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**The Military Health Services System--
Prospects for the Future**

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Subcommittee on Defense
Committee on Appropriations
United States Senate

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to provide our views on changes that need to be made to the military health services system and some suggestions for how best to achieve them. At the outset, let me say that we agree with the Department of Defense's (DOD's) recent efforts to develop and institute systemwide managed health care for its beneficiaries. Therefore, my testimony will focus principally on those efforts to implement this fundamental change in the military health care system. We will also briefly discuss other issues that we believe will affect the future direction of DOD's health care activities.

It is important to note that DOD has not yet made several difficult decisions regarding how its managed care efforts will be implemented. Thus, our views are based on our close tracking of planning activities in the Office of the Assistant Secretary (Health Affairs) and in the offices of each surgeon general, discussions with these officials or their top staff, and our experiences in dealing with both military and private sector health care issues. We have also reviewed DOD's major health care demonstration projects with a focus on their managed care features.

Mr. Chairman, as you know, the use of managed care as a tool to help control health care costs while providing accessible,

high-quality care to beneficiaries is not new. It has been attempted in various forms throughout the nation's health care system through health maintenance organizations (HMOs) and other "case management techniques." Its use in DOD, however, has been limited to congressionally mandated demonstration projects, of which I know you are aware.

The objective of managed care is to closely coordinate and organize health care resources to address specific medical problems of patients and to control the cost and volume of the health services delivered. It involves (1) providing a case manager, through whom all medical care is provided or referred, (2) seeking alternative health care settings, usually at lower cost, (3) establishing strong utilization and quality assurance programs to ensure that only appropriate, high-quality care is given, and (4) providing financial and other incentives to promote the delivery of cost-effective care. Managed care can be applied either in a prepaid health care setting, such as an HMO, or with fee-for service reimbursement.

To fully appreciate the significance of the changes we think are necessary and DOD is contemplating, it is important to focus briefly on the problems that military health care is confronting.

## MILITARY HEALTH CARE

## CHALLENGES AND PROBLEMS

DOD faces difficult challenges because it is both one of the nation's largest health care providers and a payer for the care for millions of military beneficiaries. These challenges are made even greater because it also must be ready to support troops in wartime, as the recent Persian Gulf mobilization illustrated, and it serves as a training institution for thousands of health care providers. These missions, of necessity, add considerably to the system's costs.

The military health services system, as currently structured, lacks sufficient incentives and tools to control expenditures and provide accessible care on an equitable basis. As we reported to you last March, Mr. Chairman, in recent years we have seen budgeting problems in the form of massive cost overruns in CHAMPUS[1] that stem, in part, from not being able to control and thus predict health care expenditures in DOD. Of particular concern is the continuing growth in CHAMPUS mental health costs.

CHAMPUS beneficiaries are able to seek primary or specialty outpatient care from whomever they choose. The costs for these decisions, however, are borne mostly by DOD, which has virtually

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[1]Civilian Health and Medical Program of the Uniformed Services--a DOD program to finance private sector care for 6.7 million eligible non-active-duty beneficiaries.

no say in whether the care is appropriate or whether the most cost-effective providers are selected.

In the inpatient arena, many DOD facilities are underused, thereby creating incentives to inappropriately admit patients and retain them longer than medically necessary since facilities' budgets are typically based on their workloads. Other facilities are understaffed and inaccessible to patients, resulting in care being provided in more expensive civilian hospitals. Again, DOD pays the lion's share of these costs without sufficient utilization controls.

The managed care models being developed and tested in DOD for the delivery of both medical and mental health services contain features designed to provide the necessary incentives, authorities, and disciplines to purchase and provide health care more efficiently. I would like to address each of these topics and offer suggestions for implementing them, based mostly on lessons learned from past and current demonstrations.

## LOCAL ACCOUNTABILITY

Military hospital commanders should be responsible for the provision of health services to all beneficiaries in the hospital's service area, including care delivered by civilian providers under CHAMPUS. Currently, DOD's hospital commanders do

not control beneficiaries' access to care delivered in civilian settings, nor do they have fiscal responsibility for such care. In fact, incentives exist for them to push costly care out of their facilities and into the civilian sector. Placing effective control, fiscal responsibility, and accountability for beneficiary care at the local military hospital level will help provide needed incentives and authorities to manage more effectively, such as by directing patients toward the lower priced quality providers and the least costly setting.

The demonstrations, to date, indicate that the concept of local accountability can work on a systemwide basis. Hospital commanders who have this responsibility are finding innovative ways to obtain and manage civilian care for their beneficiaries. However, there is a need for better budgeting tools, improved performance indicators, and much more technical assistance in the area of negotiating for and procuring civilian medical services before moving ahead with such efforts systemwide.

**ENROLLMENT AND PRIMARY CARE MANAGER**

Under DOD's managed care program, beneficiaries should be enrolled and assigned to primary care providers (gatekeepers), through whom all of their medical care will be delivered or referred. Real enrollment--rather than merely registration as is now done under the Defense Enrollment Eligibility Reporting

System--is important because this is the principal mechanism by which beneficiaries' health care needs will be managed. The key to managed care is that no care will be paid for that is not approved and directed by the gatekeeper, who will decide the most appropriate and cost-effective settings and sources of care for beneficiaries.

Experience with the demonstration programs around the country has shown that beneficiaries need strong incentives to enroll because they view managed care as taking away their freedom to choose physicians. The demonstrations also have shown that the enrollment process must be phased in so that the number of beneficiaries allowed to enroll is based on the capability of the managed care system to assign a primary care provider for each enrollee. This means that networks of private providers should be developed before beneficiaries are enrolled.

## UTILIZATION MANAGEMENT AND QUALITY ASSURANCE

Strong utilization management and quality assurance programs are needed to help assure that only appropriate, high-quality care is given. Presently, utilization management in DOD is an uncoordinated mix of preadmission, concurrent, and retrospective reviews of care provided in both military and civilian facilities. A more complete and systematic program is necessary, as DOD medical officials have recognized.

## PROVIDER NETWORKS AND DISCOUNTS

Because military facilities cannot accommodate all DOD beneficiaries who seek care, networks of civilian providers need to be established to augment their capabilities. The goal is to encourage providers participating in such networks to agree to substantial discounts from the fees they charge under the current military health care system.

Developing networks of private providers, including negotiating discounts, requires expertise and data that many military hospital officials do not possess, as DOD's demonstrations have shown. As a result, some hospital commanders will need the assistance of consultants or contractors to help establish networks with the right mix of providers, establish necessary assurances that these providers meet quality standards, and negotiate appropriate discounts.

## UNIFORM BENEFITS AND COST SHARING

Under managed care, we believe that each category of enrolled beneficiary[2] should have uniform benefits and cost-sharing requirements. This should be the case without regard to where the

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[2]Dependents of active duty members, retirees and their dependents, etc.

beneficiaries receive their care or where they live. Currently, benefits available from military facilities differ from those offered under CHAMPUS. Also, care in military facilities is essentially free, whereas that delivered by civilian providers under CHAMPUS involves considerable cost sharing. In addition, achieving uniformity in benefits and cost sharing within each category of beneficiary should remove much of the confusion and uncertainty that beneficiaries have about their medical benefits. At this time there are benefit differences among the demonstration sites, but no clearly superior choice has yet emerged.

## INFORMATION AND CLAIMS PROCESSING

Better information than is now available is needed under managed care for hospital commanders to effectively (1) negotiate pricing agreements with civilian providers, (2) develop accurate and realistic budgets for their operations, (3) monitor utilization and other performance aspects, and (4) learn about successful innovations at other hospitals.

For example, to create an effective local provider network, managers will need (1) information on individual physician practice patterns to identify how their use of health services compares to those of other providers, (2) profiles of their billings to negotiate discounts, and (3) data on their patients' outcomes to monitor the quality of care delivered. In reviewing

the processes in place for disseminating data on local hospital initiatives, we found that the services need to take a more proactive and systematic approach to sharing information with each other.

Civilian providers who participate in networks expect and deserve timely and accurate payment for their services. The importance of this issue should not be underestimated. I need not detail for you the substantial problems caused by the claims-processing difficulties initially experienced by DOD's CHAMPUS Reform Initiative contractor. This one issue almost caused the project to be terminated without being given a fair chance to succeed. We strongly urge that any claims-processing modifications that are necessary as a result of adopting managed care techniques be fully operational before health care is delivered under such a system.

**IMPLEMENTING MANAGED CARE**
**WILL TAKE TIME AND**
**REQUIRE CONTINUED OVERSIGHT**

Mr. Chairman, as I stated at the outset, we believe that DOD is clearly headed in the right direction with its managed care efforts. Its adoption of managed care as the centerpiece of its efforts to refine the military health care system offers the real potential for gaining more control over costs, improving

beneficiary access, and maintaining high-quality care. The features outlined in DOD's current plans embody many techniques that have proven to be successful in achieving these objectives, and its apparent commitment to these efforts greatly improves its chances for success.

Having said this, however, we see many difficult operational decisions that still need to be made that will significantly affect DOD's efforts to institutionalize managed care. Therefore, it is crucial that the lessons learned from past initiatives be incorporated into DOD's implementation plans.

It is also crucial that expectations for the success of managed care be tempered by realism about the prospects for immediate beneficial results. DOD is dealing with difficult and costly health care problems with many implications for all those affected by the military health care system. It needs time to work through how best to equitably and fairly accommodate those affected, while achieving its goal of controlling the cost growth that military health care has experienced over the last decade. It will also need the continued support and, at times, critical input from this and the other key congressional committees as it implements this ambitious concept throughout its system.

Before concluding my statement, I would like to take a moment to raise other military health care matters, outside the realm of managed care, that we believe the Subcommittee also needs to consider.

OTHER ISSUES

First, changes to the military health care system may be needed as a result of the planned downsizing of the military. Although the ramifications of total force reductions are far from clear, questions will need to be answered about the extent to which, and when, medical resources should be reconfigured or cut back given that many of the individuals who leave the services and their dependents will remain eligible for military health benefits.

Second, we believe there needs to be a comprehensive assessment of the opportunities for making more efficient and effective use of medical personnel, such as physician assistants and nurse practitioners, who might be able to perform some of the tasks that military physicians and nurses now handle. In a similar vein, we believe that DOD's prevailing practice of having military physicians serve as hospital commanders should be reevaluated in light of continuing physician retention problems and the increasing complexity of hospital administration activities.

Third, additional opportunities for sharing medical resources with the Department of Veterans Affairs should be pursued before capacities are added to the two health care systems.

Fourth, we believe there should be an assessment of physician and other nonhospital provider payment reforms under CHAMPUS similar to those occurring and being contemplated under Medicare.

Finally, Mr. Chairman, the consolidation of the administrative and command structures of the services' medical departments should also be considered to identify potential opportunities to streamline operations and improve efficiency.

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Mr. Chairman, this concludes my prepared statement. We would be glad to answer any questions you or other members of the Subcommittee may have.