The Military Health System's TRICARE Program

Statement By

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Submitted to the

Personnel Subcommittee
Committee on Armed Services
United States Senate

First Session, 106th Congress

March 11, 1999

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Mr. Chairman, Distinguished Members of the Committee, thank you for the distinct honor of appearing before your Committee today and the opportunity to share with you an overview of the TRICARE Program.

We, in the TRICARE Management Activity take seriously our obligation to ensure that TRICARE is successful in its mission to make high-quality, accessible, cost-effective health care available to our beneficiaries.

The Defense Department's TRICARE managed health care program is now in place and fully operational worldwide. The challenging journey to fully implement TRICARE began with the first contract in March 1995. In four short years we have transformed how we provide care…and how we do business.

The continued rapid rise of health care costs and the downsizing or closure of many bases and medical facilities made it necessary for the Department of Defense to explore new ways to provide our beneficiaries with a health care benefit. Although the armed services continue to reduce the numbers of active duty members, the demand for health care by beneficiaries will remain high due to continued growth of the population of military retirees and their dependents and survivors. As a result of base realignment and closure (BRAC) actions, 35 percent of the DoD military medical treatment facilities (MTFs) providing services in 1987 closed by the end of 1997. During the same time period, the number of people eligible for care in the Military Health System (MHS) decreased by only nine percent. There has been a reduction of 27 percent in the number of active duty members and their dependents that are eligible for care. Moreover, in the 1950s, our retiree population accounted for only eight percent of the population eligible for military health care. Today, our retiree population accounts for more than 50 percent.

TRICARE emerged as DoD's plan to respond to these challenges by reforming its peacetime health care while maintaining wartime readiness. TRICARE emphasizes improving the performance of an integrated military health care system and is designed to ensure the most effective execution of the military health care mission–
(1) to ensure readiness, through a fit and healthy force that's ready to fight whenever called upon; and (2) to provide health care for the military family.

TRICARE represents a rich benefit for our customers. From preventive health services, to better coordination with our civilian system, to lower out-of-pocket costs for families…we've designed and put into place a stronger, more uniform, benefit. TRICARE offers expanded access to care, a choice of health care options, consistent high-quality health care benefits, and reduced costs for beneficiaries and taxpayers alike. TRICARE offers beneficiaries three options for health care.

TRICARE Prime is modeled after civilian HMOs. Enrollees are assigned to a primary care manager (PCM), with an emphasis on keeping families healthy. TRICARE Prime includes a variety of preventive and wellness services at no additional charge as well as health risk assessment services. Another key feature is Prime enrollees do not have to file claims for reimbursement. There is a small co-pay when a network provider is chosen. There are no co-pays in MTF TRICARE Prime.

TRICARE Extra is an enhanced version of TRICARE Standard, offering the advantage of an integrated network of health care providers under the preferred provider network (PPN). Participating providers agree to charge lower fees for military beneficiaries. The beneficiaries themselves get a discount on the cost-shares. Like Prime, beneficiaries do not have to file claims for reimbursement.

TRICARE Standard is the old CHAMPUS fee-for-service option, renamed. Standard provides beneficiaries with the greatest freedom in selecting civilian providers, but has the highest cost of the three plans.

A year ago, the Deputy Secretary of Defense, in his Defense Reform Initiative (DRI), directed the establishment of the TRICARE Management Activity (TMA) to strengthen oversight and performance of the TRICARE program. When I arrived as Executive Director of TMA, my assignment was simple—do whatever it takes to ensure the success of the TRICARE Program. Since that time, TMA has effected major improvements and progress across the Military Health System (MHS). For instance, we have begun the TRICARE Senior Prime Program, which allows our Medicare-eligible beneficiaries to enroll in the TRICARE program. Our National Mail Order Pharmacy Program is now available worldwide. We are working hard to improve the access to TRICARE for our beneficiaries in remote areas of the United States. We want to make available to them the same level of benefits as we provide to people who live in the more populated areas of the nation.

We're proud of what we have accomplished so far. In addition to what I've already mentioned, a partial list of last year's achievements:

- We implemented the TRICARE Prime Program worldwide.
- All mission-critical information systems achieved Y2K compliance by December 31, 1998.
- Our Information Management/Information Technology Program was judged by the DoD Chief Information Officer to be a "Center of Excellence."

- Our Computer/Electronic Accommodations Program (CAP) received Vice President Gore's 1998 Hammer Award.
- The Defense Medical Logistics Standard Support Program received Vice President Gore's 1998 Hammer Award.
- We implemented the Mental Health Wraparound Demonstration, to test a wide array of traditional and non-traditional community-based mental health services for adolescents.
- The Chiropractic Demonstration was expanded, with the addition of three new sites to the existing 10.
- We expanded program oversight by instituting quality initiatives.
- We redesigned the Annual Beneficiary Survey to make it comparable to the Consumer Assessment of Health Plan Survey, developed by Harvard and RAND for the Agency for Health Care Policy and Research.
- We expanded the Customer Satisfaction Survey in the Continental U.S. and Europe.
- We deployed the annual 1999 Health Care Survey of DoD Beneficiaries.
- We initiated DoD and VA workshops to share work processes and implement joint projects.
- We initiated claims processing for the Supplemental Care Program.
- We implemented enrollment portability.
- We developed nearly 100 initiatives to streamline managed care contract administration and operations.
- In complying with the requirements of the Health Insurance Portability and Accountability Act (Kennedy-Kassebaum of 1996), we entered into an agreement with Health and Human Services designed to protect DoD beneficiaries and dollars from providers convicted of health care fraud in Medicare, Medicaid or other federally sponsored programs.
- We have built a customer feedback tracking system which provides the Military Health System leadership with top beneficiary concerns communicated to TMA through our interactive web forum, written correspondence, and phone calls.

TRICARE has been extremely successful in making improvements based on beneficiary concerns. We are determined to greatly improve customer service, in part by minimizing administrative layers, and by improving our responsiveness to beneficiaries' concerns. Consumer quality councils and hospital report cards will regularly inform all our patients about the top quality performance of military hospitals and clinics. Our most recent study, independently conducted by two Federally Funded Research and Development Centers (FFRDC), the Institute for Defense Analyses and the Center for Naval Analyses, reports positive news about TRICARE's progress. The study concluded that in its first year, TRICARE improved access to care, maintained quality of care, and did not increase costs to the beneficiary or the government. Further, our 1997 Annual Beneficiary Survey indicates that TRICARE is improving, both in results and visibility, with customer satisfaction high and growing higher.

In addition to surveys, our TRICARE beneficiaries provide feedback to the TRICARE Management Activity through several avenues. These include written correspondence, telephone calls, e-mails, and submissions to a web-based discussion

forum. Under our newly implemented Customer Feedback Tracking System, each inquiry is analyzed by our staff to capture the issue, region, military status, and TRICARE enrollment status. These data are funneled into a central location, where they are analyzed and summarized. The reports highlight the top five issues incoming for letter, phone and web. The reports are shared with the TMA leadership on a weekly basis for a real time monitoring of critical issues by region and enrollment status.

Even with all of our successes, we still have much to accomplish. There are several imperatives for the TRICARE Management Activity in 1999. Clearly, the inseparability of the twin missions of military medicine requires us to make TRICARE work in support of readiness. I will address some of the imperatives currently underway to achieve this important mission:

Implementing TRICARE worldwide has presented DoD with many challenges as well as unprecedented and amazing accomplishments – the uniform benefit, regionalization, capitated budgets, and comprehensive managed care support contracts. Some of the most significant problems we are addressing include:

- Transitional start-up problems associated with complicated claims and a complicated benefit in regions where TRICARE is new.

- As with any new program, we must continually provide top-quality educational support – at the national, regional and local levels.

- We continue to work on isolated problems with access to care including adequacy of provider networks, timely scheduling of appointments and referrals, and ensuring telephones are promptly answered.

- We are often plagued with anecdotal "horror stories" about managed care and a widespread perception of an erosion of benefits.

The TRICARE program has been and continues to be a significant cultural change for those within our system and for those who use our system. We are aggressively tackling these problems and are on the way to becoming the leading provider of quality care in the United States and around the globe.

Enlisted Members' Concerns

As with all of our beneficiaries, we are listening to our enlisted members' concerns. We asked our senior enlisted leaders to tell us what concerns about TRICARE they hear most often. Following are the top five major concerns and our plan of action to address each:

Access Standards Not Being Met We are encouraged by data which indicates that TRICARE Prime access standards are steadily improving, particularly in mature regions. We are continuing to work on resolving difficulties for those in remote

locations, BRAC sites, geographically separated units, and in Regions where TRICARE has been most recently implemented.

Keep the Message Simple In addition to the many initiatives included in our 1998-1999 Marketing Plan, our newest product, "TRICARE Made Simple" has been distributed in both programmable disk and pamphlet forms. Specific audiences are targeted with our "Navigating TRICARE" for Marine Corps members and "Sailing with TRICARE for the Navy. Additionally, we have developed "TNT (TRICARE in TRADOC)" targeted to U.S. Army Headquarters, Training and Doctrine Command (TRADOC) soldiers and their families.

Annual Re-enrollment is Too Frequent Annual re-enrollment will be eliminated in 1999. Beneficiaries will receive a notice that they have been automatically re-enrolled in TRICARE Prime each year, with an option to decline.

Increase the Numbers of Network Doctors While our beneficiaries only represent three percent of the U.S. population, they are now covered by a network which includes nearly 20 percent of U.S. physicians and 40 percent of U.S. hospitals. We are continuing to work to ensure provider networks are large enough to meet beneficiary needs.

Speed Claims and Stop Creditors from Pursuing Our Members We are placing special emphasis on claims processing in our start-up regions -- Northeast, Mid-Atlantic, and the Heartland.

FY2000 Defense Health Program Budget

The President's FY2000 budget request adequately supports our managed care support contracts, the transition to the next generation of contracts, the TRICARE Prime Remote program, the Family Member Dental Program expansion overseas, and the Selected Reserve dental program.

The budget continues support of our demonstration programs for providing coverage for beneficiaries aged 65 and older, including the Medicare Subvention Demonstration and the Federal Employees Health Benefits Program, a TRICARE Senior Supplemental plan and an expansion of the National Mail Order Pharmacy Program to include Medicare-eligible military beneficiaries.

Claims Processing

TRICARE claims processing is complex and unique in the industry. This is because of factors such as numerous eligibility categories; different cost-shares, deductibles and benefits for three distinct programs (Prime, Extra and Standard).

TRICARE contractors are responsible for processing TRICARE claims for eligible persons who live in their respective regions. They have delegated the processing functions to subcontractors.

Claims processing involves the accurate and appropriate adjudication of health care bills based on the rules, policies and requirements of the government for eligible beneficiaries. The current, basic timeliness standard for all contracts is that 75 percent of claims be processed within 21 days.

In calendar year 1998, approximately 27.5 million TRICARE claims were processed. Eighty-three percent of these claims were processed within 21 days, and 90 percent within 30 days. While this compares favorably with the minimum processing standard, we are pursuing measures that will improve the overall timeliness and efficiency of TRICARE claims processing by reviewing and revising prescriptive government requirements that impede efficient claims processing, and by moving to a point where we follow commercial practices. When we have these measures in place, we expect an increase in beneficiary and provider satisfaction, elimination of administrative burdens, and more control by contractors in the use of best commercial practices. By implementing these measures, we expect to reduce contract costs in this area.

Improve cycle time standards. Claims processing timeliness is being improved through the implementation of new contractual provisions that will require contractors to process 95% of all claims within 30 days and 100% within 60 days. DoD is emphasizing the importance of promptly and accurately processing claims by requiring contractors to pay interest on all claims not processed within 30 days.

Streamline controlled development. Controlled development is a process that continues to count the number of days required to process a claim even when it has been returned for additional information. Eliminating the requirements will be virtually transparent to the providers who submit 97% of claims and to our beneficiaries. When a claim is missing information needed to allow proper processing it will be returned to the submitter with a letter asking that the information be provided. This happens now. The difference is that contractor's will not be "controlling" or tracking the claim. This will free-up time to devote to actually completing the processing of TRICARE claims.

Eliminate unnecessary provider authorization. Authorizing non-network providers has been an extremely labor-intensive process for both the providers and the contractor. This process required the contractor to verify a provider's license at the beginning of every contract and again every two years. DoD is eliminating this time consuming process in favor of verifying a provider's credentials once and relying on other sources to obtain information about the very few practitioners who have lost their licenses. This giant step forward will eliminate many of the delays that occur at the beginning of each contract while also eliminating a recurring burden for TRICARE providers.

Adopt commercial utilization management practices. A concerted effort is underway to eliminate that vast majority of the government dictated medical review processes currently required. DoD will allow contractors to use their commercial medical review practices when processing TRICARE claims. This shift is expected to significantly reduce the number of claims requiring review and the amount of clinical information required. This initiative has several benefits to include the ability of providers to submit more claims electronically, less development, fewer edits in the automated claims systems, and more staff focused on timely and accurate claims processing.

Revalidate health care service record requirement. We have begun a process to revalidate the requirement for use of the Health Care Service Record to determine its suitability for meeting DoD's managed care data requirements as well as the requirements of the Kennedy-Kassebaum Act.

Appropriately align contractual incentives. We are currently reviewing financial incentives and disincentives for claims processing activities in order to align the appropriate contractual incentives to enhance contractor performance.

Implement third party liability improvements. We are moving forward on the implementation of FY99 Defense Authorization Act provision that will allow us to adopt the commercial practice of "pay and chase" replacing our current "chase and pay" system.

Review operational requirements. Many of our claims processing problems are a symptom of a complex program. We will conduct a comprehensive review of the TRICARE Operations Manual, Policy Manual and Automated Data Processing Manual to identify opportunities for simplification.

Conduct claims processing bottom up review. TMA will be contracting with a consulting firm with claims processing expertise to conduct a bottom up review of TRICARE benefits, policies, and procedures for the purpose of providing further areas of improvement.

Additional activities. We have also implemented a focused improvement plan for claims processing in Regions 1, 2 and 5. During the fourth week of February a Government Review Team conducted a review of claims processing and related activities within these regions with the goal of identifying significant issues inhibiting claims processing efficiency and effectiveness. On February 24, the TMA also convened a Claims Processing Summit with the Managed Care Support Contractors Chief Executive Officers. During this session claims processing issues were identified and a formal strategy for resolution was developed. This will be an ongoing activity that will support the objectives of the TMA's Claims Processing Enhancement Plan, scheduled for release March 10, 1999

We've looked at our procedures and have identified ways in which we can simplify and streamline the process. The first phase of changes under our Work Simplification Initiative will be implemented in April of this year. Several of these changes will directly impact claims processing cycle times, which will be changed to correspond with Medicare standards, and will include: 95 percent of clean electronic claims paid in 14 days; 95 percent of clean paper claims paid in 30 days, with 100 percent paid in 60 days; and—the contractor pays interest on claims that are not paid in a timely manner.

Quality Health Care Initiatives

In our continuing efforts to improve the quality of our health care delivery, beneficiary access to that quality care has been, and continues to be one of our top priorities. The civilian health care system has seen a dramatic transformation over the past several years and the MHS has mirrored these changes.

We have strengthened the National Quality Management Program through establishment of Joint Service and Joint Agency committees involved with improving health care through product line studies, clinical practice guidelines, and the integration of performance measurement into accreditation.

We have improved communication with beneficiaries through establishment of the Medical Treatment Facility Report Card, the Health Care Consumer Committee, and the Health Care Provider Directory.

We have established Centers of Excellence and Specialized Treatment Services for complicated surgical/medical procedures.

The DOD Risk Management committee was re-established, external peer review of malpractice cases was accomplished, and reporting health care providers to the National Practitioner Data Bank for malpractice has improved.

And, physicians with "special" Oklahoma licenses to practice were removed from practice, or put under supervision of a licensed provider and were required to obtain a valid, unrestricted license by October 30, 1999. The new DOD policy on physician licensure has also been signed and promulgated.

Also, we are making advances in automated information systems, which will enable us to track our readiness posture and clinical competence, and will facilitate electronic access to patient records, lab results, and X-rays. We are preparing the deployment of a Computerized Patient Record.

Pharmacy

The TRICARE Management Activity is also working on a comprehensive pharmacy benefit, with the goal of achieving a totally integrated program. This effort came about

because of concerns that the proportion of Defense Health Program dollars devoted to delivering a pharmacy benefit is growing faster than all other sectors of health program spending. We want to integrate the mail-order program, plus military treatment facility and contractor operations as a unified whole. Expected advantages of this integrated benefit will include better data, information sharing among the several branches of the program, clinical coordination, and a lowering of costs while improving patient care.

And, in compliance with Section 723 of the FY 99 Authorization Act, DoD will extend the pharmacy benefit to Medicare eligibles at two (as yet unidentified) sites, beginning in October of this year.

As you are aware, the General Accounting Office (GAO) reviewed the pharmacy benefit and issued a report in June 1998. The major findings included the lack of an integrated information system, and a fragmented and complicated benefit structure. GAO recommended a top-to-bottom redesign of the pharmacy benefit, including consideration of a uniform formulary, applying co-payments for prescriptions at MTFs, and expanding the pharmacy benefit to DoD beneficiaries who are Medicare-eligible. The Congress therefore placed the requirement for DoD to address this issue in the FY 99 Authorization Act.

DoD formed a working group made up of subject-matter experts, consultants with expertise in pharmacy benefit design, and managed-care support contractor pharmacy benefit managers. The group solicited input from beneficiaries and beneficiary organizations, professional pharmacy organizations, and the pharmaceutical industry. The group also considered all current commercial best business practices (BBPs). The group's report identifies numerous commercial principles that could be used to implement a uniform pharmacy benefit. These principles are currently under study within the Department. In the meantime, we have moved forward with an integrated information system across the MHS.

The best business practices in pharmacy benefit design include such things as an integrated information system, on-line edits, central funding and management, discounts and fee reductions, an integrated formulary, varying distribution, tiered co-pays and other co-pays, charge-back/rebates, choice of health plans, and a good marketing program. The work group's report provides cost estimates and benefits of implementing each of the BBPs. However, we expect that improving a part of a system will generate a positive effect on other parts. Implementing more than one BBP in a single benefit package might be expected to have a synergistic effect that makes the sum of the parts greater than the whole.

To sum up our efforts on the pharmacy benefit, we are working toward a system-wide implementation of the best business practices of the private sector, foremost among which is an integrated pharmacy data base.

Enrollment changes

As mentioned earlier, we are making changes in the way TRICARE Prime enrollment works. In accordance with the Fiscal Year 1999 National Defense Authorization Act, by October 1, 1999, we will have implemented automatic renewals of TRICARE Prime enrollment upon expiration of the annual enrollment period, unless the renewal is declined. We will also establish automatic enrollment in TRICARE Prime for the families of active-duty pay grade E-4 personnel and below, when they live in the catchment areas of military health care facilities. Lastly, we will expand on the installment payment options for TRICARE Prime enrollment fees. Retirees, and those other beneficiaries who are required to pay an enrollment fee, will be able to pay monthly via an electronic funds transfer, or through an allotment from retired or retainer pay, in addition to the current payment options of quarterly or yearly payments.

The Department of Defense is currently engaged in the necessary rule-making to modify regulations pertaining to TRICARE Prime enrollment. At the same time, we will also begin modifying our managed-care contracts to implement the changes and to develop marketing materials to inform our beneficiaries. Our goal is to have automatic re-enrollment in place by June 1, 1999. We plan to have automatic enrollment of E-1 to E-4 families ready to go on October 1, 1999.

We are also working to meet the statutory requirement to provide an allotment payment as an option for payment of TRICARE Prime enrollment fees. We want to establish one "health care allotment" from retired pay accounts administered by the Defense Finance and Accounting Services. Such an allotment could be used for retiree dental enrollment fees, TRICARE Prime enrollment fees, FEHBP premiums, or other payments that a beneficiary may make.

Health Care Initiatives for Our Over-65 Population

The Department of Defense faces a dilemma: how to keep our health care commitments to military beneficiaries in an era of downsizing. TRICARE will always be incomplete until we have the capability to enroll retirees over the age 65. Within the Continental United States, our retired beneficiaries, their families and survivors are eligible to receive health care benefits under the Medicare system when they become 65 years of age. They continue to be eligible for care in the MHS on a space-available basis, but they are no longer eligible for care in the TRICARE program once they reach 65.

DoD's policy, embraced by the Balanced Budget Act of 1997, authorized a three-year demonstration of Medicare Subvention at six sites known as TRICARE Senior Prime. All sites are now up and running. It also includes two components: under TRICARE Senior Prime, DoD may receive capitated payments from Medicare Trust Funds for beneficiaries enrolling in TRICARE. Under Medicare Partners, DoD will enter into agreements with Medicare Choice Plans and receive payments from the plans for care provided to dual-eligibles enrolled in the Partner plan.

In addition to TRICARE Senior Prime, we recently completed selection of eight sites where we will carry out a demonstration project to offer the Federal Employees Health Benefits Program (FEHBP) to our Medicare-eligible retirees and dependents, unremarried former spouses of military members, and dependents of deceased members or former members. We will undertake this Congressionally directed demonstration as part of our tests of options for delivery of health care to our over-65 beneficiaries. We will also carry out demonstrations of TRICARE as a supplement to Medicare, at two sites, and enhanced pharmacy coverage, at two sites. Health care under these projects will begin in Fiscal Year 2000.

TRICARE Prime Remote

Our active-duty service members and their families who are assigned to remote locations have had concerns about their access to quality, affordable health care. The TRICARE Northwest Region, which encompasses the states of Washington and Oregon, plus part of northern Idaho, began a demonstration program several years ago, to extend TRICARE Prime-like benefits to military sponsors and families in what we call geographically separated units (GSUs).

We have learned many valuable lessons from this test program, and Section 731 of the National Defense Authorization Act for Fiscal Year 1998 has directed the Department of Defense to provide TRICARE Prime-like benefits to active-duty members nationwide, who work and live more than 50 miles from a military hospital or clinic.

It is DoD's policy that members who meet the distance criterion are immediately eligible for TRICARE benefits, with no deductibles or cost-shares. These members can't be compelled to travel to a military medical facility unless a "fitness for duty" evaluation must be performed. Currently, DoD has drafted a contract modification to enroll active-duty members with civilian providers of care, wherever possible. The contract modification eliminates any requirement to build Prime networks in all remote sites, and thereby increases simplicity and reduces the administrative costs to the government in this initiative. A joint service office, the Military Medical Support Office (MMSO) has been established and is providing 24-hour, seven-days-a-week coverage. The MMSO will provide fitness-for-duty oversight for health care delivered by civilian providers. The managed-care support contractors will provide enrollment services, health care finder support, and claims processing functions for service members who are enrolled in TRICARE Prime Remote. Active-duty members who are eligible for this program will also be able to obtain dental services in their local community. We expect to implement this program this summer.

Currently, the law does not provide for Prime-like benefits for family members who accompany their active-duty sponsors to remote locations outside the Northwest Region. Of course, they remain eligible to use TRICARE Standard, the Active-Duty Family Member Dental Plan, and the National Mail Order pharmacy Program. We are developing an independent government cost estimate for expanding Prime-like benefit to family members. In doing so, we hope to improve family member benefits.

TRICARE 3.0

Our efforts to move away from highly prescriptive, government-developed requirements and processes, as emphasized in acquisition reform directions, has led to the initiative known as Managed Care Support 3.0. MCS 3.0 is an evolution in the nature of the contracting vehicle for civilian contractors to support the administration of TRICARE. It changes the contract, not the program. The benefits of TRICARE, the cost-sharing structure, the regional nature and the triple option features remain the same. MCS 3.0 originally developed out of the need to make the process of selecting a contractor more efficient and more effective. It identifies the government's required outcomes and invites the bidders to propose their commercial practices that will meet or exceed the outcomes stated. This allows TRICARE beneficiaries to receive health plan administration that matches the best in the commercial world and reduces the cost to the government of separately designed contractor systems and practices necessary to meet requirements unique to the government. Additionally, by reducing the government-specified requirements to the maximum extent possible in favor of commercial practices, MCS 3.0 will allow many more companies to use their commercial claims processing systems to adjudicate TRICARE claims. This will increase competition and reduce both development and operating costs to the contractor and to the government.

MCS 3.0 places significant emphasis on customer satisfaction, both of beneficiaries and of Lead Agents and MTF commanders. The entire design of MCS 3.0 is based on increasing beneficiary satisfaction. A substantial financial benefit will be available for improving customer satisfaction. Additionally, the contract will include a more effective mechanism for withholding payment to the contractor for failure to meet the terms of the contract. Contracted evaluators with substantial and relevant expertise in commercial managed care practices will assure that the offer ultimately selected for award truly includes best commercial practices with acceptable risk to the government.

Dental Programs

We currently operate three dental plans for our various categories of eligible sponsors and families: The TRICARE Retiree Dental Program, the Reserve Dental Plan, and the Active-Duty Family Member Dental Plan.

The Retiree plan, which began operations in early 1998, is open to uniformed services retirees, the families of enrolled retirees, and unremarried surviving spouses and family members of deceased retired and active-duty members.

The Reserve Dental Plan, which began October 1, 1997, offers a basic dental insurance program for members of the Selected Reserve. Coverage is limited to Reservists only. Enrollees pay 40 percent of the premiums, with the government picking up the other 60 percent. This plan helps ensure that our Reserve forces are able to

maintain a proper level of dental health, and thus contributes to their mobilization readiness.

The Active-Duty Family Member Dental Plan has been in operation the longest—since the late 1980s. It helps the enrolled families of our active-duty service members in the U.S. service area maintain their dental health even when they don't have access to military dental facilities. We have recently taken steps to expand this benefit to families overseas, and expect to have the plan fully in place everywhere by October 1 of this year.

NCI/DOD Cancer Demonstration

The Department of Defense has shared public and scientific concern about disappointing cure rates under standard cancer therapies. Accordingly, in November 1994, DoD began a demonstration project to allow CHAMPUS (now TRICARE) reimbursement for patient participation in clinical trials for breast cancer treatment. While TRICARE does not normally cover treatment that is considered "experimental," DoD financing of these procedures assisted in meeting clinical trial goals and arrival at research conclusions regarding the safety and efficacy of emerging therapies in the treatment of cancer.

In January 1996, DoD expanded the demonstration for breast cancer treatment to include treatment for beneficiaries diagnosed with other cancers. Under this expanded demonstration, eligible cancer patients can participate in both Phase II or Phase III clinical trials sponsored by the National Cancer Institute (NCI). This enables persons who prefer not to be randomized in Phase III clinical trials to participate in an appropriate NCI-sponsored Phase II protocol.

By way of definition, Phase II trials provide preliminary information about how well a new drug works, and generates more information about safety and benefit, usually focusing on a particular type of cancer. Phase III trials compare a new treatment—one that has shown effectiveness in Phase II—to a standard therapy.

We are currently evaluating the feasibility of expanding this demonstration to include cancer prevention clinical trials for people who are cancer survivors or for people who haven't had cancer.

Y2K Compliance

We have a pro-active Year 2000 Project Plan in the Military Health system, and we expect to be well-fortified against the much-publicized Y2K date processing problem when the clock strikes midnight next December 31.

Health care information systems, biomedical devices and facility components are being reviewed. Computer systems throughout the Military Health System are being

renovated and tested to ensure that two-digit date fields embedded in their many layers won't corrupt data and induce failures.

March 31, 1999, will mark a critical milestone on the road to Y2K compliance for the MHS. Within Military Treatment Facilities, systems that are critical to business and clinical operations were fully compliant by last December. Goals for March include Y2K compliance of MTF facilities and systems that are not critical to MTF missions, and the removal, repair and replacement of biomedical equipment that cannot meet Y2K compliance requirements.

The Y2K Project Plan encompasses TRICARE managed care support contractors and TRICARE partners, as well as health care providers outside the Continental United States. The Office of the Assistant Secretary of Defense for Health Affairs continuously monitors their efforts toward Y2K compliance. The MHS Y2K Management Plan provides guidance for converting programs and complying with Y2K requirements within the MHS. It ensures that external, as well as internal interfaces, such as the Defense Enrollment Eligibility Reporting system (DEERS) and the Standard Finance System (STANFINS), are Y2K compliant.

Most health plans face huge expenditures for Y2K compliance. Nationwide, health systems are allocating $6-7 billion to resolve Y2K problems. Many DoD policies stated that Y2K remedies had to be accomplished within existing operating budgets.

The present emphasis is on identifying and coordinating data exchanges between organizations. Managed care support contractors, Prime vendors, and DEERS will participate in testing with the MHS or their Y2K systems. The testing will be completed by the MHS by June 1999. Claims processing contractors are also working with the MHS to be ready for Y2K.

We have also developed contingency plans for unanticipated problems or the failure of business partners or service providers. Backup systems for power outages will be identified, rapid response teams will be formed to recover lost data and reconfigure data links, and contingency plans will be made for dealing with power failures suffered by external interfacing systems. Plans for continuity of services may include such things as preparations for manual entry of data with forms and standby personnel.

All in all, we will be ready for January 1, 2000, and we will continue to make health care available to our military sponsors and families without disruptions.

MHS Re-engineering

During last summer's program review, the MHS committed to an aggressive strategy to identify, evaluate, and achieve specific management improvements that substantially change how we deliver health care, operate our health care system, and optimize the use of scarce resources. At the center of this plan is MTF Optimization, our focus to recapture as much care as possible back to the Military Treatment Facilities and practicing population health improvement. The main components of this plan are:

- Effective use of readiness-required personnel and equipment to support peacetime health service delivery mission.
- Equitably align resources to provide as much health service delivery as possible in the most cost-effective manner.
- Use civilian "best practice" enrollment models to determine the reasonable potential system based on readiness-driven staffing.
- Use the best, evidence-based clinical practices and a population health approach to ensure consistently superior quality of services moving from intervention to prevention.

This reengineering to optimize MTF capacity is part of a comprehensive MHS TRICARE Strategic Plan that includes specific objectives, timelines, and very importantly, measures of performance. Metrics and feedback are critical to our continued success. We have implemented metrics that are reviewed regularly by the MHS leadership that tell us how we are doing toward attaining our goals. These measures of performance include:

- Enrollment/Disenrollment
- Overall patient satisfaction
- Telephone access to TRICARE Service Centers and appointments
- Satisfaction with access standards
- Claims metrics
- Current beneficiary issues by phone, letter, web correspondence
- Cost of care delivery
- Enrollment and financial status of Medicare Subvention

We know that data quality is very important. Our newly formed task force addresses data quality in general. Specifically we are looking at the Medical Expense Performance Reporting System (MEPRS), which tracks the costs incurred in hospitals on the ward, ancillary, and specialty levels; the Standard Inpatient Data Record (SIDR), capturing workload diagnoses; and the Standard Ambulatory Data Record (SADR), capturing diagnosis and Current Procedural Technologies (CPT) codes; and other workload measures. We have begun to look at improving business rules and internal quality measurements for data management.

Closing

In summary, TRICARE has made significant improvements in providing top-quality, accessible health care for uniformed services beneficiaries. However, experience has shown that new TRICARE regions take time to transition to the new system. Independent analysis has demonstrated that mature TRICARE regions have improved access to care and fewer beneficiary complaints, while holding the line on beneficiary costs. DOD beneficiary survey data also show that the overall trends in customer satisfaction with health care are improving over the last three years.

But there are definitely challenges to be tackled. At this time, TRICARE is working hard to improve claims processing, ensure that all access standards are being met in all regions, and improve our support for beneficiaries in remote areas (geographically separated units), such as recruiters and ROTC personnel. But this is not all we want to do. There's more. Much more.

We want to make TRICARE work in support of readiness.

We want to surpass members' expectations—we want to be the preferred health plan for the military family.

We want to move smartly toward the optimum health for our population—to make sure that they have the highest-quality health care.

We want to optimize the capacity of our medical treatment facilities, and recapture the care of our population to these facilities.

We want to work as a tri-service team, with our contractors as teammates.

We want to be recognized as the world's leading integrated health system.

We want our fighting forces and their families to have the best we can give them in health care. We, in the Department of Defense and the TRICARE Management Activity, are dedicated to that goal, and we won't stop anywhere short of it.

Mr. Chairman, Members of the Committee, I want to thank you for your support of the Military Health System and the TRICARE program and the initiatives that we are endeavoring to accomplish. We share the same goals -- to take care of our men and women in uniform, their families, our retired members and their families. I believe that, working together, we can make considerable strides to ensure that the TRICARE Program will be the "World's Best Healthcare for the World's Best Military."