2011 Military Health System Conference

TRICARE Fourth Generation Study Group – Exploring the Way Forward

The Quadruple Aim: Working Together, Achieving Success

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26 January 2011

T4 Study Group

Report Documentation Page

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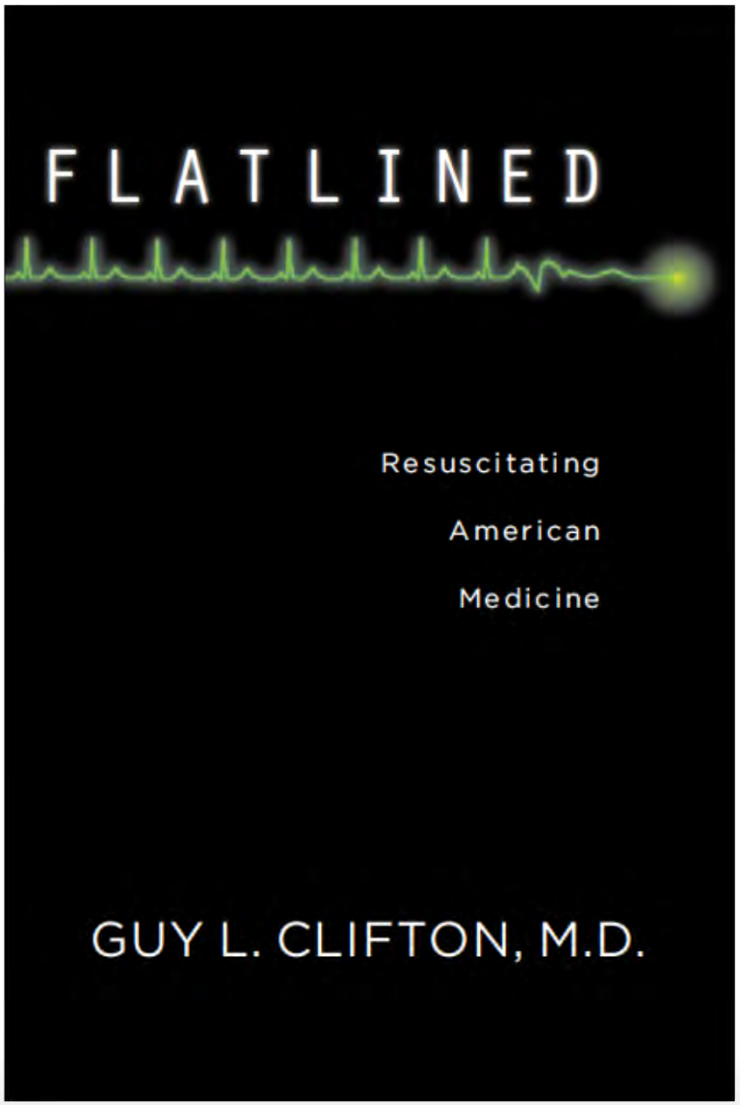
FLATLINED
Resuscitating
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Medicine
GUY L. CLIFTON, M.D.

Policy Environment

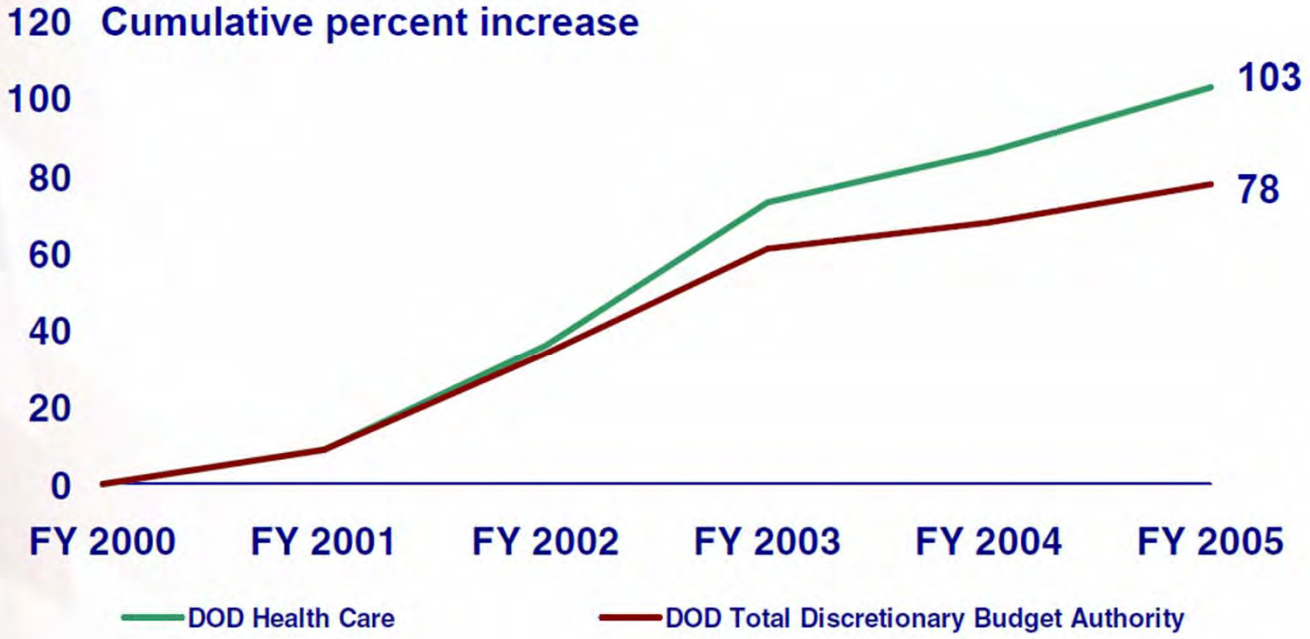
Secretary of Defense Robert Gates has recently said health care costs are "…eating us alive,"...*

***SOURCE: Gates Criticizes Bloated Military Bureaucracy--Defense Secretary Vows Top-Down Assessment of Pentagon Budget, from Staffing to Ubiquitous "Overhead" Costs, By David Martin*

Health Care Grows Faster than DOD Budget Authority

GAO
Accountability • Integrity • Reliability

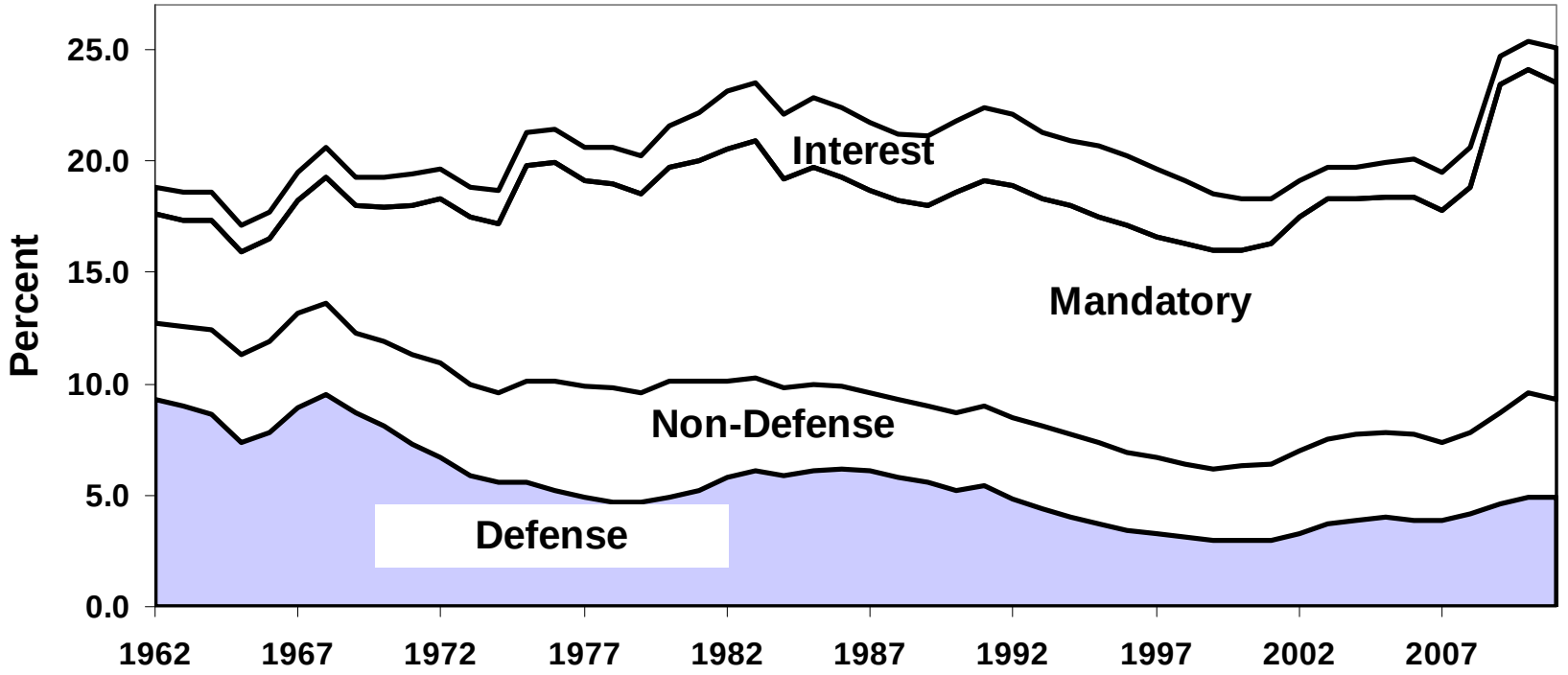
DOD Health Care Spending has been Growing Faster than DOD's Discretionary Budget Authority



Source: GAO analysis of DOD data.

In the Face of Record Federal Debt--- History Teaches that Defense Spending will be Cut.

Federal Outlays
Share of GDP

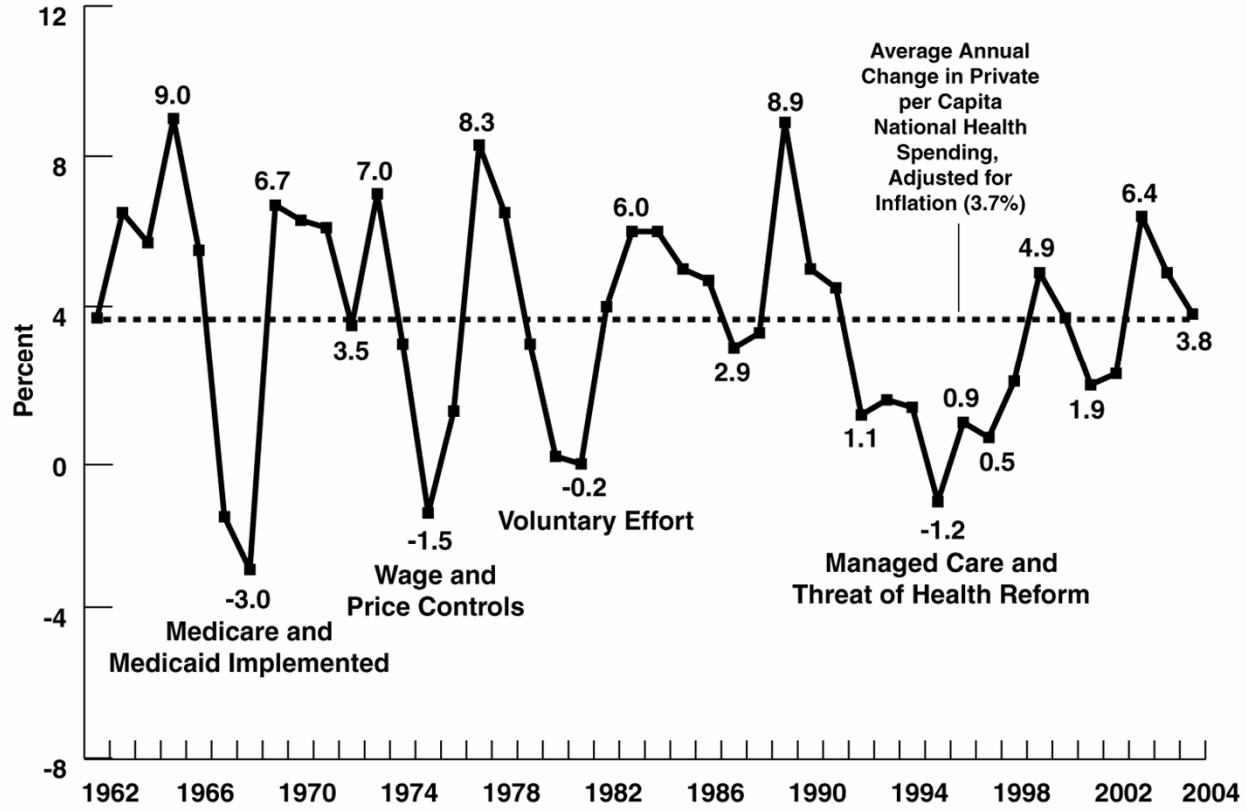


MIT Security Studies Program, November, 2010

Why Should I Care?

Price Cuts are not Effective for Long and can Destabilize Care.

Annual Change in Private per Capita National Health Spending (Adjusted for Inflation), with Historical Health Spending Events, 1960-2004



Source: Trends and Indicators in the Changing Health Care Marketplace. Exhibit 1.4. Publication 7031. Health Care Marketplace Project. Kaiser Family Foundation. May 2005.

The Way Forward

Will Providers Accept Accountability for Cost and Quality?

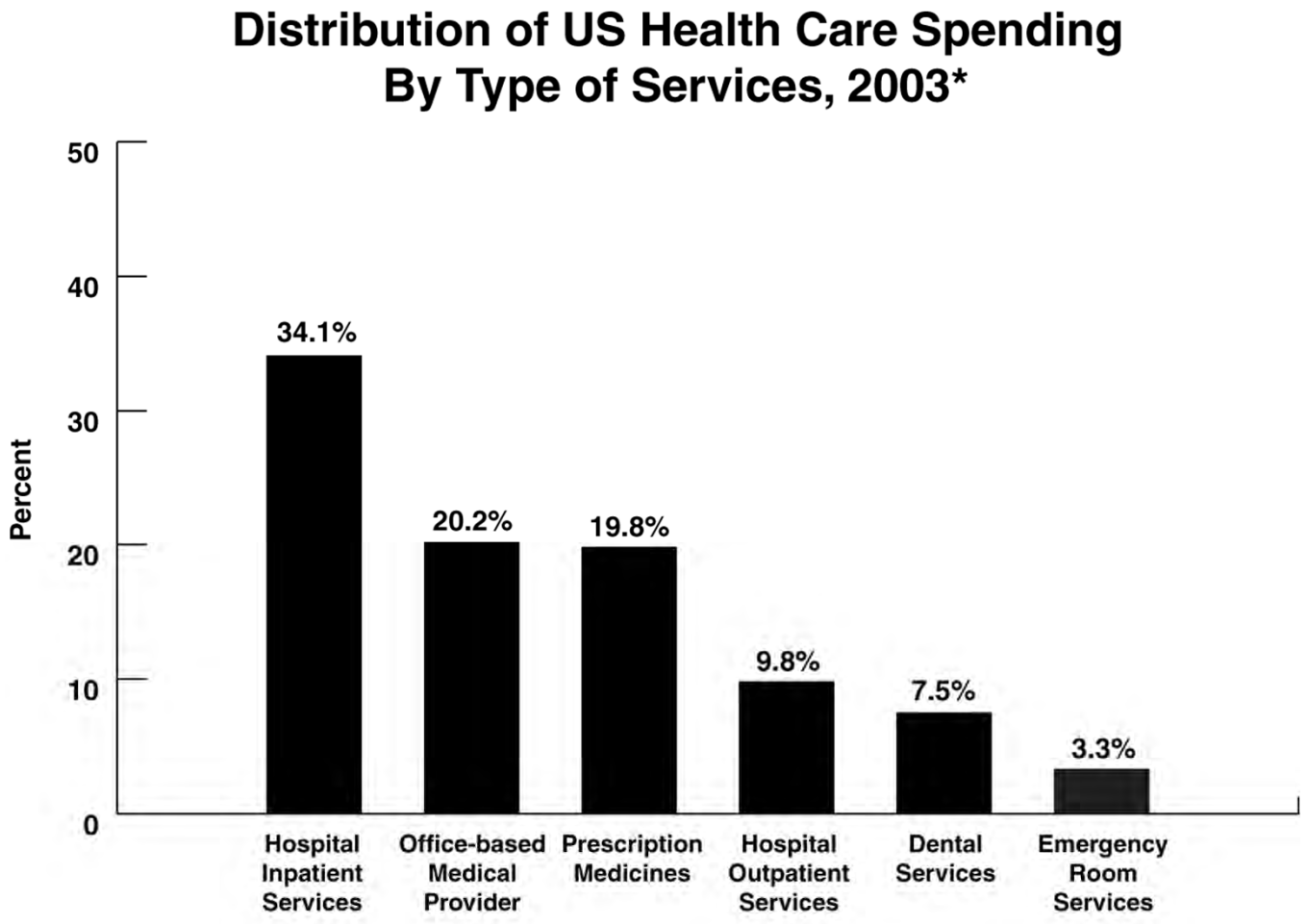
If Not, Someone Else Will…

And Neither Providers nor Patients Will Like the Result.

At Least 30% of Health Care is for Duplicative, Unnecessary, or Poorly Delivered Services

- Four certain categories of unnecessary (sometimes harmful) spending in America
  - Inefficient hospitals
  - Poor management of chronic diseases
    - 30% of health care spending
  - Unnecessary or poorly evaluated procedures
    - ≥6% of hospital spending (estimate)
  - Emergency room over-usage

Prime Direct and Indirect Spending is Similar to Overall US Health Care Spending



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2003.

**US Civilian Noninstitutionalized Population*

MHS is Probably no Exception to Wasteful Spending.

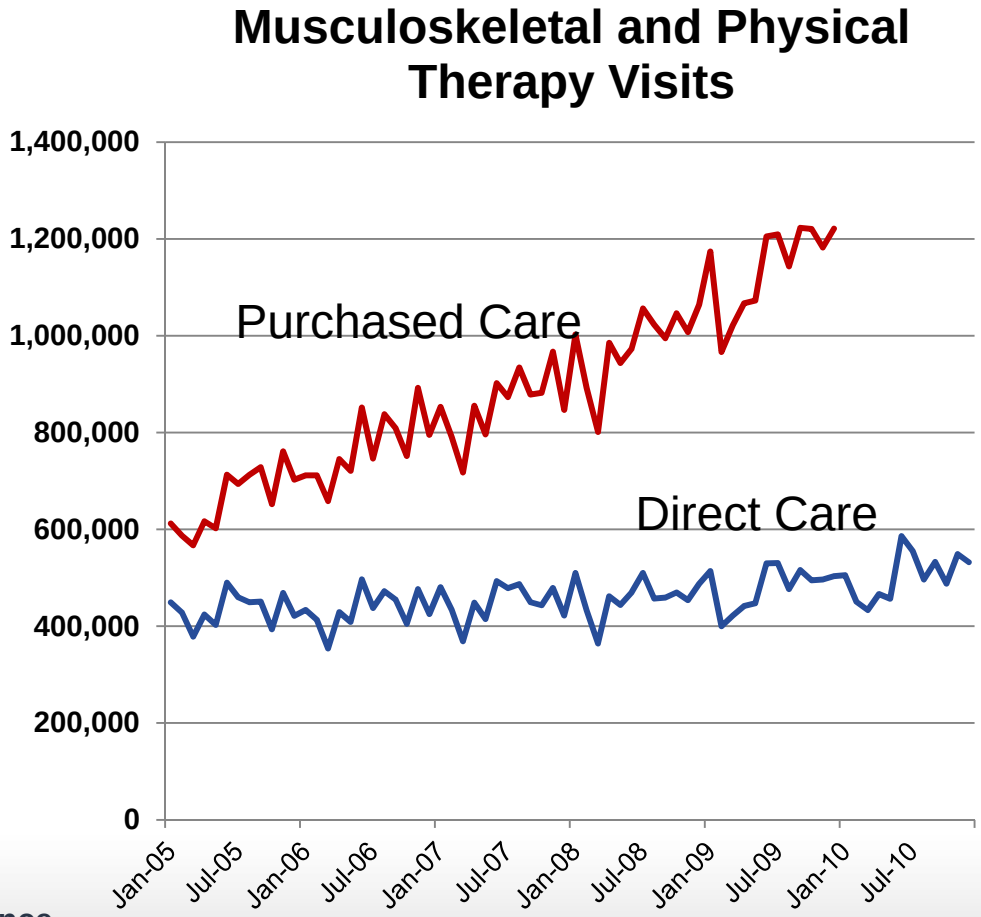
- Major categories of Probably or Certainly Unnecessary MHS Spending (percent of total?)
  - Musculoskeletal outpatient procedures and treatments
  - Emergency Room Over-usage
  - Pharmaceuticals

Probable Overuse

OUTPATIENT MUSCULOSKELETAL CARE

Growth in Musculoskeletal Visits and Treatments

- Contractors routinely authorize 20+ visits per episode



SOURCE: Dr. Bob Opsut, OSD (HA), 2010

Almost Certain Overuse

EMERGENCY DEPARTMENT VISITS

In the Bronx 80% of ER Visits Need Not Have Occurred

- New York City, 6 Bronx Hospitals, 1994/1999
  - Non emergent-41%
  - Emergent, primary care treatable-33.5%
  - Emergent, ED Care Needed, Preventable/Avoidable-7.3%
  - Emergent, ED Care Needed Not Preventable/Avoidable—17.9%

SOURCE: Emergency Department Use in New York City: A Substitute for Primary Care? Billings J, Parikh K, and Mijanovich T, Commonwealth Fund Issue Brief, 2000

Most Common Reasons for ED Visit in MHS are Primary Care Treatable/Preventable.

- Most Common MHS Emergency Department Diagnoses based on Total Visits* ; Non-AD MTF Prime Enrollee
  - Acute Upper Respiratory Infections — 62,977
  - Unspecified Otitis Media — 52,272
  - Fever — 50,758
  - Chest Pain, Unspecified — 44,108
  - Acute Pharyngitis — 39,617
  - Urinary Tract Infection — 33,687
  - Headache – 33,050

**Total Visits based on DC encounters and TED visits for 2008*

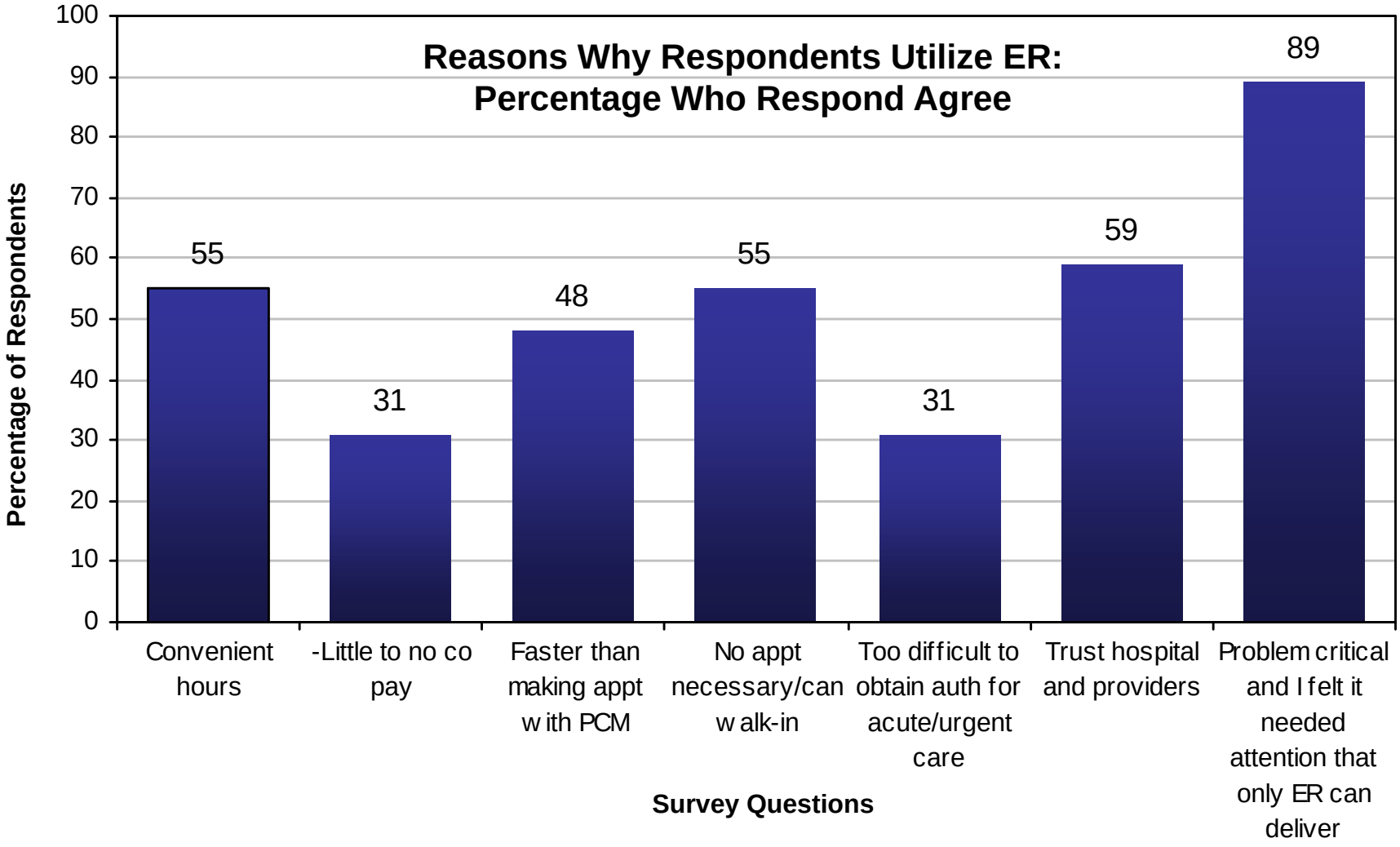
MHS Beneficiary use of EDs is Double that of Privately Insured.

- Average Emergency Room Utilization Rates

Type of Patient	Average Rate (per 1000, per year)
Privately Insured Patients	210
Medicare Patients	480
Uninsured Patients	480
Western Region Military Health System (MHS) Patients	494

SOURCE: TRICARE Management Activity (TMA) TRO-West ER Utilization Survey Results Final Report – Deloitte Consulting, 2009

Why did you go to the ED?



SOURCE: TRICARE Management Activity (TMA)
TRO-West ER Utilization Survey Results Final Report – Deloitte Consulting, 2009

Future of TRICARE

Accountability for cost and quality requires systems of care.

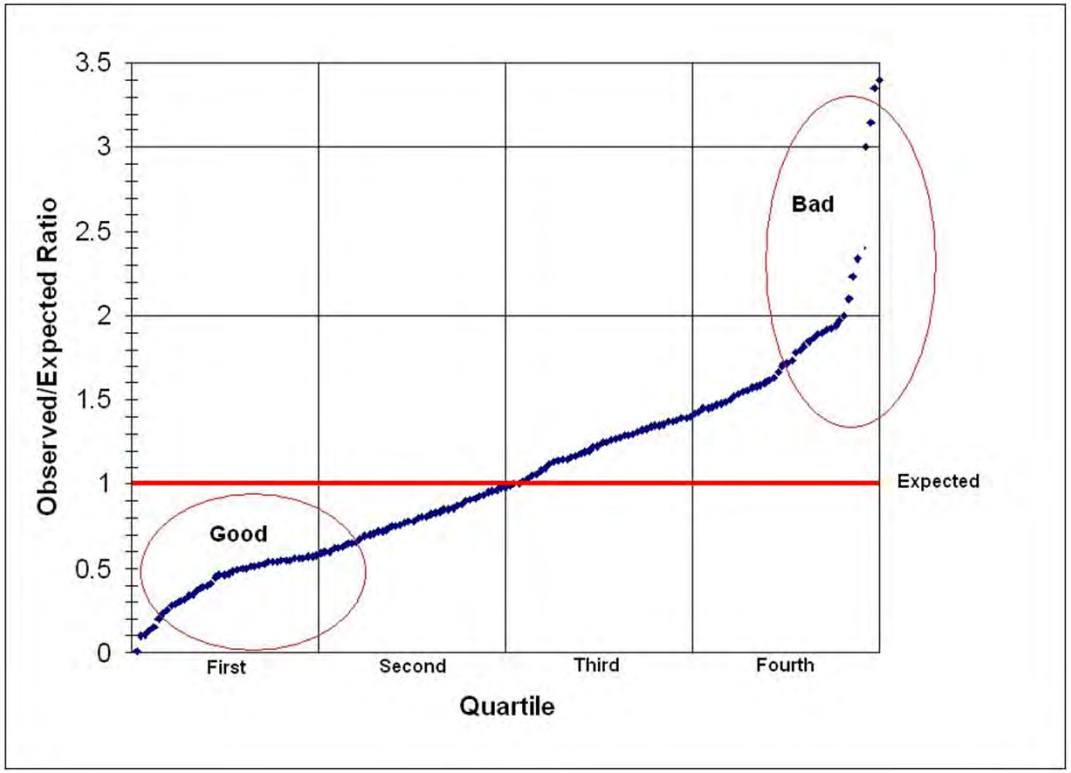
Means of Creating Value

Systems of care require clarity of purpose.

- Establish desired **Outcomes.**
- Align **Organization of Care and Provider Payments** with desired outcomes.

An Example of Aligning Outcomes with Payment.

- Observed/Expected Post-Operative Pneumonia Rates



Source: National Surgical Quality Improvement Program

A Huge Investment…

- Latter Day Saints Hospital (Salt Lake City) takes treatment of pneumonia to another level
  - Change in ICU culture
  - Collaborative protocol development
  - Monitoring of compliance
  - Reduced sedation and paralysis
  - Reduced blood glucose
  - Reduced intravenous feeding
  - Antibiotic protocol
  - Stress ulcer prophylaxis

For Which the Hospital Was Penalized.

- And loses money doing it
  - Hospital-acquired pneumonia rate decreased from 12% to 3%
  - Substantial investment in best processes reduced their cost by $5000 per patient*
  - Turned it all over to payers

**SOURCE: Clemmer et al, Critical Care Medicine, Vol. 27 1999*

Assumptions & Conclusions

- Policy makers will use price cutting to manage cost if providers do not…
- …which may result in access and quality problems for government-funded patients.
- If providers accept accountability for cost and quality they can forestall price cutting.
- Accountability for cost and quality requires systems of care
- Systems of care require clarity of purpose---benchmarks and aligned incentives.

T4 Study Group's Initial Findings

COL Brian Unwin

Membership

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	LTC Floreyce Palmer (A)
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	Mr Drew Obermeyer
	Ms Barbara Zeliff
	Mr Rick Hart
	Ms Beth Spearman

OSD-Cape	Ms Carol Moore
	Mr Garrett Summers

USUHS	CDR Glen Diehl
	COL Brian Unwin

Core Principles

- Achieve the Quadruple Aim
  - Readiness and responsiveness
  - A healthy and fit population
  - A positive patient experience of care
  - Responsible management of the per capita cost of care

T4 Study Group

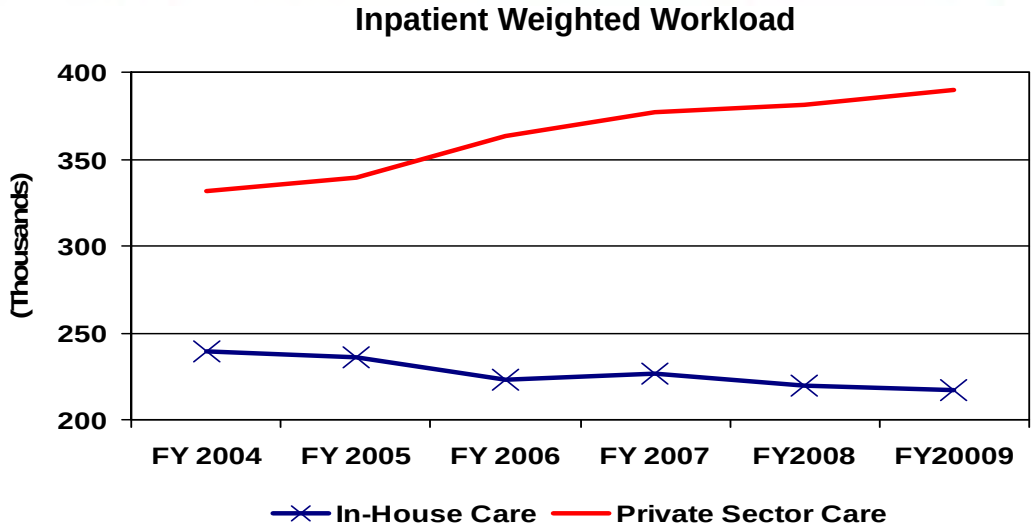
Which of These Five Options (among others we may discover) will Create the Most Value and Preserve Readiness?

1. **Incremental change to the existing Direct/Purchased (Managed) Care Regional model**
2. **Federal Employees Health Benefit Program/Medicare**
3. **MTF-Centric Systems of Care**
4. **Purchased systems of care from integrated provider groups**
5. **Model 3 + 4**

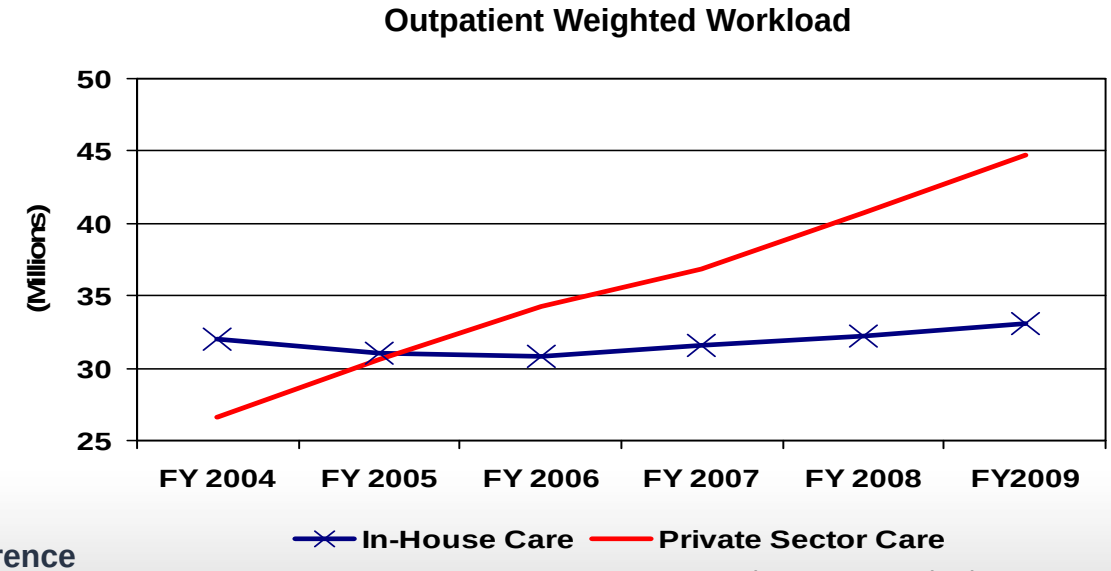
The T4 Study Group's Focus is Purchased Care, But…

Purchased care decisions will affect direct care.

Direct Care Shifts



(Excludes MERHCF)



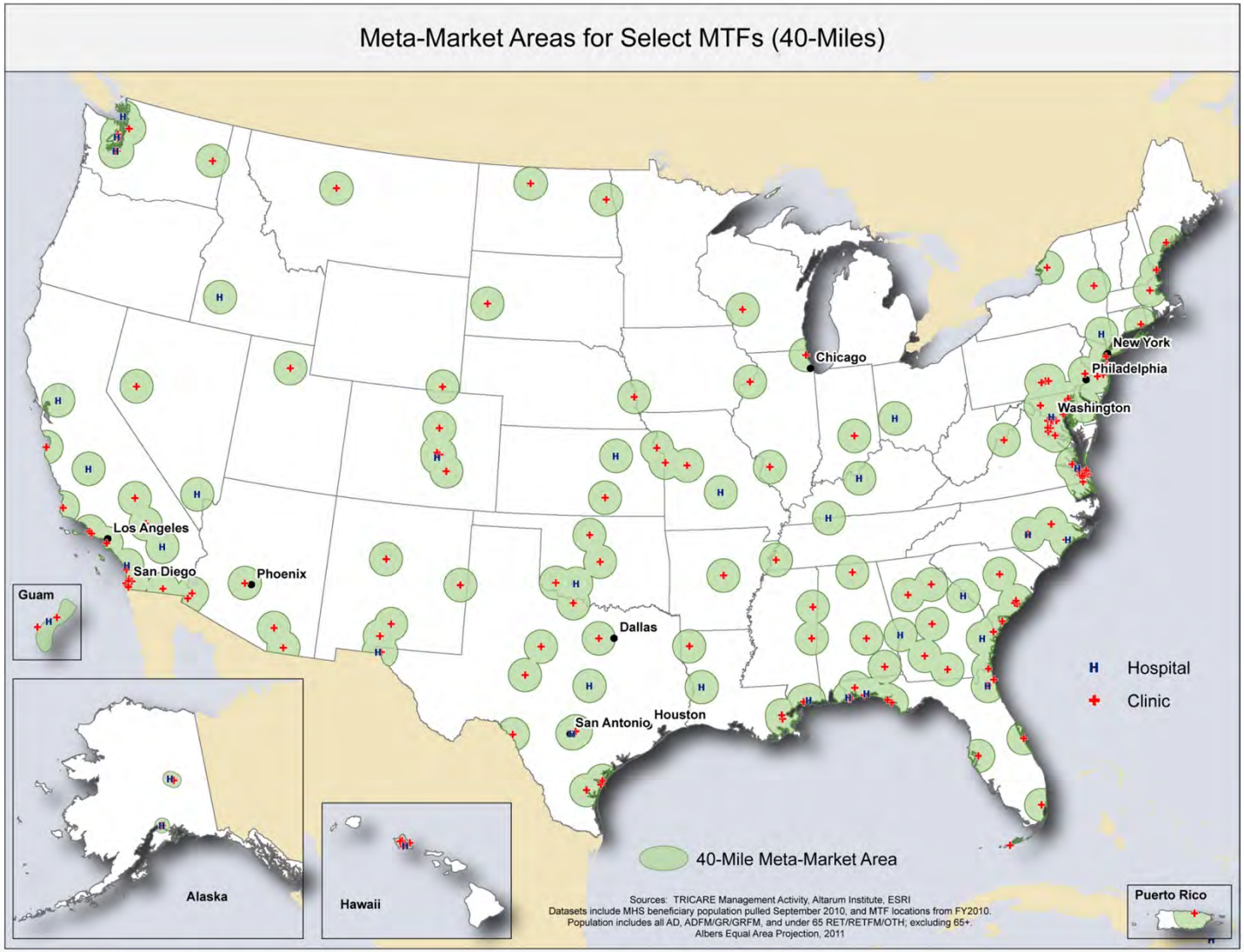
(Excludes MERHCF)

SOURCE: Dr. Bob Opsut, OSD (HA), 2010

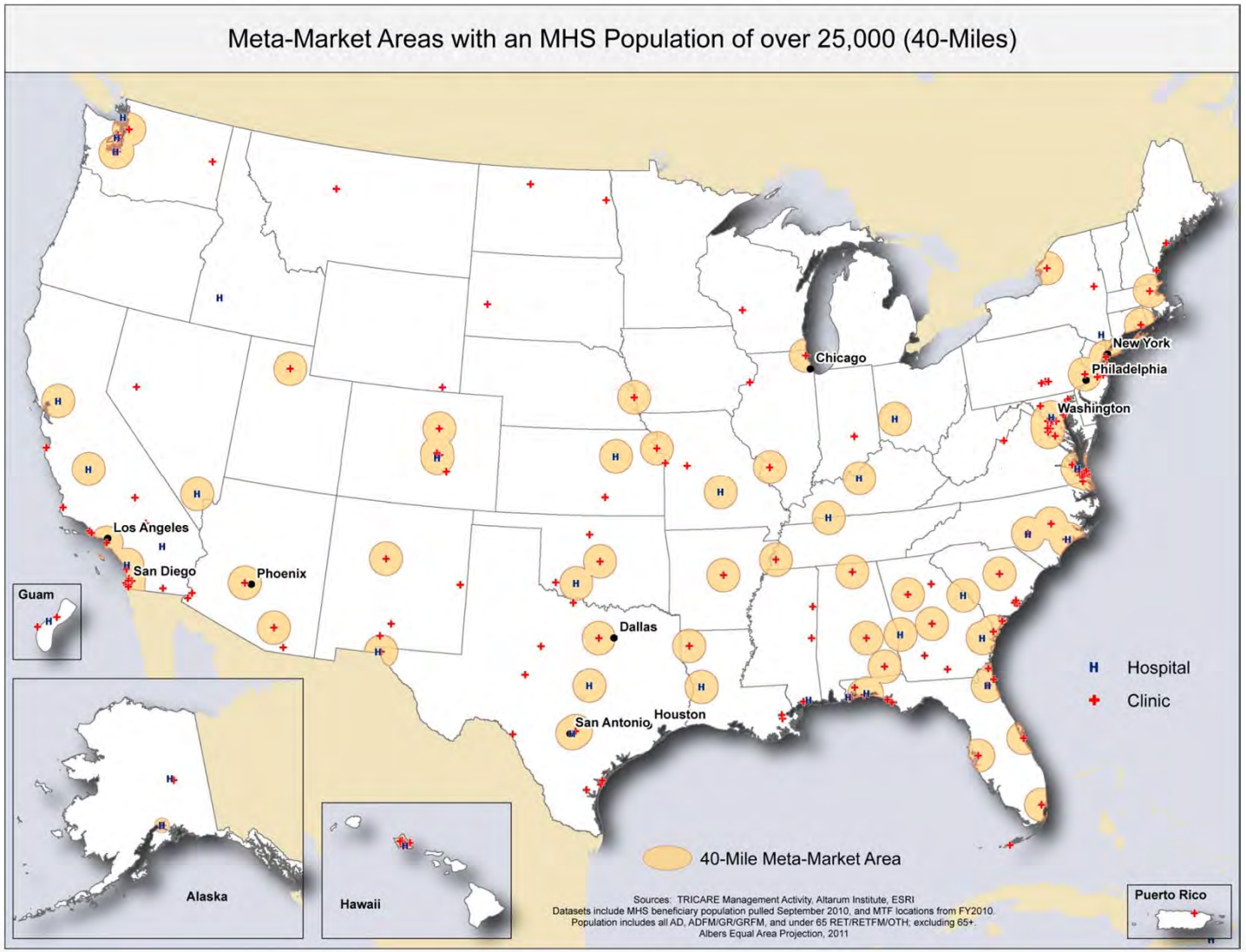
MTFs and Their Catchment Areas Vary Widely

One Size Will Not Fit All.

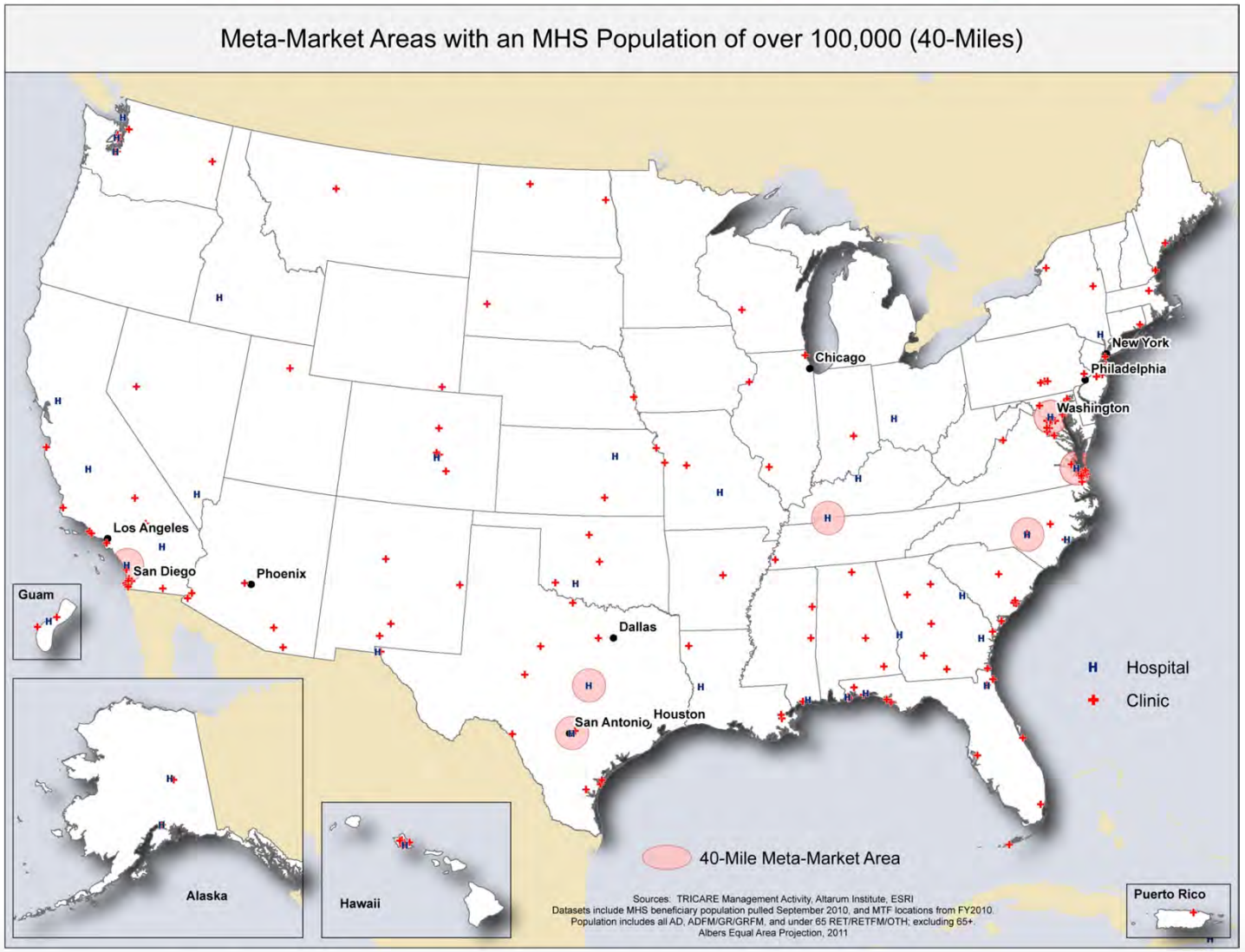
MTF Market Areas



MTF Market Areas



MTF Market Areas



Five Models

- TRICARE with incremental improvement
- FEHBP, Medicare
- MTF Centric Care
- Purchased care: Integrated Provider Groups
- MHS Preferred Systems of Care

Criterion Evaluated

- Readiness
- Population health
- Patient centeredness
- Cost management
- Provider behavior incentives
- Patient behavior incentives

- Member ranking 1-10 for each domain

Model 1: Incremental Improvements

Concept

Incremental improvement of TRICARE

Actions

- Reduce MCSC admin cost
- Preserves Readiness
- Enhance to support population health
- Acquire, manage, and adjust scope of contracts

Outcomes

- Tied to civilian cost growth and quality
- Cost controls (co-pays, other)
- No pop. health in purchased care
- PCMH in purchased care?
- Could use disease management, PCMH, and ACOs
- Beneficiaries "unattractive" because of low reimbursement

Model 2: FEHBP and Medicare

Concept

- For NAD beneficiaries
- MCSC no longer support PRIME and Standard
- MTF Prime continues where possible

Actions

- Lower admin cost with Medicare (3% v. 9%)
- Govt. pays full premium

Outcomes

- Loss of MCSC network discounts
- Increased OOP costs for beneficiaries
- Negative impact on readiness & GME
- Same cost escalation as private sector
- No population health

Model 3: MTF Centric Care

Concept

- MTF CDR responsible for capitated budget
- Primary care and Population health emphasis
- Patient complexity aligned to provider skill

Action

- MCSC: smallest number of best specialty care
- Care management and reporting to providers
- Right of 1st refusal If MTF meets quality metrics

Outcomes

- Quality measures, data collection, report cards
- MHS controls: processes, costs, & outcomes
- Integration of population health
- 5-7 year transition from TRICARE

Model 4: Integrated Provider Groups

Concept

Purchase care from groups that accept capitation

Integrates pop health, cost control and quality

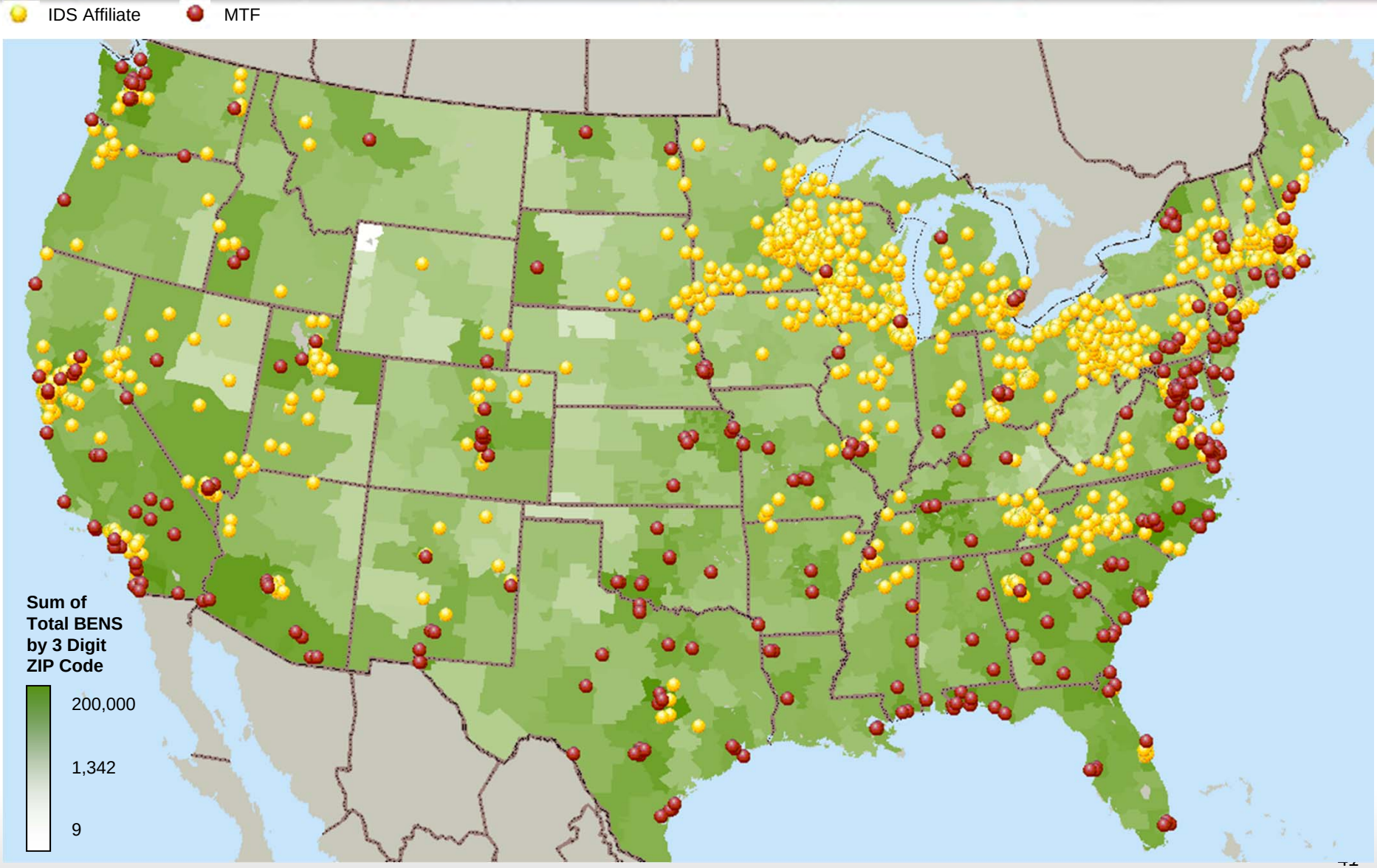
Action

Complex patient movement	Readiness impact?	GME Impact?

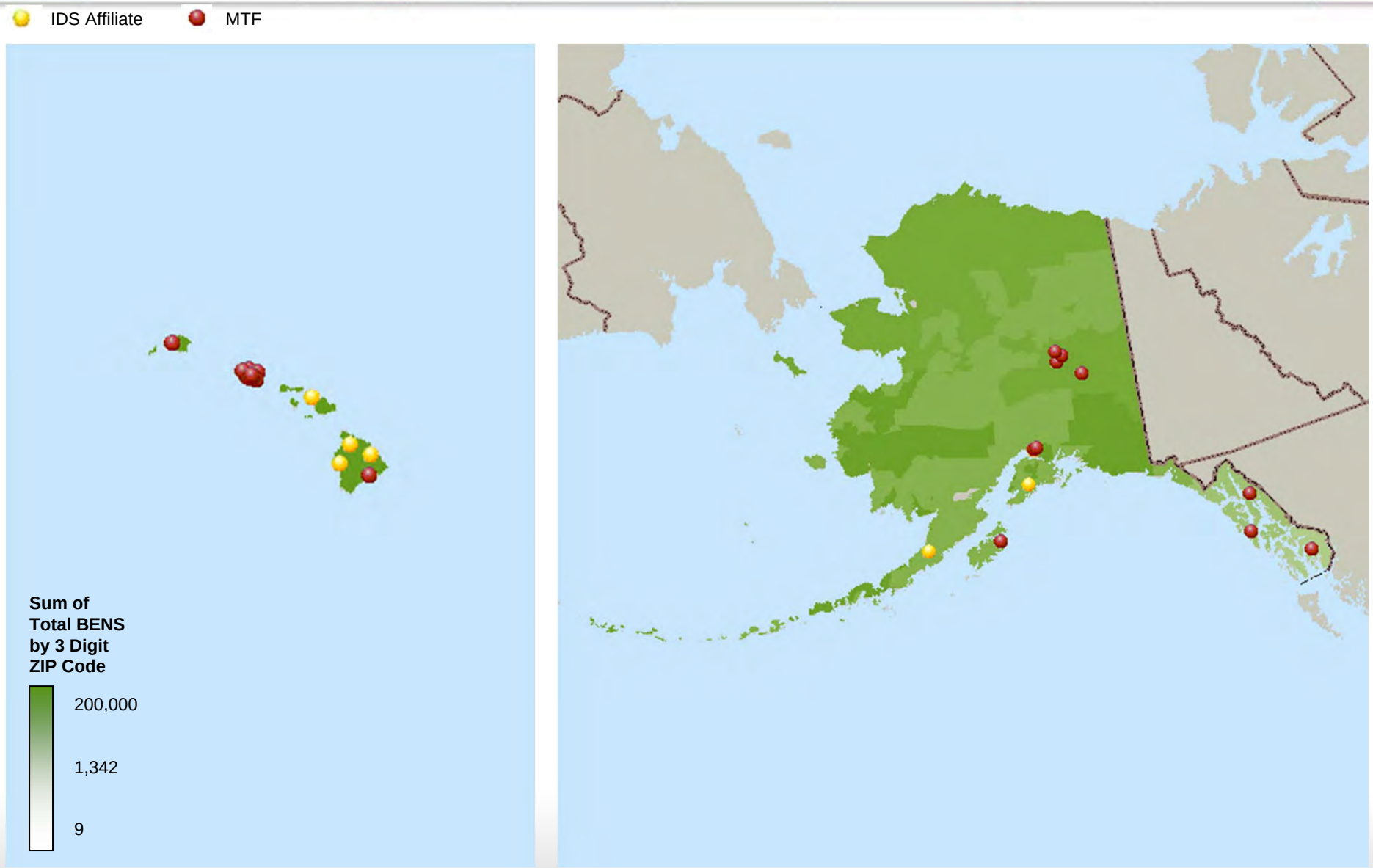
Outcome

Cost savings?	Uncertain…

Overlap of TRICARE Beneficiary Population with Civilian Integrated Delivery Systems and MTFs



Overlap of TRICARE Beneficiary Population with Civilian Integrated Delivery Systems and MTFs (HI + AK)



Model 5: MHS Preferred Care

BKU1

- Combined 3&4
  - MTF Centric and Integrated Provider Groups

Slide 43

BKU1 How is this different from current TRICARE?
BRIAN K. UNWIN, 1/21/2011

Criterion Scores by T4 Members

Criterion	Option 1 Incremental TRICARE	Option 2 FEHBP & Medicare	Option 3 MTF Centric	Option 4 Purchase care from ACOs
Readiness	7	3.8	7.3	5.3
Pop. Health	4.2	2.2	8	7.2
Patient Centeredness	4.9	3.9	7.3	7.8
Cost Management	3.9	3.8	6.3	7.7
Provider behavior incentives	5.3	3.3	7.3	7.6
Patient behavior incentives	3.6	4.1	7.1	6.9

Timeline

- Kick-Off – October 2010
- Phase 1: Framing the Problem
- Phase 2: Scenario Development
- Phase 3: Detailed Analysis—outcomes, risks, consequences, feasibility

Discussion

Mr. Drew Obermeyer