Roadman on Tricare

By Peter Grier

The Air Force surgeon general sees the military program as a model for—and a reflection of—managed care systems in the private sector.

As USAF's top uniformed health care officer, Lt. Gen. Charles H. Roadman II, the Air Force surgeon general, has lots to worry about. The job-related item that concerns him the most, he explained, is not directly related to Tricare medical program payments, contracts, or procedures. It is polarization—the gulf of mistrust that now has opened between his office and dissatisfied Tricare patients.

It's a split that was symbolized for him by a recent letter from a retired colonel, who held that "having a bad system that's improving doesn't make it a good system."

That's not an assumption with which Roadman agrees. He sees Tricare, for all its implementation problems, as a sound military health care system that will be the shape of military medicine for years to come.

"All of my working life, I have worn a uniform," said the general in an interview in his office at Bolling AFB, D.C. "The military and its retirees are the people I feel responsible for. And so, as we see rancor and angst, that just bothers me down to my core."

The surgeon general points out that the entire nation is moving toward managed care to head off health costs that could otherwise hit $2.1 trillion by 2007. If anything, Tricare is a model for, and reflection of, the health care networks that now cover more and more American civilians.

Switching military medicine to managed care has turned out to be a huge and complex undertaking. The task has not been easy, Roadman acknowledged, but he urges

everyone to put the problems in context. Kaiser Permanente has been honing managed care in the civilian world for 50 years, he noted. Tricare has been transforming the military for five.

"Good" and "Valid" Concept

"The fact of the matter is we began with a good concept," said Roadman. "The concept is still valid. We have lots of things that we've got to do."

A number of things have already been done. Roadman said that some of the Tricare issues raised by the Air Force Association and other groups have now been rectified.

One such issue concerns portability. In the past, some Tricare beneficiaries have complained of difficulties switching from one region to another. The system was not seamless: Moving from a region administered by one contractor to one run by another required starting paperwork all over again.

Contract changes mean that is no longer the case, said Roadman.

"In fact [Tricare enrollment] is now portable," he said. "You no longer have to disenroll and re-enroll."

The related problem of split enrollment has also been solved, according to the Air Force's top uniformed doctor. Having immediate family in another Tricare region—for example, a child attending college away from home—is supposed to no longer result in the need for them to re-enroll.

Similarly, AFA's position against multiple co-payments by Tricare enrollees has been adopted by DoD.

"We listen to the associations, as we listen to the patients," said Roadman. "Unfortunately, we can't turn it on a dime, because there are large contractual federal acquisition regulations [involved]."

The issue of CHAMPUS Maximum Allowable Charges (CMACs) illustrates how complex and interwoven perceived Tricare problems can become.

Some critics complain that CMACs, the reimbursement rates to health care providers for providing specific medical procedures or units of care, have been too low. The federal government's huge Medicare program pays more, say critics, and low CMAC rates are a big reason why private doctors do not accept Tricare patients or drop out of the system.

In fact, out of about 6,000 different procedure codes, only about 70 were different from Medicare, said Roadman. Some of those codes were in pediatrics, an area of medicine that Medicare does not have. And there was a regional difference in CMAC rates because from county to county there are different reimbursement rates even under Medicare.

All CMAC rates are now equal to or greater than their Medicare equivalents, said Roadman.

In some areas of the country, managed care contractors have negotiated fees with providers that are lower than the Medicare rate. These negotiated fees vary based on the market and willingness of health groups to discount their fees.

"The fact of the matter is, all these things are tools of managed care to begin to control the cost," said Roadman.

Tricare has been effective at controlling costs, particularly in areas where it has large numbers of enrollees in the HMO–like Tricare Prime option, said Roadman. He points to a recent Center for Naval Analyses study which came to just such a conclusion.

It Saves You Money

"Tricare Prime has not only decreased the cost for the government, but it has decreased the cost for people—out-of-pocket cost. It has improved the access and increased the quality," said Roadman, citing CNA's conclusions.

Critics have charged that Tricare has immense turnover in providers in its systems due to CMAC rates and late payments. Roadman said that, judging from the statistics, that is not strictly the case.

The average turnover in a civilian health care network is about 5 percent a year, he said. In the 12 Tricare regions, turnover runs from 3.5 to 6 percent.

When providers pull out of Tricare,

"Death by Anecdotes"

Individual stories about trouble with Tricare are legion—from two-star generals who can't get their Tricare enrollment cards after four phone calls, to base commanders who are referred to out-of-network providers and incur surprise point of service costs and airmen who wait days to get a pediatrician's appointment for a child.

Lt. Gen. Charles Roadman said he does not want to minimize what such individuals may have gone through. Real people incur these problems, he said. "If we mess that up through incompetence, that should not happen," he said. "That's a legitimate hit on our system, and I know we're working like crazy to solve it."

However, Roadman also talked of what he calls "death by anecdotes," in which individual horror stories overshadow the overall progress of the system.

"You've got to [include] a denominator," he said. In other words, a story about the pullout of a provider group from Tricare should include the figure that turnover throughout the system is between 3.5 and 6 percent, comparable to that in the civilian managed care world.

"What I'm saying is, 'Put [things] into context.' That is incredibly important," he said.

it makes headlines and gives beneficiaries the feeling that their health care options are evaporating. The fact that such developments cause inconvenience to patients distresses him, said Roadman.

"Do we have turnover?" he said. "More than I want. Have we had turnover that I am distraught about? Absolutely not."

All this does not mean that real problems do not remain.

Claims processing has been quite a challenge for the Tricare system, said Roadman. Problems with claims are one of the top complaints of system beneficiaries. In addition, the cost of Tricare claims crunching remains high—about fives times as much, per claim, as that of Medicare.

The difference between Tricare and Medicare is that Tricare claims processing has military specifications, to use a weapons procurement analogy.

"What you're trading off is complexity for decreased fraud," said Roadman.

The Tricare claims form is too complicated and will be simplified over the next year. But it is unlikely to become as simple as Medicare because it needs to retain some fraud protection.

The standard for Tricare claims processing is 75 percent clearance within 21 days. The system is doing well against this measure, said Roadman. TriWest Healthcare Alliance, for instance, has over 90 percent clearance within 21 days.

Given the number of claims involved, however, the 10 or 20 percent of claims that do not make the standard represent hundreds of upset patients and thousands of extra phone calls, said Roadman.

Claims Submissions at Fault

Often, said the surgeon general, Tricare officials discover that a delay in claims processing is related to the quality of the claim submitted. If a form is incomplete or contains a wrong ID number or other problem, it can take a long time to settle.

"Now, as the claims process is simplified, what's going to happen is, by policy, we're no longer going to accept non-clean claims," said Roadman. "What that means is there will be a reject rate that will probably go up, but those that are in fact clean will be paid much quicker."

Such a change will occur as more and more providers accept electronic billing, as opposed to paper forms mailed in.

That will be the 21st century way to handle claims processing, according to the surgeon general. However, moving in that direction is not entirely under Tricare's control. It will be part and parcel of national health care reforms.

In the end, said Roadman, he would never say he is aiming low when it comes to claims processing, but he's realistic. "I don't think we will ever get down to the Medicare cost [per claim] and as simple a form as Medicare."

Another of the main complaints of Tricare beneficiaries: poor access to health care. DoD does need to improve access, say military health officials. However, they claim that the record in this area is better than many Tricare participants may realize.

With the number of Military Treatment Facilities down about 35 percent since the late 1980s, there are fewer beds and waiting rooms for patients to squeeze into, pointed out Roadman.

However, a recent General Accounting Office audit found that Tricare met its standard for urgent care within 24 hours about 85 percent of the time. The standard for routine care within seven days was met about 95 percent of the time, according to the GAO.

"Does that mean we're where we need to be?" Roadman asked rhetorically. "Nope, it doesn't. Clearly, I want to meet the standard every time."

Military Treatment Facilities do not meet access standards as well as private facilities that are part of Tricare, according to Roadman. This is because Tricare Prime patients compete with space-available retiree care and other priorities in MTFs. Military facilities also need to improve their efficiency, he said, by increasing support staff so that doctors can focus on providing medical care.

The goal is to have a ratio of 3.5 support staff for each Primary Care Manager. That will break down into one nurse, two administrators, and four medical technicians for every two PCMs.

Right now the ratio is more like one support staffer for each doctor.

"That's a real problem for us—the amount of administration that's being done by a lot of our providers," said Roadman. "It decreases their efficiency. It decreases the access."

Still, while Tricare has room for improvement in the area of access, it is comparable to the civilian health system record, in the view of Roadman.

As Good as It Gets

"If you think you get better access than that in the civil sector, you need to get on the phone again and check the color of the grass on the outside," said Roadman.

Similarly, preauthorization is a problem for Tricare, but not unduly so, according to the surgeon general.

Preauthorization requirements can be contractual. In Tricare Region 1, for instance, once a patient receives a specialist referral from a PCM, there is a standard three-day cycle before the referral is authorized. According to Tricare officials, such waits exist not to delay action, per se, but to ensure the medical necessity of the referral and to make sure the PCM is included in the decision.

The purpose of such routines "is to build a bottleneck so that you can get control of continuity of care, cost of health care, and to ensure that the doctor that takes care of you knows what's going on with you," said Roadman.

Flight Medicine for All

The role of the PCM is a crucial one. As a flight surgeon, Roadman found nothing more frustrating than to have patients complain that they were not getting better and then find out that they were being seen by eight different providers, each without knowledge of the other, who were all prescribing different treatments.

The Tricare goal is for each PCM to be responsible for no more than 1,500 patients.

Continuity of care will enable prevention-oriented treatments to really pay off. "What I'm describing is flight medicine—flight medicine for everybody is the model I would use," said Roadman.

The surgeon general worries quite a bit about the situation of personnel at geographically separated units—recruiters, ROTC instructors, and others who are assigned to areas where there are no MTFs and no

The Civilian Options

The Air Force has an obligation to take care of the health needs of its retirees, said Lt. Gen. Charles Roadman. Toward that end, it is carefully watching a number of Congressionally mandated test programs, from FEHBP–65 to Medicare Subvention.

Under FEHBP–65, military retirees in selected locations are being allowed to take part in the big Federal Employees Health Benefits Program, which covers non-military government workers. Under Medicare Subvention, retirees 65 and over are being allowed to use their Medicare benefits to pay for health care in the Military Treatment Facilities they have grown used to.

When it comes to methods of handling over-65 health care, Roadman is for diversity. "I think we all see that there needs to be a mosaic," said Roadman. "One answer doesn't fit everybody." He noted, "I still do not believe that every retiree should be eligible for FEHBP–65."

The reason for that, he said, stems from the need to maintain war readiness skills. If over-65 retirees no longer come in to military facilities for treatment, said Roadman, military doctors will be left with only generally healthy 19- to 25-year-olds to care for.

"We maintain our war readiness skills based on people that are sick, and that is generally the elderly population," said Roadman.

It will be important to determine what percentage of eligible retirees actually opt for the FEHBP–65 experiment, according to the surgeon general. Many may find it more expensive than they had anticipated. It is quickly growing more expensive, too, with its premium cost having increased some 19 percent over the last two years.

With over 350 options to choose from, the federal program is also far more confusing than the three-level Tricare, said the general.

He remarked, "Everyone says, 'This is confusing. You've given me three choices.' ... Well, let's go take 350 different HMOs, each of them providing a different benefit. Now that's really confusing."

In the end, money could be a problem, for an expanded FEHBP–65 program and for Medicare Subvention and other test programs.

"If all of those [become permanent] there is going to be a funding implication to that in order to maintain our direct care facilities," said Roadman.

Tricare Prime system. Such personnel inevitably incur increased health care costs.

One of the things the Air Force is trying to do to help is to establish a central office to manage their claims. That will not be up and running, for those on active duty, until this October. It will be another year beyond that before it can handle claims from the families of active duty members.

"It's not nearly at the rate it should happen," said Roadman. "It's a recognized problem [and] we ought to be able to solve it quicker."

Funding is an area where military health officials have continued worries. Right now, the budget looks good through 2001. A Defense Department and Air Force infusion of $194 million helped put USAF's health programs back up above the "executable" line for its programs.

But increased workload means increased costs. And workload is unpredictable. The reserve call-up for the Kosovo crisis shows how fast things can change.

"We are mobilizing people to take care of our warfighters in Europe," said Roadman.

Some of the growing pains that Tricare has experienced should be seen against the context of the national struggle over health care policy, according to the Air Force surgeon general.

Through the Flak Trap?

The United States does not have universal access to health care. Tricare is struggling to hold down costs while providing high-quality care to its enrollees and figuring out how to care for military retirees—who, by the way, were promised free medicine for life. This is a microcosm of what's going on in the civilian world, said Roadman, though "it's against a much larger backdrop."

The Air Force surgeon general said he does not want to be drawn into a debate about critics' perceptions of the Tricare system. Such arguments are "steam that doesn't get to the turbine," in his phrase. "I would want us to be seen as working people's problems to solve what it is they need," said Roadman. "That's the bottom line."

He said that managed care has been vilified virtually everywhere, from newspaper articles to popular movies. There is still resistance to the concept from payers, patients, and providers, according to Roadman. However, he claimed, it's the only game in town. It is where the Air Force is headed.

He said, "I think we're about 90 percent through the flak trap. The idea of turning around and flying through the 90 percent of the flak trap going back is not appealing. It is time to throttle forward and fly through the rest of the 10 percent." ▪

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