Innovative Solutions will Reduce DOD Health Care Costs

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Executive Summary

Military Health Care is Broken: It Is Not a System

After more than 10 years of war and the associated costs of readiness and force health protection, some health care cost increases are understandable. There is a significant linkage between this “cost of readiness” and the increase in health care costs.

What is clear is that there is tremendous inefficiency and duplication in the military health care system that contributes greatly to increased costs. No fewer than 19 major reports during the last 40 years attest to this.

The design of the current military medical infrastructure has not kept pace with the rapid changes in health care delivery. While the successes of battlefield care, casualty transport, and regenerative medicines (to name a few) have been phenomenal, the basic delivery model between the direct care system and the purchased care system is, and has remained, fragmented and broken. There is no real “health system,” and after 10 years of war, many of the military treatment facilities, for various reasons, contribute to this fragmentation.

In addition, there is a lack of regional collaboration with regard to systems of care, and the current payment mechanisms do not yield optimal value.

MOAA believes innovative solutions are available to address the challenge of increasing costs without inhibiting care delivery or raising beneficiary costs. There are new models and systems of care in the civilian sector that would apply to military health care needs. The Mercy Health System or the Geisinger Health System serve as outstanding examples, among others.

There are ways to increase delivery of health care while decreasing costs. The Department of Defense (DOD) already has undertaken some initiatives – such as implementing the medical home model and taking some initial steps to promote pharmacy home delivery.

However, much more needs to be done.
Controlling Costs Requires Management Accountability, Not Merely Cost-Shifting

One of the goals of this paper is to open a dialog so experienced and interested people can create a military health care system which is customer focused, cost effective, and truly moves us from “health care to health.” Broader input with expanded collaboration and discussion among all stakeholders can refine and build on these and other recommendations and translate them into actionable proposals.

*The future of military health care is now — and so is the time to act.*

### DOD Health Care Spending has been Growing Faster than DOD’s Discretionary Budget Authority

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<th>FY</th>
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<th>DOD Total Discretionary Budget Authority</th>
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Source: GAO analysis of DOD data.

DOD is at an inflection point, where fiscal realities are clashing with meeting mission requirements.

To date, most cost-saving initiatives have focused on simply shifting a greater share of DOD costs to beneficiaries, in part because that’s easier than reforming the military health care delivery system. But any real focus on long-term cost control must focus more on the latter than the former.
MOAA recommends several strategies and initiatives DOD can use to mitigate rising costs and do their part in shaping the future.

MOAA believes the department can, and should, bring new rigor to the problem of rising costs and focus on options to save money, without shifting costs to beneficiaries through fee increases and benefit cutbacks. *It is important to look at how effectively the department spends its health care dollars in addition to how much it spends.* We hope this paper sparks new thinking by illuminating some of the military’s most critical health care issues.

**The Nature of Military Medical Infrastructure**

The Military Health System (MHS) consists of tri-service military-run fixed facilities with uniformed and civilian medical staffs (known as the “direct care system”), operational medicine components, and research and education components and is overseen by three separate uniformed service headquarters functions comprising the surgeons general offices and staffs.

The TRICARE program is the civilian care component, including both TRICARE Standard fee-for-service coverage and TRICARE Prime networks managed through contractual arrangements, usually in the form of networks of providers. This is commonly referred to as the “purchased care system.”

All of these components as well as others comprise the military’s system of providing the health care benefit in some fashion, to all of its eligible beneficiary groups.
MOAA RECOMMENDATIONS TO REDUCE MILITARY HEALTH CARE COSTS

1. Reduce Pharmacy Costs: Improve communication methods to motivate beneficiaries’ use of the home delivery option.

This initiative yields the most immediate “low-hanging fruit” and should be a source of continual focus by DOD coupled with frequent dialog with all stakeholders. Consider the following points with respect to cost savings:

• Shifting retail prescriptions to home delivery (mail-order) saves the government $125 per prescription. (Government cost for a 90-day supply of the top 500 brand medications is $169 for home delivery versus $294 for retail.)

• Currently, 24 million 90-day equivalent prescriptions are filled through retail pharmacies every year.

• Shifting just 10 percent of those to home delivery would save $300 million a year.

• The most easily convinced beneficiaries already have shifted to home delivery. Implementing improved, more beneficiary-centric incentives and methods of communication to allay beneficiary fears/questions has great potential to generate significant additional shifting (see chart on page 6).

• Create target goal of shifting 500 prescriptions per week into home delivery.
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2. Efficiently Utilize Scarce Medical Resources: Establish a Unified Medical Command or a governance model which supports better and more efficient care delivery.

Restructuring the military medical system will yield large potential savings and more responsive customer service, but it requires consolidating budget authority and accountability that is now fragmented between the three services and DOD. Consolidating service headquarters will yield modest savings. But the large savings will come from establishing a single governance structure which has authorities and is accountable to eliminate the current counter-productive competition for budget share among multiple entities. Establishing standardized and unified policies for all DOD-funded care will achieve tremendous savings, eliminate existing redundancies, and achieve much-needed budgetary and accounting standardization and transparency. We are starting to see good results from this strategy in civilian health care institutions, and the military should demand the same.

The recently proposed “governance change” for DOD health care programs is not a change in governance at all, but a re-grouping of like service functionalities such as IT, logistics, and some professional educational components, to be placed into an “agency” structure along with the TRICARE managed care functions. This re-arrangement with minimal consolidation simply does not go far enough — and for all of the effort involved will achieve marginal results.

The following issues remain unaddressed:

- There currently exists a vast amount of duplication within the current three service medical departments. This includes personnel, processes, and equipment. There is no common accounting system, and you cannot manage what you cannot see.

- Regional health care delivery between the services is still sub-optimized. Three separate services, multiple independent contractors, non-interoperable systems, and a multiplicity of oversight agencies actively impede delivery of effective care and unavoidably waste vast amounts of money. This is where the true value statement can be made between the purchased and direct care system (see chart on page 8).

- Identifying true system capacities and creating structural incentives to maximize existing infrastructure and personnel are essential. Creating a stable and predictable practice environment for the access and delivery of care is also required. Internal and external resource sharing should be emphasized where the return on investment makes sense.
In 2006, CNA’s Center of Naval Analyses economists had projected savings of at least $500 million a year from this initiative, a figure the Defense Business Board said was conservative. There have been 19 such reviews on the subject since 1947, all of which have made similar cost-savings projections.

The MHS has a total operating budget of just over $52B, most of which is used to provide care through military treatment facilities and the TRICARE Network.

Source: DOD

Identifying true system capacities and creating structural incentives to maximize existing infrastructure and personnel are essential.
3. Manage and Control Chronic Disease in the Beneficiary Population: The establishment of long-term relationships between beneficiaries and providers through prevention programs in medical home models has been shown to decrease long-term costs significantly.

- Provide for efficient and appropriate venues of care for beneficiaries when they both want and need it. Effectively expand the medical home model and other primary care models which are transparent and can demonstrate quality outcomes. For instance, the U.S. Family Health Plan’s (USFHP’s) model is demonstrating superior clinical outcomes now. Another option would establish special Medicare Advantage programs for the over 65 TRICARE For Life population, at capitated rates that guarantee savings for both DOD and Medicare. Current managed care support contractors already have much of the required infrastructure and experience to leverage into this effort.

- Decrease inappropriate emergency room usage in both the direct and purchased care environments by providing expanded clinic hours, urgent care venues, open access appointing, and true PCM availability via phone and web-based portals which will enhance the provider/patient relationship*.

- Provide comprehensive disease management with a special focus on diabetes and obesity, and include Medicare-eligibles**.

- Incentivize medication management programs (and thus reduce longer-term health costs) by eliminating copayments for medications proven to be effective in controlling chronic conditions. (Ironically, the large pharmacy copayment increases proposed in the FY2013 defense budget would actively undermine this objective by deterring some beneficiaries from strictly observing their medication regimens.)

*The rate of emergency room utilization exceeds the national average for both military treatment facility (MTF) and TRICARE network enrollees.

** Thirty percent of health care spending in the U.S. can be attributed to poor management of chronic diseases. The DOD Pharmacy Outcomes Research Team (PORT) estimates 102,000 new annual users of diabetes medications across all MHS points of service in one of the top five most costly MHS drug classes, with expenditures exceeding $311 million annually.
4. Reform the Current TRICARE Contracting and Acquisition Process.

This is one of the most important and costly areas for the military’s health care delivery system. The purchased care system currently absorbs the largest portion of the health care budget. This area should be aggressively and rigorously examined, with added emphasis in the area of creating structural incentives to decrease costs and maximize value.

The focus needs to be on the chasm which currently exists between the direct care and the purchased care systems. If this is not addressed, one side will shrink and vanish. Which one will it be?

The continued extension of the current managed care support contracts, and the modifications to those contracts as business practices change, are extremely costly to the government. The inability of the government to move forward with more progressive contracting vehicles is not only costly but also detrimental to the stability of the program and continuity of care for beneficiaries.

Actions could be taken to:

- Create contractual arrangements between the contractor (purchased care) and the military hospital commander (direct care) so both share in the risk of a capitated population. Seek innovative ways to structure this bridge between the two most costly budgetary areas, so that structurally both work together and maximize savings and efficiency.

- Provide for an insurance payment structure in the next generation of contracts which offers incentives to providers for clinical outcomes based on quality measures. Establish rewards for efficiency and value versus unnecessary or poorly evaluated procedures.***

- Consider emerging insurance payment models which redirect a meaningful proportion of professional payment toward practice transformation and population-level performance and away from volume-based practice in large network areas. A fee for value-based payment (FFV) is currently experiencing success as a pilot by Blue Cross/Blue Shield of Michigan.****

- Allow for innovative public/private contracting arrangements for the effective utilization of health care resources and capacity. The proposed fee structure in the FY2013 budget would actually inhibit the goal of recapturing expensive network care into the direct care system, as one of its objectives is to decrease Prime enrollment. These budget-driven efforts seem to contradict each other and will ultimately render the direct care system more expensive.
• Incentivize electronic interface development between the purchased care and direct care systems.

• Poor contract management has cost DOD billions. In FY 2000, Congress provided a supplemental appropriation of $1.3 billion — nearly half of which was designated for contract adjustments. Likewise, in FY 2001, TRICARE Management Activity estimated a shortfall of $1.4 billion—over a third of which was due to the settlement of contract adjustments. This pales in comparison to costs incurred between FY2009 and FY2012 as a result of repeated contract adjustments and protests. An independent review/audit of the T-3 experience would serve to provide clarity and future direction to the contracting process.

***Unnecessary or poorly evaluated procedures account for over 6 percent of hospital spending in the U.S.

****"From Partisanship to Partnership: The Payor-Provider Partnership Path to Practice Transformation” – Blue Cross/Blue Shield of Michigan, February 2012
5. Effective Use of Technology: Wounded warrior support is highly dependent on improved commonality, as are efficiencies between private-sector care and MTF care, and care between DOD and the VA.

- Common data systems can ensure access to patient information and could simplify coding and billing procedures, further reducing costs.

- Fully incorporating DOD and the VA in the president’s Virtual Lifetime Health Record initiative will provide consistency of collected information and access to common data. Both are critical to long-term care.

- MTF and civilian contracted medical providers are unable to electronically communicate between each other, further fragmenting attempts to appoint and refer patients between the systems. This intersection is ripe for innovation.
The Time to Start Was Yesterday, but We Will Have to Settle for Now

Former Defense Secretary Robert Gates and other DOD leaders repeatedly have stated that “health care costs are eating the Defense Department alive.” Over the past decade, U.S. health care costs have grown substantially, and the military health system’s costs have been no exception. The Pentagon reported health care costs have more than doubled, from $19 billion in 2001 to $52.5 billion requested for fiscal year 2012.

But focusing on the timeline since 2001 without proper context is grossly misleading.

First, a large part of the cost growth during the past decade has been driven by wartime requirements and service organizational and readiness priorities, rather than cost-efficient delivery of beneficiary care. When doctors and other health care staff deploy, for example, more patients must be shifted to more costly civilian care.

Another reason the 2001 baseline for measuring DOD health cost growth is misleading is that the BRAC-driven elimination and downsizing of hundreds of MTFs effectively disenfranchised Medicare-eligible beneficiaries from any DOD-funded care. After six years of outraged grassroots action from that population, Congress authorized TRICARE For Life and TRICARE Senior Pharmacy coverage in 2001. At the time, congressional and Pentagon leaders alike hailed this as the right and proper thing to do. In the intervening years, they have been prone to express shock at what was entirely predictable in 2001: that reinstating service-earned and well-deserved health care coverage for beneficiaries over 65 would be expensive.

Finally, the very nature of military health care management itself causes problems related to creating consistent process improvements. In this regard, the continuous turnover of hospital and clinic commanders through promotion and reassignment every two years or so actively impedes continuity of leadership, process, and oversight.

These personnel moves sometimes diminish a sense of urgency, because problems will remain for whoever comes in next. A sense of “this must be done now, not left to my successor” needs to be created, and commanders need to be held accountable.
In Conclusion: Getting From Here to There – a Call to Action

Even though we refer to the Military Health System, the reality is that there is a lack of “system-ness.” This is the root cause of poor cost and quality performance of beneficiary health care delivery. An explicit focus on system development and transformation is needed to achieve better and more transparent results at both the individual and overall population health levels.

Some positive changes have occurred in the military’s health care system over the past few years, including ongoing movement toward the medical home model of primary care and the effort to transition from expensive retail distribution of pharmaceuticals into a more cost-effective method such as home delivery. Still, these efforts are focused primarily on TRICARE Prime enrollees, with little involvement of TRICARE Standard and TRICARE For Life beneficiaries, many of the latter being at highest risk.

Further, in the current context of the U.S. health care industry, many hold the view that much broader reforms are needed to keep pace with changing patient demographics, the evolution of health care delivery, and the need to use health care technologies more effectively.

Many prior studies that called for the military’s health care system to transform have failed to produce meaningful change. Now, various forces have converged to make a more compelling case for accelerating transformative change. Yes, the cost growth of health care in the current DOD system, as in our entire country, is troubling, and everyone must do his or her part and be responsible stewards of resources. MOAA believes we should not balance the budget by simply shifting disproportionate costs onto our troops, retirees, survivors, and their families – the people who have already given the most. The first responsibility is to exercise the rigorous leadership required for transformative change.

The current heavily bureaucratic model of the military health care system is an anachronism we no longer can afford to maintain. A truly integrated model has emerged as the most effective way to deliver care. Effective integration takes dedication, work, trust, and a lot of energy by all parties. It involves breaking down silos and working in a new way, which is often uncomfortable, but absolutely essential. Delivering health care is complex, but integration is the best model for meeting the needs of patients today and improving the health of the beneficiary communities.
MOAA Mission Statement

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