



REFORMING *the* MILITARY HEALTH SYSTEM

The opportunity and dire need for change in how we care for military personnel and their families

By General H. Hugh Shelton, U.S. Army (ret.), Stephen L. Ondra, and Peter L. Levin



Center for a
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About the “Future of the All-Volunteer Force” series

The United States military faces a critical inflection point in the way that it structures the All-Volunteer Force (AVF) for the future. The confluence of personnel cost growth, decreasing Defense budgets, and post-war drawdown mean that a smaller, leaner military will have to meet the challenges of a volatile, unpredictable world. As such, the human capital of the military will be the most critical ingredient of its readiness for the future, because of the role that service members play, the long time necessary to develop and retain their capabilities, and the significant investment this nation makes in its service members. The CNAS Future of the All-Volunteer Force series examines design principles for recruiting, retaining, and managing the model AVF of the future.

Cover Image

Marine Corps Recruit Depot San Diego - Recruits of Lima Company, 3rd Recruit Training Battalion, make their way up the last obstacle, the 20-foot rope climb, during the Obstacle Course II event aboard Marine Corps Recruit Depot San Diego, Nov. 20. When recruits reached the top of the rope they had to slap the wood beam, that the rope is attached to, and scream their name, platoon number and senior drill instructor's name, which indicated the completion of the course.

(SGT. BENJAMIN E. WOODLE/U.S. Marine Corps)

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INTRODUCTION

By H. Hugh Shelton, Stephen L. Ondra,
and Peter L. Levin

In a 2010 speech at the Eisenhower Library in Abilene Kansas, then-Defense Secretary Robert Gates said: “healthcare costs are eating the Defense Department alive.”¹ In this paper, we will discuss why healthcare costs absorb a disproportionate share of the Department of Defense (DOD) budget, and how they will negatively impact our national security unless that spending trajectory is changed.

The nation has a solemn and statutory commitment² to provide healthcare to the volunteers who protect us from enemies who threaten our constitutional rights, strategic interests and cherished values. This commitment also extends to their families and those who have retired from the military.

The current crises in the Ukraine and Middle East poignantly remind us that the United States also has a vital interest to maintain its investment in military equipment, training, and rapid response capabilities. Our premise is that despite the finite economic resources available for defense, these are not irreconcilable demands. To meet them, we need to fundamentally rethink how healthcare is delivered to the All-Volunteer Force (AVF), military families, and veterans.

Given its impact on the defense budget, civilian and uniformed leaders should treat military healthcare as a fundamental question of national security. At its root this is a procurement issue, as we discuss in this report. And because of the zero-sum total between healthcare and other components of the defense budget, including readiness and defense research, it needs to be faced head on. Leadership will need to drive these changes with force and velocity; the inertia of the vested interests in the status quo are formidable obstacles to overcome. Recent experience has shown that real change will require much more than a presidential mandate, or a policy directive from the secretary. Administrations change, secretaries are replaced, and the broken system carries forward to whoever comes next.

We describe below the problem of rising costs, and explore several recommendations including a focus on value-based reforms, rewards for innovation, and use of the department's partnership power. We conclude that DOD leadership should take bold and necessary actions in healthcare procurement and service delivery, and seize the opportunity to build upon the framework already launched by the Centers for Medicare and Medicaid Services (CMS) and many private sector payers.

The Rising Cost of Military Healthcare

To define the magnitude of the problem, the Congressional Budget Office (CBO) recently released a report entitled "Approaches to Reducing Federal Spending on Military Health Care."³ The CBO's report helps quantify Secretary Gates' alarm, noting that the cost of military healthcare (not including the Department of Veterans Affairs health system) had "increased rapidly . . . outpacing growth in per capita health care spending in the United States, and growth in funding for DOD's base budget." Indeed, as a percentage of that budget, which does not include contingency operations, healthcare expenditures have risen from 6 percent in 2000 to about 10 percent today.

Even measuring the problem is difficult because of incomplete reporting, demographic complexities, differences in care coverage and complicated federal payment and incentive programs.⁴ Some may argue that costs are rising because of the increased care of battlefield casualties, and it is true that "the actual number of Iraq and Afghanistan veterans receiving government care has grown to more than 56 percent of the total."⁵ The point is that much of that care occurs at VA, and DOD's healthcare expenditures cannot be explained by the increased use of services. Importantly, as Harvard's Linda Bilmes pointed out in 2013: "taken together, the three companies that have administered TRICARE (Humana, Health Net and TriWest Health Care) would rank as the sixth largest contractor for the Department of Defense -- bigger than KBR, and

just below the biggest contracting names such as Lockheed, Northrup Grumman and Boeing."⁶

These confounding factors notwithstanding, the Center for American Progress reported that "between fiscal year 2001 and fiscal year 2012, the military health care budget grew by nearly 300 percent . . ."⁷ That growth far outpaces the top-line trend in the private sector as captured by CMS, which estimated that the national healthcare expenditure grew by 100 percent over the same period, in then-current dollars, to \$2.8 trillion.⁸

Some analyses are even more dire. For example, Maj. Gen. (retired) Arnold Punaro, chairman of the Reserve Forces Policy Board, calculated that "the total costs of pay for active duty and retirees, their health care costs, veterans and other related costs [is] \$417 billion a year -- that's 63% of the combined DOD/VA budget."⁹ He goes on to say that we "can't let DOD turn into a benefits company that occasionally kills a terrorist."¹⁰

More than half of all enrollees of TRICARE, the DOD's private sector health benefits program, are retirees or eligible family members,¹¹ further complicating the problem for DOD healthcare planners. Additionally, TRICARE utilization rates are about 40 percent higher than civilian benchmarks, presumably because the out-of-pocket costs are approximately one-tenth of comparable non-military health plans.¹²

Increased care intensity of the retiree population is a part of the reason that the majority of care for DOD beneficiaries already takes place outside the DOD. Another major factor is that many retirees and their families -- in contrast to active duty troops who live on or near military bases -- are widely dispersed, utilize healthcare more frequently, and receive most of their services from third party providers. In fact, because of base closures, facility changes, and decreased personnel availability, it is now estimated that more than 70%



of all DOD care (by volume) occurs as contract service.¹³

The core problem is that TRICARE's fee-for-service approach is subject to the same perverse incentive structures that have driven up healthcare costs in the United States by explicitly connecting payment to *volume* of care, not *value* of care.

Recognition of this is a major reason for the shift to fee-for-value models in other agencies and in the private sector. For instance, on January 26, 2015, Health and Human Services Secretary Sylvia M. Burwell announced sweeping changes to Medicare's reimbursement program. By the end of next year 30 percent of Medicare payments will directly link provider payments to the health and well-being of their patients, and by 2018 that number will rise to half. In their description, CMS wants to "reward value and care coordination – rather than volume and care duplication".¹⁴

The DOD could, and should, take advantage of these changes, to help gain control of healthcare spending. With the upcoming TRICARE procurement, the DOD has a model and framework to bend their costs towards measurable outcomes by aligning with and leveraging the work of other Federal agencies.

The Problem with the Existing Model

Of the \$52 billion allocated for defense health care in 2012, contracted care – where 70 percent of DOD care is delivered – accounted for \$15.4 billion.¹⁵ In other words, DOD spent and accrued \$36.6 billion, or 71 percent of its healthcare dollar to cover 30% of its healthcare services. This discrepancy represents the cost of a decade of war injuries, maintaining often underutilized DOD health facilities, the future cost of today's obligations to retirees, and the transcendent need to have "mission-ready" active duty healthcare providers who are well trained, well equipped, and immediately ready to support the military mission. The

question is not whether this is necessary, but rather whether the proportion is right.

That's difficult to answer with certainty. While the vast majority of military healthcare is delivered in the private sector far away from combat, clearly we also need to be prepared for unique military medical requirements, like in-theatre care delivery needs, triage, unique war injuries and emergency care. However, these two very different modes are often conflated for planning purposes, further amplifying the inefficiency of both settings.

Volume-over-value thinking has driven up costs far beyond that seen in other nations, without an associated improvement in outcome or quality.

TRICARE's use of a fee-for-service reimbursement model for the purchase of healthcare services in the private sector creates incentives to increase the volume of services, rather than the discovery of service efficiencies that can reach a desired health outcome. Volume-over-value thinking has driven up costs far beyond that seen in other nations, without an associated improvement in outcome or quality. DOD still uses this model almost exclusively in its private sector contracts – and not just for healthcare – because of its outdated procurement practices. Reforming healthcare service delivery could be a template for other DOD acquisitions, and a model for the rest of the country.

To help break this unsustainable spiral, section 731 of the National Defense Authorization Act of 2013 authorized the creation of the Defense Health Agency (DHA), whose implementation was suggested and subsequently directed by then-Deputy

Secretary of Defense Ashton Carter.¹⁶ The DHA estimated that by combining ten shared services including facilities planning, pharmacy, and medical education and training,¹⁷ they could deliver savings as much as \$800 million over six years ending 2019, though the GAO does not concur with this estimate.¹⁸

Of course, DOD and the DHA should be commended for their early accomplishments and active steps to improve the DOD health system efficiency and services. However, centralizing the health-care administration, even coupled to concomitant efforts to recapture some patients in underutilized DOD healthcare facilities, will have a minimal impact on controlling the cost of the services purchased in the private sector. Consolidation of administrative and facility costs are necessary, but not sufficient measures. Bold steps must be taken to bring the costs of DOD provided healthcare coverage under control, while keeping the nation's promise to those who serve, retirees and their families.

Plainly stated, DOD must recognize that it is simply not possible to maintain traditional fee-for-service discount purchasing strategies. The approach has not been, and will not be, an effective way to create provider networks that meet the needs of DOD beneficiaries in an economical, customer-satisfying way.¹⁹

We can fix this without spending more money.

Though danger of that economic vortex is real, there are some sensible steps that DOD could take that would navigate around the hazard without breaking the moral commitment of care to those who serve now or have served in the past.

DOD needs to understand and build on the fee-for-value²⁰ operational restructuring that has already taken root in the private sector and elsewhere in government. Performance-based payments are a symptom of DOD's antiquated and byzantine

procurement procedures. In order to improve the integrity of the system, keep faith with the nation's warfighters, and sustain healthcare expenditures at their current levels, care value must be increased without decreasing care outcomes. Value in this context is straightforwardly defined as the outcome of purchased services – which can be quantified and measured – divided by the overall cost of those services, which is a known variable. Today health-care delivery at the DOD is paid for by the quantity of the service, not by the quality of the outcome. This is precisely why both the private sector and CMS are shifting from volume- to value-driven incentives; a similar move will be key to the DOD successfully controlling its own healthcare costs.

Today healthcare delivery at the DOD is paid for by the quantity of the service, not by the quality of the outcome.

Institutional Inertia

The corroding effects of institutional inertia and resistance to change any aspect of DOD's health-care procurement are acute and plainly visible.

A prime example of obstruction is the tortured history of DOD's electronic health record (EHR). The DOD fielded its "Armed Forces Health Longitudinal Technology Application" (AHLTA) EHR system in 2005 and has spent more than \$4 billion²¹ on development and maintenance since that time, not including the funds required by its predecessor, called CHCS, or twice-abandoned plans for its upgrade. This system has been pilloried by DOD's own doctors and nurses as inefficient and poorly designed.²² It is not integrated to – nor can it seamlessly share data with – other health record systems, including the VA's EHR system, which serves an important and overlapping

population alongside DOD, and for which the seamless transfer of health information would greatly assist in health care and service-related benefits delivery.

In response to a specific instruction from President Obama in April of 2009, the two Departments agreed, two years later, to develop a joint record that would replace current systems and be used by both Departments. Specifically, in congressional testimony to a joint meeting of the House Veterans and Armed Services Committees in July of 2012, then-Secretary of Veterans Affairs Eric Shinseki said:

*“Secretary Panetta and I have committed to developing a single, common, joint electronic health record, known as iEHR. This effort began on January 21, 2009, when then-Secretary Gates and I agreed to develop that vision. Last year [2011], after two years of hard work by teams from both Departments, then-Secretary Gates and I met on 5 February, 17 March, 2 May, and 23 June. Thereafter, Secretary Panetta and I met on five additional occasions to provide continuing guidance and energy for the implementation of the iEHR. It will unify the two Departments’ electronic health record systems into a common system to ensure that all DOD and VA health facilities have servicemembers’ and veterans’ health information available throughout their lifetimes.”*²³

Secretary Panetta went on to say:

*“When operational, the integrated electronic health record will be the single source for servicemembers and veterans to access their medical history at any DOD and VA medical facility. It will help ensure they get the best care possible. It will also be the world’s largest health record system, and that could mean that other federal and commercial health care providers may adopt our protocols, which will expand the capabilities of the system still further.”*²⁴

Since then, DOD has spent billions of dollars and still not fielded any newly integrated clinician-facing software, with the important exception of a jointly created clinical user interface co-developed by a small DOD-VA interagency team.²⁵ Astonishingly, less than a year later, Secretary Hagel instructed DOD to procure its own health record system with the justification that “[the VA system does] not apply to DOD.”²⁶

The fact is that the technical plans were in place and had a straightforward to implementation pathway, had the instructions Shinseki referred to been followed. Additionally, the technical plans would not have limited future choices (including the now-ongoing commercial procurement) if they would have been executed as instructed by the president of the United States²⁷ and agreed to by three cabinet secretaries.



U.S. Army Chief of Staff Gen. Raymond T. Odierno meets Spc. Matthew D. Kemp during a visit to Brooke Army Medical Center in Fort Sam Houston, Texas Dec. 5, 2011. Kemp was assigned to 2nd Battalion, 34th Armored Regiment, 1st Infantry Division.

U.S. Army photo by Staff Sgt. Teddy Wade

The GAO highlighted this point in their February 2014 congressional testimony:

“For example, in October 2010, we previously found that after obligating approximately \$2 billion over the 13-year life of its initiative to acquire an electronic health record system, as of September 2010 DOD had delivered various capabilities for outpatient care and dental care documentation, but scaled back other capabilities it had originally planned to deliver, such as replacement of legacy systems and inpatient-care management.”²⁸

This is prima facie evidence of how the heavy gravity of the status quo, inter-service disagreements, and self-serving interests can suborn poignantly clear instructions in the name of “further study”. Given the fast pace of technology changes, we hope that DOD will not repeat the mistaken multi-billion dollar decision that will hold it captive to the innovations of any single company or the services of a solitary vendor. Because of how

enterprise systems are deployed, a poor selection at the first stage will inexorably lower performance and restrict enhancement choices for more than a decade. Alternatively, the DOD could choose a platform that is extensible, flexible and easy to safely modify and upgrade as technology improves and interoperability demands evolve.

As of this paper’s publishing, DOD is about to procure another major electronic (health records) system that may not be able to stay current with – or even lead – the state-of-the-art, or work well with parallel systems in the public or private sector. We are concerned that a process that chooses a single commercial “winner”, closed and proprietary, will inevitably lead to vendor lock and health data isolation.

Recommendations: there is a window of opportunity now

Because of the upcoming TRICARE²⁹ (also known as T-17) and health record procurements, the DOD has an opportunity to change their healthcare delivery system. Four specific recommendations are described below.

First, DOD should seize the opportunity to align with the direction that CMS and the majority of private insurers are taking, and select from a plethora of value-based models that are already being used in the private sector, to transform its healthcare delivery. As the public-private partnership announced by Secretary Burwell’s on January 26 well documents, the private sector has recognized that volume-driven provider reimbursements are one of the primary causes of the ever-increasing cost of healthcare.

In that broken frame, health outcomes are not only neglected, efficiency is perversely disincentivized. Volume-based models combined with the comprehensive benefit packages (like what DOD offers its beneficiaries) drive up costs at an accelerated rate. In contrast, according to the non-profit



ATLANTIC OCEAN (April 4, 2012) Sailors aboard the Nimitz-class aircraft carrier USS Dwight D. Eisenhower (CVN 69) fill out paper work for a medical history screening. Dwight D. Eisenhower is underway conducting training in the Atlantic Ocean.

Mass Communication Specialist 3rd Class Benjamin Woody/U.S. Navy

organization Catalyst for Payment Reform, value-oriented networks are quickly gaining traction in the market.³⁰ Another study commissioned by McKesson indicated that about two-thirds of their sample – which included over 100 payors – already include value-based reimbursement models like pay-for-performance, capitation, bundled payment or shared savings in their insurance product portfolio.³¹

Failing to choose wisely, with forethought about technological innovation, could be tantamount to having bought a twenty-year contract for the then-“state of the art” BlackBerry service in 1999.

Innovative ideas, implementation frameworks, and measurable performance impact are not the problem. The greatest obstacle will be overcoming the immense bureaucratic inertia and vested interests inside the DOD. Federal employees will make these decisions, and it is therefore important to understand their context and incentives.

Which leads us to our second recommendation: DOD needs to create both the incentives for, and protect the reputations of, those who step forward to assess, report and promote increasing the value of healthcare services purchased and delivered by the DOD.

Breaking the institutional inertia and the politics of that awful spiral is crucial. Indeed, behavioral change will be the hardest challenge of all. Like any well-established agency, many people connected administratively or clinically to providing

healthcare services and are vulnerable to being enticed into the private sector at some point, due to the large increase in pay or public service retirement. This can subtly add (even unconscious) bias to decisions that might impact their inevitable, even coerced transition to the private sector. In other words, we need to be mindful that the people making procurement decisions, as dedicated and well-intended as they may be, do not have to live with the long term consequences of their near-term choices. There is an inherent hazard that the mirage of institutional safety and personal security, will lead to decisions isolated from the reality of large-scale change.

Failing to choose wisely, with forethought about technological innovation could be tantamount to having bought a twenty-year contract for the then-“state of the art” BlackBerry service in 1999, or even 2009, just as wireless data services were changing the landscape. Installing a DOD-requirements-driven EHR platform based on current-need specifications risks missing opportunity in the rapidly changing and hard-to-predict EHR technology space, and at worst could lock the DOD into another dead end. Health information technology (IT) is one of the fastest growing and dynamically changing segments of the technological landscape.³² For the health of our uniformed service members, and to protect the promises made to retirees and veterans, DOD planners cannot allow or afford single-system lock-in to occur without allowing for flexible and market-responsive services.

Exactly the same argument holds when procuring services from the commercial market: value is key, and the ability to adapt and improve proven models as they evolve in response to customer expectations is essential.

Third, DOD can find cost-saving solutions by using its gigantic partnership power and vendor relationships than to help shape, transform and

improve beneficiary healthcare by service platform coordination and data integration efforts with VA. Renewed and performance-accountable efforts here would have the immediate benefit of dramatically improving service to uniformed military before, during, and after their transition. For example, the Blue Button personal health data program first developed by VA is being aggressively and widely adopted everywhere³³ in the US. DOD embrace of this health record option would dramatically simplify and accelerate data transfer between the two agencies, greatly increasing the value of healthcare dollars spent by DOD and other agencies.

By properly articulating performance expectations, DOD has a tremendous opportunity to create an outcomes-oriented, high-value structure.

Moreover, we believe that a sober review of mission scenarios mapped to a substantial active duty medical force would likely find billion-dollar inefficiencies. Facilities and other resources should be continuously rationalized to ensure that key mission support functions are adequately resourced and that military providers have the peacetime opportunity, and practical experience, to best meet both garrison and deployment needs. In fact, DOD healthcare planning has been exploring how to use innovative models of public and public-private partnership to maintain and improve skills of military healthcare providers.

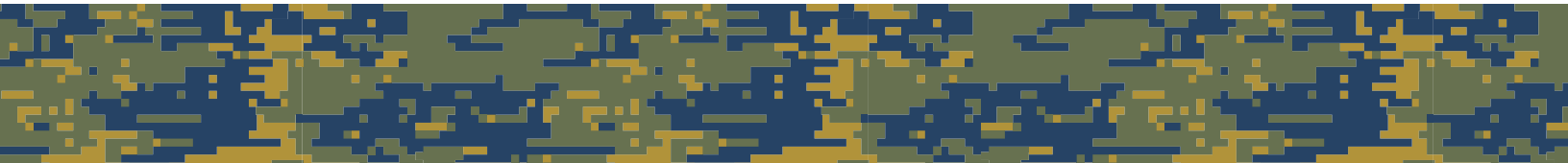
An example is the joint DOD/VA facility in North Chicago, the James A. Lovell Federal Healthcare Center, where DOD and VA physicians work together to care for beneficiaries of both systems.

This arrangement provides the VA with key specialists that are often in short supply to meet their population needs. DOD specialists benefit from having VA populations that provide an opportunity to keep skills sharp. The same is true for primary care, where the VA providers benefit from the DOD population diversity and DOD beneficiaries have access to wider primary care provider access.

Concealed behind misapplied fixed-cost investments is that the dearth of patient care opportunities that negatively impacts on skill development DOD providers, especially in the surgical and other specialty areas that coincidentally, the VA needs most. Indeed, the recent scandals at the VA have all too painfully demonstrated the dire need for improved veteran access to both primary and specialty care. The tragedy is that too many DOD doctors, especially the specialists most needed at the VA, are often underutilized in the DOD system, while VA patients wait to be seen. Again, entrenched interests, bureaucracy and antiquated paradigms are often the primary obstacle and source of frustration to those trying to make common sense changes in the DOD health system.

Finally, and directly related to the T-17 procurement, the underutilization of many DOD facilities is a problem unto itself. DOD and TRICARE have a chance to change this dynamic in their upcoming TRICARE contract. By properly articulating performance expectations, DOD has a tremendous opportunity to create an outcomes-oriented, high-value structure. Specifically, it could contract for a new kind of provider network and services management that utilize a variety of innovative, fee-for-value reimbursement models, like those promoted by the Center for Medicare and Medicaid Innovation.³⁴

Today the DOD's private sector service contracts are dominated by the fee-for-service model, with no focused effort on shared risk contracting



models. Private payers and Medicare are already moving away from traditional “service-by-the-yard” reimbursement contracts, and toward shared-risk value-based reimbursement models as quickly as possible. In fact, private-sector use of value-driven reimbursement increased from 11 percent of all disbursements in 2012 to 40 percent in 2013. This shift will continue to gain momentum, as both public and private payers continue to consistently signal and pursue a common path from fee-for-service reimbursement to a fee-for-value path.

Since no one model of shared risk is ideal for the diverse healthcare landscape, both CMS and private health insurance plans are exploring a portfolio of shared-risk approaches, ranging from Accountable Care Organizations and Bundled Care to Medical Homes and Health Maintenance Organizations (HMO). The goal of these models is to better align the value and outcomes-based incentives for payers, providers, and patients.

By signaling its preference for shared-risk alternatives in the T-17 contract, the DOD will be able to leverage forces already at play in the private sector and, in doing so, gain better control of its healthcare expenditures. Shared-risk frameworks offer DOD and DHA stakeholders a far more effective and attractive reimbursement care model, without any degradation in benefits. Any alternative approach would lock DOD into a traditional and wholly unsustainable reimbursement model through the life cycle of the T-17 contract, at least for the four years following the award. DOD would further fall behind on the relentless escalator of price inflation.

Conclusion

Providing our DOD beneficiaries – active duty and reserve service members, their dependents, and military retirees – with comprehensive healthcare is a cornerstone of the foundation of trust between our country and the AVF. It is also quickly and

unnecessarily becoming an anchor around the neck of military planners. To sustain our commitment to soldiers, sailors, airmen, marines, and other DOD beneficiaries, DOD must quickly take bold action to change how it manages and pays for care, and do this without breaking the moral or economic promises to those who serve now or have served in the past.

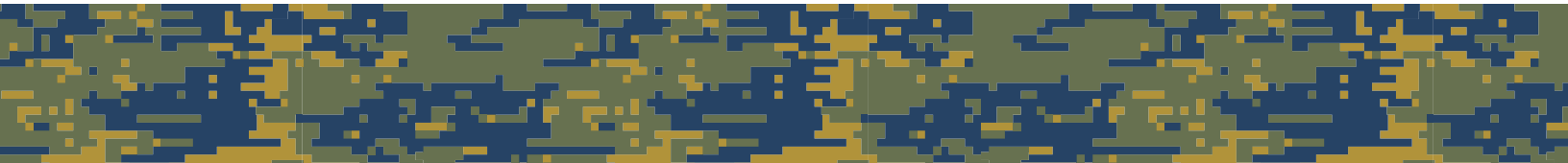
Consequently, in an era when technology and brainpower so effectively augment our kinetic delivery systems, the military’s approach to healthcare should be reconsidered from the ground up. We believe DOD would benefit immensely by a thoughtful assessment of how the quantity-over-quality culture can be changed, and the unwritten rules of “same as before” undone by creating language in the T-17 contract language stating the preference for contracting with those who can bring value based network contracts to service DOD beneficiaries. This, and other shared-risk contracting approaches, would also advance the value-driven agenda of CMS.

In the same spirit of value-based outcome assessment, DOD needs to carefully consider its go-forward plan regarding electronic health records, perhaps one of the best ways to improve outcomes. Continuing the jagged path of its troubled IT procurement history, especially for EHRs, will needlessly squander time and dollars. This is especially true since there are in-production systems that are affordable and in easy reach.

We believe that, like in so many other aspects of our society, DOD could play a leadership role. It could catalyze expectations, model behavior, and deliver measurable outcomes far outside its five walls. Nowhere is this more true, more necessary, and more far-reaching than the modernization of healthcare services.

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