

## Executive Summary — USMI Roundtable Discussion



### *The Changing Military Direct-Care System: Impact and Implications*



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An increasing proportion of military beneficiaries receives healthcare from civilian providers through contract arrangements, a trend likely to accelerate as additional base closures and consolidations take place. Beneficiaries express concern that the greater civilianization of military care disrupts the continuity of their care and removes them from a “culture” important to their wellbeing. Military officials advise that civilianization of care enhances access for beneficiaries and represents an addition to care in military settings rather than negative shift. At the same time, they recognize that a critical mass of care is needed in the direct-care system to maintain quality of practice and provider skills, and to train military health professionals in quantities needed to fight the ongoing war on terrorism.

Diverging viewpoints were presented during a roundtable discussion convened by the **U.S. Medicine Institute for Health Studies** to examine the effect of changes in the military direct-care system. However, the federal agency, congressional, beneficiary and private-sector representatives participating in the roundtable agreed emphatically that the regular exchange of viewpoints and opinions can help bridge the distance between differing perceptions. They called for additional opportunities for such exchanges, urging that new policies and programs be presented in such forums before they are implemented.

The group also agreed that engaging the entire federal enterprise — and the private sector as well — in a seamless healthcare continuum for beneficiaries could enhance quality and reduce inefficiencies.

#### **Summary of discussion**

Why is more care being provided in the civilian sector versus the direct-care system? Roundtable participants gave various possible reasons for this shift: the “semi-permanent state of war” in which the country now finds itself; the shrinking active-duty population versus the growing number of retirees; the overall shift within the Defense Department to use of contractors for activities previously performed by uniformed personnel, “even on the battlefield”; the desire among line officers to retain uniformed slots for warfighters. At the same time, both the House and Senate have expressed concern about the trend toward civilianization and seek to limit conversion of military to civilian positions. (There is special concern on Capitol Hill over placing civilians without healthcare backgrounds to manage the TriCare regional offices.)

Some discussants at the roundtable contended that care for military beneficiaries has become a “house of cards” built layer by layer without a blueprint and resting on an unstable financial foundation. All agreed it is essential to determine “what the system *should* look like” and to exchange in advance viewpoints as to how that vision best can be achieved. “We should bring stakeholders together more often, to see each other’s perspectives; otherwise, we each see only part of the problem.”

Another significant recommendation emerging from the roundtable was for an “integrated system” of care for beneficiaries that makes combined use of the DoD and Veterans Affairs

healthcare systems — the DoD system needs a mix of patients to maintain its graduate medical education programs, and the VA needs physicians to help meet an increasing and overwhelming demand for care.

Here, in greater detail, are the major issues addressed during the roundtable:

- *“Unique” aspects of care for military personnel and beneficiaries.* Personnel deployed to Iraq and Afghanistan are returning with blast injuries and combat stress conditions in which both DoD and VA excel. There was disagreement among discussants as to whether the civilian sector can — or would — provide a similar level of expertise in dealing with these combat veterans.

While some participants emphasized the importance for beneficiaries of receiving care in facilities with uniformed personnel who understand military culture and appreciate what retirees may have experienced, others contended that the civilian sector also can provide compassionate care for such patients. In fact, it was advised, DoD is making a “conscious effort” to encourage beneficiaries to use civilian care. “While military medicine is unique, the civilian community can do it for us if we ask them to.”

- *Continuity of care.* Improvements have been made in switching beneficiaries from the military to the civilian sector and back again. However, participants said, continuity of care remains a significant issue. Among steps which could improve continuity: requiring beneficiaries to choose a single defined benefit, greater information technology interoperability (especially between VA, DoD and the Centers for Medicare and Medicaid Services), and use of standards in providing care. “Continuity of care is critical. It’s where the power rests for controlling the budget.”

The TriCare program operates through systemwide standards, thus contributing to care continuity, it was noted. Besides, some roundtable participants observed, continuity is a problem in the private-sector as well — perhaps even a bigger problem, given that both DoD and VA are actually integrated healthcare systems that can coordinate patient care.

- *The need to exchange viewpoints in advance of policy changes.* Several significant changes in military healthcare are floating on the horizon — for example, proposals for creation of a Joint Medical Command, and the suggestion that there should be a program of Health Savings Accounts (HSAs) for military beneficiaries, as a way of testing HSAs nationwide. “Let’s know what we want these things to do before we create them,” participants urged.
- *Change as a continuum.* Increased dependence on contractors to provide care for beneficiaries allows military healthcare to focus on the combat mission. All agreed that however the system changes in future, its focus must remain on the needs of the warfighter.

*Participants in this roundtable: Charles Abell of DoD, Paul Arcari of NMFA, Dave Baker of Humana Military Healthcare Services, Galen Barbour of USUHS, Cynthia Bascetta of GAO, Michael Kussman of VA, C. Mark Loper of VA, Gary Matteson of DoD, Laura Miller of VA, Steve Mirick of AMSUS, Florabel Mullick of AFIP, Ray Pryor of Humana Military Healthcare Services, Melissa Rank of the Air Force, Fred Sanford of AMSUS, Steve Strobbridge of MOAA, Diana Tabler of the Senate Armed Services Committee, Carol Thompson of the Air Force, Charlotte Tsoucalas of Defense Health Advisors, and Ed Waytt of EWyatt Consulting. The discussion was moderated by James B. Peake of Project Hope.*

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