TRICARE Fourth Generation Study Group – Exploring the Way Forward

The Quadruple Aim: Working Together, Achieving Success

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FLATLINED

Resuscitating American Medicine

GUY L. CLIFTON, M.D.
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

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

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.
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

Distribution of US Health Care Spending
By Type of Services, 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

Musculoskeletal and Physical Therapy Visits

- Purchased Care
- Direct Care

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%

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

<table>
<thead>
<tr>
<th>Type of Patient</th>
<th>Average Rate (per 1000, per year)</th>
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<tr>
<td>Privately Insured Patients</td>
<td>210</td>
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<tr>
<td>Medicare Patients</td>
<td>480</td>
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<tr>
<td>Uninsured Patients</td>
<td>480</td>
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<tr>
<td>Western Region Military Health System (MHS) Patients</td>
<td>494</td>
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</table>

Why did you go to the ED?

Reasons Why Respondents Utilize ER: Percentage Who Respond Agree

- Convenient hours: 55%
- Little to no copay: 31%
- Faster than making appt with PCM: 48%
- No appt necessary/can walk-in: 55%
- Too difficult to obtain auth for acute/urgent care: 31%
- Trust hospital and providers: 59%
- Problem critical and I felt it needed attention that only ER can deliver: 89%

Survey Questions

SOURCE: TRICARE Management Activity (TMA)
Accountability for cost and quality requires systems of care.
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
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

<table>
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<tr>
<th>Service Reps</th>
<th>CAPT Lea Beilman (N)</th>
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<tr>
<td></td>
<td>Col JoAnne McPherson (F)</td>
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<td>CDR Jamie Lindly</td>
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<td>Mr Drew Obermeyer</td>
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<td>Ms Barbara Zeliff</td>
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<td>COL Brian Unwin</td>
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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
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
Purchased care decisions will affect direct care.
Inpatient Weighted Workload

Outpatient Weighted Workload

*In-House Care*  *Private Sector Care*

(Excludes MERHCF)

SOURCE: Dr. Bob Opsut, OSD (HA), 2010
MTFs and Their Catchment Areas Vary Widely

One Size Will Not Fit All.
Meta-Market Areas for Select MTFs (40-Miles)

Sources: TRICARE Management Activity, Altrun Institute, ESRI
Datasets include MHS beneficiary population pulled September 2010, and MTF locations from FY2010.
Population includes all AD, ADL/GR/GRW, and under 65 RET/RET/OTH, excluding 65+
Albers Equal Area Projection, 2011
Meta-Market Areas with an MHS Population of over 25,000 (40-Miles)

Sources: TRICARE Management Activity, Atnum Institute, ESRI
Data sets include MHS beneficiary population pulled September 2010, and MTF locations from FY2010.
Population includes all AD, ADINN/DRF/ADMF, and under 65 RETIRE/MAO/TH, excluding NDFs.
Albers Equal Area Projection, 2011
Meta-Market Areas with an MHS Population of over 100,000 (40-Miles)

Sources: TRICARE Management Activity, Altarum Institute, ESI
Datasets include MHS beneficiary assignment pulled September 2010, and MTF locations from FY2012
Population includes all AD, AOMIGR, and under 65 RETIREMOTH, excluding 65+
Albers Equal Area Projection, 2011
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

Sum of Total BENS by 3 Digit ZIP Code

- 200,000
- 1,342
- 9
Overlap of TRICARE Beneficiary Population with Civilian Integrated Delivery Systems and MTFs (HI + AK)

Sum of Total BENS by 3 Digit ZIP Code

- 200,000
- 1,342
- 9

MTFIDS Affiliate

IDS Affiliate
Model 5: MHS Preferred Care

- Combined 3&4
  - MTF Centric and Integrated Provider Groups
How is this different from current TRICARE?

BRIAN K. UNWIN, 1/21/2011
<table>
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<tr>
<th>Criterion</th>
<th>Option 1 Incremental TRICARE</th>
<th>Option 2 FEHBP &amp; Medicare</th>
<th>Option 3 MTF Centric</th>
<th>Option 4 Purchase care from ACOs</th>
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Timeline

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