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Committee on Armed Services
United States Senate

Military Health System

An Overview Statement

By

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Submitted to the

Personnel Subcommittee
Committee on Armed Services
United States Senate

March 13, 2002

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Chairman Cleland, Senator Hutchinson, and Distinguished Members of the Subcommittee, thank you for this opportunity to appear before you today to discuss the Military Health System.

The terrorist attacks of September 11th and the bioterrorist incidents that followed in October have awakened us all to a very real threat of terrorism. Through that prism we examined the Military Health System, refined its responsibilities and mapped a course that we must pursue in order to protect the health of our men and women in uniform. This course is pre-eminent in our priorities and is encompassed in our vision for military medicine. That vision is to attain world class stature as a healthcare system, one that meets all wartime and peacetime health and medical needs for the active military, retirees, their families, and other entitled beneficiaries.

Achieving this vision will require more than just the traditional focus upon preventive medicine and the delivery of restorative healthcare. To meet the health and medical needs of our entire beneficiary population while meeting our requirements for the force health protection of our active duty personnel, we must continue to improve and seek to optimize our integrated system of healthcare. This integrated system consists of uniformed, civil service and contract medical personnel working together to improve the health of our beneficiaries across the country and around the world.

This system must rapidly identify and mitigate potential health threats, and provide preventive measures and education to preserve the health and vigor of our population. Should these measures fail, we must be prepared to treat disease and restore the sick and injured to health through use of the most efficacious treatments that medical science can offer. The need for an effective, integrated system also extends beyond the period of active service, for those in need of rehabilitation following injury or illness, and for the care of our retired beneficiaries who have honorably served their country. All the while, we must continuously improve the quality of care we provide, the safety and satisfaction of our patients and exercise fiscal stewardship in managing the system.

We must use the concepts of evidence-based medicine to ensure that patients receive treatments that are effective. We must continue to contribute to the body of medical knowledge by participating in scientific research, particularly in our knowledge of hazards of the battlefield, chemical and biological terrorist threats, and the operational environment.

As we face the threat of terrorism, it is more important than ever that we ensure effective coordination and cooperation with other federal agencies and organizations with necessary expertise. These include the Congress, and especially the Departments of Veterans Affairs and Health and Human Services.

Accomplishing this vision will require that we create and maintain high quality information systems, that we attract and retain high quality medical professionals, that we provide the necessary tools and training for our personnel, and that we maintain our commitment to achieving the vision.

Military Health System Funding

In the President's Budget Request for FY 2003, the DHP submission is based on realistic estimates of providing healthcare benefits to DoD eligible populations. It includes inflation assumptions for pharmacy of 10.5% plus anticipated program growth for an overall of 15% from FY02 program. Private sector health costs have been inflated at 7% to reflect our recent experience: anticipated program growth brings the overall rate of change to 12% from FY02. We will manage the healthcare system to improve performance and contain the healthcare costs within budgeted amounts. We will make prudent decisions that result in effective performance. We seek your assistance in making permanent the contract management flexibility you provided in the National Defense Authorization Act for FY 2002 and in alleviating the restrictions on moving resources across budget activity groups. The Department must have the freedom to move funding in response to where healthcare is received, either within the military healthcare facilities or through the private sector.

The President's budget for the DHP consists of the following amounts (\$M):

Operation and Maintenance (O&M):	\$14,360
Procurement:	\$ 279
Research, Development, Testing & Evaluation (RDT&E):	\$ 67
Total	\$14,706

O&M Funding by Budget Activity Group (\$ Thousands)

Direct Care	\$ 4,070,811
Private Sector Care	\$ 7,159,674
Consolidate Health Support	\$ 809,548
Information Management	\$ 666,709
Management Activities	\$ 221,786
Education and Training	\$ 350,092
Base Operations/Communications	\$ 1,081,651
Total O&M	\$14,360,271

In addition to the DHP budget, the Military Health System is supported with \$6.0 billion for Military Personnel (MILPERS) and \$0.165 billion for Military Construction. The FY 2003 total unified MHS budget is \$20.9 billion.

The DoD Medicare Eligible Retiree Health Care Fund is projected to provide an additional \$5.7 billion for the healthcare costs of Medicare-eligible beneficiaries, \$4.3 billion for private sector care, \$0.8 billion for direct care (O&M), and \$0.6 billion for MILPERS.

This budget request reflects implementation of accrual financing for the healthcare costs of Medicare-eligible beneficiaries, including their new TRICARE for Life benefits. This will entail both payments into the fund (\$8.1 billion) to cover the government's liability for future healthcare costs of current military personnel and receipts from the fund (projected \$5.7 billion) to pay for care provided to eligible

beneficiaries. Our budget reflects a decrease to the DHP appropriation to account for the payments from the Fund and an increase to the military services' Military Personnel accounts to cover the Department's normal cost contribution. This alignment ensures consistency with the accrual funding for the military retirement pension costs under Title 10, chapter 74. We ask your help in modifying NDAA 2001 and 2002, which currently direct that the Defense Health Program make the annual contribution to the accrual fund. It is the Military Personnel accounts that should make these payments. They have received increases for this purpose in the FY 2003 Budget Request.

Force Health Protection and Medical Readiness

Even before the events of September 11th, Secretary Rumsfeld's Quadrennial Defense Review assented that both terrorism and chemical and biological weapons would transform the strategic landscape for the Department. The terrorist acts of last fall placed us on a war footing and escalated the urgency of our need for preparedness. The MHS has underway numerous activities to ensure that preparedness, including formation of a high-level working group with Department of Health and Human Services representatives to improve collaboration on defense against biological and chemical terrorism. Deliberations continue on the future of the anthrax vaccine immunization program now that we have confidence in an assured supply of FDA-approved vaccine. The MHS has also placed renewed emphasis on training military healthcare personnel in recognizing symptoms of and refreshing treatment plans for exposure to chemical and biological agents.

We are actively developing Investigational New Drug (IND) protocols and guidelines for possible use during the war on terrorism, to include protocols on smallpox vaccine, pyridostigmine bromide (PB) tablets, botulinum toxoid vaccine, and anthrax vaccine post-exposure with antibiotics. The MHS is developing and implementing a seamless system of electronic healthcare and surveillance data, integrating the entire spectrum from fixed facility systems to field hand-held technology. The deployment health system is maturing in response to a growing array of acute and chronic deployment health concerns, with recent added emphasis on environmental and occupational health surveillance.

We continue to expand and improve both the vaccine healthcare center network to support our world class vaccine safety assessment program, and the deployment health clinical center network to provide multidisciplinary evaluation and treatment of service members with deployment related health problems.

TRICARE

This military health system (MHS) program benefit provides an essential and interdependent link between medical readiness and everyday healthcare delivery. Meeting the force health protection responsibilities of the MHS depends upon the success of TRICARE in providing both quality healthcare and challenging clinical experiences for military healthcare providers. Very important to this success is a stable financial

environment. The President's fiscal year 2003 Budget Request for the DHP provides that stability.

TRICARE Contracts. TRICARE's success also relies on incorporating best business practices into our administration of the program, specifically our managed care contracts. Our new generation of TRICARE contracts (T-NEX) will encourage best business practices by the contractors without over direction by the government. We also are working with the Department of Veterans Affairs to make sure T-NEX provides appropriate opportunities for VA participation in provider networks. We have listened to the advice of industry and our beneficiaries on how to structure these contracts and we are confident that the design will help us to continue providing high quality care. We enter this new generation of contracts with a commitment to our beneficiaries to earn their satisfaction and to ensure continuity of quality services. We place a great deal of importance on contractor customer service performance -- to include positive and negative financial incentives -- to ensure that our beneficiaries are provided the kind and type of information and services they seek in a timely and accurate manner. Also, we will continue to partner with The Military Coalition and National Military and Veterans Alliance, who collectively represent the interests of more than four million current and former military personnel. This partnership ensures that we really know what our beneficiaries feel and think about the TRICARE Program. Their feedback helps us to better address the concerns and needs of our beneficiaries.

TRICARE for Life. Implementation of TRICARE for Life has proceeded exceptionally well. As in all new program startups, we have experienced problems. Nevertheless, we aggressively handle each one until we reach a satisfactory resolution. Since the October 1, 2001 start date, we have processed over six million claims and the overwhelming majority of information we receive is that our beneficiaries are extremely satisfied with TRICARE for Life. They speak very highly of the senior pharmacy program as well. This program began April 1, 2001, virtually problem-free, and through February 15, 2002, 8.6 million prescriptions have been processed through the TRICARE retail pharmacy networks and the our National Mail Order Pharmacy program, providing over \$539 million in prescription benefits for our age 65 and over beneficiary population.

Examples of the problems we identified and addressed with the initial implementation of TRICARE for Life include a group of 185,000 beneficiaries inadvertently excluded from the initial data match with CMS to verify Medicare Part A and B coverage. This problem did not involve denial of benefits for these beneficiaries. Rather, Medicare could not forward their claims automatically to TRICARE for the first 60 days. We have corrected this problem.

Another example involves approximately 4% of **potentially** eligible TFL beneficiaries who have not revalidated their military benefits eligibility status as required every four years. This affected only family members, as retirees retain eligibility without periodic revalidation. The failure to revalidate eligibility (sometimes referred to as obtaining a new ID Card) resulted in claims being denied. We have several steps underway to address this issue:

- We determined that the potential for these individuals to be eligible is so high that TRICARE began paying claims for these beneficiaries February 15, 2002. Concurrently we are notifying each beneficiary through personal letters and Explanation of Benefits messages that they must revalidate their eligibility. We will continue paying claims for these individuals through August 1, to allow them ample opportunity to update their eligibility.
- The Defense Manpower Data Center developed a letter that beneficiaries may sign and return to validate their continuing eligibility. This eliminates the need to travel to an ID card issuing facility to obtain a new ID card. In the mean-time, DoD will track these beneficiaries and use every reasonable means to assist them with this process.
- In addition to contacting individual beneficiaries, we will renew our efforts through the media, caregivers, beneficiary organizations, and other organizations to inform all beneficiaries about their TRICARE for Life opportunity.

TRICARE for Life is secondary payer to all other health insurance (OHI). When TRICARE records indicate that a beneficiary has other health insurance, an informational Explanation of Benefits is issued showing how much TRICARE would have paid had the beneficiary not had other health insurance. This provides the beneficiary with helpful information to determine if the premium they pay for their OHI is worth the benefit. When a beneficiary cancels their OHI, they may simply telephone TRICARE with the date their other coverage was canceled and TRICARE will reprocess any incorrectly denied claims.

Sub-acute and Long Term Care. The reform actions implemented through NDAA - 02 ensure availability of high-quality sub-acute and long-term medical care and services for all DoD beneficiaries in the most efficient manner. The new authority to provide home healthcare and respite care for qualifying active duty family members supports readiness through the improved quality of life for special needs families. Alignment of the TRICARE benefit and payment system for skilled nursing facility and home health care with Medicare will greatly improve coordination of benefits for our age 65 and over beneficiaries and simplify authorization and provision of medically necessary sub-acute and long-term care for all.

Portability. The TRICARE National Enrollment Database (NED), implemented July 2000, provides health coverage portability to all TRICARE Prime enrollees. NED provides a standardized beneficiary-centered enrollment process and eliminates the procedural and automated systems' disconnects that existed throughout the military health system, including the contractors' systems, prior to the implementation of the NED.

In our continuing efforts to improve and optimize our military health system, the military services are developing plans for the FY01 and FY02 optimization dollars provided by Congress. Service health leaders developed the MHS Optimization Plan in 1999 setting forth an overarching five-year strategy to guide health system improvements to achieve a more efficient, cost-effective, world class integrated health system supported by advanced

information technology and reengineering of our clinical and business processes. The foundation of the optimization plan is population health improvement and prevention, also the cornerstone of Force Health Protection in support of our readiness mission, delivered proactively with optimal use of our resources. A Special Assistant for Optimization was established at the TRICARE Management Activity to assist in integration of these efforts. A MHS Population Health Improvement Plan and Guide has been published which provides our clinical staffs with guidance for most efficiently managing the health of our beneficiaries.

Coordination, Communication and Collaboration

The MHS has built many strong relationships among other federal agencies – including the Congress - professional organizations, contractors and beneficiary and military service associations. These relationships facilitated the MHS's ability to respond in the aftermath of the terrorist actions of last fall. The MHS role in the new homeland security responsibilities will span an array of federal, state and local agencies and will demand effective cooperation among all involved. Our close working relationship with beneficiary associations and our contractors can be credited for the smooth implementation of TRICARE for Life.

DoD's collaboration with the VA dates back many years and much has been accomplished. We have eight joint ventures throughout the country providing coordinated healthcare to VA and DoD beneficiaries. We have over 600 sharing agreements in place covering nearly 7,000 healthcare services. However, all of these agreements are not fully utilized. Eighty percent of VA facilities partner with us through our TRICARE networks. It should be noted, that the level of participation by VA within the TRICARE networks varies. Our reserve components capitalize on education and training opportunities with over 300 agreements in place. DoD, VA and the Indian Health Service collaborate in the Federal Health Care Information Exchange (formerly known as the Government Computerized Patient Record) which will enable DoD to send laboratory results, radiology results, outpatient pharmacy, and patient demographic information on separated Service members to the VA. Before FY 2005, we expect not only to have the ability to transmit computerized patient medical record data to VA but also to receive this information from VA. While we have achieved many successes, it is time to reinvigorate these collaborative efforts to maximize sharing of health resources, to increase efficiency, and to improve access for the beneficiaries of both departments. The focus of our efforts is to move the relationship with the VA from one of sharing to a proactive partnership that meets the missions of both agencies while benefiting the service member, veteran and taxpayer.

Our vision of DoD/VA coordination is a mutually beneficial partnership that optimizes the use of resources and infrastructure to improve access to quality health care and increase the cost effectiveness of each department's operations while respecting the unique missions of the VA and DoD medical departments. Our guiding principles include collaboration; providing the best value for the taxpayer; establishment of clear policies and guidelines for DoD/VA partnering; and fostering innovative, creative arrangements between DoD and VA. As DoD and VA move toward a more proactive partnership, we have established short-term goals to be accomplished during this fiscal

year. These include establishing solid business procedures for reimbursement of services, improving access to health care through VA participation in TRICARE, examining joint opportunities in pharmaceuticals, facilitating healthcare information exchange, and establishing a long-range joint strategic planning activity between DoD and VA. We will accomplish this through the VA-DoD Executive Council, where senior healthcare leaders proactively address potential areas for further collaboration and resolve obstacles to sharing.

Concurrent with these ongoing efforts, DoD actively supports the President's Task Force to Improve Health Care Delivery to Veterans announced by President Bush on Memorial Day 2001. DoD has provided office space, administrative support and functional experts to ensure the Task Force accomplishes its mission of developing recommendations to improve quality and coordination of healthcare for our nation's veterans. I will continue to work closely with my colleague, Dr. Gail Wilensky, to ensure the success of the Task Force in meeting their objectives; and we look forward to the Task Force's recommendations.

Military Medical Personnel

The Quadrennial Defense Review directs development of a strategic human resource plan to identify the tools necessary to size and shape the military force with adequate numbers of high-quality, skilled professionals. The MHS depends on clinically competent, highly qualified, professionally satisfied military medical personnel. In developing the MHS human resource plan, we have begun several initiatives to determine retention rates, reasons for staying or leaving the service, and what factors would convince one to remain in the military.

At the request of Congress, we commissioned a study by the Center for Naval Analyses (CNA) to examine pay gaps, retention projections, and the relationship between pay and retention. We acknowledge the significance of the findings. The CNA study shows a relationship between pay and retention – although it points out that there are factors other than pay that affect retention. A typical military physician – for example, a general surgeon with 7 years of service – receives one half of his or her income in incentive pays. While base pay and other components which make up the remaining half of total compensation have been increasing recently, the incentive pays have not kept up with changes in the civilian community. CNA estimates the pay gap for the surgeon is currently \$137,000, or 47%. The challenges of military service can be unique and tremendously rewarding personally and professionally. We know that financial compensation is not the sole determinant of a medical professional's decision to remain in the service or to leave. We can never expect to close the pay gap completely. However, we are concerned by the CNA findings and are analyzing them now. Incentives to optimize our ability to shape military medical staff size and mix with appropriate experience levels are critical to meeting our mission requirements.

We will simplify the health professions' incentives authority to place more management authority within the Department. The rapid pace of change in the civilian healthcare personnel market, which competes directly with our military accession and

retention programs, requires flexibility in the management of incentives for optimum effectiveness.

Additionally, we are expanding our use of the Health Professions Loan Repayment Program (HPLRP). The President's Budget provides funding for an increase of 282 scholarships. In addition we are exploring ways the Department can maximize use of incentives in the efforts to optimize the accession and retention of appropriate personnel to meet mission requirements.

Military Health Information Systems

We leverage advances in information technology to contribute to the delivery of quality care, patient safety, improved system management and ease of patient access to healthcare. An essential element of quality remains the assurance of the credentials of the health professionals practicing in our health system. We have now in operational testing at ten military medical facilities a single database that supports the management of the professional credentials for active and reserve component health personnel across all services. We anticipate that this system, the Centralized Credentials Quality Assurance System, will begin full deployment to all sites this Spring. We plan to explore the potential for integrating this system with the Veterans Administration's credentials system, VetPro.

The Theater Medical Information Program supports the medical readiness of deployed combat forces. This system will aggregate medical information from all levels of care within the theater thereby supporting situational awareness and preventive medicine needs for operational forces. Medical data generated at battlefield locations will be transmitted to a central theater database, where the command surgeon will have a comprehensive view of the theater medical battlefield and be in a better position to manage the medical support to all forces. This system serves as the medical component of the Global Combat Support System and has an integrated suite of capabilities that includes the Composite Health Care System II. User testing will be conducted this summer during Exercise Millennium Challenge and initial operational test and evaluation is scheduled for later this year.

The Military Health System has successfully created an electronic computer-based patient record. The Composite Health Care System II (CHCS II) generates, maintains and provides secure electronic access to a comprehensive and legible health record. CHCS II merges the best commercial off-the-shelf applications on the market into a single integrated system capable of worldwide deployment both in fixed facilities and in the field environment, as part of the Theater Medical Information Program. The Composite Health Care System II will undergo formal operational test and evaluation this summer. Once completed, a worldwide implementation decision will be made in 3Q FY02.

Optimizing the Military Health System continues to be a high priority in our efforts to effectively manage and operate the TRICARE program. The Executive

Information/Decision Support Program assists health managers at all levels throughout the MHS. This program provides an exceptionally robust database and suite of decision support tools for health managers. It supports managed care forecasting and analysis, population health tracking, MHS management analysis and reporting, Defense medical surveillance and TRICARE management activity reporting. The data repository began operating in FY 2001.

The Defense Medical Logistics Standard Support Program reflects how information technology and business process re-engineering can lead to significant return on investment and tremendous user satisfaction. This program provides responsive medical logistics support to all military services. Electronic catalog sales have grown from \$204K in April 1999 to over \$23.2M in FY 01. The prime vendor section of this program has grown to electronic sales of \$1.3B in FY 01. More importantly, it has reduced procurement lead times from up to 45 days to 2 days or less, reduced medical logistics inventory by 85 percent and allowed a 95 percent fill rate with delivery in less than 24-hours. This program is the first in DoD to receive Clinger-Cohen Act certification.

TRICARE Online uses the Internet to assist our beneficiaries gain access to the Military Health System. It is an enterprise-wide secure Internet portal for use by all DoD beneficiaries worldwide. It provides information on health, medical facilities and providers, and increases patient access to healthcare. Beneficiaries may create their own secure health journals securely on this site, TRICARE Prime patients may make appointments with their primary care providers, and all beneficiaries may access 18 million pages of health and wellness information. This system is scheduled for worldwide deployment later this year following operational testing now underway.

We believe that our medical technologies can be helpful to the Department of Veterans Affairs and together we are exploring joint technologies as a means for closer collaboration.

As the MHS pursues the many initiatives outlined above, it will become even stronger. The Military Health System's continued mission-oriented focus on its primary responsibilities has further cemented its world-renowned stature as a leader in integrated healthcare.

Again, I thank you for this chance to speak with you about the Military Health System and the exceptional people who make it the vibrant, innovative, comprehensive system that it is.