ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

3 FEB 1976

HEALTH AND
ENVIRONMENT

SEC DEF HAS SEEN

MEMORANDUM FOR THE SECRETARY OF DEFENSE

SUBJECT: SecDef Position on OMB Health Care Study -- ACTION MEMORANDUM

In 1973, the President directed OMB to conduct a joint study with DoD and HEW of the military health care system. His decision grew out of concern about the anticipated physician shortage with the end of the draft and generally increasing overhead and support costs in DoD. (DoD outlays for medical and health related activities were $2.9 billion in FY74 and are projected at $3.7 billion for FY77.) Because of numerous problems and difficulties, the study took two and one-half years to complete. The study report will be available from the printer on or about 28 January.

There is considerable interest in the report on the part of the House Appropriations and Armed Services Committees and Senator Kennedy's Health Subcommittee of the Senate Labor and Public Welfare Committee. Also interested are the various organizations representing military dependents and retired military personnel and the service and medical press. All groups are interested primarily in the report's most controversial recommendation, which involves the possibility of reducing the amount of dependent and retired health care provided in military facilities. (Roughly half of our military medical workload consists of providing care for dependents and retirees.)

The study report contains nine recommendations for your consideration (See Tab A). In addition to the external concern referred to above regarding the first recommendation, recommendations two and three are likely to engender considerable controversy within OSD and the military departments. The report stresses that its recommendations are structured as broad concepts of management and organization and that they should be implemented on the basis of a well thought-out plan following well designed and tightly controlled

SIGNERS COPY

I agree with ASD(HE&E)'s proposed "position." You will want to sit down with Cowan and Ogilvie for 30 min. to get the feel of this study, but Dr. Cowan's summary is enough for now. The LA wording would be too legalistic in my view.

AMERICAN REVOLUTION BICENTENNIAL 1776-1976

52/19

demonstration or pilot programs. H&E is developing such plans in coordination with M&RA, PA&E and the military departments. We anticipate that this phase will take from two to three months. In the meantime, in answering queries from the Congress and the public, we propose to take the following position --

> SecDef has directed ASD(H&E), in coordination with other affected elements of the OSD staff and the military departments, to evaluate the study findings and recommendations and to develop for his consideration an implementation plan. Some changes may require demonstration or pilot programs before final decisions are made. In the meantime, the DoD will continue to maintain the required medical capability to respond to military emergencies and to provide high quality care to active duty members and, on a space-available basis, to other eligible beneficiaries.

Recommend approval of the above concept.

for James R. Cowan, M.D.

Approval _____ Disapproval _____

Date FEB 4 1976 Date _____

Coordination: M&RA J V Chapman 1/29/76 PA&E John D Chapoton 1/30/76

PA Hairston 1/30/76 LA See Nonconcurrence (Tab B)

Prepared by Col. John Murphy, X41280

Consideration of LA's Nonconcurrence

LA's nonconcurrence deals primarily with a number of procedural questions which are not dealt with in our memorandum. However, they present no problems since we are in complete agreement with LA regarding such matters. The only point of disagreement has to do with pilot programs. Under their approach, SecDef would be committed to pilot programs, whereas under our approach, he would, at this time, be committed to nothing more than "consideration" of the eventual implementation plan, which may or may not propose pilot programs. We adhere to our original position.

III - RECOMMENDATIONS

This section contains the recommendations of the Military Health Care Study. These recommendations deal with medical care delivered in CONUS fixed military facilities and by civilian providers financed by DOD through CHAMPUS. The recommendations are designed to provide the framework for more efficient and effective delivery of military health care services and intended to develop positive performance incentives within the MHSS, and should ensure that both national security and MHSS objectives are met.

Specific recommendations, developed after careful consideration of study findings, are structured as broad concepts of management and organization rather than a detailed list of improvements to be made in the MHSS.

Initially, these recommendations should be implemented within the Department of Defense on the basis of a well thought-out implementation plan. As part of this plan, major changes in management of the MHSS may be implemented following well-designed and tightly-controlled demonstration or pilot programs. For the future, these concepts should provide a basis for operation of the MHSS, and create a framework within which details of management and organization can be adapted over time to changing requirements and circumstances within and outside of DOD.

1. National Security Mobilization, Contingency and Other Essential Force Requirements Should be the Primary Determinant of the Size and Composition of the Peacetime Military Medical Force; Additions Should be Made to That Force When:

-- Adequate health care facilities for beneficiaries are not available overseas or at underserved locations.

-- A valid teaching or training requirement is being met.

-- The marginal cost to provide quality care in military facilities is less per beneficiary than nonmilitary alternatives.1/

2. A Central Entity Within DOD, Serving as a Coordinating Mechanism for Planning and Allocating Resources, Should be Established to Oversee Health Care Delivery in CONUS.

Although the direct care system as currently structured, has demonstrated a high responsiveness to support of mobilization and contingency forces, DOD health care delivery within specific geographical areas in CONUS is

1/ Comment from the Surgeon General, U.S. Army: Since manpower and facility resources required for national security, mobilization, contingency, and other essential force requirements are "unavoidable defense costs," it is my understanding that they are excluded in the calculation of these marginal costs.

fragmented. Therefore, the study recommends that a central entity be established to plan and allocate resources, and monitor the management of health care delivery in CONUS. This entity would provide the mechanism within DOD for carrying out coordinated planning, programming and evaluation of the CONUS health care delivery systems to include Tri-Service health care activities such as the Armed Services Medical Regulating Office (ASMRO), which support health care delivery. Currently hospital construction projects and planning and programming of Services' health care delivery and CHAMPUS are coordinated by the Office of the Secretary of Defense, with execution carried out independently by each Service through its direct care systems. The CHAMPUS program is executed by the Assistant Secretary of Defense (Health and Environment).

While the MHCS Steering Committee was not in agreement about the precise form of the organization, there was agreement that a central entity is necessary to provide coordination and oversight of health care delivery in DOD. Consequently, the Project Team did not attempt to prescribe an organization structure or reporting relationships for this central entity, and recommends that this be accomplished within DOD.

In general, the recommended central entity should have responsibility for overseeing the allocation of all resources to the military departments for health care delivery, including hospital construction, operations and maintenance, and personnel. While it is intended that the Services would maintain operational control of their resources, including funds, personnel, and facilities, the central entity must have a strong mandate to coordinate all CONUS health care delivery, including the most appropriate use of the direct care facilities and CHAMPUS. However, health care delivery must be provided with recognition of the differing mission requirements of the military departments.

The rationale for this central entity is to provide a mechanism which would improve the allocation of increasingly scarce resources. In addition, a coordinated approach to planning and management in CONUS is the basis for providing quality care to all beneficiaries at lowest per capita costs, for maximizing utilization of available resources, and for integrating CHAMPUS and direct care systems without degradation of support for military operations.

The central entity would ensure that resources for the essential medical forces are allocated in accordance with mobilization and contingency requirements and that peacetime medical care is provided in the most effective manner, while assuring adequate hearing for military department views. In addition, the entity should provide input on the development of standard data and information systems, along with other

management tool to assist managers in the field. The entity should establish regular programs designed to ensure that successful local innovations are disseminated to other users. 1/2/

3. Oversight of Health Care Delivery Operations Should be Assigned to Regional Authorities Responsible for all Health Care Delivery in Their CONUS Geographical Areas.

While the MHCS Steering Committee was not in agreement about the form of organization, there was agreement that some type of regional authority or coordination is necessary to ensure effective use of resources. In reviewing this recommendation, the Steering Committee directed that they be given options for implementation. These options are as follows:

(1) Implement regional coordination through the existing Service organization and Tri-Service regionalization program.

(2) Establish a regional coordinating authority, 3/ with responsibility for all health care functions.

1/ Comment from the Surgeon General of the Navy: Navy concurs with the concept of central coordination of planning for military health care resources. We understand that this recommendation:

a. Does not contemplate contravention of the authority of the Secretary of the Navy, Chief of Naval Operations, Commandant of the Marine Corps and Surgeon General of the Navy to satisfy their statutory responsibilities for the health, welfare and morale of naval personnel.

b. Provides a DOD mechanism for carrying out coordinated planning, programming, monitoring and evaluation of the CONUS health care delivery systems.

c. Contemplates continued program execution carried out independently by each Service.

d. Intends that Services would maintain operational control of personnel and facilities in order to retain the inherent flexibility necessary for medical support to emergent contingencies.

2/ Comment from the Surgeon General, U.S. Air Force: Recommendation 2 should be amended to add ". . .subject to differing mission requirements of the three military medical departments." This change is necessary to recognize differing operational support requirements within the military Services.

3/ A Coordinating Authority, which may be used for this purpose, is defined in Joint Chiefs of Staff Publication 1 (JCS Pub 1), as ". . . a commander or individual assigned responsibility for coordinating specific functions or activities involving forces of two or more Services, or two or more forces of the same Service. He has authority to require consultation between the agencies involved, but does not have the authority to compel agreement. In the event he is unable to obtain essential agreement he shall refer the matter to the appointing authority."

(3) Implement a regional management structure which allocates resources, including funds, facilities, and personnel.

Under options 1 and 2, it is not intended that regional coordinators should exercise command or operational control over funds, facilities or personnel in their region in carrying out this authority. However, option 3 would allow some level of operational or functional control over these resources.1/2/3/4/

1/ Comment from Assistant Secretary for Health (HEW): Of the three options offered, the Office of the Assistant Secretary for Health favors option 2, "Establish a regional coordinating authority, with responsibility for all health care functions." The Office of the Assistant Secretary for Health supports greater functional integration on a regional basis of the health care delivery resources of the three military Services as that integration can contribute to increased efficiency and quality of care at reduced cost, while not interferring with the three military Services fulfilling their individual responsibilities. The third option, "Implement a regional management structure which allocates resources, including funds, facilities, and personnel" is not favored because it appears to establish two lines of authority; that is, individual units potentially will be responsible to both a Tri-Service regional management structure and an individual national military Service management structure. It would appear that the implementation of a regional management structure which allocates resources including funds, facilities, and personnel does establish significant operational control over facilities and personnel in that region.

2/ Comment from the Surgeon General, U.S. Army: Option 3 creates an organizational structure incompatible with the statutory responsibilities of the Service Secretaries, Chiefs, and Surgeons General with regard to the health of their forces. Direct patient care in CONUS fixed facilities is separated from other major operational force medical missions often accomplished by the same personnel. Control of resources essential to Service-unique roles and missions is lost. This fragmentation of an essential support mission has the strong potential for degradation of effective, timely, military Service response to defense contingencies.

3/ Comment from the Surgeon General of the Navy: Navy concurs with the concept of Tri-Service regional oversight of health care delivery in CONUS geographical areas. We understand that recommendation 3:

a. Intends that the "regional authorities" will function as Tri-Service regional coordinators.

b. Does not intend that the Tri-Service regional coordinators should exercise operational control over facilities or personnel in their respective regions.

c. Intends to ensure continued responsiveness of regional health care delivery to all military priorities of the respective Services.

4/ Comment from the Surgeon General, U.S. Air Force: Since it would be difficult to conceive an organizational mode of regional managers with authority to allocate resources without exercising operational control over funds, facilities, and personnel, we believe the new regional management structure should be limited to "defining resources required for efficient and effective health care delivery, including funds, facilities and personnel."

The value of a regional health care concept already has been tested and accepted within DOD. The two-year old Tri-Service regionalization program has resulted in improved use of resources to the benefit of DOD beneficiaries, largely through sharing of specialty services and joint procurement. Strengthening this concept should produce additional savings. Eliminating unnecessary overlap and duplication, and optimizing resource allocation and utilization so the best care is provided at minimum cost, requires regional authorities with the responsibility for oversight of regional planning, programming and utilization. As part of their responsibility, regional authorities should seek efficient utilization of CHAMPUS, restoring this program to its intended role as a supplement rather than a substitute for direct care. The regional authorities should have direct access to the central entity discussed in recommendation 2, above.

In any case, regional authorities should seek quality care at lowest per capita cost, with incentives to plan effectively and make the best possible use of regional resources, while recognizing the differing mission requirements of the military departments. They should have the latitude within established guidelines to seek innovative solutions to health care delivery problems.

In regions where a number of facilities are concentrated in a local area, subregional authorities may be established. The current arrangements in the Army and Navy-Marine Corps, which ensure that health care activities remain responsive to operational commanders receiving health care support, provide experience through performance evaluation which can be used to ensure responsiveness of regional health care delivery to all military priorities.

4. MHSS Health Care Delivery Planning for CONUS Should be Primarily Based on the Size and Demographic Characteristics of the Population to be Served.

Current MHSS objectives call for quality care to be provided to all beneficiaries, as efficiently and effectively as possible, in military medical facilities or through financing in the civilian sector. To some extent, the present health care delivery planning is based on historical workload indicators such as direct care admissions, hospital days, outpatient visits, and CHAMPUS claims costs. Moreover, the process does not provide a means of quantifying MHSS objectives or measuring MHSS progress toward achieving them, since the care needs of the total beneficiary population are not defined, and the extent to which these needs are met or unmet at various workload levels, thus, cannot be determined.

In summary, planning based on workload experience, rather than a population-based forecast of demand does not encourage efficiency. Moreover, it is essential that CHAMPUS and the direct care system planning be closely integrated in order to develop a set of total CONUS requirements for the MHSS.

Therefore, it is recommended that DOD adopt a planning process for CONUS which is based primarily on the demographics of the population to be served. However, national security and contingency requirements would continue to be a major factor in the overall planning process. With the population to be cared for in-system defined, health care planning can be based on projected demand for care. Using up-to-date planning tools such as the MHCS manpower resource model, forecasts should be made for both long- and short-range demand for health care. Changes in care-providing patterns, such as the substitution of outpatient for inpatient care, can be factored into those demand forecasts. 1/ Similarly the effect on resource requirements of shifting beneficiary care between the direct and financing components of the system could be examined. A planning approach based on population demographics and total demand requirements should provide the basis for more effective resource programming. 2/

5. Resource Programming and Budgeting for the MHSS in CONUS Should be Done on a Capitation Basis.

Currently, the primary basis for programming CONUS health care delivery resources at local levels is workload based on population projections, using direct care system workload units and previous year CHAMPUS workload and claims costs. This procedure, which emphasizes inpatient care, may encourage the use of expensive inpatient care in the MHSS.

It is the study recommendation that a per capita approach to programming and budgeting in CONUS be adopted to provide positive incentives for quality care while holding costs down. However, national security and contingency requirements would continue to be a major factor in the overall planning process. At the same time, provisions must be made to maintain the quality of health care in the MHSS. 2/

6. Resource Programming for the Direct Care System and CHAMPUS Should be Integrated Within DOD.

At present, the budget for the direct care system is the responsibility of the individual military departments, while the Assistant Secretary of Defense (Health and Environment) is responsible for the CHAMPUS budget. The study results indicate that this structure does not assure the optimum allocation of resources at local levels. Therefore, it is recommended that DOD integrate the review for the direct care system and CHAMPUS resources within the Services and at a single point in the Office of the Secretary of Defense.

1/ DOD has taken steps to use population as a basis for sizing new inpatient facilities; however, as long as outpatient planning is not an integral part of inpatient planning and CHAMPUS and direct care planning are not fully coordinated, it is unlikely that facilities will be optimally sized.

2/ Comment from the Surgeon General of the Navy: We consider that recommendations 4 and 5 do not contemplate population-based resource planning for military preparedness or contingency response functions. Therefore, such resource planning would be based upon other considerations.

Wherever possible, management of direct care and CHAMPUS resources should be coordinated within the regional organizational structure previously discussed. This would encourage health care managers:

-- To identify the optimal mix of CHAMPUS and direct care for DOD as a whole, in each region and in each facility.

-- To consider the elimination of nonproductive activities.

-- To introduce cost-tradeoffs between direct care and CHAMPUS not presently being considered.

7. Costs per Beneficiary Should be Developed and Used as a Measure of Efficiency and Performance.

The study recommends the adoption of cost per beneficiary, a simple and easy-to-understand measure as an additional tool for measuring the cost efficiency or effectiveness in the entire MHSS. For comparable groups of beneficiaries, this measure provides a useful and objective indicator of health care costs. Used as a measure of managerial performance, it provides a means of rewarding increases in productivity.

In order to develop an effective measure for management and for measuring performance, two information systems should be developed. One would provide information on the population to be served by each military medical region by major demographic characteristics such as age and sex. The second would provide data on cost of care in military facilities by appropriate categories.

The first information system is necessary in order to adjust for different demographic characteristics of beneficiary populations when comparing the efficiency of one facility or region with another or when comparing DOD's medical system with other systems.

The second information system is necessary in order that facility, regional, and central managers can make accurate decisions on which type of care can most economically be treated in military medical facilities and which should be treated outside the direct care system.

Several measures of average cost based on workload units are presently used to evaluate MHSS cost efficiency, including cost per occupied bedday, cost per admission and cost per outpatient visit. Measures of cost effectiveness related to workload are useful for making specific inpatient or outpatient comparisons among facilities within a single Service, but are subject to variations in interpretation when used to evaluate an entire system. For example, average costs per workload unit can be changed significantly by changing one or more dependent variables, such as

increasing length of stay which may, in turn, lower the average cost per day, or admitting patients to the hospital who could be treated on an ambulatory basis thereby lowering costs per admission. Consequently, low average costs per workload unit may not indicate high cost efficiency, nor high average unit costs indicate inefficiency. 1/ Application of cost per beneficiary in these evaluations would provide a means, now lacking, of monitoring efficiency and effectiveness of the entire system over time, and of comparing the cost of care in the MHSS with the price of care in other systems.

8. Programs to Control Inpatient Utilization in Military Medical Facilities Should be Established.

Although the Services are presently reviewing their standards for inpatient utilization, improved controls in military medical facilities should be established to reduce the use of inpatient care when outpatient care may be appropriate and to reduce excessive lengths of stay. This, together with the per capita budgeting system recommended for the MHSS should provide positive incentives for the reduction of inpatient utilization. In addition to JCAH-required utilization review, other programs, including those now in use in the civilian sector, should be examined for their potential utility to the MHSS.

9. Consideration Should be Given to the Feasibility of Allowing Dependents of Active Duty Members, Retiree Families and Survivor Families to Select a Health Care Program Other Than That Provided in the MHSS.

While active duty beneficiaries are required to receive their care directly from DOD or from providers selected and paid by DOD as a condition of their employment, entitled nonactive duty beneficiaries receive care in military facilities on a space-available basis or through CHAMPUS. However, there is some indication that some beneficiaries would prefer to have freedom to choose health care outside the MHSS. Moreover, the study found evidence that a number of eligibles, particularly retirees and their dependents, do not exercise their entitlement to MHSS benefits, but instead use health care plans offered by other employers. It was, however, not part of the study scope to determine the numbers of eligibles who actually use their benefits.

1/ Even costs per unit of workload adjusted for patient diagnoses, age and sex are not adequate measures of cost efficiency. The cost per unit of inpatient workload adjusted for these variables, for example, may compare favorably with historical costs or prices in other systems for the same adjusted workload unit but the care may be less expensive on an outpatient basis.

It is recommended that DOD assess the feasibility of providing selected eligible nonactive duty beneficiaries the option of selecting DOD-financed care outside the MHSS, consistent with national security mobilization, contingency, and other essential force requirements. This study should be carried out jointly by the Office of the Secretary of Defense and the Services. 1/2/

A wide range of plans could be offered to nonactive duty beneficiaries, including those currently available to Federal employees. 3/ Offering beneficiaries a choice of using the MHSS or electing another system serves two important purposes:

-- The number of beneficiaries actually using the system will be firmly established; this in turn will provide MHSS planners, with more accurate estimates of requirements.

-- Beneficiaries who are dissatisfied will be able to select care that better suits their desires.

The premiums for an alternative program equivalent to some or all of the value of MHSS benefits should be paid by the Government. However, any revisions to the current MHSS cost distribution arrangements should be made so that changes in total cost of care are distributed equitably between the Government and beneficiaries.

If this approach were adopted, MHSS cost-sharing for care provided in military facilities and under CHAMPUS should be reviewed to determine the feasibility of equalizing the cost-sharing load for all nonactive duty beneficiaries, as well as the feasibility of establishing differential cost-sharing arrangements among those beneficiary categories. The review should include such alternatives as establishing premiums for all MHSS care, eliminating CHAMPUS cost-sharing, substituting a premium for current CHAMPUS cost-sharing, or others. Consistent with national health insurance proposals, there should be an annual limit on total health care cost liability under CHAMPUS for each beneficiary family. Finally, as part of the revision of current MHSS cost arrangements, the administrative rules and procedures governing the CHAMPUS benefit package should be clearly enunciated so that beneficiaries understand both included and excluded benefits.

1/ Comment from the Assistant Secretary of Defense (Program Analysis and Evaluation): Consideration should also be given to allowing active duty members to select care outside the Military Health Services System.

2/ Comment from the Surgeon General of the Navy: We assume that active duty members are not to be included in the consideration of recommendation 9, because of the medico-legal and administrative requirements associated with active duty health maintenance programs.

3/ Active duty families selecting one of these plans would maintain their eligibility for CHAMPUS handicapped program benefits.

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C., 20301

2 FEB 1976

LEGISLATIVE
AFFAIRS

MEMORANDUM FOR Dr. Cowan, Assistant Secretary of Defense (H&E)

SUBJECT: SecDef Position - OMB Health Care Study

I have reviewed your proposed release to the members of Congress and the press. It is apparent that there will be considerable Congressional interest. In order to keep the Congress fully informed of our plans I recommend we use the following approach in lieu of the approach established in your memo.

a. A drop to the entire Congress explaining the study recommendations and our method of consideration/implementation. This should involve a one page fact sheet to be forwarded over my signature prior to public release.

b. Provision of the entire report to the Appropriations and Authorizations Committees of the Congress and to the Senate Health Subcommittee. Since the report deals with significant management improvements and possible budgetary reductions, copies should also be provided to the Budget and Government Operations Committees of the Congress. If there is no executive summary to the report, then the letters of transmittal should include a summary of findings.

c. The response to query from the Congress be incorporated into the fact sheet recommended above and that the thrust be changed to reflect that the Secretary's decision on final implementation of the proposals will occur after the pilot programs are completed and that the Congress will be kept fully informed of all developments prior to public release.

John M. Maury
Assistant Secretary of Defense
for Legislative Affairs