Modernizing Military Compensation: Value Based Practices for Military Health Care
WHO WE ARE
Business Executives for National Security (BENS) is a unique nonpartisan, nonprofit organization of senior executives who volunteer time, expertise, and resources to assist defense and homeland security leaders on a variety of national security challenges.

OUR MISSION
Apply best business practices to develop, for government officials, solutions to our nation’s most challenging problems in national security, particularly in defense and homeland security.

ACKNOWLEDGMENTS
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DISCLAIMER
Certain views and information set out in this paper may not necessarily reflect the opinions of individual contributors or their employers. Responsibility for the content displayed within lies entirely with Business Executives for National Security (BENS).
ABOUT THE REPORT

“Value Based Practices for Military Health Care” is part of Business Executives for National Security’s Modernizing Military Compensation Series. Capitalizing on the knowledge and acumen of current and former private sector executives, this series examines military compensation programs and offers insights and recommendations for creating a more sustainable and effective compensation system. This paper specifically addresses military health care, and offers practices that could improve the value of the military health care system. BENS shared the substance of this report in a meeting with the Military Compensation and Retirement Modernization Commission on April 9, 2014.

The authors utilized their understanding of health care administration and practice as well as interviews of subject-matter experts to formulate their recommendations. Any mention of specific companies or products should not be considered an endorsement of that company or product. Their mention is simply used to further illustrate the information displayed within this report.
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EXECUTIVE SUMMARY

Military health care costs have grown significantly over the past decade and are now threatening to consume a larger portion of the military budget. If the military is to maintain the current budgetary mix where most of the spending is dedicated to warfighting capability and preparation, the Department of Defense (DoD) must implement strategies that better control such costs.

This paper presents three strategies shown to curb or reduce health care costs in the private sector and recommends policymakers closely evaluate and consider their implementation within DoD. These strategies address areas where production-loss or unnecessary expense is evident and offers measures that alleviate inefficiencies within the system. As an example, the first strategy, minimizing or eliminating clinical variation in accordance with evidence-based care, eliminates procedures health care professionals do not deem to be medically sound. This strategy would reduce the number of unnecessary procedures patients endure and the number of procedures for which DoD must financially compensate. Furthermore, the other two recommended strategies protect DoD from fraudulent claims by health care providers and takes further advantage of a program already shown to reduce costs of for both the health care beneficiary and DoD.

Moreover, to reduce DoD’s overhead and burden of oversight for implementing these measures, insurance intermediaries who are already paid to process DoD claims and are responsible for managing costs and detecting fraud-and-abuse should also be responsible for ensuring the measures discussed in this paper are implemented. Adding requirements into contracts that ensure a provider is minimizing clinical variation, for example, is a practice utilized in private sector health care.

Recommended Strategies

1. As part of its contracting process, DoD should require that regional insurance intermediaries ensure that their network doctors, private care facilities, and military treatment facilities (MTFs) work to minimize or, ideally, eliminate clinical variation in accordance with modern evidence-based medicine.

2. DoD contracts should be audited regularly to (i) ensure compliance with the best business practice requirements set forth in the contracts with appropriate consequences for failure to demonstrate compliance and (ii) claw-back or provide a credit for any unjustified costs for claims administration. These contracts should be used to help assure that beneficiaries are recipients of best practices in care delivery. Concepts from existing commercial insurance programs should be considered for adaptation for use for TRICARE purchased services.

3. DoD should require that monthly maintenance prescriptions are filled at MTFs or by mail-order should a current pilot program show savings and effectiveness.
INTRODUCTION

The Department of Defense (DoD) manages a large and increasingly costly health care system that compels reform as budgets become limited. The system – which serves 9.6 million individuals and is comprised of hospitals, personnel, and private sector networks – nearly doubled in cost over the past decade, with considerable continued growth over the next twenty years projected. The Congressional Budget Office estimates military health care will rise from $52.5 billion today to over $90 billion by 2030.

Until this point, growth was absorbed as overall Department budgets rose as well. However, future budgets are likely to diminish or level off, and absorbing growing health care costs will become progressively more difficult. Even with recent budget debates aside, the Department has agreed to reduce its budget over $400 billion over the next ten years, and the Obama Administration has stated a goal of reducing defense spending to 2.4% of Gross Domestic Product (GDP) by 2023. This means that at a time when health care costs are rising, overall budgets are essentially static.

Reducing health care cost is not easy. Health care is generally expensive and many cost drivers for military health care are inextricably linked to national health care costs which has experienced its own steady rise for decades. Additionally, lowering cost without diminishing beneficiary care or placing greater burden on the beneficiary is even more daunting.

Fortunately, the system is ripe for reform and can implement effectiveness and efficiency measures that will curb rising cost, while also improving care. Business Executives for National Security (BENS) has identified three measures in particular that could help achieve bottom-line reduction in the future and increase quality of care. These measures could yield significant savings and are examples of measures policy makers should explore as they consider reform of the military health care system.

Maintaining healthy service members is a vital element for a strong fighting force and providing quality health care benefits to those who serve is a hallmark of our effort to sustain a successful military.
STRATEGIES

The military health care system has considerable purchasing power and ability to encourage their health care providers to adopt practices that will lower costs and improve care. The following outlines three strategies in particular that will achieve that desired outcome. If implemented collectively, the Department of Defense (DoD) could experience significant savings annually.

1: Eliminating Clinical Variation through Best Practices

Health care delivery benefits from adherence to clinical protocols that promote use of diagnostics and treatments that have been shown to be efficacious and structures that discourage providers from performing tests and rendering services that do not correlate with better outcomes for patients. When medical care is delivered in accordance with such evidence-based guidelines, patients receive more uniform care for their particular conditions regardless of the provider treating them. The result is better clinical outcomes, and a reduction in costly services that are not medically necessary. DoD should write into their contracts that such protocols be practiced by all health care professionals and facilities where military patients are being treated.

Clinical Variation

Unfortunately, there continues to be a variation in the rates of health care service use across the US both by geography and clinical specialty areas. This is well-described by the Institute of Medicine, the Dartmouth Atlas Program and in the professional literature. This variation includes all principal areas of health care such as cardiology, spine surgery, pain management practice, aspects of obstetrics and pediatrics, cancer care, diagnostic imaging, musculoskeletal care, care for patients after their acute hospital stays (i.e., post-acute care) and all aspects of rehabilitation.

As an example, there is a 7-fold difference in the rate of back surgery in Medicare members between the lowest, Honolulu (1.5 per 1000) and the highest, Casper, WY (10.1 per 1000); the US average is 4.7 per 1000. Meanwhile, there is a 5-fold difference in the rate of total knee replacements between the lowest, Honolulu (3.4 per 1000) and the highest, Idaho Falls, ID (15.8 per 1000); the US average is 9.0 per 1000.

The observed variation in physician and overall health care practice patterns reflects an amalgam of many important, interacting influences and health care delivery system and payment system factors. These combine to help explain a large part of why health care costs per capita in the US are far greater than other comparable countries.

Payment Variation

In addition to physician-determined variation, the health care delivery systems and financial arrangements also strongly contribute to the observed variations in care delivered. For example, where preventive activities [e.g., Healthcare Effectiveness Data and Information Set (HEDIS) measures] are encouraged and supported, patients receive high rates of indicated interventions (the TRICARE Manage-
ment Activity has done well with HEDIS results). By contrast, many diagnostic and treatment interventions are highly compensated, and are frequently subject to greater use than can be shown to be appropriate using the available criteria, particularly by providers who are compensated through unmanaged service-driven reimbursement.

An Evidence-Based Approach
American medicine is specialist-intensive and not optimally coordinated to best address the patient’s overall clinical and personal goals. When coupled with unmanaged fee-for-service payments that financially reward the quantity of services rendered, this leads to more testing, more follow-ups after testing due to the burden of false-positive test results, more treatment and often overlapping and sometimes conflicting treatment strategies.

For TRICARE, DoD’s health program, obstetrics/newborns are the primary reason for inpatient admissions both by volume and cost. In FY2013 there were 132,479 pregnancy-related admissions and 120,873 newborn/neonatal admissions; costing approximately $1.2 billion. For outpatient utilization, the leading diagnosis groups were musculoskeletal in nature. There were approximately 11.8 million encounters for these diagnoses at an approximate cost of $2.0 billion. In each of these specialties there has been substantial work to develop evidence-based approaches for care with the goals of increasing quality and assuring the best possible patient outcomes.

For obstetrics, for example, it has become generally accepted that cesarean sections for physician and/or patient preference [i.e., maternal request] should not be performed. Similarly, it is also now accepted that all reasonable efforts should be undertaken to minimize premature deliveries.

For musculoskeletal medicine, acute back pain provides a good example of such a demonstrated overtreatment syndrome. At one time, bed rest was typically tried as the initial treatment for the problem. Now that this approach has been appropriately abandoned, patients find a plethora of both primary care providers and specialists [e.g., orthopedists, spine surgeons, pain management] who offer a wide range of active treatments. Despite the fact that almost all acute low back pain not due to an accident will resolve on its own within about 6-8 weeks, some providers recommend only conservative treatment plans, while many move directly to far more intensive and sometimes invasive care. For the population as a whole, long term observations strongly support a first step of conservative care with supportive therapies and not aggressive interventions.

Whether a particular patient is treated in this manner too often depends on the practice style and training of the physician, rather than on the consistent application of best available evidence-based clinical practices. The good news is that in orthopedics, as well as other clinical specialties, overused modalities have been studied and effective evidence-based clinical guidelines have been developed.

This is also true in cardiology – where the American College of Cardiology Foundation and the American Heart Association have created evidence-based appropriate use criteria that stress matching the proposed interventions to the characteristics of the patient’s condition using the extensive outcomes data which has been collected and published – as well as all other medical and surgical specialties which has been examined critically. These include those from the American College of Physicians, American Academy of Pediatrics, American Association
of Orthopedic Surgeons, American College of Obstetrics and Gynecology, American College of Radiology and others.

**Developing the Right Tools**

These variations in the content of clinical care are best addressed through management by payers, such as TRICARE, aimed at eliminating payments for excessive services that lack clinical appropriateness while creating positive incentives for the provision of appropriate care. Such efforts affect those providers who tend to practice outside of accepted norms, and are often accompanied by provider push-back in the form of changed but still non-conforming treatment patterns and aggressive billing practices as such providers seek to sustain income levels.

Therefore, payers have found that the institution of evidence-based clinical management is most effective when accompanied by programs to detect and address poor quality care as well as fraud/abuse programs to identify and intervene where that is indicated.¹

There are an abundance of well-done clinical guidelines, treatment protocols and appropriate use criteria for most aspects of medical care.² The challenge is to create and then operate systems which help to assure their use while maintaining an appropriate level of physician and patient autonomy. It is also important to allow for the needs of unusual patients and those whose clinical presentations are atypical or even highly unusual. In medicine, uncommon things do occur and it is essential to be alert for their existence. Technology now exists in hand held devices and mobile phone apps which can offer many tools to assist physicians and health care delivery organizations to provide “best practices” and low variation (from criteria) care. The organizational challenge is to find appropriate and effective ways for DoD/TRICARE to encourage, incentivize and eventually demand high levels of practice consistent with proven approaches to care.

**Management Needs May Differ for Delivery Components**

TRICARE Management Activity programs are in two large segments – direct care at Military Treatment Facilities (MTF) and purchased care in the several communities across the US and the world.

The organization and structure of the MTFs provide for consistent circumstances and directions to apply best practices. The MTFs have moved to adopt most of the proven concepts in the broader health care delivery system. These include primary care managers (PCM), programs to assure proper preventive care, patient-centered care (patient centered home movement) and expertise in the problems most commonly seen in the users of MTF (active duty personnel, their families and, when possible, retirees and their families).

The purchased services are obtained, where possible, from the large network of TRICARE participating providers and facilities. These are administered not unlike comparable commercial health insurance programs by the three TRICARE regional contractors (North, West, South) in the US and the overseas contractor for the rest of the world. There are many proven programs currently in use for commercial insurance which might be considered for adaptation for TRICARE, especially in the US, including traditional medical management as well as other initiatives.

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¹For example, the DHS Office of Inspector General, Health Care Fraud and Abuse Program. Extensive reports from this organization address most aspects of health care fraud and abuse.

The most effective programs appear to be those that review care by using skilled professionals (e.g., board certified physicians) in the same specialties as the cases being reviewed, as these practitioners are in the best position to determine conformance with evidence-based protocols and proper billing practices. They are also able to follow up with peer-to-peer discussions with treating physicians on cases under review. This is not necessary in all cases but when it is needed, it substantially improves the flow, outcome and provider-acceptance of the effort involved. These programs include diagnostic imaging, elective surgical/interventional procedures that have high variation such as orthopedics, spine surgery, cardiology/cardiac surgery, pain management, post-hospital care and rehabilitation.

It is important to recognize the need for careful targeting of programs – that is, the identification of those situations and providers for which the management interventions are most likely to provide value – so as to optimize the benefits achieved while minimizing additional administrative burdens for the providers and physicians. Targeting technologies have been developed for commercial programs and can be transferred to any comparable efforts for TRICARE.

Next Steps

BENS believes that DoD/TRICARE should explore the range of options to ensure that state-of-the-art approaches are taken to help minimize variation in health care delivery. These include: program design elements; pressing for the integration of decision-support and targeted clinical practice guideline delivery; and quality improvement efforts to further ensure individuals, groups and large systems all incorporate available programs and processes to achieve these goals. There may be many ways to achieve the overarching goals and TRICARE should tailor its energies to insure those which best serve the beneficiaries are adopted, monitored for performance and, for such processes, adopt a cycle of continuous quality improvement.

2: Conduct Compliance Audits

Building on the measure noted above, BENS recommends that all forms of contract be reviewed to ensure contractors are bound to adhere to all medical management initiatives and clinical best practices that DoD/TRICARE may adopt from time to time. DoD conducts an approximately two year contracting process which results in the award of three U.S. regional five year contracts. The process is competitive and heavily scrutinized and critically important to any meaningful reform of DoD/TRICARE’s costs. DoD/TRICARE has $50 billion of purchasing power. Clearly, it is at the contracting process stage where DoD/TRICARE has the maximum opportunity to address both the costs to DoD/TRICARE and the quality of care for TRICARE recipients.

Moreover, BENS also recommends a re-evaluation of the process used to audit contractors’ performance. We believe that while traditional retrospective performance audits should continue, consideration should be given to concurrent audits, such as pre-payment reviews of clinical services along the lines currently being tested by Centers for Medicare and Medicaid.

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1 Health Net currently has the contract for the North region. Humana has the contract for the South, United Health has the contract for the West.
2 The new series of TRICARE administrative contracts (T-3) was fully effective as of April 2013.
Service (CMS). As CMS notes, prepayment audits “ensure that the provider complied with all…payment rules…[and] also help lower the error rate by preventing improper payments rather than the traditional ‘pay and chase’ methods of looking for improper payments after they occur.” Ongoing prepayment claim review efforts for professional and other services routinely identify at least 20-30% of claim lines as not supported by documentation or as otherwise incorrect. According to a report from the Government Accountability Office (GAO), CMS determined that the Medicaid program improperly paid out $14.4 billion, or 5.8 percent of Medicaid expenditure, in fiscal year 2013.

The GAO discovered that “most state and federal program integrity officials we interviewed told us that they did not closely examine Medicaid managed care payments, but instead primarily focused their program integrity efforts on fee-for-service claims.”

With the increase in outpatient services in the code-driven purchased portion of TRICARE, such concurrent reviews could lead to both better care and waste reduction by helping to enforce the management tools described in this report. For example:

• Prepayment audits can prevent payments for services which, based on evidence-based clinical protocols, were not medically necessary. This can be particularly effective for providers who have not obtained prior authorization of the services they render.
• Prepayment audits of pharmacy claims can identify whether (as recommended in Section 3) monthly maintenance prescriptions are being filled at MTFs or by mail order.
• Prepayment audits can verify that the services in a provider’s claim were in fact documented as having been performed, thus avoiding payments for aggressive or fraudulent claims that overstate the services actually rendered to the patient.

Prepayment audits can provide real-time data, accelerating the ability for DoD/TRICARE to implement effective corrective actions when necessary, analyze the relationship between actual costs and the amounts set forth in the contracts, and to identify unjustified costs (e.g., one might find that some of the costs of claims administration set forth in the contracts are excess to the actual costs of claims administration).

In conjunction with any such new audits that may be adopted, BENS also recommends the continuation of regular audits, including the active fraud and abuse program. There should be a claw-back or credit for any unjustified cost growth towards future payments by DoD/TRICARE. In addition, whether or not pre-payment audits are effectuated, contracts should be audited annually to ensure compliance by the networks with the best business practices recommended in this report including (i) requiring MTFs, physicians and practice groups work towards eliminating clinical variation in accordance with proven and accepted methods of evidence based medicine and (ii) otherwise requiring that monthly maintenance prescriptions be filled at MTFs or by mail order.
3: Increase Role of Monthly Mail-Order Maintenance Rx

Lastly, DoD/TRICARE could also realize significant savings in the area of prescription medication by requiring TRICARE recipients to fill their monthly maintenance prescriptions at MTFs or by mail order.5,6

Military Health System pharmacy costs in 2011 were close to $7 billion. Approximately $5 billion was spent on prescription medication for TRICARE beneficiaries over the age of 65 that are Medicare eligible with chronic conditions requiring monthly maintenance medications.7

For example, the average cost of a 30-day supply of brand name prescription drugs was $44 at an MTF, $67 by mail order and $130 when filled at a retail pharmacy. In addition, the average cost of a 30-day supply of generic medication was $11 at an MTF, $9 by mail order and $20 when filled at a retail pharmacy.

In other words, filling prescriptions at MTFs or by mail order is significantly less expensive. First, both MTFs and mail order prescriptions can be filled at federal pricing levels. Federal pricing levels are significantly lower than the private sector because by law, federal facilities have access to the lowest prices that manufacturers charge. Federal facilities can also use formularies to negotiate additional discounts with manufacturers, in part due to their volume buying power. As a result, Federal facilities pay, on average, 42% of the average wholesale price (AWP) for single-source brand name medications, while conventional retail pharmacies pay about 83% of the AWP (nonfederal mail-order pharmacies pay no more than 78%).

Second, mail order facilities have a higher production capacity than retail pharmacies and realize savings through operational efficiencies and economies of scale. On average, these facilities fill thousands of prescriptions per day [i.e., as opposed to the fewer filled at a conventional pharmacy per day].

Third, labor costs are much lower at mail or-

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5For example, there could be greater co-pays for non-MTF utilization, but this might not be feasible.
6It is important to note that TRICARE could not eliminate insurance (and co-pays) for filling prescriptions at private care facilities. When a TRICARE recipient is sick in the middle of the night, they may not be able to get to an MTF or wait for the mail order prescription to be filled. Therefore, any proposal regarding prescription medication must be clear that requiring the filling of prescriptions at MTFs or by mail order would be limited to monthly maintenance drugs only.
7As the average life expectancy continues to improve, the utilization of Tricare beneficiaries of the prescription benefit will also increase. Therefore, it is critically important to address the rising costs of filling monthly maintenance prescriptions for chronic conditions.
der facilities. In general, labor costs account for about 40% of overall costs at mail order prescription facilities (as opposed to 70% of overall costs at retail pharmacies).

As one would expect, there has been some resistance to mandated mail-order prescriptions for monthly maintenance medications. Critics have argued that lack of information about incentive pay, rebate pay, volume discount pay, and administrative fees raise questions about actual cost-savings. In addition, they argue that policies limiting patients’ access to pharmacies in-person and one-on-one conversations with pharmacists harm overall health care quality.

Proponents of mandated mail order prescriptions for monthly maintenance drugs respond that home delivery may in fact contribute to improved care, as patients who receive their medication in the mail are more likely to take them regularly as prescribed. Improved adherence to doctor prescriptions can improve control of many chronic conditions, such as diabetes or high blood pressure.

In 2013, pursuant to the National Defense Authorization Act, Congress mandated a pilot program designed as a trial run for mandated mail order prescriptions. The program requires that refills for most maintenance medications be done by mail order (although TRICARE for Life beneficiaries can opt out of this program after one year of participation) and it will run from the fall of 2013 to December 2017. At the conclusion of the program, and presumably during every annual reporting period, the degree of savings (or lack thereof) will be readily measurable and apparent.

The increased use of mail order for maintenance drugs provides other valuable clinical pharmacy services such as better adherence to prescribed regimens. Many prescriptions go either unfilled or are not taken as directed. A mail order system centralizes regimens and sends prescriptions automatically at the appropriate timing and dosage prescribed by the physician. Similarly, particularly for retirees and older beneficiaries, patient medication reconciliations and pharmacist counseling might be offered for those situations where it appears there is likely benefit. These interventions will lead to better quality care and overall lower costs.

Because only nine percent of the approximately 2.6 million prescriptions were filled by mail order in 2011, BENS recommends that the pilot program for mandated mail order prescriptions for monthly maintenance drugs be carefully monitored. If the annual reports indicate significant savings, as we suspect will be the case, BENS recommends that the pilot program be made permanent and expanded to cover all monthly maintenance prescriptions.
CONCLUSION

In this report, BENS offers three strategies that should drive savings without adversely impacting the quality of health care provided to TRICARE recipients. First, BENS recommends DoD require that insurance intermediaries ensure that the networks require doctors, private care facilities and military treatment facilities (MTFs) work to minimize or, ideally, eliminate clinical variation in accordance with modern evidence based medicine. As stated, not only will this eliminate unnecessary costs, this may improve the quality of the health services provided by minimizing the amount of unnecessary and unrelated consults and testing.

Second, BENS recommends that DoD contracts should be audited regularly to (i) ensure compliance with the best business practice requirements set forth in the contracts with appropriate consequences for failure to demonstrate compliance and (ii) claw-back or provide a credit for any unjustified cost growth for claims administration.

Last, contingent on the success of DoD’s pilot program, BENS recommends that DoD should require that only MTFs or mail-order firms can fill monthly maintenance prescriptions because federal pricing levels are significantly lower than private, for-profit facilities.

There is general agreement that DoD’s cost in providing health care must be properly addressed. It is not only growing, but also it is becoming an increasingly larger portion of the entire DoD budget impacting the amounts available to DoD for its other priorities [e.g., procurement or research and development]. These recommendations would curb the rise in cost, and collectively the savings would be significant. Moreover, as insurance intermediaries would bear the burden of implementation and oversight, the direct cost on DoD to see these recommendations realized would be minimal.

Savings and improved care are possible; BENS offers these three recognized best practices. BENS stands ready to assist DoD and policy makers further should they pursue these measures.
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