

Defense Health Program - A Revolving Fund Candidate?

A Case Study

Maj Todd L. Osgood, CAAMA

Chief, Headquarters Finance Operations
Office of the Surgeon General
Falls Church, VA

The Defense Health Program appropriation funding provides for worldwide medical and dental services to active duty forces and other eligible beneficiaries, veterinary services, medical command headquarters, specialized services for the training of medical personnel, and occupational and industrial healthcare. Over the past decade, the Defense Health Program has had difficulty having sufficient funding to cover all requirements; in part, inadequate funding is due to the restrictive appropriation boundaries of the Defense Health Program. Would converting the Defense Health Program into a working capital fund provide efficiencies to allow for adequate funding?

A working capital fund, a type of revolving fund, is used to fund goods and services for various government agencies. Business areas within the government use their sales to fund future inventory for future sales without fiscal year limitations. Unlike private-sector industry, business areas within the working capital fund do not attempt to make profits. Rather, they attempt to cover their costs and break even each year, and they price their goods and services accordingly (OSD Comptroller).

In order to have a working capital fund, there must be a customer-provider relationship between support organizations and operational units. Customers are governmental agencies and DoD-authorized commercial enterprises needing goods or services. Providers are the business areas funded through the working capital fund supplying the goods and services to customers.

Before working capital fund operations can begin, both the business area and the customers need fiscal resources. In order for a working capital fund to be established, congressional legislation must first establish the fund. In addition, an initial cash corpus must be established to fund business areas prior to

any customer orders being placed. Before customers can place orders, they must first establish a budget, which is then approved and appropriated funds are received. Customers can then send orders to business areas, which in turn bill the customer at a pre-established rate to ensure all costs for producing the goods or services are met (Defense Working).

The intent of working capital funds is not to save money but rather to allow for total-cost visibility. By making all costs visible, managers have the opportunity to better control costs and find efficiencies, which ultimately allows them to make informed budgetary decisions.

It is crucial for working capital funds to accurately determine the costs of producing goods and services. In order to do this, all the costs of business areas, including support costs, must be considered. To set unit prices for goods and services, activity-based costing, which is also known as cost-per-output, must be calculated. Simply put, this accounting method divides total cost of production by the total number of units produced.

Unlike private industry, working capital funds are fundamentally different in several ways, especially concerning incentives. For instance, profit is an incentive in private industry, while the working capital fund strives to neither lose money nor make a profit. Each working capital fund business area has the primary goal of achieving an accumulated operating result of zero each fiscal year. If a profit were achieved, the business area would likely lower its cost per unit. On the other hand, if a loss were achieved, the cost per unit would be increased in order to break even. So, while the working capital fund doesn't save money, it seeks to find efficiencies by conserving and extending resources, and consolidating logistics and support functions (OSD Comptroller).

Within private industry, a free-market approach is used to create an economic market regulated by supply and demand. For the most part, private industry is not restrained by government interference and regulation. The goal of a working capital fund is to adopt similar business rules to allow for peak efficiency. One of the business rules for the working capital fund is activity-based cost data. Activity-based cost data

is an accounting methodology that can be used to define processes, calculate unit costs, and allow the establishment of performance-based budgets. What's more, this methodology virtually eliminates product-costing distortions that result from capricious allocations of indirect costs. For instance, traditional line item budgets fail to link costs directly to product outputs, while activity-based costing directly links costs to outputs.

There are four steps to creating and implementing activity-based costing. First, one must identify activities through performing an analysis of the operating processes for each responsibility segment; each process may include more than one activity required by outputs. Second, one must assign resource costs to activities; this process is occasionally referred to as tracing. Tracing is simply identifying costs to cost objects to understand why costs were expended. Tracing involves identifying three kinds of costs, including direct, indirect, and general and administration. Direct costs are costs that can be directly traced to one output. An example of direct costs would be the supplies required to see a patient, such as rubber gloves, tongue depressors, throat swabs, etc. Unlike direct costs, indirect costs cannot be allocated to an individual output. For example, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inspections costs cannot be tied directly to the costs of one patient visit. Finally, general and administrative costs, also known as overhead, are costs that cannot be reasonably allocated to a specific product or service output. Such costs include personnel salaries not associated with direct patient care and hospital facility expenses. Third, each output must be identified for an activity segment. Once again, outputs include products or services for which the government agency is required to support. The fourth and final step in creating and implement activity based costing is to assign activity costs to outputs using activity drivers. Activity drivers allocate costs to outputs based upon consumption demands. An activity driver may be the length of time (duration driver), such as a patient visit or might include the number of times an activity is performed (Transaction Driver).

Annually, working capital funds receive their operating budget, which contains unit cost goals. In return, they earn their cost authority when customers place their orders for supplies or services. Operators are allowed to make decisions regarding the desired level of service based upon available resources and

necessary requirements. Thus, a clear incentive exists within a working capital fund for support functions to contain costs and focus on meeting customer needs. Additionally, there is a greater incentive to alleviate the use of costly resources. Ultimately, the free market approach provides a healthy tension between suppliers and customers. The customer desires to receive the best possible product or service at the best possible price, and the provider desires to meet the customer's needs to prevent them from acquiring goods or services from other sources (Rand Corporation). The remainder of this case study analyzes the impact of including the Defense Health Program into the Working Capital Fund.

The Defense Health Program fails to meet the requirements for becoming a working capital fund and should consider other methodologies for preventing budget shortfalls. The four basic requirements that an entity must meet include the following: outputs, cost accounting systems-cost of producing outputs, customers, and most importantly, the buyer/seller relationship.

The Defense Health Program meets the requirement for outputs; however, due to the nature of military medicine, outputs are generally more expensive than non-DoD medical outputs. The Military Health Service peacetime output includes patient encounters, which are measured through medical coding and billing. However, trying to separate the readiness mission from the peacetime mission is challenging. Part of the Defense Health Program's mission is to provide medics prepared to respond to wartime requirements, natural disasters, and other missions as directed by leadership. The ebb and flow nature of military medicine makes it difficult to calculate output costs, and when calculated, it is unlikely that output costs will be competitive with non-DoD healthcare entities.

For the most part, the Defense Health Program also meets the requirements for cost accounting systems and can measure the costs of outputs through use of the Medical Expense and Performance Reporting System. While data quality with the Medical Expense and Performance Reporting System continues to be a major concern, ultimately, output costs are measurable. Ideally, the activity based costing methodology would be used to meet this requirement, but requiring a new methodology would come at the price of a new accounting system.

The Defense Health Program also meets the requirements for having customers. The Defense Health Program's output is patient care, and the Defense Health Program's customers in peacetime are patients. Under the construct of the working capital fund, the TRICARE Management Activity, Office of the Secretary of Defense, and other agencies are not Defense Health Program customers. They, as entities, do not experience patient encounters or in any way influence a patient's decision to seek medical services or goods. It is crucial that leadership realizes and accepts that patients are the customers in the buyer/seller relationship if the working capital fund concept is going to be applied to the Defense Health Program. Creating a working capital fund under the guise of the TRICARE Management Activity as the customer for the sake of eliminating appropriation boundaries is a mistake, and will not lead to more efficient operations.

Finally, the Defense Health Program fails to meet the fourth requirement of having a buyer/seller relationship. To meet this requirement, there must be a "healthy tension" between the buyer and seller. In other words, the customer must have a vested interest in output costs. To the contrary, TRICARE Prime patients have little, if any incentive to contain costs since nearly all services are provided without any direct cost to the patient.

Critical to the success of any entity as a working capital fund is the proper alignment of the buyer/seller relationship. In theory, the patient would be provided the funding at the beginning of each fiscal year, and the Defense Health Program would earn back funding. Also, patients would have the option to use their funding to purchase healthcare at a more affordable rate outside of the military health system.

One of the reasons the Defense Health Program may use to justify moving into a working capital fund is that it would provide flexibility when requirements exceed funding within an execution year. This claim requires consideration, but first one must examine the history of the Defense Health Program's track record of exceeding requirements.

Since fiscal year 1986, the Defense Health Program has exceeded requirements by \$8.5 billion, which is approximately \$447 million per year. Through reprogramming and supplementals, the Defense Health Program has been able to meet requirements. It would be irresponsible to argue that creating a working capital fund in 1986 would have prevented a shortfall of \$8.5 billion to date. Clearly requirements exceeded resources and converting to a different funding mechanism would not have eliminated requirements. Likewise, it would be senseless to argue that performance-based management would have prevented \$8.5 billion in spending since 1986, since a buyer/seller relationship did not exist (DoD Financial).

There are several critical factors for working capital funds that must be considered. First, maintaining sufficient funding is critical. The Defense Health Program has averaged approximately \$447 million in shortfall each year. Additionally, under the working capital fund paradigm, there is the added requirement to pay civilian equivalent of officer pay. In other words, since the military is composed primarily of officers, this will actually create an additional bill for the Defense Health Program. This creates the tendency to convert military authorizations to civilian ones in effort to reduce cost, despite the negative impact on the readiness mission. Finally, there is no benefit to having “no year” funding if it is hamstrung by a cash shortfall. Clearly, the Defense Health Program would have a cash shortage problem quickly if converted over to a working capital fund (Defense Working).

Why do the Defense Health Program requirements exceed the funds available each year? Simply put, Congress keeps sweetening the TRICARE benefit, thus increasing funding requirements. In fiscal year 2001, the co-payment was eliminated, the catastrophic cost was reduced, and the TRICARE Prime Remote benefits were put into law at a cost of \$492 million. In fiscal year 2002, TRICARE for life, the elimination of the non-availability statement, and increase in prosthetics and hearing aid benefit cost approximately \$5 billion. In fiscal year 2003, the TRICARE Prime Remote benefit was expanded and other initiatives cost an extra \$54 million. In fiscal year 2004, the guard and reserve TRICARE benefit cost an extra \$278 million and \$300 million in the first quarter of 2005.

Is performance-based management the solution? No! Likewise, it would be senseless to argue that performance based management would have prevented \$8.5 billion in spending since 1986, since a buyer/seller relationship did not exist. Unfortunately, many of the efforts made to improve the TRICARE benefit would have to be undone to create a healthy tension between the buyer and seller. For instance, research suggests that co-pays are an effective tool used to prevent needless over-utilization of goods and services. Eliminating co-pays only served to reduce the healthy tension required between the buyer and seller in a working capital fund and was a costly step in the wrong direction (International Foundation).

Another reason that performance-based management will not work is that it has not worked since 1986. One of the key ingredients in a working capital fund is total-cost visibility. In theory, cost visibility allows decision-makers to run operations more efficiently. If the Defense Health Program converted to a working capital fund, it would most likely do so using the medical expense and performance reporting system, which has provided total-cost visibility to leaders for many years. Despite having total cost visibility, the Defense Health Program has failed to contain costs.

A host of other attempts have been made to make health care operations run more efficiently including primary care manager by name (PCMBN) and business plans. Under PCMBN, traditional roles or “stovepipes” filled by enlisted personnel were merged into a generic role working under one medical provider. The provider team was staffed with support personnel to see 1,500 patients and care for all of their needs, including medical records administration. Tasks were in essence decentralized, resulting in the loss of both task expertise and accountability. Instead of providers becoming more efficient, their support staff found themselves overwhelmed with administrative duties and lots of tasks went undone since there was little, if any accountability with decentralized functions. Unfortunately, leadership failed to accomplish a full autopsy on PCMBN and has moved on to a new models aimed at performance-based management known as business plans. As with a working capital fund, the buyer/seller relationship is critical to the success of any plan. The PCMBN failed miserably because the buyer/seller relationship was ignored. Likewise, the business plan paradigm will fail for many reasons. However, the key to its downfall will likewise be the lack of a buyer and seller relationship.

Would capitation payment succeed at making operations run more efficiently? Once again, no plan will succeed without a healthy tension between buyers and sellers. Capitation payment in the civilian industry has a direct impact on the medical provider's income. Likewise, patients are not entirely insulated from costs, unlike the military health system. Within the military health system, physicians and other potential revenue producers receive the same pay and benefits regardless of outputs. How will total cost visibility motivate them? They are not true stakeholders, and there is no incentive for them to be more efficient in their operations. Metrics and total-cost visibility are great tools for decision makers and stakeholders alike. However, if the organization's stakeholders are not the producers, then the organization should not expect results from total-cost visibility and other metrics. Along the same lines, TRICARE Prime patients pay nothing for services. Therefore, there is nothing to curtail demand, other than frustration with gaining access to care.

Since the working capital fund is not the solution, what would it take to create a buyer/seller relationship that would result in success under the current Defense Health Program funding mechanism? A healthy buyer/seller arrangement must make patients and producers financial stakeholders. Patients need to take additional financial responsibility for the healthcare. Co-pays, coinsurance, and deductibles for all TRICARE patients need to be added back into law to help curtail unnecessary demand. Also, those providing direct patient care should earn their medical professional pay. Additionally, medical providers should receive a substantial portion of third party collections to further incentivize medical coding accuracy and provider productivity. When seeing more patients becomes more financially beneficial for providers, and patients have an incentive for avoiding unnecessary healthcare, a healthy tension will exist between buyers and sellers. This healthy tension between buyers and sellers will result in free market forces regulating supply and demand.

Those of us within the Department of Defense have heard it said many times that the DoD is not a business and should not be treated as such. Revolving funds operate just like a business and have been around since the National Security Act of 1947 established them. While the military health system is not a

business, it is able to apply many business-like tools to motivate the behaviors of others, even tools outside the working capital fund. Consider for instance force shaping tools or reenlistment bonuses. Both of these are human resource tools used to maintain the workforce or reduce the workforce modeled after commercial enterprise. Likewise, consider the new National Security Personnel System, which is a pay-for-performance system that replaces the old civil service rules that rewarded employees for length of service rather than performance. Why not follow the lead of the National Security Personnel System and create a pay system that rewards our military medical producers for their output, and eliminate professional pays to fund this new incentive program? (Defenselink.mil)

Finally, the Defense Health Program fails to meet the criteria for becoming a working capital fund. Even if it met the criteria, bringing the Defense Health Program into a working capital fund would create significant cash-flow problems and would not correct the cause of the problem—lack of a buyer/seller relationship and legislation making the TRICARE benefit too rich. Until a healthy buyer/seller relationship is achieved, the military health system will struggle with having sufficient funding.

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