"Defense Health Care Reform"
Testimony before the
Personnel Subcommittee of the
Senate Armed Services Committee
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February 23, 2016

Introduction

Good afternoon Chairman Graham, Ranking Member Gillibrand, and members of this distinguished Committee.

Thank you for the invitation to appear before you today at this initial hearing on Defense Health Care Reform. I applaud you and your colleagues for taking on this subject and I am pleased to share with you my views on this topic, as you and the Defense Department seek to ensure that the Defense Health System remains strong and is able to provide optimal support to those who wear the cloth of the nation, their families and those who earned a retirement health benefit due to their career of service in the uniformed services.

For almost 20 years I have had the distinct privilege of co-founding and leading a company, TriWest Healthcare Alliance, whose sole mission is standing alongside the federal government – initially with the Department of Defense and now with the Department of Veterans Affairs (VA) – in serving the health care needs of those who serve this country in uniform and their families. Prior to this privileged work, I had the honor of serving almost nine years in the offices of the U.S. Senate, where I was responsible for health-policy issues for the Chairman of this Committee, Senator John McCain, and Senator Slade Gorton (R-WA). That time included much engagement in this space, including at the time of the birthing of the TRICARE program legislatively.

It is with this comprehensive policy and business background that I am in front of you today. I did not go out looking to testify before you but I feel it is my personal responsibility, based on my experience in working with the federal government in this critical space and in understanding the needs of our deserving Service members and their families, that I share with you my view of how to bring best commercial practices to bear in the military health space while also maintaining the readiness of our military and ultimately ensuring the long-term fiscal health of the Department of Defense (DoD).

In 1996, a group of non-profit health plans and university health systems came together and founded TriWest Healthcare Alliance. Our initial mission was to serve the DoD in bringing up the first TRICARE contract in what were then Regions 7 and 8, which we assisted the DoD in folding into the TRICARE Central Region at a savings to the government. We then went on to serve the 21-state TRICARE West Region. And while today TRICARE is recognized as a solid benefit for our nation's Service members and their eligible family members, it took many years of hard work, focus, and most importantly partnership between the contractor community and

DoD's health care system to mature it to the point of stability and fashion it into the successful program that it is today. I am proud of the role TriWest played, along with our colleagues in the contractor community, in the implementation, maturation, and improvement of that program during our years of service in support of the Defense Department. And, after being toughened up a bit, I am even more proud today to have the privilege of bringing that same focus and singular-purpose intensity to the side of VA as they seek to enhance access to care in the community and re-set themselves for this generation's Veterans and those that will follow.

In addition, TriWest has the privilege of serving the U.S. Marine Corps as the worldwide operator of the DSTRESS stress and suicide-prevention contact center and providing back-up to their Sexual Assault Prevention and Response (SAPR) line. While certainly not perfect, I am proud to say that we have not lost a Marine in our nearly seven years of work in this critical space. We also serve the U.S. Air Force by providing appointing service in three Military Treatment Facilities in the Continental U.S.

At TriWest, we found that the successful delivery of all of these services demands a collaborative approach between all the stakeholders. And, I believe that history will continue to reflect positively on the road that we collectively traveled during our time at the side of DoD, as we achieved much collective success to the benefit of those that we were jointly privileged to serve. And, though it took a bit of time to mature, as all large and complicated programs do, TRICARE demonstrated one of its core intended purposes in being stood up… giving the direct care portion of the DoD Health System the ability to necessarily project forward into a theater/theaters of war and continue to provide for the needs of those staying behind given the elasticity provided through consolidated civilian provider networks. I am also very proud of the unique success we had in mapping and developing networks to Guard units across the vast expanse of our 21 states of operation, so that they and their families might have access to the basics when they were not available in their geographic locale through DoD's physical footprint.

Much of the work we did so successfully at the side of DoD has carried over to that which we are now privileged to do in support of VA as it seeks to re-tool to more successfully meet the needs of Veterans, including those of our generation's War on Terror. While that work, much like that which we were privileged to perform in support of DoD, demands our all at this moment, it was nice to have a reason to step back and reflect a bit… and be prepared to share with you a few of my thoughts regarding the next generation of refinement/reform of the Military Health System (MHS).

Mr. Chairman and members of this distinguished Committee, I believe that any framework for reform needs to begin with an assessment of what is working and not working, what the environmental conditions are likely to look like in the future – including the "Go to War" capabilities, and what approach will likely ensure success in the future.

It goes without saying that the DoD Health System, like VA, is not the private sector… and, parts of their mission and the expectation we all have as citizens in how we will care for and support those who put themselves in harm's way – sometimes at a very high personal cost to their health – necessarily means that it will not and should not mirror the private sector. However, there are definitely places where the private sector can ensure elasticity of access for

the direct care system and bring core competencies to the equation that also afford the direct care system the ability to achieve its quality objectives and keep costs under control.

As I stepped back and thought about the reform question, based on now having the benefit of 20 amazing years of serving those who serve at the side of DoD and now VA, I would be asking four questions.

First, knowing what we know today and looking into the future, do we have the optimal footprint and most effective/efficient management structure and tools/support system? And, are we effectively and efficiently optimizing the investment in the direct care system?

Second, does the benefit available to the population make sense, and is it priced properly?

Third, is access to care easy and do we have the optimal approach to provide the direct care system with needed elasticity in access to providers when they are unable to meet the health care need directly?

And fourth, are we optimally promoting health and effectively and efficiently supporting those whose unmanaged health issues are both bad for the individual and more costly to the DoD?

Optimal Footprint, Management Structure and Tools

First, knowing what we know today and looking into the future, do we have the optimal footprint and most effective/efficient management structure and tools/support system? And, are we effectively and efficiently optimizing the investment in the direct care system?

There is a great deal of expense inherent in the physical footprint, the equipment that has to be purchased and kept current, and the personnel required to staff the footprint. Over the years, the DoD has had a solid focus on downsizing from hospitals to clinics where it made sense and testing various models for how to make more efficient use of operating resources. As you know, there has even been the exploration of joint use DoD/VA facilities over the years, with the most recent project in Chicago. There is great efficiency and effectiveness to be gained when sizing, make versus buy and collaboration are approached properly, and I believe it is time to look at making this approach the rule instead of the exception. I also think that evaluating leasing options versus traditional ownership is worthwhile.

I would suggest that part of optimal footprint design is the leveraging of telehealth. While DoD has made much use of this technology over the years – and certainly has been very effective in harnessing it of late to support the needs of the warfighter – I believe there would be much gained from exploring its application, and the associated tools that are starting to emerge in the marketplace, in optimizing the reach of both military and civilian providers in supporting those who use today's manpower-intense nurse advise lines, those who suffer from chronic illnesses and those for whom behavioral health counseling would be more accessible through leveraging this mode of access.

I would also observe that all of us in health care are increasingly learning the importance of data, and data analytics capability to feed optimal decision-making… whether it is used to determine what is made versus bought, identify the most effective targets for disease and condition management investment, or how to optimally tailor provider networks to effectively meet patient need. Solid data and the skilled people who have the ability to understand and use it must be at the core of any health reform effort. This is an area where investments are essential, and if done properly will yield much dividend down the line. Thus, I would encourage a deliberate focus on what is needed to achieve success… in terms of the systems, the data analytics tools, and the investment in personnel needed to give the MHS the critical tools needed in this area.

As for management structure, there has been much written, proposed and discussed over the years. It would seem that there is opportunity in this space as well to achieve savings and enhance effectiveness, just has been done with the evolution in the way in which the military medical community is collaborating and integrating to support the warfighter. While not easy, streamlining the number of players and consolidating functions will also make the organization more agile in the work that it does.

TRICARE Benefit

Second, does the benefit available to the population make sense and is it priced properly?

As we all know, the TRICARE benefit has evolved into a solid element of the compensation package for military personnel, their families and military retirees. The early days of the program were not easy as tweaks needed to be made. But, we all stayed at it and at the time we left our work at the side of DoD, it had evolved into one of the highest rated health plans in existence.

Having said that, one of the challenges that seem to perpetually exist is what to do with the pricing structure for the various elements of the TRICARE plan. As you and the Department work through this year's version of those decisions, I would encourage serious consideration be given to how to effectively establish an indexing approach that is simple, actuarially-based and has automatic triggers so that the need for Congress to engage in rate-setting decisions on an annual basis becomes a thing of the past.

Access to Care

Third, is access to care easy and do we have the optimal approach to provide the direct care system with needed elasticity in access to providers when they are unable to meet the health care need directly?

One of the areas we spent a great deal of time and energy on during our work supporting the Defense Department and its TRICARE beneficiaries in the West Region was easing the complications of access to care when the supply existed within the Military Treatment Facilities. It required an elaborate and evolved set of tools and processes customized to each location to support the referrals into the facilities. When we came into the second generation of the TRICARE contracts there was to have been an electronic system which we were to connect to in order to make the process seamless. It was never built. And, rather than wringing our hands, we

stepped back and re-configured our approach in order to make the processes work in the absence of the electronic systems availability. My understanding is that such a system that allows for the connection between the direct care system and the TRICARE contractor seeking to ensure the maximal use of the direct care system, to the benefit of the patients and the taxpayer, still does not exist. It was a worthy notion then, and I believe that remains the case.

In working this piece, it is critical, though, that the focus not just be on electronics. It needs to start with a review of the processes for how appointments are made and managed and how authorizations move between the direct care system and the TRICARE contractors. This review should be done in order to both allow for the refinements in those processes and ultimately to ensure that the systems work for the processes they were designed to serve.

Lastly, a core element of access to care is ensuring that the networks built by the TRICARE contractors are constructed to match the need that exists for care in the community. They should provide optimal elasticity for the direct care system, which means that it is incumbent on the direct care system to be engaged in recurring Demand Capacity modeling with the TRICARE contractors. And, in order to optimize the budget, the networks should be priced at market rate.

Optimally Promoting and Paying for Health

And, fourth, are we optimally promoting health and are we effectively and efficiently supporting those whose unmanaged health issues are both bad for the individual and more costly to the DoD?

With infrastructure optimized, critical tools in place and fully leveraged, and access to care within the direct care system being fully leveraged with necessary and appropriate elasticity available through the provider network in the community, we are to the final piece I would like to touch on. That is optimally promoting health… which starts with supporting the patient, and, if done right, results in cost avoidance.

It is about improving value for the patient and improving value for the taxpayer. If done right, these are not mutually exclusive concepts. And, indeed, those who are doing it well in the private sector are demonstrating that both are possible. My colleagues on this panel, in fact, are very steeped in this topic.

When I look at it from my vantage point, I think there are several core elements to success.

First, it is segmenting the population and focusing in on those who benefit most from assistance in the management of their conditions. To facilitate this, I would suggest that requiring an annual analysis of the population's health by both the MHS and the TRICARE contractor would be of value.

Second, it is the development and deployment of an integrated approach to disease management for that specific profile of conditions… so that the treatment will be coordinated and well managed regardless of whether a specific component of care is delivered by a provider in the direct care system or a provider in the network.

Third, it is the development of a customized treatment plan for the individual patient and the modification of the TRICARE program to provide a series of incentives and disincentives for compliance with the treatment plan. The most effective programs in the country are using a mix of carrots and sticks to encourage adherence.

And, fourth, is the adoption of provider payment models that appropriately reward providers for quality outcomes and reductions in overall spend as the key partner that they are in serving the patient. I would suggest doing pilots in this area to test what would work optimally in a unique system like the MHS, but I am confident that you will find significant benefit from a better alignment with the new pay tools that are emerging in the private sector and also being tested in Medicare.

Conclusion

In closing, I want to thank you for the invitation to appear before you today. It was an honor and privilege for my colleagues and I at TriWest Healthcare Alliance to be of service to the beneficiaries of the Military Health System as it is to now be of service to our nation's Veterans at the side of VA. I hope that my testimony today has been helpful to you as you contemplate the way ahead as it relates to continuing to refine the Military Health System and the TRICARE benefit, and I look forward to answering any questions you might have.