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Military Health System (MHS) Reform: The Options Under Consideration (Presentation)

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About this Publication

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Military Health System (MHS) Reform: The Options Under Consideration

Sarah Burns

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Executive Summary

The House and Senate marks for the FY 2017 National Defense Authorization Act (NDAA) contained significant reforms to the Military Health System (MHS). This briefing provides a review of the provisions contained within each bill. It begins with a brief overview of the MHS, including its mission, the current delivery system, and the TRICARE health benefit. This is followed by a short discussion of some of the most salient challenges facing the MHS today (rising costs, beneficiary satisfaction, and the lack of emphasis on the readiness of the medical force) that have contributed to the congressional reform effort. It then provides an overview of the actual provisions included in the bills. This discussion is organized around four of the most significant reform themes that were present in the bills of both chambers of Congress. These include reforms aimed at:

- Altering beneficiary cost shares
- Realigning the Military Treatment Facilities (MTFs) under the Defense Health Agency (DHA)
- Reforming the TRICARE contracts (or how DoD purchases civilian healthcare), and
- Increasing the emphasis on readiness

The presentation identifies which provisions relate to each of these four themes and, in some instances, includes excerpts from the actual legislation. Where relevant, it also contrasts how the House and Senate bills differ.

Several other minor provisions are also highlighted following the coverage of the four main reform themes. References to the specific sections of the House and Senate bills are provided for each topic to guide readers seeking further information.

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Mission, Delivery System, and the TRICARE Health Benefit

MHS BACKGROUND

Mission

The Military Health System (MHS) has a dual mission:

Maintaining the skills of the medical force

(approximately 120,000 uniformed medical personnel)

Providing a health care benefit (TRICARE)

(approximately 9.6 million beneficiaries)

The mission is conducted in two settings:

The direct care system (DC)

55 hospitals and over 300 clinics managed by the Services

The purchased care system (PC)

civilian health care procured through large regional Managed Care Support Contracts (MCSCs)

The benefit has two main plans:

TRICARE Prime: lower cost for less choice

Active Duty Family Members (ADFMs) pay nothing out of pocket

Retirees pay modest enrollment fees and co-payments (for network)

TRICARE Standard/Extra (S/E): the network benefit

Annual deductibles and cost sharing (lower for network providers)

Challenges in Military Health Care

WHY REFORM THE MHS?

Costs are High

The annual appropriations that fund the MHS have grown by over **$50 billion**

This accounts for roughly **10%** of **DoD's overall budget**

DoD's corporate answer has been to propose raising beneficiary cost shares

Beneficiary Satisfaction is Low

Beneficiaries complain about the quality of the benefit

Purchased care has **limited choice** and **narrow networks**

MTFs are unresponsive and have **limited access**

If we have to **pay more**,

we should **get more** in return

Readiness Second to Beneficiary Care Mission

"the MHS, designed decades ago, has increasingly emphasized delivering peace time healthcare at the expense of strengthening operational medical force readiness" (Senate MHS Reform overview)

Independent analyses find problems across the MHS such as:

Medical force mix: military force focused on commercial activities; risk taken against military essential requirements; poor reserve integration for support of operational requirements

Military hospitals: high cost; should be limited in use to support readiness but instead are used to support commercial activities that can be purchased more cheaply

Graduate Medical Education (GME) programs: high cost; not focused on operational requirements; distorts specialty mix of force

House and Senate marks for the FY 2017 National Defense Authorization Act (NDAA) contained **proposals for significant reform** to the MHS that targeted

the **mission**

(by increasing the focus on readiness)

the **delivery system,** and

(MTF realignment and purchased care contracting)

the **benefit**

(beneficiary cost shares, improved access, and purchased care contracting)

Selected Provisions of the House and Senate Marks

WHAT'S IN THE BILLS?

Both chambers include provisions that:

Alter Beneficiary Cost Shares

Realign the MTFs under the Defense Health Agency (DHA)

Reform the TRICARE Contracts

Increase Emphasis on Readiness

Some Other Stuff

House Bill

Improved access to care (in network and MTFs)

Adoption of Core Quality Performance Metrics

MTF rationalization

Senate Bill

Authority for military-to-civilian conversions

Beneficiary incentives for better health management

Authority to contract with certain entities to provide care

Comparing the House and Senate Proposals

BENEFICIARY COST SHARES

Both Chambers Increase Beneficiary Cost Sharing

House Bill (Section 701)

TRICARE Preferred and Other TRICARE Reform

Alters TRICARE Prime cost shares

Replaces TRICARE Standard/Extra with **TRICARE Preferred**

Senate Bill (Section 701)

Reform of health care plans available under TRICARE

Alters TRICARE Prime shares

Replaces TRICARE Standard/Extra with **TRICARE Choice** and introduces **TRICARE Supplemental**

Changes to Prime Cost Shares (House vs. Senate)

Increased enrollment fees for **Prime** beneficiaries

Annual Enrollment Fees (Individual/Family):

	Proposed		
	House	**Senate**	**Current**
ADFMs	**$180/$360**	$0	$0
RETFMs	$325/$650	$350/$700	$283/$565

House and Senate Bills leave co-payments at $0 for ADFMs* but **increase** retiree co-payments **for civilian care**

*Care must be authorized

Senate Bill **raises the catastrophic cap** by $500 for ADFMs ($1000 for RETFMs)

House Proposal for Network Benefit Cost Shares

"TRICARE Preferred"

TRICARE Preferred Cost Sharing (Individual/Family):		
	ADFM	**RETFM**
Enrollment	$300/$600	$425/$850
Deductible	$0	$0
Catastrophic Cap	$1000	$3000
Outpatient Visit	$15 primary care $25 specialty care Out of Network 20%	$25 primary care $40 specialty care Out of Network 25%
Inpatient Visit	$40 20% Out of Network	$60 25% Out of Network

Adds enrollment fees

RETFMs pay more than ADFMs for going out of network

No deductibles or changes to catastrophic caps

Changes only apply to beneficiaries who become eligible after January 1, 2018

Senate Proposal for Network Benefit Cost Shares

"TRICARE Choice"

TRICARE Choice Cost Sharing (Individual/Family):		
	ADFM	**RETFM**
Enrollment	$0	$150/$300
Deductible	$100/$200 (E4 and below) $300/$600 (E5 and above)	$300/600
Catastrophic Cap	$1500	$4000
Outpatient Visit	$15 primary care $25 specialty care Out of Network 20%	$25 primary care $30 specialty care Out of Network 25%
Inpatient Visit	$80 20% Out of Network	$250 25% Out of Network

Adds enrollment fees for retirees

Raises deductibles

Increases catastrophic cap

Replaces cost shares with fixed co-pays

Both chambers raised beneficiary cost shares

House bill introduced enrollment fee for Prime ADFMs

Both chambers replaced TRICARE S/E with new benefit

TRICARE Preferred (House)/TRICARE Choice (Senate)

Out-of-pocket expenses are increased under both plans

Comparing the House and Senate Proposals

MTF REALIGNMENT

Both Chambers Realign MTFs under DHA

House Bill (Section 702)

Reform of Administration of the Defense Health Agency and Military Medical Treatment Facilities

Senate Bill (Section 721)

Consolidation of the medical departments of the Army, Navy, and Air Force into the Defense Health Agency

House MTF Realignment Proposal (Sec 702)

*Beginning October 1, 2018, the Director of the **Defense Health Agency** shall be responsible for the administration of each military medical treatment facility, including with respect to*

Budgetary matters

Information technology

Health care administration and management

Administrative policy and procedure, and

Any other matters the Secretary of Defense [SecDef] determines

House MTF Realignment Proposal (Sec 702)

"*The commander of each military medical treatment facility shall be responsible for –*

Ensuring the readiness of the members of the armed forces and civilian employees at such facility

furnishing the healthcare and medical treatment provided at such facility"

Administration under House Realignment Plan

"The Secretary of Defense Shall establish within the Defense Health Agency a professional staff serving in senior executive positions to carry out this subsection"

Assistant Director for Health Care Administration (Chief Executive Officer)
Deputy Assistant Director for Information Operations (CIO)
Deputy Assistant Director for Financial Operations (CFO)
Deputy Assistant Director for Health Care Operations (COO)
Deputy Assistant Director for Medicinal Affairs (clinical quality)

Senate MTF Realignment Proposal (Sec 721)

*"The Secretary of Defense shall disestablish the medical departments of the Armed Forces and consolidate all activities of such departments into the **Defense Health Agency**"*

Administration under Senate Realignment Plan

"The Director of the Defense Health Agency shall be an officer of the Armed Forces" *(lieutenant general or vice admiral)*

The Defense Health Agency shall have four subordinate organizations:

- An organization that includes all MTFs
- An organization responsible for recruitment/retention, medical training, education, R&D
- An organization responsible for all of DHA's current activities
- An organization responsible for readiness

The head of each subordinate organization will be an officer of the Armed Services (major general or rear admiral)

Both chambers realign MTFs under DHA

House plan calls for more **civilian leadership**

Senate plan calls for more **military leadership**

Surgeons General are left to focus on readiness

Comparing the House and Senate Proposals

REFORMS TO TRICARE CONTRACTS

Both Chambers Propose Reforms to MCSCs

House Bill (Section 706)

Incentives for Value-Based Health Under TRICARE

Senate Bill (Section 726)

Acquisition of medical support contracts for TRICARE

House Value-Based Health Proposal (Sec 706)

This section would authorize the SecDef to:

develop and implement **value-based incentive programs** as part of the TRICARE contracts to encourage health care providers under the TRICARE program to **improve the quality of care** and the experience of the covered beneficiaries.

Not later than one year after implementation of a value-based incentive program and annually thereafter through 2022, the SecDef would be required to brief the Committees on Armed Services of the Senate and the House of Representatives, and any other appropriate congressional committee, on the **quality performance metrics** and **expenditures related to the incentive program**.

Senate Medical Support Contracts Proposal (Sec 726)

The committee recommends a provision that would require the SecDef to:

conduct a **new competition** of all medical support contracts, with private sector entities, under the TRICARE program by January 1, 2018, upon expiration of each such contract.

New contracts would be **competitively procured** and **automatically renewable** for a period of not more than 10 years. The Department would award contracts with a combination of **local, regional and national private sector entities** to develop individual and institutional networks of high-performing health care providers.

Acquisition of Medical Support Contracts (Sec 726)

For new medical support contracts, the Department would be required to include, to the extent practicable:

- maximum flexibility in network design and development
- integrated medical management between military MTFs and network providers
- maximum use of the full range of telehealth services
- use of value-based reimbursement methods
- use of prevention and wellness incentives

House Bill calls for Value-Based Health to improve benefit quality

Senate Bill goes **much further**

> Calls for new competition of medical support contracts that will increase **competition**, contractor **risk-bearing**, and contractor **flexibility**

Comparing the House and Senate Proposals

INCREASED EMPHASIS ON READINESS

Section 709

Joint Trauma Education and Training Directorate

Section 707

Improvements to Military-Civilian Partnerships to Increase Access to Healthcare and Readiness

Section 708

Joint Trauma System

Creates DHA organization to serve as reference body for all trauma care provided within the MHS, establishes care standards, coordinates research and lessons learned

Section 709

This section would require the SecDef to:

*"assess the number of **traumatologists needed to meet the requirements** of the combatant commanders and to establish a Joint Trauma Education and Training Directorate to create **enduring partnerships with civilian trauma centers.** These military trauma surgeons and physicians, along with the clinical support teams, would be **embedded within civilian trauma** centers to maintain professional readiness to treat critically injured patients."*

Senate Proposals

Section 706

Evaluation and treatment of veterans and civilians at MTFs

Section 729

Establishment of centers of excellence for specialty care in the military health system

Section 734

Improvement and maintenance of combat casualty care and trauma care skills of health care providers of DOD

Section 735

Adjustment of medical services, personnel authorized strengths, and infrastructure in military health system to maintain readiness and core competencies of health care providers

Section 752

Implementation of plan to eliminate certain graduate medical education programs of DOD

Section 734

The committee recommends a provision that would require the SecDef to:

implement measures *to* ***improve and maintain the combat casualty care*** *and* ***trauma care skills*** *for health care providers of the DOD*

(1) conduct a ***comprehensive review of combat casualty care*** *and wartime trauma systems from January 1, 2001 to the present time*

(2) expand ***military-civilian trauma training sites*** *to provide enhanced training for integrated combat trauma teams;*

(3) establish a personnel management plan ***for important wartime medical specialties***

(4) develop ***standardized tactical combat casualty care instructions*** *and training for all service members*

(5) develop a ***comprehensive trauma care registry***

(6) develop ***quality of care outcome measures*** *for combat casualty care*

(7) conduct ***research*** *to understand better the* ***causes of morbidity and mortality of service members*** *in combat.*

Section 735

The committee recommends a provision that would require the SecDef to:

implement measures *to* ***maintain the critical wartime medical readiness skills*** *and* ***core competencies*** *of health care providers within the Armed Forces.*

The provision would require the Secretary to implement a measure to ensure the military Services ***do not substitute a medical specialty required for medical force readiness with another medical specialty****. Additionally, the provision would require the Secretary to:*

(1) modify medical services

(2) reduce authorized strengths of military and civilian personnel

(3) reduce or eliminate unnecessary infrastructure in the military health system such that ***MTFs would provide only those services required to maintain the critical wartime medical skills*** *and core competencies of health care providers and to ensure the medical readiness of the Armed Forces.*

Readiness Emphasis Summary

Embeds military providers in civilian trauma centers

House Bill (Section 709) and Senate Bill (Section 734)

Brings civilians and veterans into MTFs for readiness skill maintenance

House Bill (Section 707) and Senate Bill (Section 706)

Develops trauma system that includes trauma registry, standards, quality metrics, and research

House Bill (Section 708) and Senate Bill (Section 734)

Eliminates GME programs that do not directly support readiness

Senate Bill (Section 752)

Additional Selected Provisions

OTHER REFORMS

House and Senate Proposals for MTF Rationalization

House Section 703

Military Medical Treatment Facilities

Senate Section 725

Authority to realign infrastructure of and healthcare services provided by military treatment facilities

House Proposals for Improved Access

Section 704

Access to Urgent Care (UC) Under TRICARE

Expands MTF hours to 11:00 pm

Eliminates preauthorization requirement for network UC

Section 705

Access to Primary Care Clinics at MTFs

Expand hours beyond “standard business hours”

Section 710

Improvements to Access to Health Care in MTFs (Sec 710)

MTFs to implement and consistently practice: first call resolution, standardized appointment scheduling, increased provider productivity, managed utilization through telehealth

Section 711

Adoption of Core Quality Performance Metrics

This section would require the SecDef to:

> *"adopt the **core quality performance measures** agreed upon by a collaborative group of Federal agencies, health plans, national physician organizations, employers, and consumers"*

Quality measures would be used to evaluate MTFs and TRICARE network

Senate Proposals for Improved Access

Section 727

*Authority to enter into health care contracts with **certain entities** to provide care under the TRICARE program*

Certain entities includes **the Department of Veteran Affairs (VA)** and Indian tribes or **tribal organizations** (mainly in Alaska or other remote areas)

Care will be provided for beneficiaries covered by TRICARE

Senate Proposal for Mil to Civ Conversions

Section 724

Authority to convert military medical and dental positions to civilian medical and dental positions

Authorizes the DoD to convert military billets to civilian billets if:

- Conversion would not result in a loss of a military-essential position
- Conversion would not result in degradation of medical care or medical readiness
- Conversion to a civilian position will be more cost effective

Section 728

Improvement of health outcomes and control of costs of health care under TRICARE program through programs to involve covered beneficiaries

Encourage beneficiaries to share more responsibility for improvement in their health outcome

Encourage participation in intervention programs (smoking, obesity, chronic conditions)

Authorizes charging fee for missed appointments in MTFs

Summary

Both chambers:

Increase beneficiary **cost shares**

Realign MTFs under DHA

Increase **emphasis on readiness**

Reform TRICARE Contracting for Purchased Care

BACKUP

Contracts with Certain Entities (Sec 727)

The committee recommends a provision that would authorize the SecDef to:

enter into contracts to provide health care to covered beneficiaries under the TRICARE Program with any of the following:

the Department of Veterans Affairs

an Indian tribe or tribal organization that is party to the Alaska Native Health Compact with the Indian Health Service

an Indian tribe or tribal organization that has entered into a contract with the Indian Health Service to provide health care in rural Alaska or other locations in the United States.

Senate Bill

The Surgeon General of each Service serves as **principal advisor** to the **secretary of their respective military department** on all health and medical matters including **strategic planning** and **policy development**

The Surgeon General of each Service serves as the **chief medical advisor** of their service to the **Defense Health Agency** on matters pertaining to **military health readiness**

The committee recommends a provision that would require the Secretary of Defense to implement a phased plan, within one year of the date of enactment of this Act, to

eliminate those **GME programs** of the Department that **do not directly support** the **medical force readiness requirements** for health care providers within the Armed Forces.

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14. ABSTRACT

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MHS reform

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