel more confident in facing mission challenges because they know they are more fit and better prepared than enemy forces both physically and emotionally. Combatant commanders know they command a force that can sustain great stress on the battlefield; this gives them an overwhelming advantage.

Mission Element 3: Healthy & Resilient Individuals, Families & Communities

The MHS provides long-term health coaching and health care for 9.2 million DoD beneficiaries. Our goal is a sustained partnership that promotes health and creates the resilience to recover quickly from illness, injury or disease.

Mission Outcomes:

A. **Healthy Communities/Healthy Behaviors (Public Health)**
   Improved health is the result of shared accountability between the health system and the patient. Healthy behaviors improve quality of life; alternatively unhealthy behaviors such as smoking, over-eating, a sedentary lifestyle, alcohol abuse and family violence reduce well-being and readiness. MHS success is engaging all beneficiaries and enabling them to take control of their health, so that together we create a more robust and resilient military community.

B. **Health Care Quality**
   Our beneficiaries expect that the MHS holds itself to the highest standards of safety, efficacy and evidence-based care. We achieve success when our hospitals, clinics and civilian physician and hospital partners demonstrate outstanding quality and make their outcomes public. We are proud to compare ourselves with the finest civilian institutions.

C. **Access to Care**
   Our beneficiaries deserve access to appropriate health care in a reasonable timeframe and without administrative hassles. They should have access to a variety of quality providers that meet their unique needs.

D. **Beneficiary Satisfaction and Perception of MHS Quality**
   To achieve an effective health partnership with our beneficiaries we must provide caring, compassionate and convenient service. We must see through the eyes of our beneficiaries in order to design our systems of care to meet their expectations. We must demonstrate that our quality compares favorably with the best of civilian health care.

Mission Element 4: Education, Research and Performance Improvement

Sustaining our mission success relies on our ability to adapt and grow in the face of a rapidly changing health and national security environment. To do this we must be a learning organization that values both personal and professional growth and supports innovation.

Mission Outcomes:

A. **Capable Medical Workforce**
   We have the needed team of health professionals with the right training and skills to accomplish our wartime and humanitarian assistance missions.

B. Advancement of Medical Science

While focusing our education and research efforts on serving unique military missions we will inevitably make discoveries in medical science that will benefit the world. We will share knowledge, devices, medicines, vaccines, new procedures and delivery models freely. We will reflect our success in anticipating and developing new solutions to meet the needs of our warfighters and in contributing to the health of society.

C. Advancement of Global Public Health

Through our global reach and surveillance we will identify and track emerging threats to human and animal health, and develop solutions such as new vaccines, sanitation methods, and treatments that will benefit both the community and society at large.

D. Create and Sustain the Healing Environment (Facilities)

Our facilities will be inviting to patients and staff. Their design will promote safety, efficient care and patient empowerment. Their aesthetic qualities will promote healing.

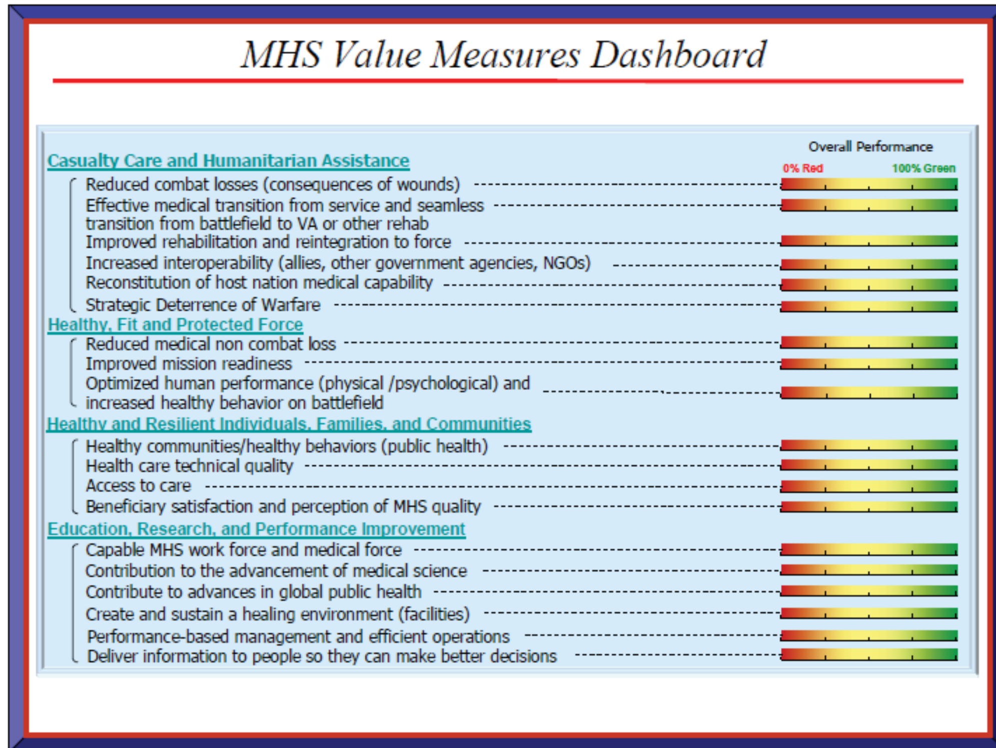
E. Performance-Based Management and Efficient Operations

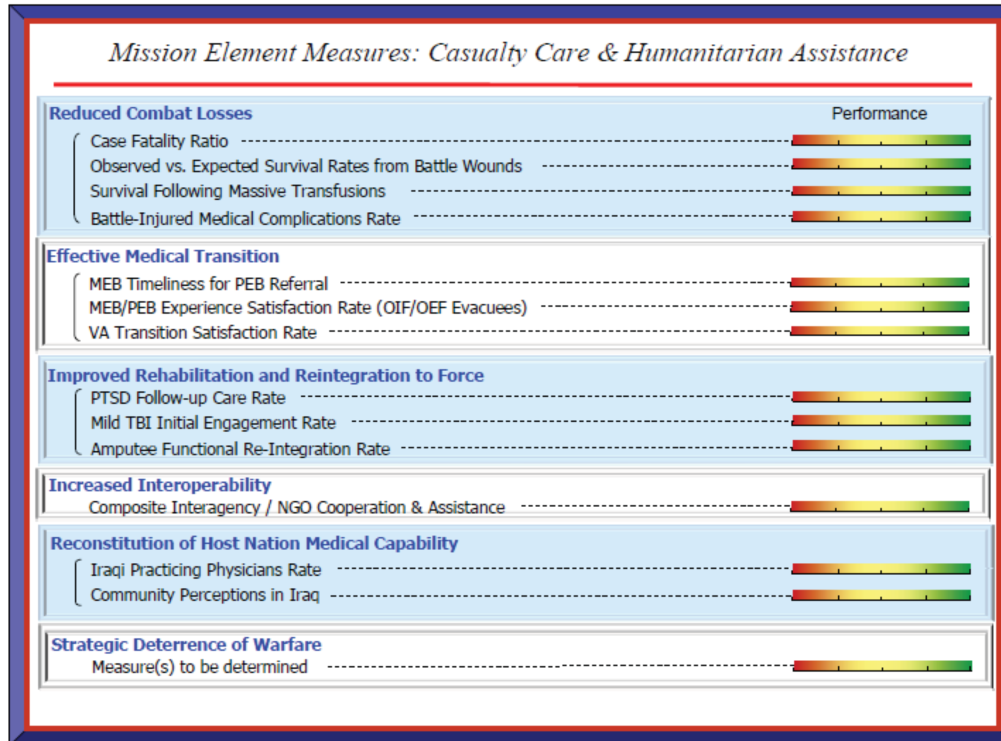
We will carefully define measures of value and put in place incentives that reward value creation, and we will ensure that our people have the capability to continuously improve quality and efficiency.

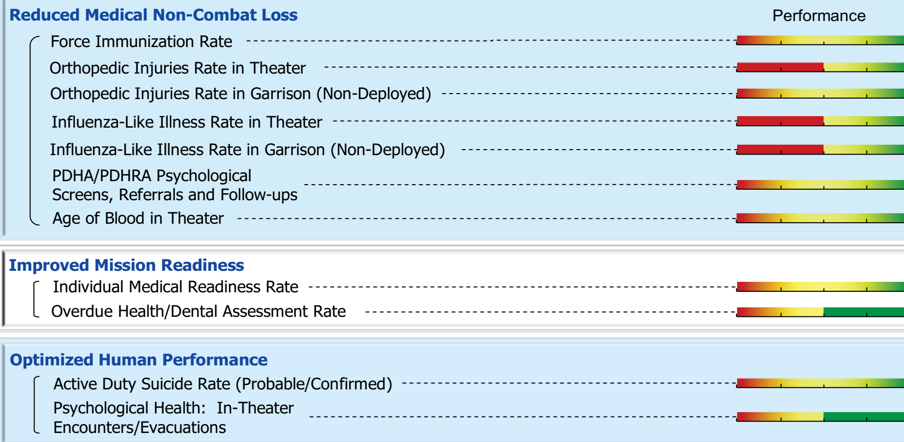
F. Deliver Information to People so They Can Make Better Decisions

We strive to ensure that we turn data into information, information into knowledge and by continuously learning from our experience, knowledge into wisdom. The electronic health record and personal health record will help patients and their health teams make better clinical decisions. Having mission focused performance data available at all levels will enable better strategic, tactical and operational decisions.

Appendix R12B: The MHS Value Dashboard and Measures



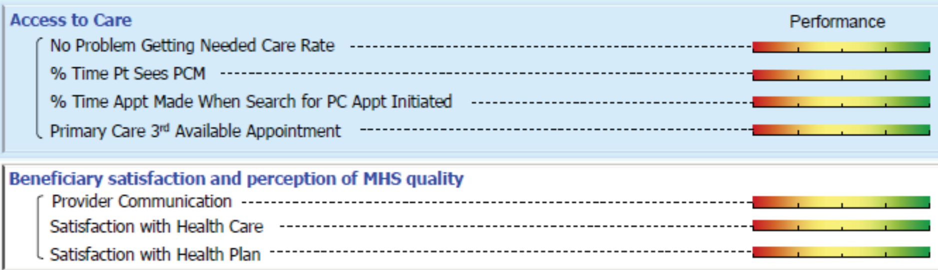




Mission Element Measures: Healthy, Fit and Protected Force
Reduced Medical Non-Combat Loss
Performance
Force Immunization Rate
Orthopedic Injuries Rate in Theater
Orthopedic Injuries Rate in Garrison (Non-Deployed)
Influenza-Like Illness Rate in Theater
Influenza-Like Illness Rate in Garrison (Non-Deployed)
PDHA/PDHRA Psychological Screens, Referrals and Follow-ups
Age of Blood in Theater
Improved Mission Readiness
Individual Medical Readiness Rate
Overdue Health/Dental Assessment Rate
Optimized Human Performance
Active Duty Suicide Rate (Probable/Confirmed)
Psychological Health: In-Theater Encounters/Evacuations

Mission Element Measures: Healthy and Resilient Individuals, Families and Communities
Healthy Communities/Healthy Behaviors
Performance
MHS Tobacco Use Rate
Active Duty Lost Work Days Rate
MHS Body Mass Index Rate
Alcohol Screening Assessment Rate
Dependent Mental Health Demand for Services
FAP-Substantiated Child/Spouse Abuse Rate
Influenza Immunization Rate
Health Care Quality
HEDIS Quality Index
ORYX Quality Index
CONUS Ventilator Associated Pneumonia
Health Care Personnel Flu Vaccination Rate
Hospital 30 Day Disease Mortality Rate

Mission Element Measures: Healthy and Resilient Individuals, Families and Communities (Continued)



Mission Element Measures: Education, Research & Performance Improvement

Appendix A
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Appendix B
Acronyms

AE - aeromedical evacuation
AFMS - Air Force Medical Service
AHIC - American Health Information Community
AHLTA - Armed Forces Health Longitudinal Technology Application
AHRQ - Agency for Healthcare Research and Quality
AM&S - Acquisition Management and Support
AMEDD - Army Medical Department
AVS - Automated Voucher System

BAG - Budget Activity Group
BHIE - Bi-directional Health Information Exchange
BRAC - Base Realignment and Closure
BUMED - Bureau of Medicine and Surgery

C&CS - Communications and Customer Service
C&PP - Clinical and Program Policy
CCATT - Critical Care Air Transport Team
CCM - Chronic Care Model
CHAMPUS - Civilian Health and Medical Program of the Uniformed Services
CHCBP - Continued Health Care Benefit Program
CHCC - Center for Health Care Contracting
CHF - congestive heart failure
CHPPM - U.S. Army Center for Health Promotion and Preventive Medicine
CIO - Chief Information Officer
CM - case management
CMAC - CHAMPUS Maximum Allowable Charge
CMOP - Consolidated Mail Outpatient Pharmacy
CMS - Centers for Medicare & Medicaid Services
COLA - cost-of-living adjustment
CONUS - Continental United States
COPD - chronic obstructive pulmonary disease
CPB - Clinically Preventable Burden
CPG - clinical practice guideline

DASD - Deputy Assistant Secretary of Defense
DAWIA - Defense Acquisition Workforce Improvement Act
DCoE - Defense Centers of Excellence
DCS - direct care system
DEERS - Defense Enrollment Eligibility Reporting System
DEPSECDEF - Deputy Secretary of Defense
DHB - Defense Health Board
DHP - Defense Health Program
DHS - Department of Homeland Security

DIMHRS - Defense Integrated Military Human Resources System
DM - disease management
DMAA - Disease Management Association of America
DMDC - Defense Management Data Center
DoD - Department of Defense
DoD IG - Department of Defense Inspector General
DPO - Defense Privacy Officer
DSCP - Defense Supply Center Philadelphia

EAG - External Advisory Group
EHR - electronic health record
EMR - electronic medical record
ERP - Enterprise Resource Planning
ETP - Enterprise Transition Plan

FEDS_HEAL - The Federal Strategic Health Alliance
FEHBP - Federal Employees Health Benefits Program
FFMIA - Federal Financial Management Improvement Act
FHP&R - Force Health Protection and Readiness
FHPO - FEDS_HEAL Program Office
FIAR - Financial Improvement and Audit Readiness
FICA - Federal Insurance Contributions Act
FIRP - Federal Individual Recovery Plan
FOGO - Flag Officer/General Officer
FOH - Federal Occupational Health
FRC - Federal Recovery Coordinator
FRCP - Federal Recovery Coordination Program
FSS - Federal Supply Schedule

GAAP - Generally Accepted Accounting Principles
GAO - Government Accountability Office (prior to name change effective July 7, 2004, was General Accounting Office)
GDP - Gross Domestic Product
GFEBS - General Fund Enterprise Business System
GME - General Medical Education
GWOT - Global War on Terrorism

HA - Health Affairs
HSA - health savings account
HSA - hospital service area
HB&FP - Health Budgets and Financial Policy
HCA - Head of Contracting Activity
HCAA - Health Care Acquisition Activity
HDHP - high-deductible health plan
HEDIS - Healthcare Effectiveness Data and Information Set
HHS - Department of Health and Human Services

HIPAA - Health Insurance Portability and Accountability Act of 1996
HMO - Health Maintenance Organization
HPA&E - Health Program Analysis and Evaluation
HPO - Health Plan Operations

ID/IQ - Indefinite Delivery/Indefinite Quantity
IDA - Institute for Defense Analyses
IG - Inspector General
IM/IT - information management/information technology
IMR - Individual Medical Readiness
IPT - Integrated Product Team
ISA - Individual Set Aside

JEC - Joint Executive Council
JTF CapMed - Joint Task Force National Capital Region Medical

LOA - Line of Action
LOD - Line of Duty

MCC - Member Choice Center
MEB - Medical Evaluation Board
MEDCOM - U.S. Army Medical Command
MEDRETE - Medical Readiness Training Exercise
MEPRS - Medical Expense and Performance Reporting System
MEPS - Military Expenditure Panel Survey
MERHCF - Medicare-Eligible Retiree Health Care Fund
METC - Medical Education and Training Campus
MHS - Military Health System
MHSPHP - Military Health System Population Health Portal
MilPers - Military Personnel
MM - medical management
MMSO - Military Medical Support Office
MOU - Memorandum of Understanding
MRMS - MTF Refill Mail Service
MRPU - Medical Retention Processing Unit
MRR - Medical Readiness Review
MSM - Multi-Service Market
mTBI - Mild Traumatic Brain Injury
MTF - Military Treatment Facility

NAVMEDLOGCOM - Naval Medical Logistics Command
NAVSUP - Naval Supply Systems Command
NCA - National Capital Area
NCPP - National Commission on Prevention Priorities
NCQA - National Committee for Quality Assurance
NCR - National Capital Region

NDAA - National Defense Authorization Act
NGO - nongovernmental organization
NICoE - National Intrepid Center of Excellence
NIH - National Institutes of Health
NMCSD - Naval Medical Center, San Diego, California
NMOP - National Mail Order Pharmacy
NOE - Notice of Eligibility

O&M - Operations and Maintenance
OCHAMPUS - Office of CHAMPUS
OCONUS - Outside Continental United States
OEF - Operation Enduring Freedom
OHI - other health insurance
OIF - Operation Iraqi Freedom
OIPT - Overarching Integrated Product Team
OMB - Office of Management and Budget
OPM - Office of Personnel Management
OSD - Office of the Secretary of Defense
OTC - Over-the-Counter

PAR - Performance and Accountability Report
PBD - Program Budget Decision
PCM - Primary Care Manager
PDTS - Pharmacy Data Transaction Service
PEB - Physical Evaluation Board
PEC - Pharmacoeconomic Center
PEO - Program Executive Offices
PhRMA - Pharmaceutical Research and Manufacturers of America
PPO - Preferred Provider Organization
PSA - prime service area
PTSD - Post-Traumatic Stress Disorder

QALY - Quality-Adjusted Life Years
QDR - Quadrennial Defense Review
QRMC - Quadrennial Review of Military Compensation

RA - Reserve Affairs
RDT&E - Research, Development, Test, and Evaluation
RFI - Request for Information
RFP - Request for Proposal
RHRP - Reserve Health Readiness Program
RVU - relative value unit
RWP - relative weighted product

SCRA - Servicemembers Civil Relief Act of 2003
SES - Senior Executive Service

SMA - Services Medical Activity
STB - Sustaining the Benefit

T2 - TeleHealth and Technology
T3 - The Next Generation of TRICARE Contracts
TAC - TRICARE Advisory Committee
TAMP - Transition Assistance Management Program
TBI - Traumatic Brain Injury
TDP - TRICARE Dental Program
TeamSTEPPS - Team Strategies and Tools to Enhance Performance and Patient Safety
TFL - TRICARE for Life
TMA - TRICARE Management Activity
TMOP - TRICARE Mail Order Pharmacy
TPharm - Combined TRICARE mail and retail pharmacy contract
TPRADFM - TRICARE Prime Remote for Active Duty Family Members
TRAC - TRICARE Regional Advisory Committee
TRO - TRICARE Regional Office
TRRx - TRICARE Retail Pharmacy
TRS - TRICARE Reserve Select
TSC - TRICARE Service Center
TSF - transitional support facilitator
TSO - TRICARE Support Office
TSRx - TRICARE Senior Pharmacy
TTAD - Temporary Tour of Active Duty

UM - utilization management
UMC - Unified Medical Command
UMWA - United Mine Workers of America
USAMRAA - U.S. Army Medical Research Acquisition Activity
USDA - U.S. Department of Agriculture
USERRA - Uniformed Services Employment and Reemployment Rights Act
USFHP - US Family Health Plan
USPSTF- United State Preventive Services Task Force
USTF - Uniformed Services Treatment Facility
USUHS - Uniformed Services University of the Health Sciences

VA - Department of Veterans Affairs
VHA - Veterans Health Administration
WPMC - Wright-Patterson Medical Center
WRNMMC - Walter Read National Military Medical Center
WTU - Warrior Transition Unit
WWRC - Wounded Warrior Resource Center

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Key Resources

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