STATEMENT OF MR. DAVID J. McINTYRE, JR.
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INTRODUCTORY COMMENTS

Mr. Chairman, Senator Cleland and distinguished members of the Senate Armed Services Committee Subcommittee on Personnel, I would like to thank you for the invitation to again appear before your committee to discuss the state of the TRICARE program and what can be done to speed along maturation in several areas. My name is David McIntyre. I am the president and CEO of TriWest Healthcare Alliance, the organization which serves as the prime contractor for the TRICARE Central Region.

TriWest Healthcare Alliance is a closely held corporation that was formed for the express purpose of bidding on and administering the TRICARE contract for the former 16 state TRICARE Regions 7 and 8, now known as the TRICARE Central Region. TriWest is owned by eleven Blue Cross and Blue Shield plans, two University Hospital systems and a for-profit HMO, all of which hail from the geographic area that comprises the Central Region. Most of these health care entities have been serving the health care coverage needs of the communities in which they have been located for more than fifty years. Today, in addition to the more than 750,000 TRICARE-eligibles in the Central Region, these prominent local health care entities serve the health care coverage needs of some 11 million individuals located within the Region.

What a Difference a Year Makes

What a difference a year makes…

At the time of last year's hearing, we were rapidly approaching our first anniversary of service as a TRICARE contractor. I was telling you of our efforts to tackle delays in claims processing, overwhelming telephone wait times and our attempts to keep the provider networks together in some difficult areas.

Since that time, we have overcome many of the difficulties that seem to be inherent with the start-up of TRICARE. In many cases, I believe TriWest and the Central Region have become an example for what is good and right about TRICARE. Our service levels are high and our enrollment has exceeded our fifth year projections and continues to grow**.** We enjoy a healthy working relationship with the MTF's in our Region and the Lead Agency that oversees the success of the program in our Region (even having successfully weathered the consolidation of our Lead Agency oversight structure, which we believe stands as a model for other areas). Our networks are for the most part complete and stable. We enjoy one of the best, if not the best, claims processing records of all of the contractors, and our TRICARE Senior Prime Demonstration Project in Colorado Springs has come off without a hitch.

Importance of Partnership

I have often been asked the question of what has made our Region a success. While there are many elements, the core concept comes down to partnership.

Making TRICARE work and work well requires a strong and effective partnership between the prime contractor, MTF Commanders, Lead Agent, TRICARE Management Activity (TMA), Health Affairs and the Services. Some might ask, why is an effective and strong partnership so critical? I would submit the reason is that TRICARE is designed to be a virtually integrated health care system. And integrated health care systems are only successful if there is effective coordination between the efforts of various entities. This bears itself out in everything from how appointments are made to developing a complete direct care and civilian network to meet the health care delivery needs of the beneficiaries.

The strength of our partnership in the Central Region is what has allowed us to effectively and collaboratively work through a whole series of issues. In fact, the partnering concept for TRICARE (for which the Central Region was the pilot) has so matured in our Region that the MTF Commanders, Lead Agent and myself now meet for a day each quarter (as we just did last week) to discuss how to best resolve our individual and collective challenges. The result of this partnership has not only been a successful daily operation in our Region, but the development of a number of collaborative initiatives (such as UM Reengineering) that will further benefit the virtually integrated health care system.

In concluding my thoughts on partnership, I would be remiss if I did not applaud the current leadership of the Department of Defense for the work that they are doing in this arena. Their efforts were most recently evident in the "Claims Summit" held several weeks ago in Washington involving the Health Affairs and TMA leadership, along with the contractor CEO's. It is this type of collaboration on critical operational issues that I believe will ensure maturation of the TRICARE program operations.

Having said all of this, we are not necessarily here to focus on our successes. What we are here to talk about today is how we can more quickly mature the TRICARE program so that it better meets the needs of beneficiaries, is more user friendly to providers, and meets the goal of enhancing access while containing cost growth. In this vein, I would like to focus this testimony on three critical issues: access, claims and pharmacy reengineering.

BENEFICIARY ACCESS

The first critical area for maturation in the TRICARE program is beneficiary access. It is often said that a health care system is only as good as the timely and effective access to the services and care that it delivers. This is as true in the public sector as it is in the private sector, and the TRICARE program is no exception.

While I cannot speak to all components of the system, I can tell you about the Central Region and TriWest. After all, the issue of "access" has been one of the critical areas of focus for our current Lead Agent.

When I think of the issue of beneficiary access, I separate it into several components: access to support services, access to providers, including in both the MTF and civilian network; and the associated issue of payment rates.

Access to Support Services

On the issue of access to support services, while we had challenges in the early weeks of going live, we resolved these issues very quickly. For example, we went from 45 minute telephone wait times to several minute waits within two weeks. Since the early days of our contract, our phone call answer rates and walk in responses for appointments, benefit information and health questions are well within the access standards.

Access to Providers

On the issue of access to providers, it is important to look at both the MTF and civilian network.

Within the MTF environment, our Lead Agent has been working with the MTF's. Monitoring and discussions have begun around those areas where improvement may be warranted to ensure that the standards are being met routinely and beneficiaries are gaining access to services.

As a parenthetical, I believe it is important to note that the access standards defined for this program are among the tightest in the health care industry today. And, while the standards may not yet be fully adhered to, the experience today is a far cry from where things were prior to the implementation of this program when beneficiaries often experienced multiple hour waits on the telephone for an appointment and in the waiting room itself when they arrived for care. Thankfully, such experiences are the exception and not the rule in the Central Region today.

To enhance access to public sector providers, we have also been working with the Veterans Administration. Today, we have seventeen contracts with VA Medical Centers in eleven of the sixteen states in our TRICARE Central Region. These VA facilities provide a diverse array of diagnostic and therapeutic modalities including audiology and speech pathology, mammography, hospice inpatient care, durable medical equipment, smoking cessation, dialysis, outpatient and drug dependent treatment programs, prosthetics and orthotics, nuclear medicine, and full medical, surgical, psychiatric and psychological care for TRICARE beneficiaries.

In addition, we are currently exploring several new initiatives that would further the cooperative relationship between TriWest and the Veterans Health Administration. These

initiatives involve teleradiology, pharmacy services, and the development of community-based Outpatient Clinics in TRICARE and VA underserved areas. TriWest and the Veterans Health Administration believe that maximization of VA capabilities and capacity in our Region is good for all concerned. As such, we will continue to explore how we can further our collaborative efforts to the benefit of TRICARE beneficiaries in the Central Region.

Focus on this issue of provider access also necessitates a look at the civilian network. With the exception of those areas which simply do not contain a provider of a specific specialty-type or where the government-established maximum allowable charge rates are deemed to be too low by the providers to justify their entering our network, our networks are complete in the "catchment areas."

To ensure that access standards are met by our network providers, our provider contracts contain language specifying the access requirements as a condition of participation in the TRICARE network for the Central Region. We then use a number of tools to track beneficiary access:

- Annual visits to provider offices by our network subcontractors, who are responsible for building and managing our networks.
- Our appointments staff pays very close attention to network appointment availability. If a beneficiary is unable to get an appointment within the program standards, or if our staff (in the process of making an appointment on behalf of a beneficiary) is unable to make one with a particular provider, the appointments staff will search for another provider in the network who does have capacity to see the beneficiary for the needed service. They will then go back and work with the provider office that was unable to accommodate the beneficiary to determine the reason. If a particular provider is full and unable to handle additional beneficiary assignments or referrals, we will try to steer beneficiaries to a provider that does have capacity so that the beneficiary doesn't have a problem in getting an appointment within the access standards for the program.
- We also pay very close attention to complaints provided by beneficiaries through the following mediums: Congressional inquiries, comment cards at our TRICARE Service Centers, and grievances. These complaints are worked individually by our staff and trends are monitored by senior staff on a monthly basis.

We believe this multi-faceted approach has served us well in the Central Region. And, quite frankly, we have had few problems. The exception seems to be in those areas where we have either been unable to provide a network encompassing all the specialties required or are unable to hold the network together. The issue in these circumstances seems to revolve around insufficient reimbursement rates in isolated areas.

CHAMPUS Maximum Allowable Charges (CMACs)

There is an old adage that "all health care is local." The truth of that statement is made clear when we are looking at the provider fee issues in general, and the CHAMPUS

Maximum Allowable Charge (CMAC) rates in particular. As the government continues to "right size" the direct care system and reduce its capacity leaving it unable to meet all of the needs directly, the integrated TRICARE system becomes more reliant on the local provider community to fill the gaps. Whether a fee is too low or high largely depends on what others are paying for the same service in that community. In Washington, as I learned from my tenure here, the focus tends understandably to be on the big picture health policy issues and discussion of budgets amounting to billions of dollars. Unfortunately, sometimes this means that the effect on the local providers and the health needs of the TRICARE beneficiaries who live and work in those local communities is not in as sharp a view as it ought to be.

The local perspective is particularly important to a region such as the one which TriWest serves. We cover a vast land mass, and our service area is a microcosm of the entire health care system in America. However, much of our region is classified as underserved, with limited physician and provider capacity to meet local needs – even on the commercial side. Isolation, sparse population, and constrained infrastructure make these mostly rural markets especially challenging to providers and payers.

Today, I'd like to spend some time talking about the other players in the marketplace with whom the TRICARE program works side-by-side. The key players are Medicare (primarily fee-for-service), and private commercial health insurers (including plans that serve the government employees in FEHBP).

In 1991, Congress urged the DOD to lower reimbursement rates paid to civilian physicians under CHAMPUS. Previously, CMAC rates were based on a calculation of the 80th percentile of physicians' actual charges statewide. In many cases, these rates were significantly higher than those paid for similar services under Medicare. CHAMPUS began its transition to Medicare payments at precisely the time Medicare itself was implementing a dramatic change in its fee schedule calculations. The adjustments downward toward Medicare rates have saved DOD millions of dollars, but have also created some negative ramifications which cannot be ignored.

Medicare Fees

In order to understand the strengths and limitations of CMAC, one must understand the Medicare fee structure. It would take a long time to tell the story of the rocky road of physician fees in the 1990s, as Congress mandated the conversion of Medicare charge-based payments to a unique "resource-based" system. Passed in OBRA '89, and begun in 1992, the transition is still underway. The Medicare physician fee structure is very complicated, with lots of moving parts and frequent legislative and regulatory changes.

Today, I'd like to make three points about Medicare fees. I will be drawing your attention to these issues from the physicians' perspective, as they are the ones with whom we try and contract. My observations are not meant to be judgmental about the Medicare program or its relationship to CMAC.

First, throughout this decade, physicians have generally experienced flat rates or rate reductions. For example, from 1995 to 1996, ophthalmology services fell 9.l6%, cardiology fell 6.5%, and pathology fell 6.2%. The Balanced Budget Act of 1997 flattened or reduced average rates still further.

Second, recent controversies in the Medicare fee schedules relate to the reallocation of dollars from specialties to primary care. The new formula was to be implemented in 1998. Concern about the validity of the formula led to a delay in the implementation, but has not abated concerns, primarily among specialists, of further potentially dramatic rate reductions. The issue is currently being litigated in the courts.

Third, Medicare fees include a geographic adjustment factor (GAF). While some may assume that Medicare fees are uniform for each service, the GAF means that fees for the same service may vary significantly from area to area. Rural and underserved areas received adjusted rates that are far below their urban counterparts. For example, physicians in Manhattan are paid 34% more for a level 3 office visit (Code 99213) than physicians performing the same service in their offices in South Dakota. While the GAF is a good faith effort to measure input prices, in some cases they have not sufficiently factored in the common sunk costs for all providers, regardless of location. What's more, if other payers do not follow suit, Medicare rates may end up being dramatically below the commercial payers in rural areas and underserved areas. And indeed this has proved to be the case in some areas, leading providers of some speciality-types to not take Medicare patients at all. I would submit the same is true of TRICARE.

As I stated earlier, federal policy has been to adjust the fees for the TRICARE program downward so that they come close to the Medicare model. And, while many of us thought at the time that was an acceptable methodology, in some communities it is having the effect of making network access impossible as the fees represent such a significant disparity from the commercial market rates (including what is paid to providers who participate in FEHBP plans). So, how do these rates compare with private health plans in the local marketplace?

Commercial Rate Comparisons

Our surveys in our markets indicate that the commercial plans pay considerably more than either Medicare or CMAC to provide the same services. Commercial plans negotiate rates in local markets, while Medicare rates are based on administered prices determined by arbitrary formulas designed at the national level. Commercial plans have more flexibility, and the fees are more likely to reflect what markets will bear. Interestingly, FEHBP reimbursement experience, since the rates also tend to reflect the local market, is close to commercial.

While the problem does not face all areas, I tried to specifically focus on those areas where there has been a historical problem or where there is talk of downsizing MTF's from inpatient facilities to outpatient clinics… the effect of which will be to shift the demand for services to the providers in the local community.

The following are some specific examples of the reimbursement trend differentials:

- Boise, Idaho
  For Code 27447, Total Knee Replacement, commercial managed care pays $4,256.00; indemnity pays $4,370.76; and Medicare pays only $1803.43.

- Rural Utah
  For Code 10040, Acne surgery, commercial managed care pays $73.00; indemnity pays $75.75; and CMAC pays $35.31.

- Montana
  For Code 71020, a Chest X-ray, Blue Cross pays $57.07; CMAC pays $20.38.

- Kansas
  For Code 29355, Application of long leg cast, FEHBP pays $116.83 and CMAC pays only $59.48.

Additionally, commercial rates in Minnesota's Twin Cities, including those for HMOs which dominate the commercial market, are 10-25% higher than CMAC in the metro area. In the rural areas, which are predominately fee-for-service, the commercial rates are 30% higher than CMAC. Recall that Medicare rates, on which CMAC is based, are reduced by the GAF. Commercial plans appear to be paying more consistent rates throughout the state, while Medicare and CMAC are adjusted downward from the low base in rural areas.

It is no wonder that physicians gravitate to urban areas and that those physicians who stay in rural markets are often dissatisfied with Medicare and CMAC.

Rates are not the only relevant factor when a TRICARE contractor enters a rural marketplace. A recent GAO report noted that the degree of HMO penetration and the size of the TRICARE patient base were also relevant to physician participation. Physicians who practice in high penetration markets are much more likely to join networks than their counterparts in low penetration areas. Most rural areas have low penetration and there is a fair amount of hostility to managed care. In addition, the size of the patient base is important because physicians need to protect their patient flow. Where the numbers of TRICARE patients are small and the rate of HMO penetration is low, physicians will resist joining a TRICARE network, accepting negotiated discounts, or even serving TRICARE beneficiaries in any form. For overworked specialists, the combination of forces is particularly challenging.

Last year I had the occasion to personally meet with an Ear, Nose and Throat (ENT) provider in Reno, Nevada to discuss the possibility of his participation in our network, as

there were no ENT providers in Fallon, where the Navy's "Top Gun" site is located and where we had a number of beneficiaries at the base who needed these services, including the son of the base chaplain. We were trying to contract with a local provider in Reno so that the family did not have to travel regularly to California to simply receive cost-effective care. What I discovered, which has been repeated over and over again in some communities within the Central Region, was shocking to me.

This provider had taken the time to have his billing clerk pull together the information on what he was paid for the typical services by the lowest to best paying commercial plans and what he was paid by Medicare and TRICARE. What I discovered was that the differential was not 10 percent, or even 20 percent. It was nearly 50 percent. And, subsequently, his response probably won't surprise you. He said in essence: Look, I have more to do than I can accomplish with the patient population I currently have. What's more, the TRICARE and Medicare populations only represent 5-7% of the population in this community and, while I used to, I am not willing to subsidize the care to this population anymore. To this day, we still don't have an ENT provider in Reno, Nevada. And, there are no ENT providers in Reno accepting Medicare assignment either.

What is the Solution?

Because TRICARE operates in local markets, it must be a wise market player. Clearly, the program should never pay more than is reasonable and necessary to contract with qualified physicians in any community. In many communities, particularly urban areas, CMAC schedules, even with negotiated discounts, may be sufficient and acceptable. However, we must revise our approaches in certain limited markets.

Legislation recently introduced by Senator Kay Bailey Hutchison recognizes the fact that CMAC rates may be too low in underserved areas. The contractors in these unique areas should not be penalized by having to pay dollars above and beyond the federally-set CMAC rates to contract with providers. Nor should the beneficiaries have to deal with unwilling physicians or limited networks. Additional funds should be made available to the contractors under tightly defined parameters to allow for increased payments in those areas where contracting is otherwise not possible. We believe that the characteristics of these special areas can be delineated so as to provide boundaries on rate flexibility and prevent unnecessary expenditures.

For example, there is a federal designation for underserved areas so geographic limits can be easily identified. The exception could apply to certain designated specialties for whom the differentials and the variations are most pressing. Because we have gathered considerable information on the problem in preparation for this analysis, we would be pleased to work with the Department and Congress to clarify the scope of the problem and to offer our thoughts on how to craft an efficient and appropriate solution that will not unravel networks already in place across the system. I believe that not dealing with this issue, however, could serve to compound the effect of the downsizing efforts in the pipeline and only exacerbate problems with access to health care.

Change Needed in Recent 115% Policy

While we are on the issue of rates, I want to express my serious concern about the implementation of a policy that I believe was well intentioned but will likely backfire. I am referring to the change in policy that entails paying non-network doctors up to 115% of CMAC. Yet, as a condition of network participation, network providers have agreed to not charge more than CMAC. I believe this move was designed to protect beneficiaries in areas where there is a network shortage from having to pay more money out of pocket. Yet, with this new rule, providers are being told that if they refrain from signing up for the network they will be paid more for their services. I would submit that as providers figure this out some will be reluctant to sign up.

It is my hope that this issue could be revisited before networks start to unravel and create the unanticipated and unintended consequence of hurting beneficiaries and giving economic preference to those providers who do not become part of the networks.

CLAIMS PROCESSING

The second critical area for maturation in the TRICARE program is claims processing. In my view, when rates are as aggressive as they are under federal programs, it is imperative that providers are paid timely and accurately. Not doing so harms providers and beneficiaries alike.

TriWest, as has been the case with all of the preceding and subsequent TRICARE contractors, experienced significant claims processing backlogs early on in our contract. Following an extensive and intensive focus in this area, I am pleased to report that we have the best overall claims processing record of all contractors for six months running. Additionally, we have been processing claims over and above our contract requirements for nearly a year now. Such results have not come easily and have not come without a high cost both financially and to those who have put in the effort to produce the results. Yet, for the beneficiaries, the providers in our Region, our staff and the program as a whole, the effort has been worthwhile because it is a demonstration of the fact that the issues can be addressed with success if people roll up their sleeves and work together.

Having said that, I believe we must work together to simplify claims processing to produce even better results. To this end, I want to compliment the Department of Defense, and particularly Under Secretary DeLeon, Assistant Secretary Bailey, TRICARE Management Executive Director Sears and TRICARE Management Chief of Operations Carrato, for their efforts the past several months. Most recently, the DoD sponsored a “claims summit” with the prime contractors to focus on what could be done to improve claims performance.

We covered a lot of ground in the “summit” and shared information that will quickly bring improvement in some areas and result in the avoidance of problems in others. There was agreement that any significant and effective work in this area was going to require a delicate balance between a focus on cost, timeliness and fraud detection. In my

view, this was a good start to a constructive dialogue and working relationship in an area that is critical to the program's success. This meeting came on the heels of several months of long work by a "work simplification" task force that has been meeting to focus on changes that might be made to the TRICARE system/rules to simplify a number of areas to reduce hassle, unnecessary work and reduce cost.

While we seek to continue to make progress on some of the broader issues in the claims area, including the implementation of some of the initiatives already forwarded by the DoD in this area, I would submit there are several other areas thought ought to receive prompt attention and action.

Carefully Reviewing the Necessity of the HCSR

First, a hard look needs to be taken at the current approach to capturing and submitting information on claims to the Department of Defense. The current approach, which is much more complicated than HCFA's process with the use of the HCFA 1500 and UB92 based back-end approach, is much more costly and cumbersome. It seems that there should be some approach other than use of the current Health Care Service Record with its detailed edit requirements; thereby simplifying the process, lowering the cost and easing the difficulty for provider staffs of having to follow so many different sets of rules for payment of claims under the various federal programs. I am glad that the Department has agreed to hold a discussion on this issue and believe it will be very constructive.

Structured Benefit-by-Benefit Review

Second, a structured benefit-by-benefit review needs to be conducted of the TRICARE program to determine where possible changes would simplify claims processing. As I have come to find, some of the well intentioned benefit changes that I even contributed to while I was a Hill staffer have left the system more cumbersome than is necessary. It is critical that a review not only be conducted of what minor changes can be made in the benefit design to make claims adjudication easier under the current program, but that all additional changes go through an operational simplification review before they are adopted by either Congress or the Department.

By way of example, several years ago then Assistant Secretary Martin and Congress restructured the mental health benefit out of concern for the fact that beneficiaries were being institutionalized for too long. As a result, we worked to institute a policy of seven free visits before the beneficiary was to be evaluated and a treatment plan put in place and subsequently reviewed on a periodic basis. At the time, little did we realize (because no operational review was conducted prior to fashioning the policy or enacting it) that it could not be adjudicated in the claims processing system. In fact, it has taken two years to get this glitch fixed in the Central Region.

Suffice it to say, I believe we can do us all a favor with some coordinated advanced planning and review.

Adopt Single Provider Number

And, third, we should consider no longer requiring providers to bill under multiple provider numbers, which has increased the complexity and cost of processing, limited the ability of providers to bill electronically, increased the hassle factor for providers and increased the risk that claims process inaccurately.

To remedy this situation, I believe that TRICARE should move as soon as possible to the UPIN, a single provider number. Most of the data required to determine pricing and the contractual relationships of providers can be obtained through a combination of the provider single number and the provider's address. Requiring a complicated coding structure, such as that which exists today and which varies based on place of service, is the single data barrier to electronic claims submission left after work simplification.

Collections Cases

As I conclude my focus on claims, I would like to briefly address the so-called "collections" issue. At least from the standpoint of the Central Region, there is no systemic issue with "collections." Having said that, however, it is an issue that has and continues to demand focus and vigilance on the part of all involved. And, wherein there are beneficiaries that are sent to collections for an issue they did not create, it is imperative that the system come to their aid quickly and effectively.

Very early in the Central Region contract, on hearing of a couple of beneficiaries having problems with "collections," TriWest established a team of individuals in our internal claims department to intervene in "collections" cases on behalf of beneficiaries. When a beneficiary is identified to have a "collections" issue, their case is assigned to an individual on the collections team in the claims unit. All TriWest staff are trained to refer all correspondence or calls related to collections to this team. The information regarding the issue is then logged in our internal tracking system which permits all staff to know about the problem the beneficiary is facing and its status should the beneficiary come into contact with the company on this or another issue.

The collections case then begins to be worked by the staff in this special unit. The individual to whom the case is assigned intervenes with the collection agency and/or provider to request that a hold be placed on the account (a request which is usually granted) while the issues are worked. When all of the issues have been worked and the facts are ascertained, the collections unit then contacts the beneficiary and the collection agency and/or provider to close out the case.

This process has worked well in the Central Region, and we have a high success rate in resolving "legitimate issues" where the reason for the "collection" action was not due to action or lack of action on the part of the beneficiary.

To date, our experience has yielded the following conclusions:

First, the very early "collections" cases in the Central Region were largely the result of mistakes made by TriWest staff, providers and/or PGBA.

Second, as we have worked through the issues that caused the early "collections" issues, the experience has changed. Now, we are seeing that the bulk of "collections" cases are caused by two things: benefit cost shares/co-pays not being paid by beneficiaries, and beneficiaries not clearly understanding how other health insurance (OHI) works (this is the biggest issue). Beyond that, many issues which are identified as "collections" issues end up merely being an explanation of benefits which is misread as a bill for services or an early request for payment by a provider office or facility which has yet to be paid.

We are pleased with the result of the collections team within our internal claims unit. Through their work, we were able to wrestle any issues to the ground very quickly. We remain concerned, however, about the effect that beneficiaries' decisions or lack of understanding of the program is having on them. While we cannot prevent the consequences of people's decisions to not meet their obligations, we ought to be fast tracking the simplification of the OHI process so as to reduce what is proving to be the biggest cause of the "collections" cases we have been seeing over the last year. In addition, if the Department deems it prudent, it might consider a "system-wide" communication to beneficiaries on the effect of not adhering to the rules of the program (paying cost-shares, etc.). Educating those who are raising the issue about what the real experience seems to be yielding would probably be a good idea as well.

PHARMACY REDESIGN

I would now like to turn to the third critical maturation issue -- the need to develop a fully integrated, well-functioning pharmacy program across the entire military health care system. The pharmacy benefit is a critical component of the TRICARE program, but there is work to be done here. From my perspective, the goal of reform in this area has to be the creation of an integrated approach that will ensure access to appropriate pharmaceutical agents at the most cost-effective price.

In a recent report entitled, "Fully Integrated Pharmacy System Would Improve Service and Cost-Effectiveness," the General Accounting Office (GAO) recommended that the Secretary of Defense undertake a top-to-bottom redesign of the prescription drug benefit across the military treatment facilities, TRICARE contractors' retail pharmacy networks, and the national mail-order pharmacy program. Congress, too, saw the wisdom of a thorough examination for opportunities to improve the cost-effectiveness and beneficiary service quality of the pharmacy benefit. The Report of the Congressional Commission on Service Members and Veterans Transition Assistance, often referred to as the Dole

Commission, also made recommendations regarding the most cost-effective purchase of pharmaceuticals.

TriWest shares the GAO's serious concerns regarding the continued increases in drug spend, given our experience in the Central Region. In the first year, we watched the drug spend in our Region increase some 165%, which represented an increase from as little as 7% in one catchment area to 344% in another. And, it is an experience that far outpaces that of the private sector, where 12-17% drug spend increases have not been uncommon in each of the last couple of years. In short, it represents a several million dollar impact to our bottom line… an impact for which there is not yet a remedy as the contract does not adequately account for these actions in the current bid price adjustment process.

So, why the problem? Unfortunately, at this time the TRICARE program does not avail us or our colleague contractors with the tools that are commonly used in the marketplace to keep drug spend under control. And, this reality means that we are not maximizing the benefit for the beneficiary or the taxpayer due to the fact that too much money is leaking out. For example, the TRICARE program lacks a common formulary across the entire pharmaceutical product delivery system (MTF, retail pharmacy network and National Mail Order Program). Only the MTFs and the National Mail Order Program have a formulary. And, we have continually seen MTF Commanders across our Region struggle with the decision of whether to stock a specific expensive drug and blow their budget or merely have the downtown pharmacy provide it and have the contractor absorb the cost. Thus, the effect is that such costs were and are being shifted to us. I am told the same is true for the other contractors. While I understand that the Department is currently reviewing this issue, my hope is that relief comes soon for the sake of the beneficiaries, taxpayers and contractors.

So what do we do? From a pure contractors perspective, we should simply strip pharmacy out of the contracts all together in terms of contractor risk. But, I understand that such a thought may be unrealistic. So, in the interest of the beneficiaries, taxpayer and contractors, I would like to propose that if we do nothing else, we adopt the following**:** consolidate the budget for pharmacy, institute a separate bid price adjustment process for pharmacy, implement an integrated national pharmacy data system, make use of prior authorization in this area, institute a common formulary across the entire TRICARE system, and maximize use of the national mail order pharmacy program.

<u>Consolidated Budget for Pharmacy</u>

It has become apparent that as long as there are winners and losers financially in the decision of where a script is written, rather than simply looking at the most cost effective medium in which to deliver the pharmaceutical agent, the system isn't going to make the best decision in the interest of the taxpayer; thus maximizing access to the benefit. One of the ways to fix this is to set aside pharmacy from the MTF and contractor budgets and deal with it in a consolidated fashion.

Institute a Separate Bid Price Adjustment Process for Pharmacy

Today, the way in which workload shift between the MTF and the contractor is handled is through a bid price adjustment, the goal of which is to even the score financially. Unfortunately, this process as it is currently designed does not fully account for the pharmacy workload shift, which can leave the contractor incurring a significant financial hit due to a workload shift in this area, as the contractor is not sharing its losses with anyone. The answer, it seems to me, is to establish a separate bid price adjustment process, which the Department has indicated that they are willing to seriously evaluate.

Implement an Integrated Pharmacy Data System

The implementation of an integrated pharmacy data system is critical to effectively managing pharmaceutical care. As the GAO report pointed out, the Department of Defense currently provides prescription drug benefits through three programs: MTF outpatient pharmacies, TRICARE contractors' retail pharmacies, and a national mail order service. Representatives from these three pharmacy providers must work together to expeditiously integrate the existing MTF, TRICARE retail, and national mail order pharmacy patient databases and provide for an automated prospective drug utilization review (PRODUR) program at the earliest possible date.

It is essential that all efforts to effectively manage prescription drug costs be integrated into an overall approach to medical management. Best commercial practices have proven that the integration of medical and drug data and management can improve practice patterns and healthcare outcomes. Included in this process is comparative data on health outcomes, provider profiling with peer group and best practice comparisons, and disease state management programs such as asthma, diabetes, and cardiovascular disease. The potential clearly exists to improve clinical outcomes and quality of care, and at the same time optimize healthcare expenditures.

I am pleased that the Assistant Secretary of Defense for Health Affairs has directed the implementation of a Military Health System (MHS) Integrated Pharmacy Program. The first phase of this task is the development of a centralized pharmacy profile system. The purpose is to provide the capacity to create a common Department of Defense beneficiary pharmacy patient profile system that can be used to conduct prospective drug utilization review clinical screening and to provide the ability to produce Military Health System pharmacy care management reports.

At this very moment a two-day meeting is underway at the TRICARE Management Activity office in Aurora, Colorado to plan for the implementation of the MHS Integrated Pharmacy System. Through proven pharmacy benefit management practices an integrated pharmacy patient data base will facilitate prior-authorization, early refill edits, duplicate therapy edits, drug interactions, and physician-approved therapeutic substitution. The results will be better patient care that is more cost effective and efficient.

Prior Authorization

The current program does little to ensure that beneficiaries are getting the most appropriate pharmaceutical agent. Effective resolution of this issue would involve the adoption of a prior authorization program similar to those used by commercial Pharmacy Benefit Manager companies.

The goal of prescription drug prior authorization programs is to assure that the utilization of selected medications is safe, appropriate, and cost-effective. The prior authorization feature allows for the exclusion or restriction of coverage for certain categories of drugs, while ensuring that patients can receive these drugs when they are therapeutically appropriate. Medications are typically selected for a prior authorization program if they meet one of the following criteria:

- High cost injectable agents;
- High cost biotechnology agents;
- Medications with high potential for inappropriate use; and/or
- Medications deemed problematic.

The DOD could adopt the prior authorization criteria that is currently used by the TRICARE regional contractors, and best commercial practices from the pharmacy benefit management industry (practices which mirror that outlined above). In addition, the DOD Pharmacoeconomic Center staff may be a resource to conduct extensive reviews of the medical literature and manufacturers' product information to help develop prior authorization criteria. Military and civilian board-certified physician specialist consultants should be used to review and make recommendations on appropriate prior authorization criteria. TriWest recommends that when appropriate, the criteria be in accordance with the National Committee on Quality Assurance Standards, be approved by the DOD Pharmacy and Therapeutics Committee, and be approved by the DOD Pharmacy Board of Directors.

Institute a Common Formulary Across TRICARE System

In order to ensure that the maximal effort is made to provide pharmaceutical products in the most cost-effective environment, and thus maximize taxpayer resources, we recommend that the DoD institute a common formulary across the TRICARE system: MTF, retail and mail order. This formulary should cover all therapeutic classes, and be uniform throughout the system. Today, only the MTF and mail order environment are able to have a formulary and that merely creates the opportunity to shift work to the retail setting, not for convenience sake, but to save the MTF resources.

At the end of the day, such a cost shifting decision is not often in the best interest of the taxpayer (assuming that the DoD eventually has to make the contractors whole for the cost-shift that is occurring). As an example, in our Region today a new respiratory agent for young children called Synagis is not typically being stocked in the MTF. When a child needs this agent he or she is being sent downtown to one of our network providers

to receive this medication. Yet, ironically, the cost of a drug series which is available in the private setting for $6000 is available to the MTF at nearly half the cost.

In instituting a common formulary across the system, beneficiaries should be able to go outside of the formulary for reasons of medical necessity without incurring a penalty. It is also critical, in my view, to make sure that it is possible for beneficiaries to go outside of the formulary for reasons other than medical necessity if they so choose but such a choice would mean that they had to pay more. Thus, you have preserved choice while providing the incentive for making the appropriate decision.

Maximize Use of the National Mail Order Drug Program

I believe we need to take steps to maximize the use of the national mail order drug program… particularly when it comes to maintenance drugs. Today, the average supply being dispensed in the retail pharmacy setting is 20 days. However, TRICARE beneficiaries are authorized to obtain up to a 90 day supply. We should be encouraging beneficiaries to use the national mail order program for prescriptions that are filled beyond the 30th day. After all, not only is the national mail order drug program user friendly, it is able to make use of DAPA pricing which is much more preferential to the taxpayer than the retail setting. While we could simply enhance the education efforts in this area, I would suggest we should go a step further and institute an additional co-pay for those who opt to continue to go to the retail network for the dispensing of a prescription beyond the 30th day as a way to encourage use of the national mail order drug program. I would submit that such a move would not inconvenience the beneficiaries but would maximize the resources consumed on pharmaceuticals.

The pharmacy benefit is critical to the TRICARE program, but it is in need of reform. The GAO ought to be applauded for the study they conducted, and quick action should be taken to resolve the issue facing the pharmacy program so that we can continue to assure access to the agents beneficiaries need while maximizing the benefit by not letting unnecessary funds leak out. If we do not act, and quickly and effectively, I submit to you that the program will continue to be under funded in this area and the eventual reality will be an erosion in the benefit. I have appreciated the opportunity to have my staff involved in a number of the discussions regarding pharmacy redesign, as the Assistant Secretary of Defense for Health Affairs has attempted to get affected parties involved in the dialogue about pharmacy reengineering. But, the time has come for action.

CONCLUDING COMMENTS

Again, Mr. Chairman and distinguished members of the Senate Armed Services Committee Subcommittee on Personnel, I would like to thank you for inviting me to appear before you to discuss TriWest's views on the critical maturation issues facing the TRICARE program.

In spite of the challenges that this program has and is facing in its implementation, I still believe it to be the correct route to ensuring that the Department of Defense is able to build an integrated Military Health Care System that can meet its unique needs. This

isn't just any health care system, it is the system that has to serve the peace-time and war-time needs of the military beneficiary population. A critical, but not daunting task. Just like pay and retirement, health care benefits are critical to attracting and retaining our finest men and women in the military.

If one goes back to the experience of the Medicare implementation of more than forty years ago and looks at those implementation challenges, I would submit that our implementation of TRICARE pales in comparison. What's more, as I discussed in the section on CMAC rates, policy makers and operations people are continually reforming that system. Unfortunately, it seems as though constant reform and reengineering is inevitable in today's health care environment. The challenge for all of us is to harness the energy that was expended in the implementation of the change embodied in TRICARE (which is virtually unprecedented in the health care delivery system) and apply it to maturing the system as rapidly as possible. I would submit that, if you look to the young experience of TriWest and the Central Region, not only is the goal of maturation possible but it is attainable in a short period of time provided that we together work smartly and aggressively. I look forward to continuing to be involved in the dialogue and assisting on my side with whatever maturation to this program is deemed prudent by Congress and the Department of Defense.