Military Health System

Overview Statement

By

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Senator Chambliss, Senator Nelson, Distinguished Members of the Subcommittee, I am honored to have this opportunity to discuss with you the Military Health System. Military medical personnel have superbly supported military operations in Afghanistan, Iraq, and elsewhere. We have awarded a full suite of new TRICARE contracts, extended our sharing and cooperative efforts with other federal agencies, and continued to provide quality healthcare to our 8.9 million beneficiaries. Using the balanced scorecard approach to strategic planning, we have focused on readiness, effectiveness of our health plan and patient satisfaction with access to care.

Military Health System Funding

Before describing our activities, I would like to address our funding situation and highlight initiatives to manage costs. Defense Health Program (DHP) costs continue to rise due to increased utilization of the Military Health System (MHS). The Fiscal Year 2005 DHP funding request is $17.640 billion for Operation and Maintenance, Procurement and Research, Development, and Test and Evaluation Appropriations to finance the MHS mission. We project total military health spending to pay for all health-related costs including personnel expenses, and retiree health costs, to be $30.4 billion for FY05. In 2003, the DHP experienced a seven percent increase in new users, and we anticipate another seven percent growth for 2004. This growth is the result of increased healthcare costs in the private sector, and the consequent election of MHS-eligible beneficiaries, mainly our retirees, to drop private insurance coverage and rely upon TRICARE. Additionally, activation of Reserve Component members adds to the number of MHS-eligible beneficiaries. To fund this growth, the Operation and Maintenance

Appropriation submission is 15 percent more than the Fiscal Year (FY) 2004 appropriated amount.

The Department has taken several actions to better manage resources. The MHS is implementing performance-based budgeting, focusing on the value of services delivered rather than using other cost methods. We are introducing an integrated pharmacy benefits program that uses a standardized formulary that is clinically and fiscally sound. Federal pricing of pharmaceuticals in the TRICARE retail pharmacy program will significantly contain costs. Quality management programs continue to ensure that care provided is clinically appropriate and within prescribed standards.

Performance-based budgeting. With this budgeting approach, we intend to base MTF budgets on output or work-related factors such as the number of enrollees, hospital admissions, prescriptions filled and clinic visits, rather than on anticipated requirements such as number of staff employed, increased supply costs, and historical workload. We will institute a Prospective Payment System for MTFs with capitation payments for their enrollees. We will also include a fee-for-service funding mechanism for MTFs that is tied to the value of care provided for beneficiaries not enrolled at their facility.

Integrated pharmacy benefits program. The redesign of our pharmacy programs into a single, integrated program, beginning in June 2004, simplifies and allows us to more effectively manage this $4 billion benefit. We will standardize formulary management, achieve uniform access to all medications, enhance portability, and involve beneficiaries in formulary decision-making. We will promote the use of more cost-effective products and points of service.

Application of federal pricing for the retail pharmacy benefit will allow the Department to obtain manufacturer refunds for medications obtained through this point of service. We currently use federal pricing for mail order and MTF pharmacy services.

Quality management programs. We continue to improve the quality of care delivered throughout the MHS, employing sound management practices and metrics to ensure appropriateness of care. We monitor the health of our population using Healthy People 2010 goals as a benchmark, and we measure the quality of care provided using Joint Commission on Accreditation of Healthcare Organizations Oryx indicators.

Our new healthcare contracts use best-practice principles to improve beneficiary satisfaction and control private sector costs. Civilian partners must manage enrollee healthcare and can control their costs by referring more care to MTFs. In concert with these new contracts, and the implementation of the Prospective Payment System to create financial incentives for MTFs, we need the flexibility to flow funds between MTFs and the private sector. Currently, MTF revised financing funds are in the private sector budget activity group. Restricting the movement of DHP funds does not allow MTFs to use these revised financing funds to increase productivity and workload without prior-approval reprogramming. We appreciate the Congressional intent to protect direct care funding. However, the current restrictions on funding adversely affect MTFs as well as care in the private sector. We urge you to allow MTFs and the MHS to manage the DHP as an integrated system. Funds must be allowed to flow on a timely basis to where care is delivered. We need your help in restoring flexibility needed to manage DHP resources across budget activity groups.

Force Health Protection

The Department's Force Health Protection program is designed to preserve and protect the health and fitness of our service members from the time they enter the service until their separation or retirement. The Services have utilized preventive health measures, environmental surveillance, and advances in military medicine to support military operations worldwide. Despite deployments to some of the most austere environments imaginable, observed disease non-battle injury and illness rates remain the lowest in modern military history. This is the result of increased screening, line commitment and service member education.

Health assessments. We ensure a healthy force by applying high medical standards at accession, conducting periodic medical and dental examinations and health assessments, providing required immunizations, and providing high quality healthcare when needed. Learning from the Gulf War, our policy now requires that before and after deployment service members receive health assessments to ensure health readiness and to identify and capture any health issues upon their return. Records are maintained in the individual's permanent health record and an electronic copy of the post-deployment health assessment is archived for easy retrieval. We have started an aggressive quality assurance program to monitor conduct of these health assessments.

Besides conducting a pre-deployment health assessment, deploying personnel are provided required personal protective and medical equipment, serum samples are obtained, dental readiness is determined and health briefings are conducted.

We use post-deployment health assessments to gather information from deployed service members and assist medical personnel evaluate health concerns or problems that may be related to deployment. Individual discussions with licensed healthcare providers help to determine the need for more detailed medical follow up care. Blood samples are collected within 30 days of redeployment and are retained in the DoD Serum Repository. Post-deployment health assessments and deployment health records are maintained in the permanent health record, which is available to the VA upon the service member's separation from the military.

In January, I established a deployment health quality assurance program. The Defense Medical Surveillance System (DMSS) provides periodic reports on centralized pre- and post-deployment health assessment programs, as well as reports on service-specific deployment health quality assurance programs, and includes periodic visits to military installations to assess program compliance. DMSS maintains a centralized database of deployment health assessments. DMSS provides weekly reports on post-deployment health assessments and monthly reports on pre-deployment health assessments. Post-deployment reports include data on service members' health status, medical problems, mental health and exposure concerns, blood samples, and referrals for post-deployment care. Over 90 percent of the 300,000 redeploying service members have reported their health status as good, very good, or excellent.

Immunization programs. Immunizations offer protection from endemic disease, as well as from agents that could be used as biological weapons, including anthrax and smallpox. Vaccines against these disease threats are highly effective. Our programs are based on sound scientific information and verified by independent experts. They are essential to keep our service members protected. The Department has succeeded in protecting many hundreds of thousands of service members against two deadly infections—anthrax and smallpox. We protected over a million service members against anthrax, and over 580,000 personnel have received the smallpox vaccination.

The National Academy of Sciences' Institute of Medicine, in a congressionally mandated report, concluded that anthrax vaccine is both safe and effective to protect humans against all forms of anthrax. Those receiving the vaccine commonly experience some local discomfort, such as redness, itching or swelling; these reactions are comparable to those observed with other vaccines. On December 30, 2003, the Food and Drug Administration issued a final rule and order for a number of products, including anthrax vaccine. They concluded, "the licensed anthrax vaccine is safe and effective for the prevention of anthrax disease, regardless of the route of exposure."

Like the anthrax vaccine, the smallpox vaccine is fully licensed by the FDA and is safe and effective. However, there are more risks associated with administration of the smallpox vaccine. By carefully screening recipients with known risk factors, we have kept serious adverse effects well below the number anticipated when the vaccination program began. The Centers for Disease Control and Prevention tracks possible reactions to these and other vaccines through the

Vaccine Adverse Event Reporting System (VAERS), which is co-sponsored by the Food and Drug Administration. DoD encourages all service members to report any reactions to VAERS. Like all vaccines, most adverse events noted with smallpox vaccine are minor and temporary. Serious events, such as those requiring hospitalization, are extremely rare.

Combat casualty care. For military operations in Afghanistan and Iraq, medical care was deployed far forward, available within minutes of injury. Based on our current analysis, over 98 percent of those wounded have survived, and one-third returned to duty within 72 hours. It is clear that far forward medical care, improved personal protection, and operational risk management techniques continue to save lives. For Operation Iraqi Freedom, the rate of non-combat disease or injury is lower than in any previous U.S. conflict.

Mental healthcare is an integral part of the MHS, and we have programs in place to identify and support service members and families with special needs. The military services have a full range of mental health services available for deployed personnel, including suicide prevention programs sponsored by the service leadership and tailored to operational environments. Each service has a program to ease the return and reintegration of deployed service members to families and life at home.

For service members sustaining serious injury or illness, the MHS can rapidly evacuate them to definitive care. Our aeromedical evacuation system has advanced to the point that specialized teams can accompany and treat patients during transit to the next level of care. In the United States, two of our premier medical centers, Walter Reed Army Medical Center and the

National Naval Medical Center, provide service members extraordinary care. Walter Reed operates the US Army Amputee Patient Care Program, featuring a highly skilled multi-disciplinary staff and first-of-its-kind technology. In association with the Department of Veterans Affairs, this program strives to return patients to pre-injury performance levels. Walter Reed is one of two sites worldwide that is fitting patients with the Utah-3 arm, a technology that permits simultaneous motion for the elbow and wrist. It is the only facility fitting patients with a fast sensor hand that automatically maintains consistent hand pressure. Many soldiers with above-the-knee amputations receive the C-leg, a device containing a computerized chip to analyze motion 50 times per second, making ambulation on stairs possible.

Medical technology on the battlefield. Last year we introduced elements of the Theater Medical Information Program (TMIP) and Joint Medical Workstation for Operation Iraqi Freedom (OIF). These capabilities enable medical units to electronically capture and disseminate near real-time surveillance information to commanders. Information provided includes in-theater medical data, environmental hazard identification and exposure data, and critical logistics data such as blood supply, hospital bed and equipment availability. TMIP, through the Joint Medical Workstation, links care in theater with the sustaining base using interoperable data collection tools. This system serves as the medical component of the Global Combat Support System.

New medical devices introduced during OIF provided field medics with enhanced blood-clotting capability, and light, modular diagnostic equipment for use by far-forward medical forces. Advanced personal protective gear prevents injuries and is saving lives.

Medical hold. One consequence of improved pre and post-deployment health assessment screening is the identification of service members medically unqualified for deployment, or even military service. This has generated additional Medical Evaluation Board processing workload, and resulted in large numbers of service members awaiting healthcare and specialty consultations at mobilization sites. The Army has acted to alleviate this backlog, and has significantly reduced the numbers of individuals in this category. We remain committed to deploying healthy and fit service members and to providing consistent, accurate post-deployment health evaluations with appropriate, expeditious follow-up care when needed.

Individual medical readiness. Among the performance measures we track is the individual medical readiness status of all service members. For the first time, the MHS has a common tool to track individual medical readiness metrics for health and dental assessments, immunizations, laboratory tests, required medical equipment and limiting medical conditions. This tool allows unit commanders to monitor the readiness of their members and units.

Transition to VA Care. After returning from deployment, service members may receive care by military or DVA providers. Service members referred for a Physical Evaluation Board attend the Disability Transition Assistance Program, where VA counselors advise on benefits, disability ratings and claim processing procedures. Members voluntarily separating and not referred to a Physical Evaluation Board receive mandatory pre-separation counseling through the Transition Assistance Management Program, receiving briefings on VA benefits and availability of VA healthcare services.

We achieved a significant advance in our efforts toward a seamless transition with the establishment of the Federal Health Information Exchange. This exchange transfers electronic health information on separating service members to the VA. Currently, we provide the VA laboratory results, outpatient pharmacy data, radiology results, discharge summaries, demographics admission, disposition and transfer information, allergy information and consultation results. We are on still on track to have two-way real time exchange of electronic health information with the VA by the end of FY 2005. In addition, we have created integration points, with VA, that will permit VA to access the Defense Enrollment and Eligibility Reporting System (DEERS) in real time by the end of 2005.

Biological, Chemical and Nuclear Warfare Medical Countermeasures

Announced last year, Project Bioshield calls for identification and procurement of medical countermeasures to weapons of mass destruction (WMD). With the Departments of Health and Human Services and Homeland Security, we are actively developing a national priority for medical countermeasures to biological, chemical, and nuclear threats. This national priority will allow the US government to attract industry to develop and manufacture needed medical WMD countermeasures. The work collaboratively done on anthrax and smallpox is a start, but the effort is more comprehensive. Future work will include additional medical countermeasures.

DoD – VA Partnership

We have successfully shared healthcare resources with the Department of Veterans Affairs for twenty years, but opportunities remain. We recently introduced a common national billing rate for our sharing agreements, greatly simplifying administrative processes. In 2003, the President's Task Force to Improve Health Care Delivery for our Nation's Veterans outlined a broad and substantive agenda to foster greater collaboration. We have already taken action on a number of recommendations. We initiated a joint strategic planning process, began sharing medical information electronically, identified additional joint contracting opportunities, and included the VA in the development of the Request for Proposal for the Next Generation of TRICARE Contracts. Greater collaboration on capital planning and facility life-cycle management will benefit beneficiaries and taxpayers alike.

We have initiated seven demonstration projects at seven sites with the VA. These demonstrations entail budget and financial management, coordinated staffing and assignments, and sharing of medical information and information technologies. Our joint Health Executive Committee approved the following sites for these demonstrations:

- Budget and Financial Management
  - VA Pacific Islands Health Care System – Tripler Army Medical Center
  - Alaska VA Health Care System – Elmendorf Air Force Base, 3rd Medical Group
- Coordinated Staffing and Assignment
  - Augusta VA Health Care System – Eisenhower Army Medical Center
  - Hampton VA Medical Center – Langley Air Force Base, 1st Medical Group
- Medical Information and Information Technology
  - Puget Sound VA Health Care System – Madigan Army Medical Center

- El Paso VA Health Care System – William Beaumont Army Medical Center
- South Texas VA Health Care System -- Wilford Hall Air Force Medical Center and Brooke Army Medical Center

TRICARE – The Military Health Plan

We have embarked on a comprehensive transformation for how we will organize, manage and motivate our health delivery system to better serve our beneficiaries. Our goal remains constant; providing accessible, quality healthcare that fosters patient satisfaction with all aspects of their healthcare. Highlights of this transformation include family centered care, patient safety, health plan governance, and new TRICARE contracts.

Family centered care. To improve satisfaction with the Military Health System, we introduced family centered care this year, focusing on obstetrical and newborn care. Using beneficiary input, we revised maternal and newborn services in our military medical facilities to enhance emotional well-being, privacy and personal preferences. This program respects family and cultural beliefs and offers treatment choices including pain management, and testing options before, during and after childbirth. We encourage families to participate in the birth experience. Childbirth is a special time for the family. Unfortunately, many service members are not available to participate in this experience. We believe it is critical that the MHS accommodates the unique requirements of our service members and their families. Our healthcare personnel know first-hand about the separation aspects of military life. We want to be our beneficiaries' first choice for healthcare and it starts at birth.

Patient safety. We place a high priority on patient safety, and remain committed to providing all resources to prevent medical errors and ensure patient safety. Our Patient Safety Center collects and analyzes safety data from military medical facilities and advises the Patient Safety Executive Council, chaired by the Deputy Assistant Secretary of Defense for Clinical Programs and Policy. Our safety record is strong, and we intend to be a model for other healthcare systems.

Governance. The new TRICARE organizational structure will streamline healthcare management and enhance efficiency, productivity and customer service. This restructuring strengthens the partnership between the direct care system and our purchased care contractors by providing more flexibility and interoperability in the MHS. Three TRICARE Regional Directors will integrate military treatment facilities and civilian networks to ensure support to local commanders and oversee regional performance.

We increased medical commander responsibilities and accountability for their local health care markets. Commanders will be directly responsible for all healthcare services and support provided to their patients, including patient appointing, utilization management, the use of civilian providers in military hospitals and clinics (i.e., resource sharing providers), and other local services. We will have 13 multi-MTF markets with Service-assigned senior market managers to effectively use available resources.

The central management effort in TRICARE will be to establish and then manage toward objectives set in annual business plans; plans developed locally and then built into service and regional plans. The new Regional Directors have a key role in improving provider participation in TRICARE, and in improving TRICARE Standard support. Gaining beneficiary support and satisfying their healthcare needs serve as the objectives for which the TRICARE contracts and organization are designed.

TRICARE Contracts. The first step in redesigning TRICARE was to simplify. We reduced the number of TRICARE regions from eleven to three, and reduced the number of contracts from seven to three. With these new contracts, beneficiaries will realize improved access to care, better customer service and enhanced quality of care. Current and future contractors have committed to smoothly transition every aspect of their responsibilities while maintaining the highest standard of care and service. The Department remains committed to keeping beneficiaries informed throughout this transition.

We have "carved out" major elements of the current TRICARE contracts into separate entities. These new contracts leverage the expertise resident in companies whose core competency is pharmacy management, claims processing and marketing. We have established national contracts that improve management and beneficiary satisfaction.

Pharmacy management. An integrated pharmacy benefits program brings consistency to our military, mail-order and retail pharmacies. It uses a uniform formulary that is clinically appropriate, cost-effective, and developed with beneficiary input. This integrated program

allows federal pricing of pharmaceuticals for our retail program, allows better management and improves beneficiary satisfaction by making it easier to obtain prescriptions while traveling.

Claims processing. We have markedly improved claims processing performance and now lead the industry in all measures. During 2003, we processed 104.6 million claims, with over 99 percent of clean claims processed within 30 days. Only one percent of claims cannot be processed and are returned for correction; the industry experience for returned claims frequently exceeds 25 percent. Audits of processed claims show that errors remain below two percent for payment and three percent for other errors. This compares favorably with published rates for managed care carriers that range from 6 percent to over 30 percent. The claims processing "carve out" will focus on those claims submitted by our senior beneficiaries as supplemental to Medicare in the TRICARE for Life program. Establishing a single claims processor for dually eligible Medicare-TRICARE patients adds consistency and enhances beneficiary satisfaction.

Marketing. A consistent approach through a national suite of marketing and educational materials will bring clarity and consistency to the TRICARE messages. Materials development will involve beneficiaries, research of current trends and analysis of past approaches. Materials will include beneficiary and provider handbooks, briefings, brochures, health and wellness pamphlets, newsletters and bulletins. Regional content is included and templates are created to allow for local modification.

TRICARE Standard improvements. To better assist beneficiaries who choose to use the TRICARE Standard option, we recently updated our on-line provider directory, streamlining

search capabilities and adding questions and answers. We have emphasized the need for accuracy and reliability of provider information and customer satisfaction in the new TRICARE contracts. Based on congressional direction last year to better serve TRICARE Standard beneficiaries, we have initiated provider surveys and outreach assistance to these beneficiaries. The Regional Director will have the responsibility to ensure that TRICARE works for Standard beneficiaries in the region.

Reserve Health Benefits

In addition to the enhanced benefits the Department offered to activated Reserve Component members and their families during 2003, the FY04 DoD Supplemental Appropriations Act and the FY04 National Defense Authorization Act included additional benefits. Assuring the medical readiness of reservists when called to active duty is among our highest priorities. Providing support to families of activated Reserve Component personnel is vitally important especially in the sponsor's transition to and from active duty. As the Department proceeds in this area, we must carefully review the cost of providing increased entitlements and benefits to Reserve Component personnel who have not been activated -- perhaps through a limited demonstration program to test feasibility and effectiveness. A key issue would be the effect of a new entitlement on recruitment, retention, and medical readiness of both reserve and active duty members.

Information Technology

The MHS continues to introduce state-of-the-art information technology solutions and products to our healthcare team worldwide. Some of these solutions – the Pharmacy Data Transaction Service and the Defense Medical Logistics Support System (DMLSS) to name two, have received national awards for the application of technology in support of medical readiness and patient safety.

This year we will introduce globally the Composite Health Care System II (CHCS II), the military electronic health record. After years in design, development and testing, we are embarking on one of the most comprehensive technology deployments ever undertaken by a healthcare system. By the end of 2005, we will have completed this implementation. CHCS II represents a quantum leap in our ability to collect, retrieve and analyze patient data. Clinical applications of CHCS II will populate the Theater Medical Information Program in battlefield versions. Clinical information will be sent to CHCS II and stored in the DoD Clinical Data Repository. CHCS II met the eight functions determined by the Institute of Medicine to be essential to enhance safety, quality and efficiency of healthcare delivery. It ensures health information continuity and patient-centered delivery, and is an industry leader. This system will vastly improve the quality and efficiency of care, and support medical and line commanders.

Another enhancement to healthcare delivery is TRICARE Online, our enterprise-wide, secure online medical portal for use by DoD beneficiaries, providers and managers to access available healthcare services, benefits and information. This Health Information Portability and Accountability Act (HIPAA) compliant tool provides beneficiaries with a communication system for appointment scheduling, access to 18 million pages of quality medical information,

interactive health tools, and administrative information on our medical facilities and providers. Future capabilities will include pharmacy refill and renewal, appointment reminders, an ability to request routine tests, structured provider to patient messaging and more. TRICARE Online has received the Government Solution Center's 2003 Excellence in Government Pioneer Award for Best Practice Application and the International Association of Business Communicators' Silver Inkwell Award honoring the industry's best in strategic communication.

Mr. Chairman, distinguished members of the Subcommittee, you have graciously allowed me to outline many of the programs and activities currently under way in the Military Health System. I would like to take a moment to tell you about the men and women who accomplish the mission of the MHS. I've been on the job now for two and one half years, and I have had the opportunity to visit military medical units across the United States, Europe, Southeast and Southwest Asia and at sea. I am extremely proud of the military and civilian men and women in the Military Health System who serve their country. They are courageous, dedicated, exemplary professionals whose talents are second to none. They are America's best, and I am proud to serve with them.

Healthcare is a key quality of life issue for our service members and their families. We believe that with many of our new initiatives focused on our patients, on quality and effectiveness, and on ensuring readiness that we offer a valued healthcare benefit. With your

support, we will continue to offer the uniformed men and women of the United States world-class healthcare. Thank you.