Response to Questions for the
DoD Task Force on the Future of Military Health Care

1. Can you specify any management efficiencies that would decrease the overhead associated with the TRICARE Program?

In addressing this question, our company has compiled a listing of suggestions that draw from our industry experience. However, it is important for the Task Force to understand that delivering services within the civilian environment – particularly at this point in our Nation’s history – is quite different from the forces impacting today’s military leaders. In particular, the suggestions below tend to focus solely on cost – as opposed to the larger concept of value.

Stated simply, the listing which follows makes no judgment on the value derived by the Department of Defense from current TRICARE contract requirements. Rather, it tends to focus on those aspects of the program which generate cost and which are significantly different from current industry practice. Input regarding the value of the requirements should be sought from leaders within the Military Health System.

With those caveats in mind, thank you for the opportunity to render the following suggestions for consideration by the Task Force:

a. Carve-Out Contracts. Unlike previous TRICARE contracts, the current contracts “carved-out” certain functions normally associated with delivering integrated health plan offerings. Separate contracts were issued to provide these “carve-out” functions. In particular, the following functionalities were “carved-out” of the last round of managed care support contracts: (1) marketing/education; (2) TRICARE-for-Life (TFL) claim processing; and (3) pharmacy. Such “carve-outs” do not represent current industry best practices. Rather, they impact operational effectiveness, and they appear to drive additional overhead costs, including separate procurement and oversight expenses.

We recommend that the Government reevaluate the efficiency and effectiveness associated with “carve-out” contracting for the functions noted above.

b. Provider Alignment with Medicare: For many years now, the Department of Defense has attempted to align TRICARE maximum reimbursement levels with those established for Medicare. In large part, this alignment has been completed.

At the same time, current rules mandate that institutional providers who participate in Medicare are also required to participate in TRICARE. However, this rule does not apply to individual providers. This requirement does not apply to individual providers, however.
We recommend that the Department of Defense seek legislation to deem all Medicare non-institutional providers as participating TRICARE providers. Such a strategy would eliminate confusion on the part of TRICARE beneficiaries, and we believe it would represent an appropriate alignment strategy.

c. **Performance Standards.** Today’s TRICARE contracts contain a multitude of performance standards – many of which far exceed those normally associated with current industry practice. (For example, TRICARE telephone responsiveness standards require that 80% of calls be answered within 20 seconds and that 95% be answered within 30 seconds. Current industry practice typically mandates the 80% standard, but does not mirror the additional 95% TRICARE standard.)

Although the high performance required by the TRICARE contracts does improve service levels and may contribute to beneficiary satisfaction, we recommend that the Government evaluate the benefits associated with those standards which exceed industry practice. (NOTE: This may be an area where the application of uniform standards for both TRICARE and Medicare would make sense.)

d. **Out-of-Region Claims.** Within TRICARE, the rules associated with claim payment responsibility are linked to the beneficiary’s residence as opposed to the location where services are rendered. That is, responsibility for those beneficiaries who reside in the South Region are the responsibility of Humana Military Healthcare Services – as the South Region TRICARE contractor. The rules make sense – and work smoothly – as long as care is delivered by providers who are also located in the beneficiary’s home Region. However, in those instances when care is delivered “out-of-region”, the result is double work (added administrative expense) and loss of network discounts (added health care costs).

An example may help to clarify the situation: If a TRICARE Prime enrollee from the South Region receives services from a network provider in the West Region, the provider submits a claim to the West Region contractor. The West Region contractor queries the eligibility system and determines that the beneficiary resides in the South Region and transfers the claim to the South Region. Since no network contract exists between the South Region contractor and the provider, the processor adjudicates the claim as being “out-of-network”. Under this scenario loses the network discount negotiated by the West Region contractor.

We recommend that the policy be modified such that the payment is based on where the services were rendered rather than on the basis of the beneficiary’s address.

e. **Referral Process.** Processing of referrals serves a useful purpose in terms of controlling utilization and enhancing clinical quality. However, current TRICARE referral processes are manual and involve the faxing of referral requests between military treatment facilities and contractors. These manual processes are cumbersome and drive added administrative costs.
We recommend that the Government expedite implementation of information technology infrastructure to automate the referral process within the MTFs and for referral interface with TRICARE contractors.

f. Consultation Reporting. Today, many military treatment facilities (MTFs) use manual processes to support receipt and data entry for consult reports received from civilian providers. The process is labor-intensive and expensive.

Recommend that the Government implement electronic data interchange capabilities to automate (to the extent possible) the consult return process from civilian providers to military treatment facilities.

g. PCM-by-Name Assignment. The assignment of military primary care managers (PCMs) by name was implemented a few years ago in order to ensure that all Prime enrollees knew the name of their primary care providers. The concept made logical sense, and it undoubtedly enhanced beneficiary satisfaction and the quality of clinical care delivered.

However, with the advent of the Global War on Terror, turnover among military healthcare providers has increased dramatically. As a consequence, there is much more “churn” associated with the PCM-by-Name assignment process. With each deployment, wholesale reassignment actions are required. These actions are both cumbersome and expensive.

Recommend that the Government evaluate the clinical value proposition, beneficiary satisfaction, and true cost of the PCM-by-Name assignment requirement. In such an analysis, we urge the Government to take into account both the contractor-incurred costs and the MTF-incurred costs.

h. Enrollment Fee Payments. For those non-active duty family members who elect to sign up for TRICARE Prime, there is an annual enrollment fee of $230/year (individual) of $460/year (family). Currently, beneficiaries can submit enrollment fee payments via check, credit card, payroll allotment, and electronic funds transfer on a monthly, quarterly or annual basis. While these options provide great flexibility for beneficiaries, they are not without cost.

We recommend that all enrollment fee payments be moved to an allotment basis – or at least to other electronic means. We believe this recommendation could reduce billing costs, premium posting/reconciliations, and service costs.

i. Business Planning. In the current TRICARE environment, business planning processes for the Military Health System (MHS) and the Purchased Care System (PCS) for the most part occur independent of one another. We believe that this “closed-system” perspective hampers the abilities of both MHS and the PCS participants to optimize the entire system.

Recommend that the Government explore ways of employing a more system-wide business planning process.
j. TRICARE Service Centers (TSCs). Today’s TRICARE Service Centers provide a walk-in capability not duplicated in the private sector. This service adds significant value, but in some cases, it is underutilized.

We recommend that the Government reexamine the value of walk-in TRICARE Service Centers serving small populations or where transaction volumes within the TSCs are low.

k. Length of TRICARE Contracts. Today’s Managed Care Support contracts specify five option years; all are due to expire on March 31, 2009. (Since our full contract in the South Region began on November 1, 2004, this means that service delivery is scheduled to conclude 4 years and 5 months following start-up.) We understand that the Department of Defense is poised to begin a re-procurement process with the issuance of Requests for Proposal (RFPs) sometime during 2007.

We understand – and fully subscribe to – the need to ensure full and open competition for Government business. Such strategy is essential to ensuring that the Government receives “best value” for the services it procures. However, we also understand the need for stability – and minimized disruption – during this critical time of our Nation’s history. Thus, we urge the Government to carefully weigh the costs and potential benefits associated with TRICARE procurements. If warranted, we urge that the Department of Defense use its authority to extend the duration of the current contracts. In the future, we also recommend that DoD consider awards of longer duration.

2. How effective is the TRICARE Regional Office in managing your Managed Care Support Contract?

Today’s Managed Care Support Contracts are extremely complex and require extensive performance monitoring to ensure that the Government receives full value. In the TRICARE South Region, we are indeed fortunate to work with a dedicated team of professionals at the TRICARE Regional Office (TRO) – superbly led by Mr. Michael Gill, SES – who collectively holds us accountable for operational service delivery across a broad spectrum of contractual requirements. We believe this was the intent of the Department of Defense in creating the TRO structure, and we believe TRO-South is effectively accomplishing its mission.

To illustrate, our TRO has defined a total of 162 separate operational metrics with defined standards of performance. On a monthly basis, our company reports actual results against the standards. When shortcomings occur, members of the TRO demand that we furnish targeted action plans to achieve acceptable levels of performance. Plans are meticulously evaluated to ensure that our efforts deal with root causes, and that corrective actions are logically constructed. Once agreement is reached, subject matter experts monitor our progress until closing criteria have been satisfied. Simply put, TRO-South ensures that, as a company, we deliver the services we have promised.
The TRO also has served as a very effective communication/coordination link between all major TRICARE stakeholders, including approximately 60 military treatment facilities (MTF), elements of the TRICARE Management Activity (TMA), and the individual services (Army, Navy, Air Force, and Coast Guard). The creation of the TRO structure seems to have achieved administrative efficiencies by eliminating three separate “Lead Agent” offices which previously existed in the South Region under legacy TRICARE contracts. However, given the widespread dispersal of South Region MTFs, the geographic separation from other TMA organizational components and the lack of direct TRO operational authority, the structure appears to have introduced certain span-of-control challenges. Thus, we would respectfully suggest that the Task Force pose this question to other TRICARE stakeholders.

3. **Can you summarize for the Task Force the wellness initiatives and disease management initiatives that are a part of your region’s health care delivery? Specify the population that is effected by each of these initiatives.**

HMHS has implemented many wellness and disease management initiatives in the TRICARE South Region. These programs are described below.

**WELLNESS INITIATIVES**

**a. Provider Education.** Wellness – indeed all health care services – begins with the interaction between patients and their providers. Thus, we believe a key component of any wellness program to be provider education.

To that end, HMHS offers a provider newsletter, provider handbook, and provider seminars to aid providers in assisting beneficiaries regarding health promotion, health protection, and preventive services. These initiatives are focused on:

- Increasing span of healthy life;
- Reducing health problems; and
- Promoting access to clinical preventive services for effective preventive care.

Provider education materials and seminars are available to both network and non-network providers in the South Region.

**b. Health Awareness Letters.** Health Awareness Letters (HAL) integrate several activities designed to improve preventive services and to reduce disparities in care by reminding beneficiaries and their Primary Care Managers (PCMs) of prevention and wellness recommendations.

The HAL program serves beneficiaries enrolled to civilian PCMs. In the South Region, Health Awareness Letters are mailed monthly to beneficiaries in targeted age and gender populations. These letters offer preventive health service recommendations (based on the guidelines from the United States Preventive Services Task Force, the American Academy of Pediatrics, and the Centers for Disease Control and Prevention) for the identified age and gender populations.
group, and provide safety tips. Six months after the HAL mailings, claims data are examined and used to determine if targeted preventive services have been rendered. If not, a letter to the beneficiary’s PCM is generated, advising that these important preventive services have not been reported.

HMHS monitors the adherence of targeted cohorts to preventive care recommendations. We typically find that adherence doubles in the 12 months after mailings to beneficiaries.

c. Quality Report Card. Objective evaluation of outcomes is also a key element for ensuring the delivery of high quality health and wellness services. To that end, our company recently studied 2005 healthcare outcomes for South Region TRICARE beneficiaries. We published the results of our study in a document titled, “Mapping the Patient Experience – Humana Military’s Clinical Quality Report Card.” Measurement methodologies, benchmarks and goals were acquired from respected sources including the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ) and Healthy People 2010. Our Report Card addresses 25 separate indicators across seven domains of healthcare quality in the purchased care environment: (1) Preventive Services and Wellness – use of screenings to identify diseases that benefit from early detection; (2) Mental Health; (3) Living with Illness – provision of best practice, evidence-based care to persons with chronic diseases; (4) Patient Safety and Selected Procedure Utilization; (5) Provider Network – the numbers, distribution and quality of providers available to beneficiaries; (6) Cost of Care – controlling health plan costs within budget; and (7) Customer Service – meeting service standard and satisfying beneficiaries.

Overall, HMHS compared favorably with accepted standards for indicators measured in the Report Card. Specific results appear below.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Number of Metrics</th>
<th>Better Than Expected</th>
<th>Results As Expected</th>
<th>Worse Than Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services and Wellness</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Living With Illness</td>
<td>7</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Patient Safety &amp; Procedure Utilization</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Provider Network</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cost of Care</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Customer Service</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>25</strong></td>
<td><strong>10</strong></td>
<td><strong>13</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

*Figure 1 – 2005 HMHS Health Care Quality Report Card Results in Purchased Care Sector*

As noted, two measures fell below expectations based on national benchmarks: (1) our screening of diabetic patients for kidney disease did not meet national standards; and (2) our rate
of hysterectomies in the South was higher than the nationwide norm. In response, we mailed reminders for kidney screening to selected physicians and patients, and we are implementing a clinical study to explore possible interventions to influence our rate of hysterectomies. Notwithstanding our two negative outliers, we are pleased with the results seen to date. And we will continue to measure and intervene where indicated.

d. Demand Management. Donald M. Vickery, M.D. and Wendy D. Lynch, PhD. introduced the concept of demand management in health care in 1995, offering the following definition:

“Demand management is the support of individuals so that they may make rational health and medical decisions based on a consideration of benefits and risks.” (Journal of Occupational and Environmental Medicine 1995; 37 (5): 1-7.)

Demand management is the process of empowering patients to make wiser health care decisions. It is not necessarily about reducing demand. Demand management engages the beneficiary in the quest for appropriate care. When health care is provided in a cost effective manner with appropriate utilization, the end result is healthier beneficiaries, increased beneficiary satisfaction, and lower costs. HMHS is fully engaged in this process and supports demand management in the following manner.

The HMHS web site, www.humana-military.com provides web-based health and wellness information and links to many high quality health resources.

Our web site, www.humana-military.com also provides a link to TRICARE Online through its Beneficiary Resources page. TRICARE Online is available to all TRICARE beneficiaries. Guidelines for the treatment of common diseases such as asthma and diabetes are available. TRICARE Online provides a wealth of health tools including drug information, diagnostic and surgical procedure information, health calculators, a personal health journal, anatomy explorer and condition explorer, and cancer information.

HMHS provides a toll-free telephone access audio library that is available 24 hours a day, 7 days a week (24/7). The audio library provides high quality health information on pertinent health topics such as asthma, arthritis, allergy, children’s health, cancer, diabetes, men’s health, women’s health, common illnesses, and common symptoms. The audio library can be accessed by dialing a toll-free number (1-877-217-7946). An automated menu system assists the beneficiary to select a health education audio reference category. Once a category is selected the beneficiary is given a list of topics from which to choose.

The following table lists the categories of Health Education Audio Reference topics that are currently available.
Provider locator services are available to the beneficiaries 24/7 by calling a toll-free telephone number (1-800-444-5445).

Demand Management resources are available to all TRICARE eligible beneficiaries. We promote demand management resources via our beneficiary handbook, newsletters, our web site, and through face-to-face briefings. Beneficiaries who access and use these resources will make more informed health care decisions, choose appropriate self care more frequently, and interact more productively with their providers.

**DISEASE MANAGEMENT**

Disease management programs can have a significant impact on controlling costs and enhancing the delivery of high quality clinical services. We appreciate the opportunity to update the Task Force on the status of our current disease management programs.

Our first program, focusing on patients with a history of heart disease – the nation’s number one leading cause of death - began nearly two years ago, and currently serves nearly 2,700 beneficiaries.

At the direction of the TRICARE Management Activity (TMA), we implemented a disease management program for asthmatics about seven months ago. In a very short timeframe, we were able to target and enroll over 5,600 people into the Asthma program. Both programs teach patients how to live healthy lifestyles, and they provide participants medical guidance from
registered nurses. Our nurses provide realistic goals for each patient with appropriate follow-up, and they facilitate physician appointments when necessary.

Our data demonstrate that active participation in these programs assists beneficiaries and providers with the management of patient diseases. For example, among participants in our heart disease program, we have documented an 11 percent increase in the use of ACE inhibitors and beta blockers. Moreover, 75 percent of smokers who set goals to reduce or quit smoking have succeeded.

We have also seen a high degree of acceptance and satisfaction among program participants. Beneficiary feedback indicates 96 percent of a recent sample expressed satisfaction with the information provided to them. Seventy-nine percent of those enrolled in the programs indicate their health status has improved. Seventy-eight percent felt their quality of life had improved since enrolling in a disease management program and 89 percent indicated they would be willing to participate in other disease management programs if offered.

With the obvious success of these programs, HMHS would like to expand these services to other clinical conditions. We are anticipating new programs coming on-line this year as a result of the legislative language in the 2007 National Defense Authorization Act, requiring the Department of Defense to offer additional disease management programs for Diabetes, Cancer, Chronic Obstructive Pulmonary Disease and Depression/Anxiety Disorders. We stand ready to implement these much needed programs when directed to do so by DoD.

4.a. What are the costs of health care in your region?

Because care is delivered to beneficiaries within military treatment facilities and in the private sector, we do not know the total costs of health care in the South Region. However, we do know the costs associated with the purchased care sector. By payment category, they are displayed in the following table for the TRICARE South Region for calendar year 2006:

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>2006 Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTF Enrolled</td>
<td>$901,129,667</td>
</tr>
<tr>
<td>Civilian Enrolled</td>
<td>$1,050,870,875</td>
</tr>
<tr>
<td>Not Enrolled</td>
<td>$640,968,922</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$2,592,969,465</strong></td>
</tr>
</tbody>
</table>

*Figure 3. South Region Purchased Care Expenses for CY 2006*

The category *MTF Enrolled* represents those beneficiaries in TRICARE Prime who are enrolled to Military Treatment Facilities (MTFs), plus active duty service members. The category *Civilian Enrolled* represents those beneficiaries in TRICARE Prime who are enrolled to a civilian primary care manager. The category *Not Enrolled* represents those beneficiaries who are not enrolled in TRICARE Prime. These definitions are used throughout this document.
4.b. **What is the cost for referral services for Prime patients referred from the MTFs?**

We believe that this question pertains to purchased care expenditures for TRICARE Prime beneficiaries enrolled to military treatment facilities (MTFs) plus active duty service members. With that as our working definition, South Region purchased care expenditures for TRICARE Prime beneficiaries for calendar year 2006 are shown in the table below.

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>2006 Membership</th>
<th>2006 Expenditures</th>
<th>2006 PMPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTF Enrolled</td>
<td>941,335</td>
<td>$901,129,667</td>
<td>$957</td>
</tr>
</tbody>
</table>

*Figure 4. South Region Purchased Care Expenses for MTF Enrollees (CY 2006)*

4.c. **What is the trend for health care services referred from the MTFs?**

Information used for the response to this question is provided in the table below.

<table>
<thead>
<tr>
<th>MTF Enrolled</th>
<th>CY 2005</th>
<th>CY 2006</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>969,462</td>
<td>941,335</td>
<td>-2.9%</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$793,283,700</td>
<td>$901,129,667</td>
<td>+13.6%</td>
</tr>
<tr>
<td>Cost PMPY</td>
<td>$818</td>
<td>$957</td>
<td>+17.0%</td>
</tr>
</tbody>
</table>

*Figure 5. South Region Cost Trends for MTF Enrollees (CY 2006)*

As noted above, the total purchased care cost trend for beneficiaries enrolled to South Region MTFs for the period CY2005 to CY2006 was 13.6%. However, after adjusting for changes in the MTF enrolled population, the purchased care cost trend for the same period was 17.0%.

4.d. **How much is spent on TRICARE Standard and for how many beneficiaries?**

It is important to understand that, within TRICARE, beneficiaries either enroll in TRICARE prime or they do not enroll. Those who choose not to enroll are empowered to use their TRICARE Extra benefit simply by choosing a network provider. Those non-enrollees who choose a non-network provider are using their TRICARE Standard benefit.

With these distinctions in mind, we have interpreted the use of the term “TRICARE Standard” in this question to refer to beneficiaries who are not enrolled in TRICARE Prime.

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>2006 Beneficiaries</th>
<th>2006 Expenditures</th>
<th>2006 PMPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Enrolled</td>
<td>795,782</td>
<td>$640,968,922</td>
<td>$805</td>
</tr>
</tbody>
</table>

*Figure 6. South Region Purchased Care Expenses for Non-Enrollees (CY 2006)*
4.e. What is the cost for TRICARE Prime offered by the managed care support contractor?

Total purchased care expenditures for the civilian enrolled population for Calendar Year 2006 appear in the table below:

<table>
<thead>
<tr>
<th>Payment Category</th>
<th>2006 Beneficiaries</th>
<th>2006 Expenditures</th>
<th>2006 PMPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civilian Enrolled</td>
<td>477,804</td>
<td>$1,050,870,875</td>
<td>$2,199</td>
</tr>
</tbody>
</table>

Figure 7. South Region Purchased Care Expenses for Civilian Enrollees (CY 2006)

Please note that the figures above represent only claim costs; and exclude administrative costs and TRICARE Prime enrollment fees.

5. What are your recommendations for improving the TRICARE program?

HMHS believes that the TRICARE program is effective, efficient, and provides high quality services to a deserving population. Notwithstanding the many “wins” of the TRICARE program since its inception, we believe there are always opportunities to improve. Within that context, we submit the following recommendations for consideration by the Task Force:

a. MTF Optimization. Fully utilizing military treatment facilities (MTFs) and staffs is another way in which contractors like Humana Military Healthcare Services can assist their DoD partners control healthcare spending. Collectively, we call our efforts “MTF Optimization”.

One optimization approach involves the placement of civilian providers and support personnel into military facilities. I am happy to report that, in the past year, we saw an increase of 75 percent in such arrangements, netting healthcare costs savings of more than $7 million annually. Another optimization tool – called “External Resource Sharing” – allows military providers to deliver care to TRICARE beneficiaries in civilian network facilities. Last year, our External Resource Sharing efforts yielded an additional $3.9 million in net savings.

Notwithstanding recent incremental improvements, in our view, optimization initiatives have been stymied by a mis-alignment of financial incentives and an artificial “fencing” of dollars allocated to the direct care system. To illustrate, since the start of the South Region Contract, our company has identified approximately $109 million in gross savings that could have been recaptured through MTF optimization initiatives. Including the $7 million noted above for last year, contract-to-date agreements have netted savings of only $13.6 million of the $109 million opportunity we have identified.

While we think we understand the concerns which led to the “fencing” of resources, the net effect is to increase the total cost of delivering care within the Military Health System. We urge that this issue be resolved so that military hospitals and clinics can be fully utilized and so that total system-wide costs can be reduced.
b. Disease Management. Earlier, we provided a response to your question regarding disease management. We noted that the 2007 National Defense Authorization Act (NDAA) contained language calling for Department of Defense implementation of seven (7) disease management programs including: diabetes; cancer; heart disease; asthma; chronic obstructive pulmonary disorder; and depression and anxiety disorders. To date, we have implemented two programs related to heart disease and asthma.

Since strong evidence suggests that disease management programs do indeed help control costs and improve clinical outcomes, we urge rapid implementation of the additional programs set forth in the 2007 National Defense Authorization Act.