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Are the DHP Savings From Utilization Management Achievable?

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Are the DHP Savings From Utilization Management Achievable?

Robert A. Levy
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March 1999

Project Tasking and Sponsor

- **Tasking**
  - **Are the DHP savings from utilization management achievable?**
  - **Are the FEHBP and private-sector options more cost competitive?**
  - **What is the feasibility of an enrollment process?**
  - **What problems are associated with TRICARE?**
- **Sponsor**
  - **Under Secretary of Defense for Personnel and Readiness**

The Defense Health Program (DHP) faces a number of important issues over the next several years. In the summer 1998 submission for the Program Objectives Memorandum for FY 2000, Health Affairs (HA) projections for FY 2000 through FY 2005 (from its capitation model) originally showed a large gap between what would be required to fulfill the DHP's medical missions and what would be available under the fiscal guidance provided to the program.

The Under Secretary of Defense, Personnel and Readiness, therefore tasked CNA and RAND to examine a number of questions associated with the DHP budget, its costs, and possible alternatives available for providing health care in the civilian market.

CNA will answer the four questions shown in the slide. The answer to the first question was required as part of the submission for POM 2000 that was due in the late fall of 1998. This annotated briefing presents the findings of our analysis. We examined the effects of reductions in the DHP budget associated with efficiencies arising from practicing utilization management (UM) at military medical treatment facilities (MTFs) and clinics. Since we first presented our findings to the Under Secretary, the combination of additional money for the DHP and cost-saving efficiencies have eased the immediate concerns for the next few years. Nonetheless, growing health care costs and budgetary issues will continue to confront the DHP. We are scheduled to report our findings for the last three questions by the end of calendar year 1999.

Approach

- **Compare DHP with civilian health care**
  - **UM measures**
  - **Cost per user**
- **Examine effects of cuts in DHP budget on**
  - **Access to care**
  - **Health care quality**
  - **Discretionary spending**
- **Develop model of UM**
  - **Examine feasibility of cuts**

This slide lists the three main elements in our approach to answering whether the direct care system could achieve the UM savings. First, we compared key measures of efficiency and cost between the DHP and the civilian health care market. Specifically, we examined several commonly used measures of UM as well as the cost per user in the two systems. UM and the cost of health care are linked, as we'll explore later in our briefing.

Second, we wanted to determine how the system would respond to cuts in the budget due to UM efficiencies. The cuts associated with UM may lead to efficiencies and lower costs. Alternatively, the cuts may lead to reductions in access to care by DOD beneficiaries, in the quality of the care they receive, or in certain discretionary accounts in the DHP budget. None of these outcomes is the intended consequence of the UM budget cuts. Before we could reasonably say the cuts were achieving their intended purpose, we needed to ensure that these three areas were not bearing the brunt of the cuts in spending.

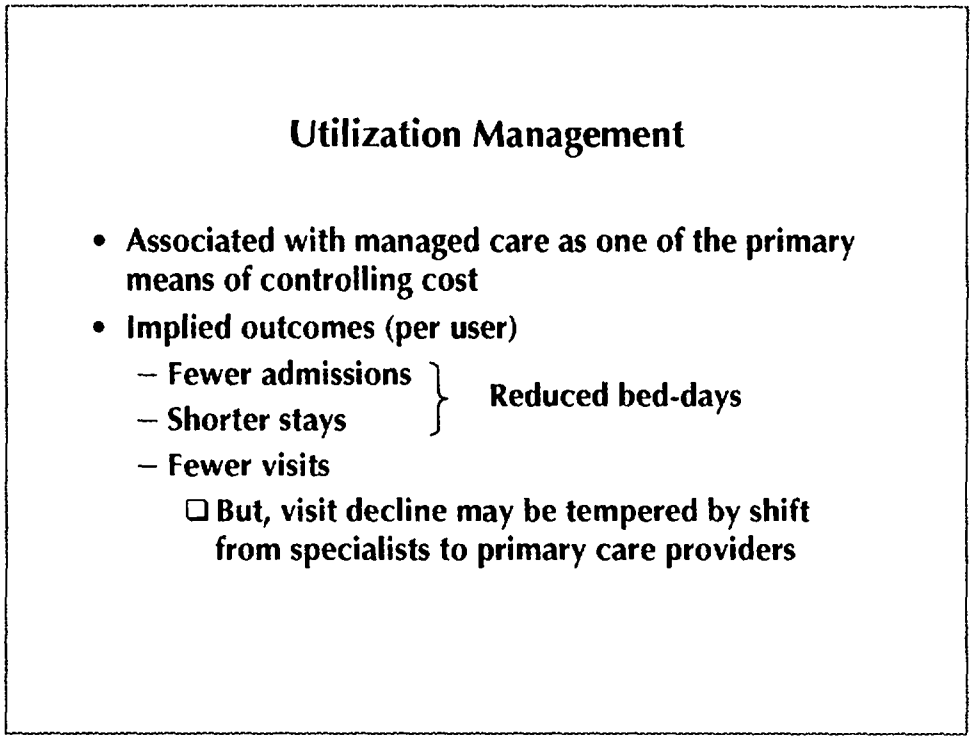
The third and final focus of our approach was to develop a simple mathematical model that captured the way that money could be saved by practicing UM within the DHP. If efficiencies could be found within the system, we could then conclude that the UM savings were feasible without producing adverse effects on the three services' provision of health care to their beneficiaries.

Summary of Findings

- **Mandated UM savings are achievable**
  - **Direct care system has already improved (i.e., moved closer to HMO norms)**
    - ❑ **Room for additional improvement**
- **Larger problems**
  - **UM wedge represents relatively small reductions**
  - **Even if DOD meets UM efficiencies, cost pressures will continue in the out-years**
  - **UM efficiencies harder to make in austere climate**

This slide summarizes what we found. We believe that the mandated UM savings are achievable. The direct care system has already made a number of improvements throughout the system's MTFs. We measure improvement in the DOD system by comparing certain UM measures to those achieved by health maintenance organizations (HMOs) that we believe provide efficient, yet high-quality, health care. Despite the improvement observed in the DHP, the UM measures indicate that the direct care system is not as efficient as the HMOs we emulate as standards. There is some room for improvement. As we'll show shortly, the improvement allows the MTFs to recapture workload from the civilian managed care contractors that will help pay for budgetary reductions associated with UM at these facilities.

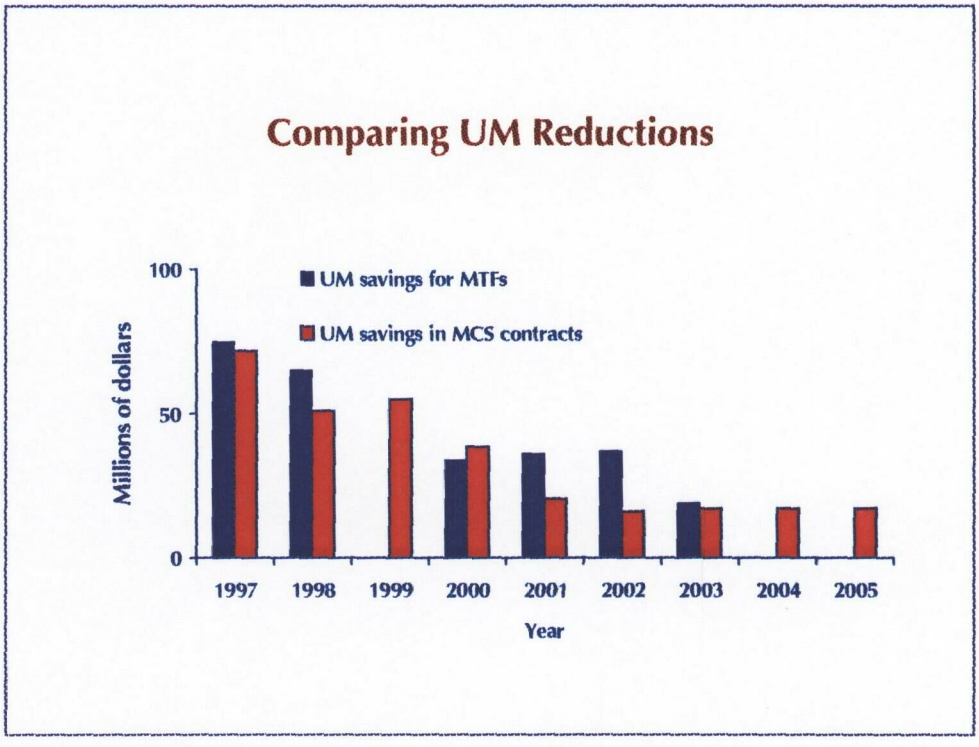
Does that mean the savings will be easy to achieve? The answer is no: the DHP faces several potentially difficult problems that will make it hard to achieve the intended savings. The cuts in the budget associated with UM (or what is often referred to as the UM "wedge") are relatively small; even with these cuts and new monies for 2000 and 2001, the DHP faces cost pressures that will continue into the future. Practicing utilization management is not costless; it requires investment by the system and learning by health care providers and managers. This investment may not be available in an austere budgetary climate.



Without providing a formal, clinical definition of UM, we do want to describe what is meant by UM and discuss how we measure it for purposes of our study. UM is associated with managed care as a primary way of controlling cost, but without reducing the quality of the health care provided to the patient. The idea is to provide only what's required for treatment—no more. Unnecessary procedures or stays in hospital are costly without providing added benefit to the patient.

Two implied outcomes from practicing UM are fewer admissions (and equivalently fewer discharges) and shorter stays. The combination of fewer admissions and shorter stays means a reduction in the number of bed-days per beneficiary within the system.

One might also presume that there would be fewer outpatient visits to the system by each user, but that is much less clear. Reducing the inpatient stays and length of time in hospital may require more outpatient visits to the clinicians. Another outcome of UM might be fewer visits to specialists, but more visits to the patient's primary care provider, particularly for preventive care.



Now we turn to two slides that show the size of the UM cuts over time. In this slide, we compare the past and proposed cuts at MTFs with the projected UM savings in the managed care support (MCS) contracts. For 1997, 1998, and 1999, the savings represent the actual cuts taken out of the direct care budget at MTFs—about $75 million, $65 million, and $0, respectively. For 2000 through 2005, the blue bar represents what had been proposed as part of POM '00, or roughly $35 million per year through 2002, about $19 million in 2003, and $0 for 2004 and 2005. When the UM savings are compared to total spending for CONUS beneficiaries' care—which is made up of category 3[1] operations and maintenance (O&M), base operations, and military personnel (MILPERS)—the percentage varies from about .25 percent to just under 1 percent in any given year.

The MCS contract savings, shown by the red bars, represent the expected savings over all contracts over all regions for that year, as compiled by Kennell and Associates, which, as a contractor to Health Affairs, provides technical support and has access to costs and so-called trend factors in the contracts. From the information Kennell provided to us, we then derived the value of annual savings for 1997 through 2003 (which is the last year of any current contract) and extrapolated to determine savings through 2005. When compared to the total value of the MCS contracts, the projected UM savings vary between about 1 and 4 percent of total patient care costs.

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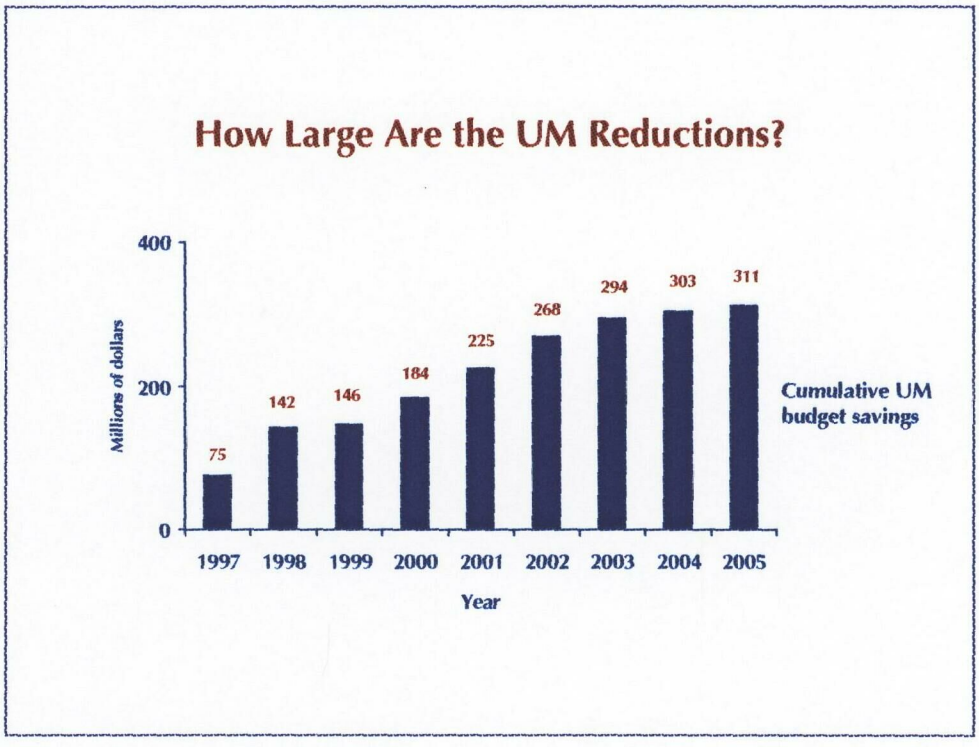
1. Category 3 represents care provided at CONUS MTFs, at related nondefense facilities (i.e., USTFs), and at civilian facilities, but paid by CHAMPUS.



In this slide, we present the accumulated value of the UM savings in each year. The UM numbers grow over time because a cut in one year reduces the budget base in the next year from which the next cut will be taken. Thus, the initial UM cut in 1997 was $75 million. For 1998, multiply this $75 million by the projected DHP medical inflation rate of about 2.8 percent and add it to the 1998 cut of about $65 million to derive a total value of $142 million. Proceeding in this way, the value of the cuts taken out of the budget would accumulate to about $311 million by 2005.

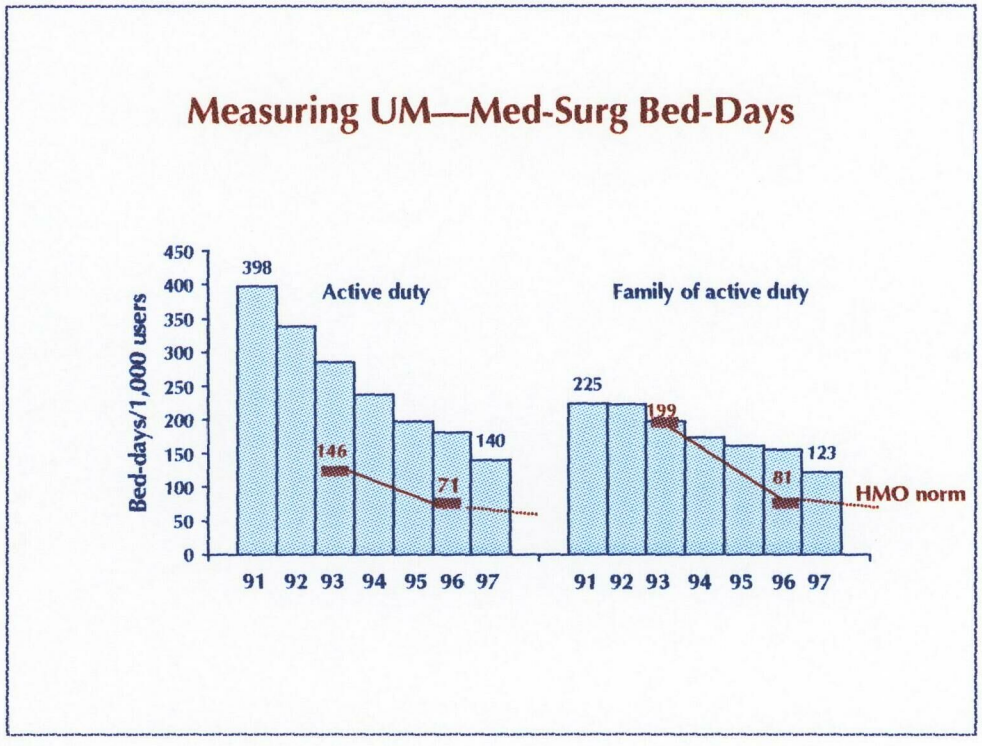
There are other ways of placing these values in context. Over the POM, these savings (or cuts from the budget) would reduce per capita health care spending by about $34 in 2000 to $58 in 2005. The accumulated value of all savings for the six years totals more than $1.5 billion, a not inconsequential amount of money. But, the total value of health care spending on patient care during that time will be more than $74 billion. The cuts, therefore, represent only about 2 percent of this total spending.

Comparing DHP to Civilian Norms

- **Examine UM measures over time**
  - **Bed-days, visits, and discharges**
    - ❑ **Focus on active duty and their family members**
  - **Compare values at MTFs with values computed for Kaiser-Permanente (K-P)**
- **Examine differences in cost per user**
  - **Efficiencies should be easier to make when DHP is more costly than civilian plans**

In this and the next few slides, we will make several comparisons of both UM measures and cost between the DHP and civilian health care organizations. We examine how UM measures have changed over time in the direct care system for two groups of beneficiaries—those on active duty (AD) and their family members (ADFM). The AD population relies almost exclusively on the direct care system for its care, and ADFMs rely on it for most of their care. Although the numbers for ADFMs do include some stays or visits associated with CHAMPUS, they represent only a small portion of the total. Therefore, the numbers represent what's been happening at MTFs.

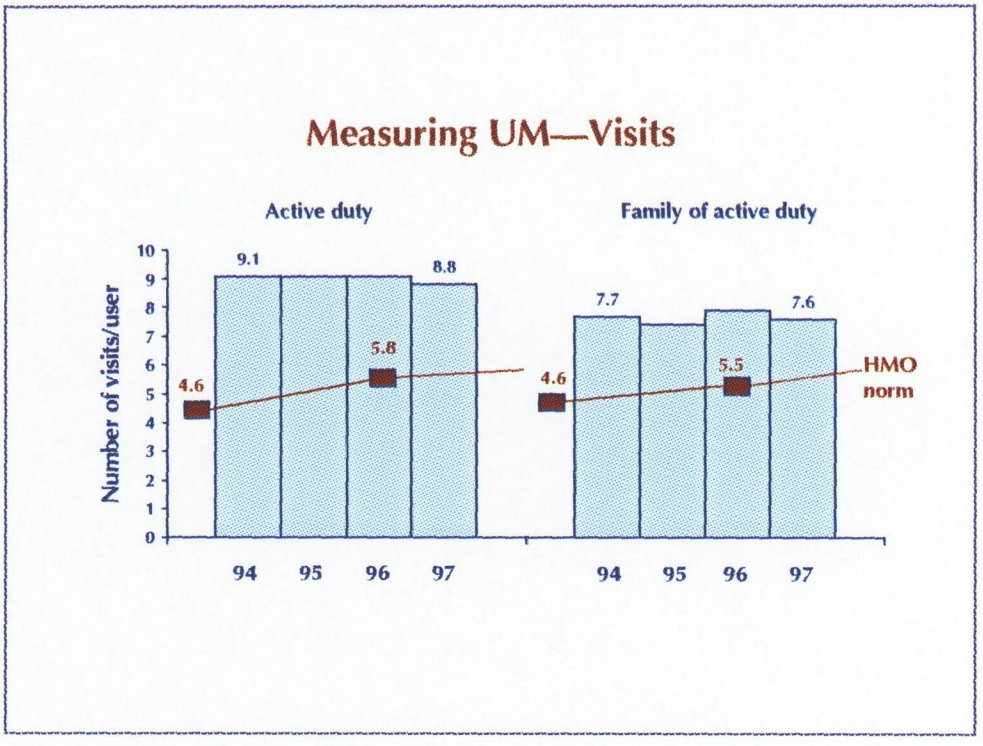
We represent the HMO norm for various UM measures, such as bed-days, discharges, and visits, with data from the Kaiser Foundation Health Plan. Kaiser-Permanente (K-P) is one of the largest HMOs in the country. It is what's known as a group-model HMO, which is analogous to the DOD system in that its clinicians generally work only for Kaiser. K-P itself consists of a number of regional plans, such as in Northern and Southern California and the Mid-Atlantic region. We had the best information from the Mid-Atlantic region, including values on bed-days and visits for 1993 and 1996. We could also draw on aggregate measures during 1997 for the entire K-P system. All such measures came from HEDIS reports (version 3.0 for 1996 and 1997) that have been developed under the auspices of the National Committee for Quality Assurance (NCQA).



We begin by examining the number of medical-surgical bed-days per 1,000 users for 1991 through 1997 (the last year available). Bed-days have declined steeply for both those on active duty and their family members, particularly for the AD population. Their average number of bed-days fell from almost 400 in 1991 to about 140 by 1997, which was only slightly above the corresponding number for the ADFM population.

We also present numbers representing the HMO norm for 1993 and 1996 for both beneficiary groups (the numbers differ across the two groups because we adjusted the raw numbers within Kaiser to match the demographics, at least age and sex, of the AD and ADFM populations). By 1996, the number of bed-days also dropped to roughly half of their earlier levels because of a concerted effort by K-P Mid-Atlantic to reduce the amount of unnecessary care. As we'll see later in the briefing, much of this drop was the result of a decrease in the discharge rate (as opposed to the length of stay). We were told that K-P Mid-Atlantic would like to decrease bed-days a bit further in the near future, again by lowering discharge rates by a few more percent.

The numbers shown in the slide are slightly below the K-P system in total in 1997. The K-P national values for bed-days were about 81 for the AD population and about 87 for ADFMs. As we'll see, when we focus on discharge rates, the difference is caused mainly by higher lengths of stay at other regional Kaiser plans.



In a similar manner, we compare the number of visits in the direct care system for active duty and their family members with the HMO norm drawn from Kaiser. We had numbers for only four years, from 1994 through 1997. Again, the numbers for the active duty population are higher than those for family members, but neither group has changed very much during the period.

Interestingly, the HMO norm number, representing K-P Mid-Atlantic, has risen slightly from 1993 to between 5.5 and 5.8 visits per year per member by 1996 (which is slightly above the average of just under 5.0 for the U.S. population over all plans).[1] This is well above the system-wide average K-P number for all plans in 1997, which was about 4.0 for the population similar to AD and 4.1 for the population similar to ADFMs.

Although there are good reasons why the DOD population may have a higher visit rate than those enrolled with an HMO—sick call for the active duty population, lack of copays for both groups—the differences between the direct care and HMO numbers are relatively large.

1. We calculated the average for 1995, which was the last year for which data were available from the U.S. National Center for Health Statistics, *Vital and Health Statistics*, Series 10, No. 193.

Effects on Cost

- **UM measures suggest DHP less "efficient" than civilian HMO**
  - **But are DHP costs much higher?**
- **Should be easier to implement more UM if DHP costs are higher**
- **Need to compute cost per user in DHP and compare with HMO alternatives**
  - **Some differences due to differences in benefits and cost accounting**

The UM measures we've just examined show that the DHP has not yet achieved the levels observed for the HMO norms. But, how do the DHP and civilian plan costs compare? If DHP costs were much higher than comparable civilian HMO plans, it might suggest that the reason, at least in part, is the additional bed-days and higher visit rate. It should be somewhat easier to make additional UM cuts and gain savings than if they were already close in cost.

We recognize that the different plans offer slightly different sets of benefits, and costs can never be precisely calculated across plans without more information than is generally available. Nonetheless, even if the constructed costs are approximations, we believe it's important to understand whether the DHP's cost of providing care to its CONUS beneficiaries is close to that of civilian HMOs. We can also make a limited comparison with an HMO plan under the Federal Employee Health Benefits Program (FEHBP).[1] Therefore, we have carefully constructed a DHP cost per user that we can compare to civilian health care costs. We show the comparisons of cost next.

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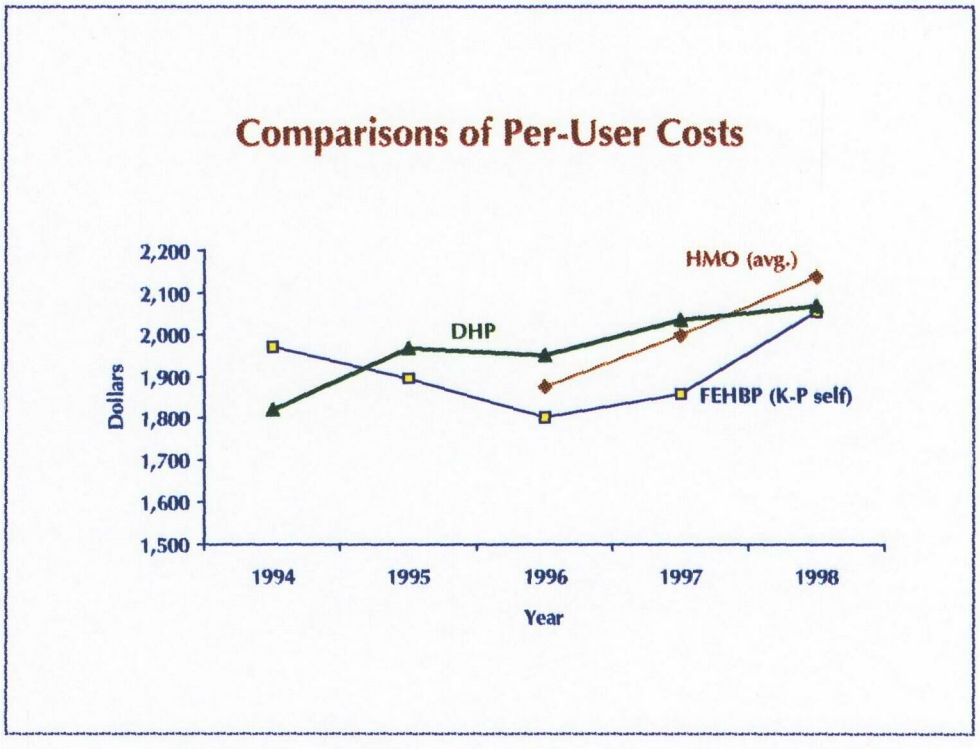
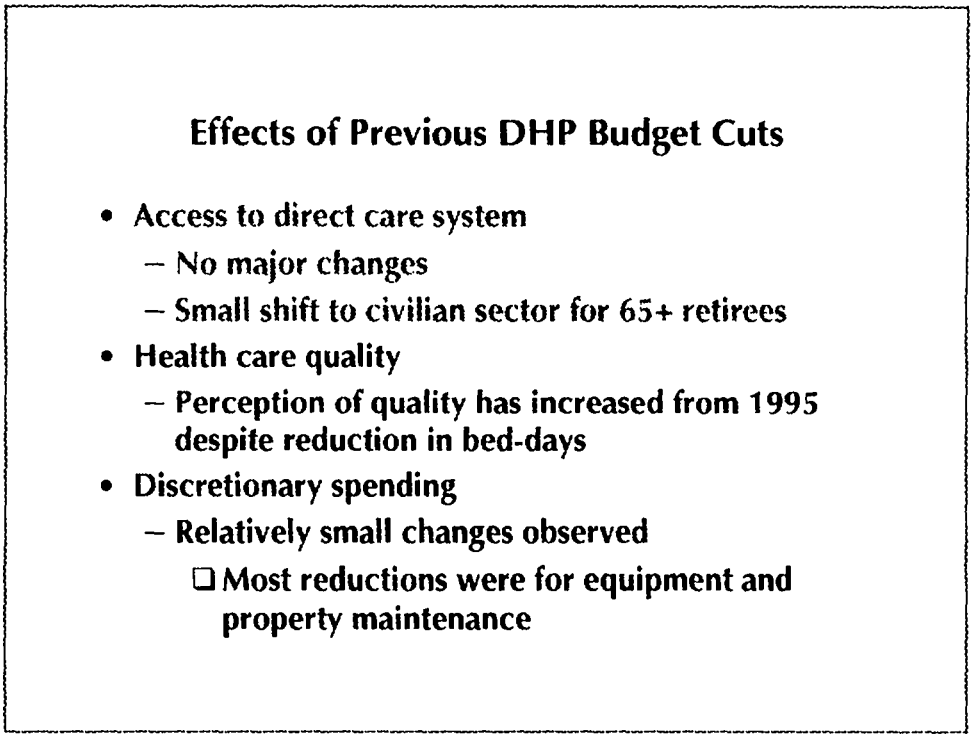
1. We could not calculate an overall average cost for the specific HMO plan within FEHBP because we didn't have the enrollment numbers for all beneficiaries who participate as part of a family. Therefore, we'll show the premium costs for the self-only plans.



We derived a value for the DHP based on category 3 costs for O&M, base operations, and MILPERS. For 1994-97, we received this information in a format similar to the capitation model runs used for projecting costs for the POM years. For 1998, we relied on the Health Affairs allocation model run (which is used to allocate funds across the three services for the current year). We added other overhead costs, such as for the TMA management activity and central computing. Finally, we divided the total cost by the CONUS user population.

We compared these numbers over time with (1) an average drawn from all individuals with HMO coverage, and (2) the premium cost of the K-P Mid-Atlantic self-only plan for those who participate in FEHBP. The HMO (average) is based on the 1987 National Medical Expenditure Survey (NMES) and new projections from 1996 through 2005 that have been benchmarked to the 1996 National Health Accounts (from HCFA) and CBO projections beyond 1996. These numbers include our estimates of the administrative cost and the beneficiaries' out-of-pocket (OOP) costs. The K-P premium includes administrative costs but excludes OOP costs (which should be small). As a means of comparison across K-P plans, the annual premium in 1998 for the Mid-Atlantic region was $2,055 versus the K-P Northern California premium of $1,862 and $2,122 in Southern California.

The main point is that all three values are close. The overall average for K-P would be lower if family plans were included. Family plans cost more but often cover children. Nonetheless, despite the higher values for UM measures within the DHP, cost per user is close to that of civilian HMOs.



Earlier, we stated that, in addition to efficiencies that might result from UM cuts, there might be other adjustments in the system. We wanted to see what might have changed in the system in response to lower budgets. We relied on the annual survey of DOD beneficiaries to determine whether access to care or the quality of care had declined, at least for the period covered by the survey. We've seen that bed-days had been declining since 1991 and that the budget was cut by about $75 million in 1997. Therefore, the 1995 through 1997 surveys should show any concerns with the system expressed by beneficiaries over that time period.

We found few significant changes with regard to access to the direct care system. There was a small shift to the use of civilian providers and/or facilities for the 65+ retirees. By 1997, fewer of them were relying on MTFs exclusively for their care, although more were relying on it for at least part of their care.

The perception of the quality of care increased from 1995 to 1997. Bed-days had gone down, but this didn't undermine the perceived quality of care to DOD beneficiaries.

Finally, there are several discretionary spending accounts that can respond to cuts (for UM or anything else), at least in the short run. For example, travel, property maintenance, and equipment purchases did fall to some extent, although it seems unlikely that any reductions could continue into the future without major consequences on the direct care system.

How Can UM Wedge Be Achieved?

- **Cut staff and infrastructure**
  - **But, DOD faces readiness mission and BRAC**
- **Maintain current staff and infrastructure, but cut costs**
  - **Reduce bed-days and/or visits**
    - ❑ **Can save on consumables—but, likely small $**
    - ❑ **Best bet—recapture CHAMPUS workload and earn the *full* cost of care—*much more lucrative***

If access, quality, and other spending don't fall sufficiently to account for any UM cuts, how can the UM wedge be achieved? If the services' medical departments faced no readiness requirements or restrictions on cutting personnel and facilities, facilities could be closed and the number of staff reduced. As bed-days fall, wings of hospitals could be shuttered and physicians and nurses cut from the staff. But, although some cuts have been made, readiness constraints may preclude further reductions.

The DHP could maintain all current staff and infrastructure, but implement UM, reduce bed-days and possibly visits, and save some money. But, these marginal savings from implementing UM would likely be small. Fewer bed-days mean fewer beds to be made or meals to be served, but there would have to be a huge reduction in bed-days and visits to achieve anything close to the cuts being made.

There is, however, a way for the direct system to save enough from implementing UM, and this method stems from the unique combination of the direct care system and CHAMPUS being available to most DOD beneficiaries. The MCS contractors can gain if they direct patients to the MTFs. The MTFs would earn the full cost of care, not just the marginal cost. This would be a much more lucrative alternative than simply having fewer beds filled. But, space must be made available for additional patients. The question remains: how feasible would it be to reduce bed-days and/or visits by enough to make up any UM cuts? We turn to that next.

The CNA UM Model

- **Calculates what discharges and visits would have to be in the future to pay for budget cuts taken**
- **Assumes CHAMPUS recapture**
- **Two types of costs associated with UM**
  - **Fixed costs associated with implementing UM at MTFs**
  - **UM budget cuts that vary by year**
- **Accounts for "volume tradeoff factor" and gain-sharing arrangements between MTFs and MCS contractor**

We developed a simple model that would predict what the discharge and visit rates would have to be to recapture CHAMPUS workload and pay for UM cuts. We use the average cost associated with CHAMPUS discharges in a given year, a value slightly higher than $5,000 in 1997. Similarly, we used the average cost of a CHAMPUS outpatient visit, about $79 in 1997.

Because it costs money to implement UM, we used the Joint Audit Report, *Military Health System Utilization Management Program at Medical Centers*, May 1998, to derive the required investment. The report discussed the additional personnel required at NMC Portsmouth for UM review; we then applied a similar percentage increase in O&M costs across the system. For example, in 1997, we added the required $15 million investment that we derived to the $75 million UM cut taken in that year.

Our model also takes account of the volume tradeoff factor (VTF, or v) and gain-sharing arrangement with MCS contractors. The VTF accounts for differences in utilization between MTFs and the civilian sector. It's usually assumed that the VTF is greater than 1, implying that 1+ visits will result at an MTF for every 1 visit shifted from the civilian sector.[1] The gain-sharing percentage (denoted by r in the next slide) reflects the fact that 80 percent of the lower costs (through reduced workload) and resulting higher profit experienced by the MCS contractor is paid back to the direct care system.

1. For both discharges and visits, we set $v = 1.5$. When the VTF is greater than 1, it becomes necessary to incorporate a marginal cost at the MTF in the model.

Model Specification

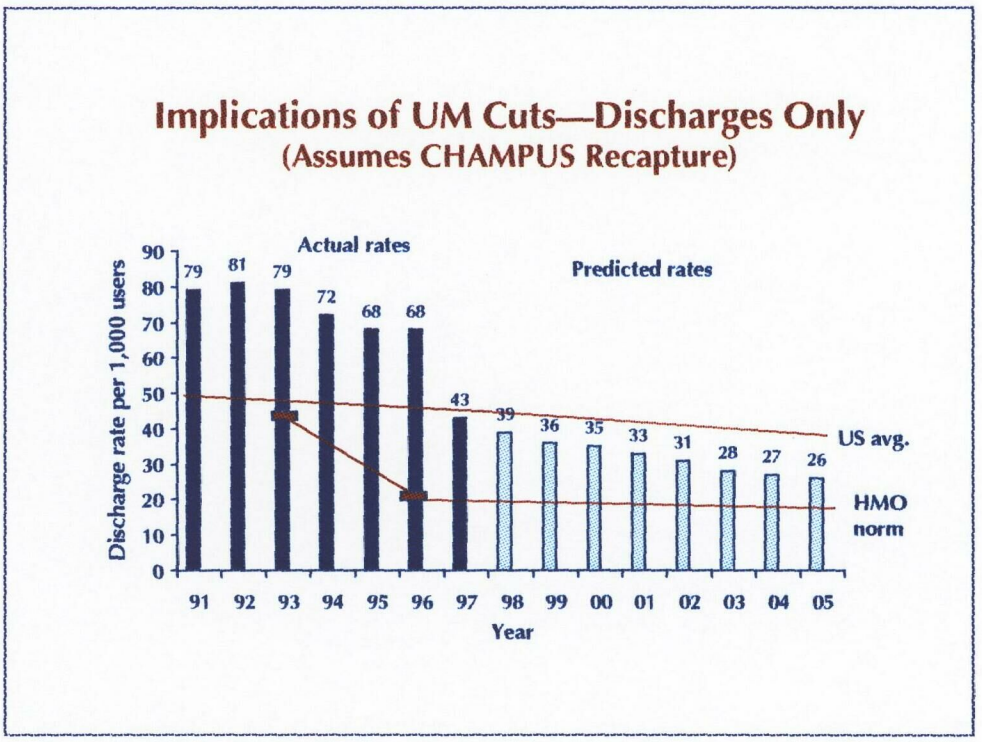
- **Two-step process in reaping UM benefits**
  - **Reducing utilization at MTFs saves marginal cost of care: $N \times C^{mtf}$**
  - **Bringing in CHAMPUS workload increases revenue: $N \times C^{ch}$**
    - **But, some new costs due to recaptured workload and VTF: $v \times N \times C^{mtf}$**
- **Must offset UM cuts *(S)* and implementation costs *(A)***
  - **Solve for workload *(N)* to determine required decline in discharge or visit rates**

This slide provides some of the mathematical details of our model. There are two parts to the process of reaping benefits from implementing UM. First, reducing utilization at the MTFs by, say, N units (either in terms of discharges or visits) saves C^{mtf}, representing the marginal costs of care at MTFs given fixed labor and facilities. This is a small number, and workload would have to fall by a lot to outweigh the UM costs. The reduced workload should free up space in the MTFs for the CHAMPUS workload to be recaptured. Revenue goes up by the additional workload N multiplied by C^{ch}, the full cost of CHAMPUS care. However, MTF costs will now increase as well. We must include the higher utilization of health care at MTFs, which is captured by the VTF, denoted by v in the slide.

As we said earlier, we had values for the CHAMPUS costs for a stay in hospital or a visit, but not for the marginal cost of care at MTFs. Therefore, we assumed there was a simple proportional relationship between C^{mtf} and C^{ch}, where the proportionality factor is given by f. We had no direct measure of consumable costs, but ultimately ended up assuming that f was equal to 0.1.

Our model solves for the minimum value of N that would need to be achieved to free up the necessary space for the recaptured CHAMPUS workload. Solving for N, we obtain the following mathematical expression that we used to determine the feasibility of UM:

$$\frac{S+A}{r \times C^{ch} \times (1+f(1-v))} \leq N$$

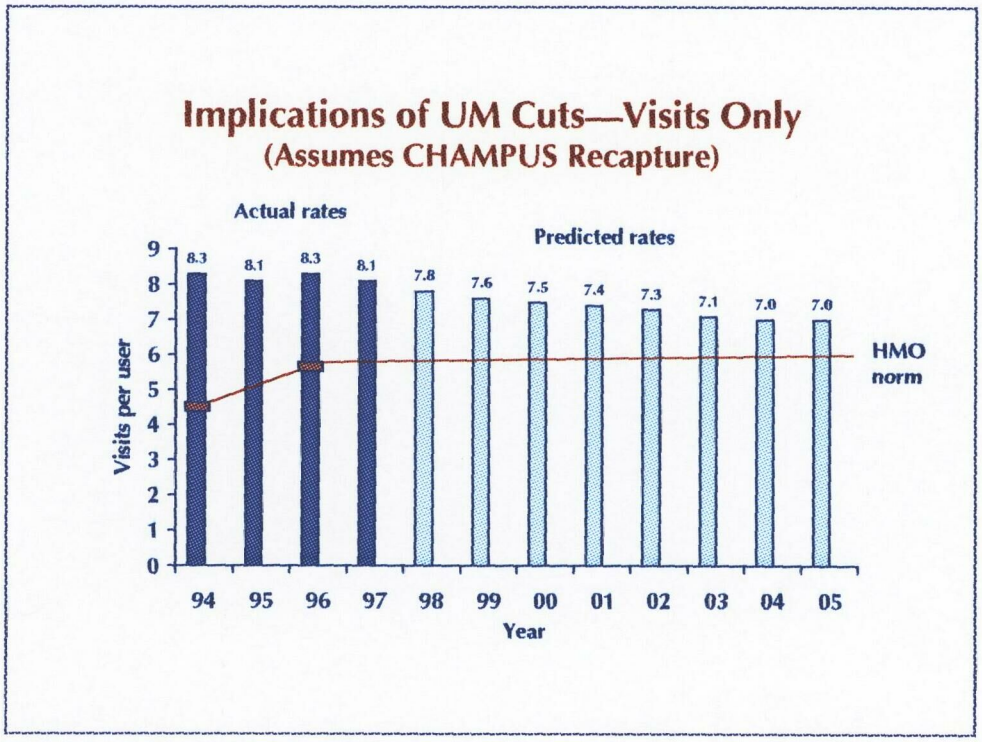


We begin with the results when only the discharge rate is used to make up for any UM costs. The slide above shows several different variables. First, we present the actual DOD discharge rate for the combination of the AD and ADFM populations from 1991 through 1997 (the dark blue bars). The rate had been falling, with the sudden drop in 1997. Much of the latter resulted from a redefinition of same-day surgery, from an inpatient stay to an outpatient visit.

We also show the U.S. average discharge rate, which has been slowly declining over time. By 1997, the DHP and the U.S. average rates were quite close, about 45 discharges per 1,000 users. But, the HMO norm was much lower than both by 1996, about 22 per 1,000 users. As before, we rely on the K-P Mid-Atlantic values, but they are very close to (actually slightly above) the national K-P values.

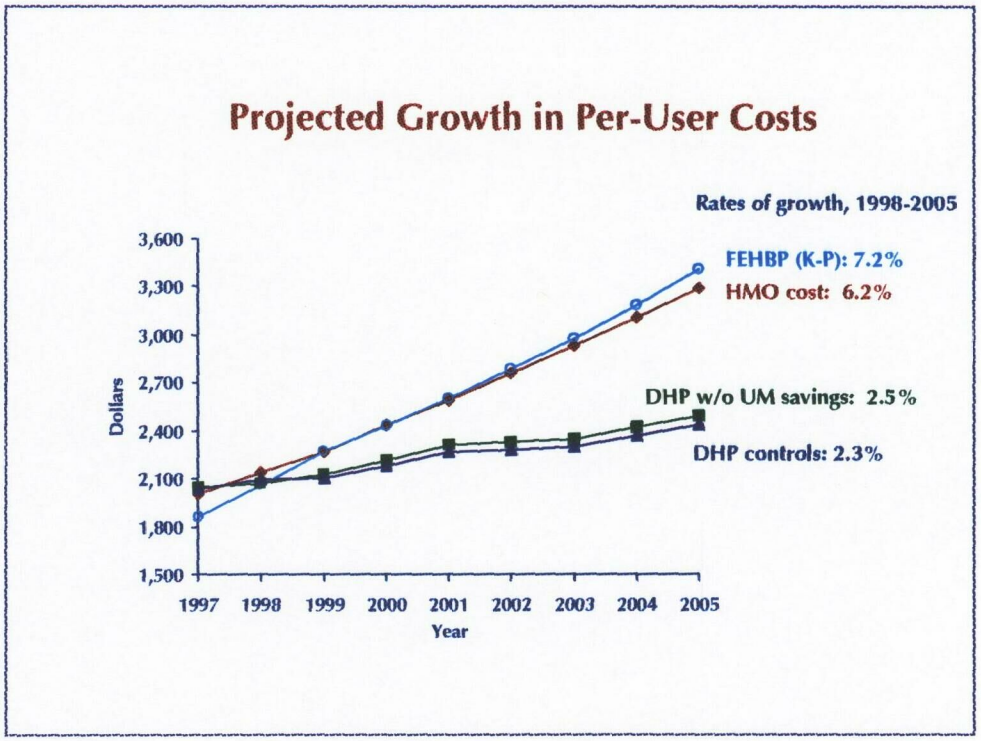
The light blue bars represent what the discharge rate for all DOD users would have to be to make up the UM costs of implementation and budget cuts. Thus, in 1998, the rate would have to fall to 39 per 1,000 users to make up the $90 million in costs imposed on the direct care system. Again, the overall workload would probably increase slightly at the MTFs because recapture means shifting care from the MCS contractor to the MTFs.

To make up all of the cuts, the discharge rate would have to fall to 26 per 1,000 users. This is, indeed, a large drop from the 1997 value, but it is still above the HMO norm.



We performed the same kind of analysis for visits. Even with the increase in the visit rate observed for K-P Mid-Atlantic, the DHP rate would have to fall to 7.0 per user, a value higher than the HMO norm of under 6.0.

These two figures show what would be needed if only the discharge rate or the visit rate were reduced in isolation. Although the DHP rate for each would remain above each respective norm, each would have to fall fairly significantly. However, if both rates could be reduced through implementing UM procedures, the rates of both would still need to fall, but not by as much.



Our model shows that, in isolation, it would be possible to implement UM and find the needed savings, but questions remain as to whether other factors might complicate such efforts. For example, the DHP faces many of the same cost pressures that civilian health care organizations face.

Clearly, no one knows what the future holds. In the slide, we compare the projected growth in per-user costs for the DHP and projections of HMO costs based on the NMES and K-P premium costs (from OPM). As we showed earlier, all three values of per-user costs were similar in 1998.

We present two projections for the DHP. The lower line shows what would happen assuming budgets are constrained by fiscal guidance. Through 2001, the numbers reflect the new values for the DHP budget resulting from the recent Program Budget Decision (PBD) 041C. It shows a rate of growth from 1998 to 2005 of about 2.3 percent per year. The next set of values for the DHP adds back the accumulated budget savings resulting from implementing UM. It adds as much as about $58 per person by 2005, but really adds little to the overall growth rate for the period, increasing it by about 0.2 percent per year for 1998 through 2005.

In contrast to these values are the projections for HMO annual cost growth based on NMES of more than 6 percent, or the expected annual premium growth for K-P, which OPM projects will be more than 7 percent. If these hold, the difference by 2005 between the K-P per-user cost and the DHP under fiscal guidance will be almost $1,000 per user.

Conclusions

- **UM cuts are modest, compared to direct patient care spending at DOD MTFs**
  - **About 1% in any given year**
  - **But, cumulative nature of UM savings requires major efficiencies**
    - **Will still be above managed care norms**
    - **Harder to meet for discharges than visits**
- **Savings must be found from CHAMPUS recapture**
  - **Depends crucially on MCS contracts**
  - **MTFs must have the appropriate specialty mix**

Compared to the differences in cost per user if medical inflation rises faster than DOD health care budgets allow, the cuts are relatively modest. Over the POM (i.e., years 2000 through 2005), the projected UM cuts as a percentage of any year's direct patient care budget are never greater than 1 percent. Yet, because the cuts are cumulative, UM would require major efficiencies, particularly for the discharge rate, to approach managed care norms.

One of the most important points is that savings from implementing UM can be significant only by recapturing the workload from CHAMPUS. If UM is implemented and the workload goes down through a reduction in bed-days or visits, savings will be minimal without CHAMPUS recapture or facility and personnel reductions. But, for CHAMPUS workload to be brought into the MTFs, the MCS contracts have to ensure that it will happen without major impediments. Furthermore, the MTFs must have the appropriate specialties to treat the new patients. If the contracts hinder bringing the additional workload into the MTFs, or the MTFs themselves see little benefit in doing so, all that UM will do is increase capacity with little effect on DHP cost.

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