REPORT DOCUMENTATION PAGE

1. REPORT DATE	2. REPORT TYPE	3. DATES COVERED
May 1991	Final Report	

4. TITLE AND SUBTITLE

Report on the PRIMUS/NAVCARE Programs. Prepared for the Office of the Assistant Secretary of Defense (Health Affairs)

5a. CONTRACT NUMBER

5b. GRANT NUMBER

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

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5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Lewin/ICF

Vector Research, Incorporated

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION/AVAILABILITY STATEMENT

Available for public release; distribution unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT

All three of the military medical departments have implemented contract primary care clinics under the Primary Care for the Uniformed Services (PRIMUS) or Navy Cares (NAVCARE) programs. The PRIMUS centers of the Army and Air Force and the NAVCARE centes of the Navy are contractor-owned, contractor-operated, free-standing clinics positioned near heavily-utilized military hospitals to augment the delivery of routine ambulatory health services. PRIMUS/NAVCARE contractors are reimbursed by the government at a fixed price per clinic visit. The centers are open to any uniformed services beneficiary eligible for direct care. PRIMUS/NAVCARE centers have proven extremely popular with their target populations, and 25 have become operational since the first Army PRIMUS cetners opened in October 1985. In FY 89, PRIMUS/NAVCARE centers accounted for approximately 1.5 million primary care visits and almost 200,000 other visits (such as prescription refills and mammograms) at a cost of $71.5 million. This represents nearly five percent of all direct care outpatient visits-both primary care and non-primary care-provided in CONUS

15. SUBJECT TERMS

Military medicine; cost effectiveness; hospitals; savings, outpatient clinics; medical services; military personnel; military dependents

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			19b. TELEPHONE NUMBER
U	UU				

Standard Form 298

REPORT ON THE PRIMUS/NAVCARE PROGRAMS

Prepared for

The Office of the Assistant Secretary of Defense (Health Affairs)

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May 1991

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EXECUTIVE SUMMARY

BACKGROUND

All three of the military medical departments have implemented contract primary care clinics under the Primary Care for the Uniformed Services (PRIMUS) or Navy Cares (NAVCARE) programs. The PRIMUS centers of the Army and Air Force and the NAVCARE centers of the Navy are contractor-owned, contractor-operated, free-standing clinics positioned near heavily-utilized military hospitals to augment the delivery of routine ambulatory health services. PRIMUS/NAVCARE contractors are reimbursed by the government at a fixed price per clinic visit. The centers are open to any uniformed services beneficiary eligible for direct care.

PRIMUS/NAVCARE centers have proven extremely popular with their target populations, and 25 have become operational since the first Army PRIMUS center opened in October 1985. In FY 89, PRIMUS/NAVCARE centers accounted for approximately 1.5 million primary care visits and almost 200,000 other visits (such as prescription refills and mammograms) at a cost of $71.5 million. This represents nearly five percent of all direct care outpatient visits -- both primary care and non-primary care -- provided in CONUS during that time frame. Dependents of active duty members are the dominant beneficiary type at PRIMUS/NAVCARE centers, receiving approximately 70 percent of all services.

CHANGING ROLE OF PRIMUS/NAVCARE IN COORDINATED CARE

In June of 1990, the Department submitted to the Congress the "Report on the Reorganization of Military Health Care." This report discussed the Department's Coordinated Care Program, which will provide MTF Commanders the tools to better manage the delivery of care to enrolled beneficiaries and ensure that enrolled beneficiaries will have access to high quality, cost-effective care. The Coordinated Care Program will be oriented around local health delivery systems based on arrangements between military and civilian health care organizations.

The linchpin of DoD's Coordinated Care Program delivery system will be Primary Care Managers (PCMs) -- a specific clinic site or group of providers with which each enrolled beneficiary will establish and maintain an ongoing medical affiliation. The PCM can be either a practice site (such as an MTF clinic, a PRIMUS/NAVCARE clinic, a USTF, or an HMO) or a single primary care physician. Commanders will have the flexibility to assign each beneficiary, or allow each beneficiary to choose, a PCM.

The PCM will refer the beneficiary to other sources of care as needed. Once a beneficiary has a PCM, he or she must be referred by that primary care manager to receive specialty care. Civilian PCMs will refer specialty care to the MTF if the MTF is able to provide this care. Only if the MTF does not have the capacity to deliver the care will specialty care be referred to civilian physicians. This will improve access to and continuity of health services for beneficiaries. It will increase efficiency by reducing unnecessary higher level care.

While many features of PRIMUS/NAVCARE clinics will have to change if these clinics are to play a role as Primary Care Managers in DoD's Coordinated Care Program, several features of the existing PRIMUS/NAVCARE program already comply with operational requirements under the Coordinated Care Program. For example:

- PRIMUS/NAVCARE clinics already utilize the MTF to the extent possible when making referrals.
- PRIMUS/NAVCARE clinics are required, at a minimum, to comply with MTF UM/QA protocols.
- PRIMUS/NAVCARE clinics maintain medical records of the clinic's encounters and track consultation forms, prescriptions, and other critical medical information.
- A system for checking patient eligibility is already in place at most clinic locations.

However, there remain several features which must be modified. These changes will require that the statement of work in new PRIMUS/NAVCARE contracts be changed and that some current PRIMUS/NAVCARE contracts be renegotiated. First, the clinics will have to be

modified to accommodate enrollment. Currently, PRIMUS/NAVCARE clinics take all MHSS-eligible patients. Under DoD's Coordinated Care Program, local MTF Commanders would assign enrolled beneficiaries to a PCM (such as an MTF clinic, a PRIMUS/NAVCARE clinic, or a civilian HMO) or allow them to select a PCM. Thus, beneficiaries would select or be assigned to a PRIMUS/NAVCARE clinic as their PCM. In order for PRIMUS/NAVCARE clinics to function as a PCM, they would have to establish a system which screens beneficiaries to ascertain whether the PRIMUS/NAVCARE center is their PCM. No longer would all beneficiaries be able to use the PRIMUS/NAVCARE center for nonemergent care.

A second change is that the PRIMUS/NAVCARE center would have to take a much more aggressive role in coordinating services for their patients. This means having a much stricter set of procedures to follow when making referrals. These procedures must specify when a physician should refer to the MTF and, if referring to a civilian provider, specify which civilian providers are part of the joint MTF/civilian network. The PCM would have to make appointments for patients they refer to the MTF or to civilian specialists. Currently, PRIMUS/NAVCARE clinics make referral appointments for some patients but not for others. Under the Coordinated Care Program, the PRIMUS/NAVCARE clinic would be responsible for ensuring that appointments for all necessary referrals were made by the PRIMUS/NAVCARE clinic. The role of the PCM will be to promote high quality of care by acting as the manager of services, assuring the appropriateness of services provided and encouraging continuity of care through the establishment of the primary care giver relationship.

Third, PRIMUS/NAVCARE clinics will need to keep the medical records for all patients for whom they serve as PCM and to require consulting physicians to return consultation forms to the clinic to complete the medical record. This will aid in the quality of care and will help ensure continuity of care.

Fourth, PRIMUS/NAVCARE clinics may have to modify their staffing in order to accommodate the patients for whom they act as PCM. Not only the mix of specialties but also the mix of types of professionals may have to be modified. For example, some MTFs provide most primary care services to a subset of the patient population but depend upon the PRIMUS/NAVCARE clinic for specific procedures such as performing inoculations, pap smears, or mammograms for this population. As a result, the PRIMUS/NAVCARE clinic may have a greater proportion of nurses or technicians than would be found in a facility responsible for all primary care services for a specified population. Based upon the new role of the PRIMUS/NAVCARE clinic and the enrollment priorities specified by the MTF Commander, each PRIMUS/NAVCARE clinic may need to modify its staffing profile.

Fifth, the Services will probably need to change the way they reimburse PRIMUS/NAVCARE centers. Currently, PRIMUS/NAVCARE clinics are paid on a fixed price per visit basis. Given that they will be responsible for an enrolled population, it may be more appropriate to pay them on a capitated basis. This will remove any incentive to have patients return for unnecessary repeat visits.

Sixth, PRIMUS/NAVCARE centers will have to revise their data reporting to facilitate the tracking of patients, the utilization of services, and costs. Under the Coordinated Care Program, the MTF Commander will be accountable for the costs of his or her PRIMUS/NAVCARE center. This accountability will require the Commander to have the ability to supervise the PRIMUS/NAVCARE clinic closely. In order to manage effectively, he or she will need detailed information on utilization, referral patterns, and costs so that the costs of caring for patients can be compared between the MTF, PRIMUS/NAVCARE centers, and civilian clinics. In addition, the current UM/QA audit requirements used by the COR may need to be modified to improve the Commander's ability to assess the PRIMUS/NAVCARE clinic's performance. These data will help support the DoD-wide tracking system to monitor the

PRIMUS/NAVCARE program's achievements and results that was announced by Dr. Mendez in July 1990.

Seventh, the PRIMUS/NAVCARE centers will have to use the UM/QA standards set by MTF Commanders. While PRIMUS/NAVCARE clinics currently must comply with MTF UM/QA requirements, these requirements are generally Service branch level requirements and do not reflect the new standards which will arise out of Coordinated Care. Presumably, the MTF Commander will require additional UM/QA procedures that support the Coordinated Care Program.

Finally, the PRIMUS/NAVCARE contracts will have to be modified to reflect the greater responsibility of the MTF Commander in determining catchment area priorities and the role of the PRIMUS/NAVCARE clinic in meeting the needs of the local patient population. The contracts must be flexible enough to allow Commanders to modify clinic staffing requirements, services to be provided, referral protocols, and other service delivery characteristics which are specific to the local area.

HISTORICAL REVIEW FINDINGS

Purpose

The Omnibus Defense Authorization Act of 1984 required DoD to conduct studies and demonstration projects to improve the quality, efficiency, convenience and cost-effectiveness of providing health care to military beneficiaries. The Department of Defense Authorization Act for Fiscal Year 1988 mandated the continuation of PRIMUS/NAVCARE and included a process for evaluating the demonstration projects and reporting findings to Congress. In response to the objectives of Congress and of the PRIMUS/NAVCARE program, the Department evaluated the PRIMUS/NAVCARE program based on the extent to which it has historically:

- improved access to primary care;

- relieved military treatment facility (MTF) overcrowding;
- delivered cost-effective care; and
- achieved acceptable quality of care.

Access to Care and Relief of MTF Overcrowding

Historically, the main objective of PRIMUS/NAVCARE clinics has been to improve access to primary care. This review found that PRIMUS/NAVCARE clinics have made access to primary care more convenient and accessible by:

- not requiring appointments;
- generally being sited in locations convenient to beneficiaries;
- having extended hours of operation relative to MTFs, particularly at night and on weekends;
- not requiring cost sharing, while CHAMPUS requires the payment of a deductible and 20 or 25 percent cost sharing above the deductible; and
- providing some preventive primary care services such as Pap smears, mammograms, and school physicals which are difficult to obtain at most MTFs and which had not been covered or are not covered by CHAMPUS.

This review also found that the opening of PRIMUS/NAVCARE clinics has led to a reduction in waiting times at Emergency Room clinics at MTFs during PRIMUS/NAVCARE center hours. Analysis of data from 18 PRIMUS/NAVCARE sites revealed the following effects of PRIMUS/NAVCARE centers on MTF primary care visits:

- substitution of PRIMUS/NAVCARE visits for MTF visits -- at three of the 18 sites there was a reduction in MTF primary care visits which was roughly equivalent to the number of PRIMUS/NAVCARE visits provided.
- expansion of primary care -- at seven of the 18 sites there was little reduction, no reduction, or an actual increase in MTF visits associated with the opening of the PRIMUS/NAVCARE center.
- mixed effects -- at eight of the 18 sites there was some reduction in MTF visits but overall there was a net increase in primary care visits in the area.

On average, our analysis of the 18 sites indicates that for every 10 PRIMUS/NAVCARE visits, there are 4.4 fewer MTF primary care visits.

These analyses indicate that PRIMUS/NAVCARE centers do have the potential to relieve MTF overcrowding and increase access to primary care. Because there is a reduction of 4.4 MTF visits for every 10 PRIMUS/NAVCARE visits, PRIMUS/NAVCARE centers clearly have the potential to relieve MTF overcrowding. In addition, it appears that there are 5.6 more primary care visits for every 10 PRIMUS/NAVCARE visits: direct evidence of increased access to primary care.

Cost Impact

There is disagreement over how the unit costs of services provided at PRIMUS/NAVCARE centers compare with the direct care system and CHAMPUS. Some studies have found that PRIMUS/NAVCARE is less costly than CHAMPUS on a per visit basis. More recent work by the DoD Inspector General's (IG) office suggests that CHAMPUS may actually be the least costly alternative from the government's perspective on a cost per visit basis.

The average cost of a PRIMUS/NAVCARE visit in FY 89 was $48.52. This is significantly higher than the estimated marginal cost of a similar MTF primary care visit ($33.60). The average cost of a PRIMUS/NAVCARE visit was somewhat less than our estimate of the average total CHAMPUS charges for providing the same services provided in PRIMUS/NAVCARE visits ($51.81 in FY 89), but was higher than the average government cost under CHAMPUS of providing the same services provided in a PRIMUS/NAVCARE visit ($38.52).[1]

One must exercise caution in using these results on unit costs because it is extremely difficult to control for all the differences in visits provided to patients in different settings. For example, this study evaluated the cost under CHAMPUS of providing the same set of services

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[1] The government cost of CHAMPUS is lower than average total CHAMPUS charges because of beneficiary cost sharing, payments by other insurance, and any amount in excess of CHAMPUS allowable charges.

provided to patients in PRIMUS/NAVCARE visits. But patients who see a physician under CHAMPUS may receive different services than they would in a PRIMUS/NAVCARE clinic, particularly because CHAMPUS physicians have incentives to provide more services per visit (because they can bill separately for each service) while PRIMUS/NAVCARE clinics have incentives to minimize services per visit (because they get paid a fixed price per visit).

Our analysis does indicate that PRIMUS/NAVCARE centers increase aggregate government costs because, as intended by the developers of the program, they increase the number of primary care visits. We found that, on average, PRIMUS/NAVCARE centers cost the government an additional $29.40 for each visit they provide. This accounts for both the increase in access due to PRIMUS/NAVCARE centers and the fact that PRIMUS/NAVCARE centers are a more expensive site of care than MTFs or CHAMPUS. As a result, we estimate that PRIMUS/NAVCARE centers resulted in an increase in government cost in FY 89 of more than $44 million.[1] However, as noted above, much of this increased cost was for care that would not have been received otherwise. This increase in aggregate costs was expected because the goal of PRIMUS/NAVCARE was to improve access; attaining this goal is bound to have some costs.

Quality of Care

A medical care quality assurance (QA) expert examined PRIMUS/NAVCARE QA plans as part of this review and found them to be representative of the traditional QA model in which the goal is to measure quality, find substandard quality, and improve it through "corrective actions."

We found other evidence that quality is not a problem at PRIMUS/NAVCARE clinics. First, the clinics have typically fared very well in patient satisfaction surveys. For example, in

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[1] To the degree that CHAMPUS and MTF physicians provide more services per visit than in a PRIMUS/NAVCARE visit, this estimate may overstate the additional costs of PRIMUS/NAVCARE clinics.

the Navy-wide 1990 Annual Patient Evaluation of NAVCARE clinics, 92 percent of the respondents gave an overall rating of outstanding, excellent, or satisfactory. Second, site visit interviews with local MTF commanders and primary care physicians generally revealed a high regard for PRIMUS/NAVCARE physicians and the care they deliver.

CHAPTER I

OVERVIEW OF THE PRIMUS/NAVCARE PROGRAM

I. INTRODUCTION

A. COORDINATED CARE

All three of the military medical departments have contracted with primary care clinics under the Primary Care for the Uniformed Services (PRIMUS) or Navy Cares (NAVCARE) programs. The PRIMUS centers of the Army and Air Force and the NAVCARE centers of the Navy are contractor-owned, contractor-operated, free-standing clinics positioned near heavily-utilized military hospitals.[1] PRIMUS/NAVCARE centers have proven extremely popular with their target populations, and 25 have become operational since the first Army PRIMUS center opened in October 1985.

Historically, their primary goal has been to augment the delivery of routine ambulatory health services. An ancillary benefit of the clinics has been to provide a referral base for the military specialty clinics, thus avoiding costly specialty care under CHAMPUS. The Centers have been regarded by the Services as operational extensions of their direct care systems and are open to any uniformed services beneficiary eligible for direct care.

In June of 1990, the Department submitted to the Congress the "Report on the Reorganization of Military Health Care." In this report there was a discussion of the current Military Health Services System (MHSS), followed by the three main elements of DoD's plan for the future: 1) the Department's Coordinated Care Program which will be applied both to care in military hospitals and clinics and to care purchased in the civilian sector; 2) internal reorganization of the Office of the Assistant Secretary of Defense (Health Affairs); and 3) reorganization of the management structure of the MHSS with an emphasis on centralized monitoring and decentralized execution.

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[1] One clinic is government-owned and contractor-operated.

The Coordinated Care Program will provide MTF Commanders the tools to better manage the delivery of care to enrolled beneficiaries in their service areas and to ensure that enrolled MHSS beneficiaries have access to high quality, cost-effective care. To accomplish these goals, the Coordinated Care Program includes several integrated components which will improve the efficiency and effectiveness of health care delivery.

The centerpiece of the Coordinated Care Program will be local health care delivery systems based on arrangements between military and civilian health care organizations. These delivery systems will be locally managed, and MTF Commanders will be responsible for the delivery, cost, and quality of health services provided to enrolled beneficiaries in their area. The Coordinated Care Program will have local accountability with centralized monitoring.

PRIMUS/NAVCARE centers will play an important role in the Coordinated Care Program. However, their functions will need to change significantly under the new program. The linchpin of the Coordinated Care Program delivery system will be a primary care manager (PCM) -- a specific clinic site or group of providers with which each enrolled beneficiary will establish and maintain an ongoing medical affiliation. Commanders will have the flexibility to assign each beneficiary, or allow each beneficiary to choose, a PCM. The PCM can be either a practice site (such as an MTF clinic, a PRIMUS/NAVCARE clinic, a USTF, or an HMO) or a single primary care physician.

The PCM will refer the beneficiary to other sources of care as needed. Once a beneficiary has a PCM, he or she must be referred by that PCM to receive specialty care. Civilian PCMs will refer specialty care to the MTF if the MTF is able to provide this care. Only if the MTF does not have the capacity to deliver the care will specialty care be referred to civilian physicians. This will improve access to and continuity of health services for beneficiaries. It will increase efficiency by reducing unnecessary higher level care.

B. PURPOSE

Although the functions of PRIMUS/NAVCARE centers will change significantly under DoD's Coordinated Care Program, it is useful to evaluate how they are currently functioning. In addition, the Omnibus Defense Authorization Act of 1984 (ODAA) required the Secretary of Defense to

> "... conduct studies and demonstration projects on the health care delivery system of the uniformed services with a view to improving the quality, efficiency, convenience, and cost-effectiveness of providing health care services ... to members and former members and their dependents."

The Department of Defense Authorization Act for Fiscal Year 1988, in what is often referred to as the Kyl Amendment, expanded upon this by mandating a series of alternative health care delivery demonstrations for the MHSS, including PRIMUS/NAVCARE, and by providing specifications for the content of the report to Congress.

This report addresses the requirements of the Kyl Amendment directive. The report presents the results of a review which has measured the extent to which the program has historically:

- improved access to primary care;
- relieved military treatment facility (MTF) overcrowding;
- delivered cost-effective care; and
- achieved acceptable quality of care.

C. OVERVIEW OF REPORT

Chapter I provides background information on the PRIMUS/NAVCARE program including findings from interviews with individuals responsible for developing and/or operating the program at the Service branch level. Chapter II discusses how the PRIMUS/NAVCARE program can best be integrated into the Coordinated Care Program. Chapter III analyzes the historical impact of PRIMUS/NAVCARE on beneficiaries' access to primary care services, the

cost-effectiveness of PRIMUS/NAVCARE, and the quality of care provided by PRIMUS/NAVCARE.

II. BACKGROUND

The PRIMUS/NAVCARE program evolved out of a concern for what was perceived to be increasingly inaccessible primary care services within the direct care system.[1] Non-active duty beneficiaries were being turned away from the MTFs due to limited resources, and some did not seek care in the civilian sector due to the cost sharing required by CHAMPUS or due to their lack of understanding of CHAMPUS procedures. Waiting times for ambulatory care appointments at the MTF had increased substantially, and in many cases appointments were unavailable. Walk-in clinics at the MTFs required beneficiaries to wait for hours at a time. The inaccessibility of the system was further marked by the misuse of the emergency rooms at MTFs, with beneficiaries utilizing the ER for primary care services when the appointment backlog at the clinics frustrated their attempts to get care promptly. The most essential changes necessary for improving access, as one interviewee stated, were to improve beneficiaries' proximity to care and reduce waiting times for appointments.

Congress, meanwhile, provided the incentive and the authority for implementing new programs to improve the military health care system. Conference language for P.L. 97-377 directed the Services to "report to the Committees on Appropriations what actions are being taken to increase the specific numerical workload goals for beneficiaries treated in military medical facilities."

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[1] This history of the PRIMUS/NAVCARE program is based on an examination of legislative changes and internal memoranda within the Services, on a series of interviews with individuals involved with developing, managing, and overseeing the program, and on PRIMUS/NAVCARE operating statistics provided by the service branches. The individuals interviewed represented the following offices: the Assistant Secretaries of Defense for Health Affairs, Force Management and Personnel, and Program Analysis and Evaluation; the Comptroller of the Department of Defense; the Surgeons General for each of the service branches; the Service Commands; and the Office of Management and Budget.

While the main catalyst for primary care clinics was to increase access to care, other factors were also important. One factor was that the MTFs were overcrowded; moving some of the primary care services out of the MTF would reduce the strain on the MTF while allowing a greater emphasis on readiness-related types of care within the MTF. Another factor was the lack of utilization control over CHAMPUS outpatient care. While the NAS requirement forced beneficiaries to present first to the MTF for inpatient care, there was no control over outpatient utilization or referrals once beneficiaries entered the civilian health care system through CHAMPUS.

As a result of these factors, the Office of the Army Surgeon General conceived the idea of the Satellite Primary Care Clinics staffed by uniformed family practice physicians and civilian ancillary staff. However, the concept did not win internal approval because it required shifting scarce uniformed physicians from an existing installation to staff a new clinic. In response, contractor-owned, contractor-operated clinics, staffed by civilian physicians but treated as an extension of the MTF, were proposed. The clinics would be treated like primary care satellite clinics subject to the same oversight as other MTF clinics. The proposed program was named Primary Care for the Uniformed Services, or PRIMUS.

Those involved with developing the PRIMUS concept believed one benefit of the program was that directly contracting with civilian providers for primary care services allowed DoD to negotiate rates below those experienced in CHAMPUS. While cost reduction was never a goal, cost containment through the negotiation of rates lower than government costs incurred for CHAMPUS providers was considered to be an important part of the program.

III. IMPLEMENTATION OF THE PRIMUS PROGRAM

The first PRIMUS clinic was opened by the Army in Fairfax, Virginia in October 1985. As of June 1990, there were 25 clinics (10 Army, 10 Navy, and 5 Air Force). The locations, opening dates, contractors, and other information for each clinic are shown in Exhibit 1-1.

The clinics are owned and operated by the contractor with the exception of the Army's Presidio of Monterey clinic, which is government owned and contractor operated.

A. QUALITY ASSURANCE REQUIREMENTS

Because the PRIMUS/NAVCARE clinics are considered to be extensions of the MTF, they are subject to quality assurance requirements similar to those imposed on military primary care satellite clinics. The medical director of a PRIMUS/NAVCARE center is required to be board-certified. Specialty board certification is not a requirement for the remainder of the physician staff, nor is it at direct care facilities. The original policy of the Army did not require PRIMUS centers to be accredited by any sanctioning body, although contractors were required to establish a quality assurance program in compliance with the Ambulatory Health Care Standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).[1] While the Army still does not require a JCAHO survey, both the Navy and Air Force require their centers to be surveyed by JCAHO within one year of start-up.

B. SITE SELECTION

Various factors were mentioned as factors in site selection, including:

- a high percentage of active duty families among the MHSS population. Specific clinic locations were usually chosen based on the residences of the active duty population;
- poor beneficiary access to MTF primary care services;
- relatively high CHAMPUS costs for the population;
- special problems, such as the cancellation or postponement of a demonstration slotted for a specific MTF;[2]

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[1] This is consistent with the Army policy of subjecting only its hospital-based direct care clinics to the JCAHO survey and accreditation process. One Army PRIMUS contractor proposed to obtain JCAHO accreditation.

[2] Such selections, however, do not necessarily mean the site would not have been otherwise selected for PRIMUS/NAVCARE in the ordinary course of events, since these MTFs had been chosen for their original demonstrations based on a need to improve health care delivery in their areas.

- other demonstrations in the catchment area which might interfere with a PRIMUS clinic; and
- the level of support from the base and command.

In most cases, sites selected for the clinics appear to have been very successful in terms of improving access to care. Although those interviewed indicated that the Davis-Monthan clinic in Tucson and the Long Beach clinic were not optimally placed and have as a result been under-utilized, all other clinics have reportedly been met with enthusiastic support from the beneficiary population.

C. BENEFITS PROVIDED

The services offered at PRIMUS/NAVCARE centers are comparable across service branches, due to the fact the Air Force and Navy programs were modelled directly after the Army's PRIMUS program. Generally, the centers are required to provide Family Practice/ Primary Care programs that meet or exceed nationally-recognized standards. This level of care includes responsibility for routine lab and radiology studies and formulary medications. The centers focus on preventive and acute care and the acute aspects of chronic health problems. Specific benefits include mammograms, PAP smears, inoculations, school physicals, and other services that have not traditionally been covered by CHAMPUS. Medical emergencies are beyond the scope of the centers and are transferred to the nearest appropriate facility. Consultations and referrals are directed primarily to the parent MTF, as are active duty members with conditions affecting their duty status.

The following chapter discusses the modifications necessary to incorporate PRIMUS/NAVCARE as an integral part of the Coordinated Care Program.

CHAPTER II

RECOMMENDATIONS FOR INTEGRATING PRIMUS/NAVCARE INTO THE COORDINATED CARE PROGRAM

The Coordinated Care Program delivery system will be built around primary care managers (PCMs). PCMs will be primary care clinics or group practices, such as an MTF clinic, a civilian HMO or a PRIMUS/NAVCARE center. Each enrolled beneficiary will establish and maintain an ongoing medical affiliation with a PCM. Once a beneficiary has a primary care manager, he or she must be referred by that primary care manager to receive specialty care. Both civilian and PRIMUS/NAVCARE PCMs will refer specialty care to the MTF if the MTF is able to provide this care.

While many features of PRIMUS/NAVCARE clinics will have to change if these clinics are to play a role as Primary Care Managers in DoD's Coordinated Care Program, several features of the existing PRIMUS/NAVCARE program already comply with operational requirements under the Coordinated Care Program. For example:

- PRIMUS/NAVCARE clinics already utilize the MTF to the extent possible when making referrals. PRIMUS/NAVCARE clinics are typically well integrated into the operations of the MTF and understand which MTF clinics have excess capacity. In addition, some PRIMUS/NAVCARE clinics are aggressive about setting up appointments at the MTF, discussing patient needs with individual MTF physicians or MTF clinic personnel, and following through to ensure that patients receive needed services.

- PRIMUS/NAVCARE clinics are required, at a minimum, to comply with MTF UM/QA protocols. PRIMUS/NAVCARE contractors typically impose additional UM/QA programs on their clinic staff. In addition, the PRIMUS/NAVCARE clinic's medical director is required in most cases to participate in MTF QA committee meetings and the MTF's Contracting Officer's Representative (or equivalent) is required to audit various utilization reports and monitor quality indicators.

- PRIMUS/NAVCARE clinics do maintain medical records of the clinic's encounters and track consultation forms, prescriptions, and other critical

medical information. This function will have to be strengthened under the Coordinated Care Program, however.[1]

- A system for checking patient eligibility is already in place at most clinic locations. PRIMUS/NAVCARE clinics verify patients' DEERS enrollment, and this process can be easily modified to require clinics to verify the patients' PCM assignment.

However, there remain several features which must be modified. These changes will require that the statement of work in new PRIMUS/NAVCARE contracts be changed and that some current PRIMUS/NAVCARE contracts be renegotiated. Whether renegotiations will be necessary for all PRIMUS/NAVCARE contractors will depend upon the timing of the implementation of the Coordinated Care Program.

First, some of the clinics will have to be modified to accommodate enrollment. Currently, PRIMUS/NAVCARE clinics take all MHSS-eligible patients. Under DoD's Coordinated Care Program, local MTF Commanders would assign enrolled beneficiaries to a PCM (such as an MTF clinic, a PRIMUS/NAVCARE clinic, or a civilian HMO) or allow them to select a PCM. Thus, beneficiaries would select or be assigned to a PRIMUS/NAVCARE clinic as their PCM. In order for PRIMUS/NAVCARE clinics to function as a PCM, they would have to establish a system which screens beneficiaries to ascertain whether the PRIMUS/NAVCARE center is their PCM. No longer would all beneficiaries be able to use the PRIMUS/NAVCARE center for nonemergent care. Only those beneficiaries who have a PRIMUS/NAVCARE center as their PCM would be able to use the PRIMUS/NAVCARE clinic for non-emergent care. Since most PRIMUS/NAVCARE clinics now check beneficiaries' enrollment in DEERS, this

[1] One issue which will have to be resolved is the Army's requirement that there be only a single medical record, maintained at the MTF, for each patient. If duplicate records are not allowed, this will create complications for patients with PRIMUS PCMs and who are referred to the MTF.

modification should not impose any real burden on the clinics. Those clinics which do not have access to DEERS may have to be provided with a DEERS terminal.[1]

A second change is that the PRIMUS/NAVCARE center would have to take a much more aggressive role in coordinating services for their patients. This means having a much stricter set of procedures to follow when making referrals. These procedures must specify when a physician should refer to the MTF and, if referring to a civilian provider, specify which civilian providers are part of the joint MTF/civilian network. The PCM would have to make appointments for patients they refer to the MTF or to civilian specialists. Currently, PRIMUS/NAVCARE clinics make referral appointments for some patients but not for others. Under the Coordinated Care Program, the PRIMUS/NAVCARE clinic would be responsible for ensuring that appointments for all necessary referrals were made by the PRIMUS/NAVCARE clinic. The role of the PCM will be to promote high quality of care by acting as the manager of services, assuring the appropriateness of services provided and encouraging continuity of care through the establishment of the primary care giver relationship.

Third, PRIMUS/NAVCARE clinics will need to keep the medical records for all patients for whom they serve as PCM and to require consulting physicians to return consultation forms to the clinic to complete the medical record. This will aid in the quality of care and will help ensure continuity of care. This will require changing procedures at some PRIMUS/NAVCARE clinics but not at others.

Fourth, PRIMUS/NAVCARE clinics may have to modify their staffing in order to accommodate the patients for whom they act as PCM. For example, an MTF Commander

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[1] An alternative is to issue enrollment cards which identify a beneficiary's PCM and which must be presented when requesting services. The shortcoming in this approach is that beneficiaries will still have these enrollment cards if they lose MHSS eligibility, move, or otherwise change their enrollment status, while DEERS will be updated continuously for such changes. This shortcoming would be diminished if cards were issued with expiration dates, to be re-issued every twelve months.

may have the ability to assign all enrolled active duty dependents and their families to have the MTF as their PCM. Consequently, the PRIMUS/NAVCARE center would serve primarily retirees. This might mean that the PRIMUS/NAVCARE center would need fewer pediatricians and more internists. Not only the mix of specialties but also the mix of types of professionals may have to be modified. For example, some MTFs provide most primary care services to a subset of the patient population but depend upon the PRIMUS/NAVCARE clinic for specific procedures such as performing inoculations, pap smears, or mammograms for this population. As a result, the PRIMUS/NAVCARE clinic may have a greater proportion of nurses or technicians than would be found in a facility responsible for all primary care services for a specified population. Based upon the new role of the PRIMUS/NAVCARE clinic and the enrollment priorities specified by the MTF Commander, each PRIMUS/NAVCARE clinic may need to modify its staffing profile.[1]

Fifth, the Services will probably need to change the way they reimburse PRIMUS/NAVCARE centers. Currently, PRIMUS/NAVCARE clinics are paid on a fixed price per visit basis. Given that they will be responsible for an enrolled population, it may be more appropriate to pay them on a capitated basis. This will remove any incentive to have patients return for unnecessary repeat visits and, by capitating the clinics for all services rather than just primary services, will eliminate any incentive to "dump" patients onto specialists and assure the Government that the clinics are managing services. The actual reimbursement rates should reflect the available alternatives in the local catchment area. It may be that there exist other arrangements by which the new PCM role could be filled more cost effectively.

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[1] This will depend upon the priorities set forth by the MTF Commander and the role the Commander sees the PRIMUS/NAVCARE clinic playing under Coordinated Care. It may be that the MTF will continue to use the PRIMUS/NAVCARE clinic for ancillary services for some patients, and will want the clinic to maintain its current staffing profile. The contractor must be responsive to the needs of the local catchment area, as set forth by the MTF Commander.

Sixth, PRIMUS/NAVCARE centers will have to revise their data reporting to facilitate the tracking of patients, the utilization of services, and costs. Under the Coordinated Care Program, the MTF Commander will be accountable for the costs of his or her PRIMUS/NAVCARE center. This accountability will require the Commander to have the ability to supervise the PRIMUS/NAVCARE clinic closely. In order to manage effectively, he or she will need detailed information on utilization, referral patterns, and costs so that the costs of caring for patients can be compared between the MTF, PRIMUS/NAVCARE centers, and civilian clinics. In addition, the current UM/QA audit requirements used by the COR may need to be modified to improve the Commander's ability to assess the PRIMUS/NAVCARE clinic's performance. Data from PRIMUS/NAVCARE centers will need to be consistent across the MHSS. This will support the DoD-wide tracking system for the PRIMUS/NAVCARE program announced by Dr. Mendez in July 1990.

Seventh, the PRIMUS/NAVCARE centers will have to use the UM/QA standards set by MTF Commanders. While PRIMUS/NAVCARE clinics currently must comply with MTF UM/QA requirements, these requirements are generally Service branch level requirements and do not reflect the new standards which will arise out of Coordinated Care. At a minimum, the centers must comply with any standards imposed by the Services and the MTF. In addition, the MTF Commander will review any additional UM/QA procedures proposed by the contractor. Some, if not all, PRIMUS/NAVCARE clinics have financial incentives for providers to see more than a minimum number of patients per hour. In addition, there are contractor-performed audits to review the number of lab tests and x-rays requested by providers. These incentives will have to be modified to emphasize the cost-effectiveness of services in light of each patient's total demand for health care services, rather than the number of services being provided on a "per visit" basis. As noted above, the reimbursement system used to reimburse these contractors should create the appropriate incentive to manage all patient care.

Finally, the PRIMUS/NAVCARE contracts will have to be modified to reflect the greater responsibility of the MTF Commander in determining catchment area priorities and the role of the PRIMUS/NAVCARE clinic in meeting the needs of the local patient population. The contracts must be flexible enough to allow Commanders to modify clinic staffing requirements, services to be provided, referral protocols, and other service delivery characteristics which are specific to the local area.

CHAPTER III

HISTORICAL REVIEW

As discussed in the first two chapters, the role of PRIMUS/NAVCARE centers will change markedly in DoD's Coordinated Care Program. Although significant changes will occur, it is still useful to examine how well these centers have performed historically. Consequently, this chapter examines five key features of PRIMUS/NAVCARE centers: 1) the characteristics of patients they have served; 2) how well they have increased access to care for patients; 3) whether they have relieved MTF overcrowding; 4) whether the centers have been cost effective; and 5) the quality of care.

I. HISTORICAL ROLE OF THE PRIMUS/NAVCARE CLINICS

PRIMUS/NAVCARE clinics provided over 1.6 million clinic services in FY 1989. These services consist of visits and other contract-specified billable health services.

The majority of clinic services, about 70 percent, has been provided to the dependents of active duty members, while active duty personnel account for 6 percent (see Exhibit III-1). The high percentage of PRIMUS/NAVCARE services used by active duty dependents indicates a certain level of success by the Services in targeting and serving active duty dependents rather than the retiree population.[1]

Exhibit III-1 shows the number of clinic services by the service branch of the beneficiary's sponsor. Navy and Marine Corps beneficiaries received approximately one half of all PRIMUS/NAVCARE services in FY 1989, with Army beneficiaries receiving another third, and the balance provided to beneficiaries of the Air Force and other uniformed services.

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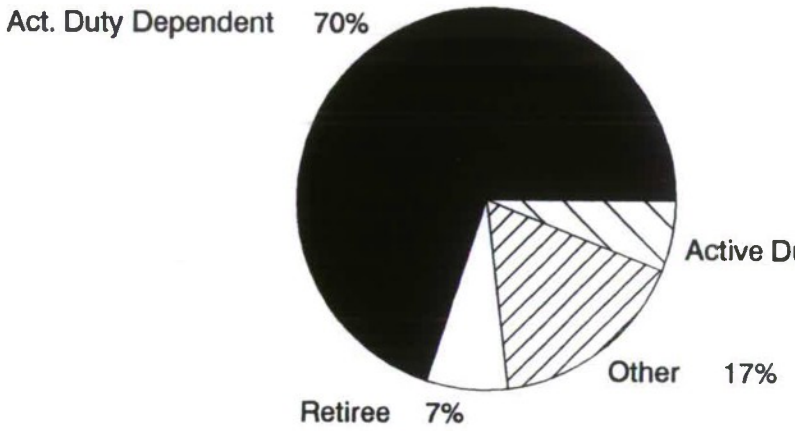
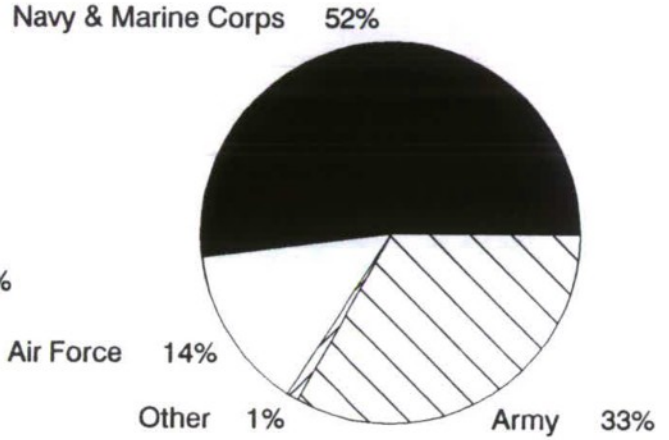
[1] In addition, active duty members were not a priority for these clinics; in fact, some MTF commanders discouraged active duty members from using the clinics in order to keep their medical records within the MTF.

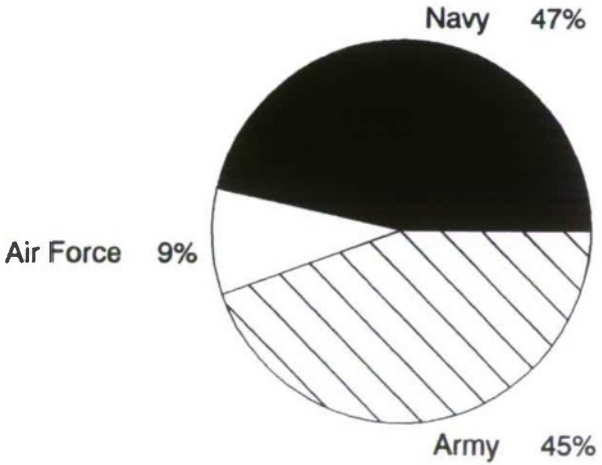
FY 89 TOTAL PRIMUS/NAVCARE SERVICES = 1,644,378



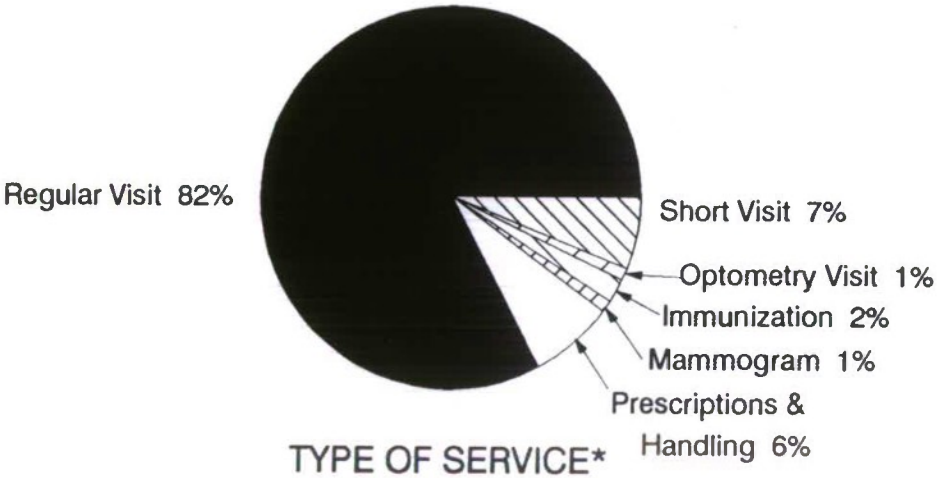
BENEFICIARY CATEGORY



SPONSOR SERVICE BRANCH



PARENT MTF SERVICE BRANCH



TYPE OF SERVICE*

* Ambulance Transfer <0.5%.

Exhibit III-2 summarizes PRIMUS/NAVCARE utilization and expense by the service branch of the parent MTF (rather than the service branch affiliation of the patient). In FY 1989, the Navy furnished the greatest volume of services followed closely by the Army. The Air Force clinics provided approximately one-fifth of the volume of services experienced by the Army clinics. At $37.1 million, the Navy also bore the largest share of the $71.5 million total spent on the PRIMUS/NAVCARE program in FY 1989. Army and Air Force expenses were $27.2 million and $7.3 million, respectively.

Exhibit III-2 also shows the number of services by type of service and the average expense per service for FY 1989. The three military branches have slightly different service types, as reflected in Exhibit III-2. For each military branch, the most intensive type of service (i.e. regular, full or long visits) accounted for the greatest number of services, followed by short (limited) visits. Average expense per type of service also varied. For the Army, the most expensive visit averaged $46 for a regular visit, with immunizations averaging the least ($3). Ambulance transfers for both the Navy and Air Force were the most expensive type of "visit" ($187 and $190, respectively), with prescription handling and refills the least expensive.

II. ACCESSIBILITY

It is generally agreed that the need to improve access to primary care was the main impetus to the establishment of the original PRIMUS clinics. One of the key indicators of inadequate access to such care was the overcrowded conditions in many MTF primary care clinics. Health care is made more accessible when convenience and availability are improved and cost to the user is reduced. PRIMUS/NAVCARE clinics can enhance accessibility by:

- reducing beneficiary waiting times;
- bringing care closer to the beneficiary;
- making care available during extended hours;

EXHIBIT III-2

PRIMUS/NAVCARE UTILIZATION AND EXPENSE BY TYPE OF SERVICE, FY 1989

Army						
	Regular Visit	Short Visit	Prescription Refills and Dispensing Fees	Immunizations	Optometry Visit	"No Charge" Visit
Total Services	559,680	47,888	66,909	26,225	17,769	15,814
Expense Per Service	$46	$6	$10	$3	$22	NA
Total Cost (1000 $)	$25,711	$302	$643	$72	$382	NA
Navy						
	Full Visit	Limited Visit	Prescription Handling	Immunizations	Mammography	Ambulance Transfer
Total Services	668,591	51,867	27,647	3,645	14,877	748
Expense Per Service	$53	$5	$.50	$3	$62	$187
Total Cost (1000 $)	$35,728	$272	$14	$12	$919	$140
Air Force						
	Long Visit	Short Visit	Prescription Refills	Immunizations	Mammography	Ambulance Transfer
Total Services	123,818	6,720	4,586	4,622	2,944	28
Expense Per Service	$57	$7	$.60	$4	$40	$190
Total Cost (1000 $)	$7,071	$48	$3	$18	$119	$5

SOURCE: Military Medical Departments.

- eliminating out-of-pocket expenses;
- offering services not available at MTFs; and
- increasing primary care capacity so that more beneficiaries can obtain free care.

This review found that PRIMUS/NAVCARE clinics have made access to primary care more convenient and accessible by:

- not requiring appointments;
- generally being located in areas convenient to beneficiaries;
- providing the necessary referrals to MTF specialty and ancillary services;
- having extended hours of operation relative to MTFs, particularly at night and on weekends;
- providing prescriptions which may be in short supply at the MTF pharmacy;
- not requiring cost sharing, while CHAMPUS requires the payment of a deductible and 20 or 25 percent cost sharing above the deductible; and
- providing some preventive primary care services such as Pap smears, mammograms, and school physicals which are difficult to obtain at most MTFs and which had not been covered or are not covered by CHAMPUS.

Historically, retirees and their dependents frequently have had trouble accessing primary care services at the MTF due to the priority system. Because MTF primary care physicians are in high demand, active duty dependents often take all of the available slots. In the PRIMUS/NAVCARE program, however, patients in the absence of an emergency are seen on a first-come, first-served basis regardless of beneficiary category. Consequently, this reflects a substantial increase in accessibility for this population.

One of the most compelling indicators of improved access to care is increased utilization. Therefore, we studied the impact of PRIMUS/NAVCARE clinics on the overall utilization of free primary care. We assembled data on 20 PRIMUS/NAVCARE clinics at 18 sites that had opened recently. Because of a lack of data we did not include the two sites that had opened in 1990 or the three Northern Virginia centers that had opened in 1985 and

1986.[1] For each site, we looked at MTF primary care utilization prior to clinic opening and PRIMUS/NAVCARE and MTF primary care utilization immediately after the clinics opened. We used monthly data to more sharply divide pre-opening and post-opening trends.[2]

Exhibit III-3 presents clinic-by-clinic results of our analysis of the impact of PRIMUS/NAVCARE on MTF utilization. The first column shows average monthly PRIMUS/NAVCARE visits in the months immediately following the clinic opening. The second and third columns present MTF monthly visits before and after the clinic openings. The fourth column is the change in MTF visits associated with PRIMUS/NAVCARE clinic openings (computed as column three minus column two). The last column (percentage "offset") can be viewed as the percentage of PRIMUS/NAVCARE visits that were previously provided by the MTF.

We characterized each clinic according to whether its visits appear to represent:

- a "substitution" of PRIMUS/NAVCARE visits for previously existing direct care visits (more than 75% offset) -- which we found at three of the 18 sites;
- a "mixed" response (between 25% and 75% offset) -- which we found at eight of the 18 sites; or
- an "expansion" of previously existing direct care visits (less than 25% offset) -- which we found at seven of the 18 sites.

The bar chart following Exhibit III-3 summarizes the results. It shows that most clinics result in a net increase in direct care visits (defined here as PRIMUS/NAVCARE plus MTF visits) with

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[1] Due to their close proximity, we would have had to treat the Northern Virginia clinics as a single site. However, the early opening of the Fairfax clinic in October 1985 made "pre-opening" data unobtainable, and the 14-month lag between the Fairfax opening and the Woodbridge opening made this site difficult to analyze.

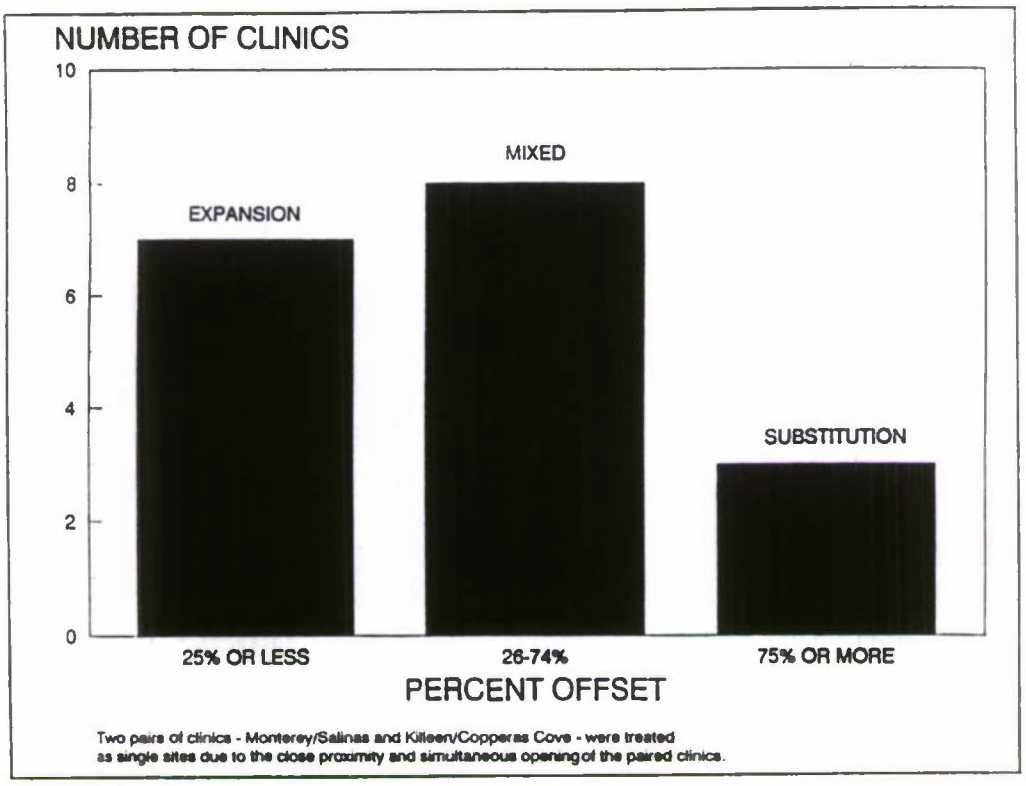
[2] These results are described in more detail in "PRIMUS/NAVCARE Utilization Analysis," 8 April 1991.

EXHIBIT III-3

PRIMUS/NAVCARE VISITS ARE OFFSET TO SOME DEGREE BY DECLINE IN MTF VISITS

Site	PRIMUS/NAVCARE Visits	MTF Visits Before	MTF Visits After	MTF Visits Difference	% Offset	
Norfolk	5,000	61,800	50,400	(11,400)	228%	Substitution
Columbus	4,500	21,900	17,500	(4,400)	98%	
South Bay	5,500	27,500	22,500	(5,000)	91%	
Jacksonville	4,300	25,500	22,400	(3,100)	72%	Mixed
Charleston	5,100	27,600	24,100	(3,500)	69%	
Monterey/Salinas	7,200	17,600	13,100	(4,500)	63%	
Omaha	4,400	15,500	12,800	(2,700)	61%	
Fayetteville	6,500	32,600	29,400	(3,200)	49%	
Mayport	3,000	29,500	28,600	(900)	30%	
Riverside	3,200	15,600	14,700	(900)	28%	
Killeen/Copperas Cove	11,100	20,800	17,800	(3,000)	27%	
Savannah	4,200	12,300	11,700	(600)	14%	Expansion
Oakland	2,400	38,500	38,300	(200)	8%	
Oceanside	4,800	13,800	13,400	(400)	8%	
Virginia Beach	8,700	48,500	48,000	(500)	6%	
Tucson	2,800	11,100	11,000	(100)	4%	
San Diego	9,000	22,100	24,200	2,100	(23%)	
Long Beach	3,400	6,800	7,700	900	(26%)	
TOTAL	95,100	449,000	407,600	(41,400)	44%	

Two pairs of clinics - Monterey/Salinas and Killeen/Copperas Cove - were treated as single sites due to the close proximity and simultaneous opening of the paired clinics.



only three cases falling into the "substitution" category in which most PRIMUS/NAVCARE visits are offset by a corresponding reduction in MTF visits.

Note that these data do not reveal the motivating factors underlying the direct care utilization response. For example, in the case of substitution, the data do not permit a determination of whether PRIMUS/NAVCARE patients were drawn from the MTF or diverted from the MTF by a constraint in MTF resources.

We found considerable variation in behavior from site to site. However, on average, our analysis of the 18 sites indicates that for every 10 PRIMUS/NAVCARE visits, there are 4.4 fewer MTF primary care visits. Generalizing this finding to FY89 suggests that about 44 percent of the nearly 1.5 million PRIMUS/NAVCARE visits occurring in FY89 were offset by a corresponding reduction in MTF primary care visits. Put another way, PRIMUS/NAVCARE was responsible for a net increase of about 840,000 primary care visits in the combined MTF and PRIMUS/NAVCARE system in FY89. This net increase in the use of free primary care is

perhaps the most convincing evidence of the success that PRIMUS/NAVCARE clinics have had in improving access to care.

All of the DoD health planners we interviewed agreed that utilization has increased due to the PRIMUS/NAVCARE program. Most thought this was beneficial, and that the program was fulfilling its objectives. Some were more concerned about the impact on aggregate spending for the MHSS.

Since the implementation of the PRIMUS/NAVCARE program, cost containment has become a much higher priority for MHSS health care planners. While many involved with the PRIMUS/NAVCARE program address this concern by emphasizing the low negotiated rates per visit, others call into question the necessity of the increased accessibility of services and suggest that many clinic visits are accounted for by "ghosts," beneficiaries who would not have incurred costs through CHAMPUS in lieu of the PRIMUS/NAVCARE clinic. These ghosts are thought to be mainly Medicare-eligible beneficiaries and retiree families with other health insurance.[1] Critics of the PRIMUS/NAVCARE clinics point out that PRIMUS/NAVCARE does not increase these individuals' access to care, but increases their access to free care. Others counter that it is the obligation of the service branches to provide this care, and that not providing it will hurt retention of personnel and represent the government's reneging on an implied promise made during the recruitment process.

In general, DoD officials interviewed as part of this report would prefer to see military physicians providing the primary care services to the beneficiary population. However, they see the MTFs as being unable to provide the care due to manning restrictions, an emphasis on wartime-related specialties, space constraints, and restrictions on new construction. Given

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[1] Retirees and their families account for approximately 24 percent of PRIMUS/NAVCARE visits (compared to almost 50 percent of the entire MHSS-eligible population); the percentage of PRIMUS/NAVCARE users who are eligible for Medicare is not known.

these impediments, they view the PRIMUS/NAVCARE program as the next best way of improving access to primary care services.

III. RELIEF OF MTF OVERCROWDING

The results of our analysis of utilization suggest that PRIMUS/NAVCARE was associated with a reduction of about 660,000 MTF visits in FY89. This translates into approximately a nine percent reduction in primary care visits at the affected MTFs. This reduction was observed in most primary care clinical areas including pediatrics, family practice, primary care, and gynecology. It is significant that there was also an observed reduction in emergency room visits.

While this reduction in MTF primary care visits does not guarantee a lessening of MTF overcrowding, it certainly provides an opportunity for such a reduction. Among those interviewed as part of this review, there was some agreement that PRIMUS/NAVCARE has reduced the inappropriate use of MTF emergency rooms as entry points for primary care. However, most did not believe that PRIMUS/NAVCARE clinics have significantly reduced MTF overcrowding. For example, at the sites we visited, MTF officials reported that there was no decline in demand for primary care services at their clinics.[1] Instead, the MTFs we visited reported that the unmet demand for primary care services was so high that opening PRIMUS/NAVCARE clinics did not seem to affect demand at the MTF and simply led to more visits overall.

Some of those interviewed as part of this review indicated that the clinics had changed the mix of services handled by the MTF, with MTF physicians treating cases more relevant to

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[1] One MTF did notice a decline in pediatrics immediately after the clinic opening. However, the number of pediatric visits at the PRIMUS/NAVCARE clinic was not substantial, and it appears that the decline represented a seasonal effect rather than a shift to the new clinic.

their specialties rather than providing primary care services.[1] MTF emergency room visits have declined in areas with PRIMUS/NAVCARE centers, and some MTF clinic queues have become shorter. Morale at the MTFs has seemed to improve as the backlog of cases is reduced.

IV. COST-EFFECTIVENESS

This report examined PRIMUS/NAVCARE cost-effectiveness from two perspectives:

- First, how do PRIMUS/NAVCARE unit costs compare with CHAMPUS and direct care unit costs?
- Second, given these unit costs and what has been learned about utilization patterns, what impact has the PRIMUS/NAVCARE program had on the overall cost to the government of providing the primary care benefit?

A. UNIT COSTS

There is disagreement over how the unit costs of services provided at PRIMUS/NAVCARE centers compare with the direct care system and CHAMPUS. Some studies have found that PRIMUS/NAVCARE visits are less costly per visit than CHAMPUS. More recent work by the DoD Inspector General's office suggests that CHAMPUS may actually be the least costly alternative from the government's perspective on a cost per visit basis.

Estimating the average cost of a PRIMUS/NAVCARE, MTF, or CHAMPUS visit is not in itself a difficult task because all three systems maintain cost and workload data expressed in terms of dollars and visits. However, due to differences in case mix and the type of services provided in a visit, the "average cost per visit" may not be analytically comparable between PRIMUS/NAVCARE, MTFs, and CHAMPUS.

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[1] While this claim was made by some of the Service-level policymakers and program administrators, none of the individuals interviewed on our four site visits were able to corroborate this claim.

The methodology used in this report controls for case mix differences between PRIMUS/NAVCARE, MTFs, and CHAMPUS. However, due to data limitations, it does not control for differences in the types of services provided in a visit between the CHAMPUS system, MTFs, and PRIMUS/NAVCARE. PRIMUS/NAVCARE clinics are paid a fixed amount per visit, regardless of the services performed, and thus have an incentive to minimize the number of services provided in a visit. CHAMPUS physicians, on the other hand, have an incentive to maximize the number of services for which they can separately bill at a given visit. For example, a CHAMPUS physician may conduct more lab tests or x-rays at a given visit because he or she can separately bill for those services while a PRIMUS/NAVCARE clinic cannot.

Therefore, this report examines the unit cost of providing the same set of services associated with the typical PRIMUS/NAVCARE visit in the CHAMPUS and MTF settings. The services provided in a CHAMPUS visit might exceed those provided in a PRIMUS/NAVCARE visit because of the incentives to increase services per visit under CHAMPUS. Consequently, one must interpret the findings in this section on unit costs with caution.[1]

1. Methodology

The methodology we used involved estimating the cost to the government of:

- a typical PRIMUS/NAVCARE visit;
- a typical PRIMUS/NAVCARE visit if the same services provided in the PRIMUS/NAVCARE visit were paid for under CHAMPUS; and
- a typical PRIMUS/NAVCARE visit if the same services provided in the PRIMUS/NAVCARE visit were performed in an MTF.

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[1] The methodology and results are described in detail in "PRIMUS/NAVCARE Cost-Effectiveness Analysis," 8 April 1991.

By examining individual cases we were able to eliminate any case mix differential between PRIMUS/NAVCARE, CHAMPUS, and MTF visits. However, as discussed above, this methodology does not estimate the unit costs associated with the typical set of services provided in CHAMPUS visits.

The ten major steps are described briefly below. Step 1 pertains to the development of PRIMUS/NAVCARE unit costs. Steps 2 through 7 relate to CHAMPUS unit costs. MTF unit costs are described in steps 8 through 10.

1. To estimate PRIMUS/NAVCARE unit costs, we simply divided government payments (including start-up costs prorated over a five-year period) to PRIMUS/NAVCARE contractors by the number of visits performed.

2. We reviewed visit descriptions in the medical records of PRIMUS/NAVCARE patients at two sites and broke each visit down into component procedures and medications dispensed or prescribed.

3. For each procedure identified in step two, we assigned the average amount that historically has been billed to CHAMPUS.

4. We estimated medication costs of each visit.

5. We summed procedure and medication costs over each visit. The result is the total "CHAMPUS-Equivalent Cost" of a given PRIMUS/NAVCARE visit.

6. We determined the CHAMPUS administrative costs on a cost per visit basis.

7. We determined the government's share of the CHAMPUS-Equivalent Cost by applying a historical ratio of government-to-total cost.

8. We summed procedure and medication costs over each MTF visit. The result is the total "CHAMPUS-Equivalent Cost" of a given MTF visit.

9. We indexed MTF case mix to PRIMUS/NAVCARE case mix, using CHAMPUS-Equivalent Cost as an indicator of case mix complexity.

10. We applied this index to the marginal cost of an MTF visit to obtain the MTF's case mix adjusted cost per visit.

a. The "CHAMPUS-Equivalent Cost" Concept

The essence of this methodology is to derive the "CHAMPUS-Equivalent Cost" of the typical PRIMUS/NAVCARE visit and the typical MTF primary care visit. These costs are based upon the procedures performed during the typical PRIMUS/NAVCARE and MTF visit and the national average CHAMPUS charge per procedure for the services provided in the typical PRIMUS/NAVCARE and MTF visit.

To implement this approach, we first decomposed the sampled visits (described below) into their parts -- physician services, allied health professional services, laboratory services, radiology services, and pharmaceuticals -- each of which is associated with a CPT-4 procedure code.[1]

We calculated the CHAMPUS-Equivalent Cost of a visit by identifying the procedures performed in the typical PRIMUS/NAVCARE and MTF visit and summing the national average CHAMPUS charges for each of these procedures. Estimated costs of medication are also included in this computation.

b. Medical Record Sampling

A sample consisting of 1,422 medical records was gathered over a two-day period in July 1990 at two PRIMUS/NAVCARE clinics[2] and the adult and pediatric primary care clinics of their sponsoring MTFs:

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[1] The methodology used in the unit cost analysis takes advantage of the fact that the bills that physicians submit to OCHAMPUS must be itemized by CPT-4 code. As a result, the charge, for example, for setting a simple fracture of the finger is known (CPT-4 code 26720, $133), as is the cost of setting a compound fracture of the finger (26730, $323), as is the relative value of the two (2.43).

[2] According to IAW Army Regulation 40-66, "The use of Army medical records in the preparation of this material is acknowledged, but it is not to be construed as implying official Department of the Army approval of the conclusions presented."

- PRIMUS Killeen/Darnall Army Hospital, Fort Hood, Texas; and
- PRIMUS Omaha/Ehrling Bergquist Strategic Hospital, Offutt AFB, Nebraska

The sample was limited to this size because of the expense involved in gathering and coding medical records. It is important to consider the adequacy of this sample for the purposes of the study. Key concerns include the adequacy of the sample size and the extent to which the sample is nationally representative in terms of visit content.

For each medical record, the Standard Form 600 bearing the most recent dated entry was photocopied on-site. Off-site, patient demographic information (age, sex, beneficiary category) was abstracted from each SF 600, which was then reviewed by a licensed medical records technician.[1] Procedures documented in the record were assigned a CPT-4 procedure code. The diagnosis that most prompted the clinic visit was identified and assigned an ICD-9-CM diagnosis code. Lastly, medications dispensed or prescribed during the visit were tallied. After excluding cases in which the SF 600 was illegible or complete patient demographic information was lacking, and excluding optometry visits at PRIMUS Killeen, 1,294 usable cases remained.

The size of the sample proved to be adequate for identifying statistically significant differences among unit costs. Without additional data collection, it is not possible to determine conclusively whether or not the sample is nationally representative in terms of actual visit content (i.e., procedures and medications per visit). However, for PRIMUS clinics, we found that the sample was nationally representative in terms of the mix of beneficiary types treated.

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[1] SF 600 (Chronological Record of Medical Care) is a problem-oriented medical record that is used to document clinic visits typically in a standard SOAP format (subjective findings, objective findings, assessment, and plan). The most recent entry on a given SF 600 was defined as a visit -- i.e., no attempt was made to construct episodes of care spanning more than one treatment encounter.

Due to the absence of national data on the beneficiary mix of MTF primary care visits, we could not test the representativeness of the beneficiary mix in our MTF sample. However, because MTF costs were case mix adjusted separately for children and adults, this potential problem was minimized to the extent possible.

c. PRIMUS/NAVCARE Unit Costs

The government pays for PRIMUS/NAVCARE visits on a visit-by-visit basis. The cost of a given PRIMUS/NAVCARE visit, however, varies according to three factors.

- Type of service -- the government is charged less for an abbreviated visit, for example, than for a full-length visit.
- Volume -- most PRIMUS/NAVCARE contracts include unit cost discounts at predetermined volume thresholds. As a result, a visit occurring late in the contract year is generally less expensive to the government than one occurring early in the year.
- Contract specifics -- there is considerable diversity across PRIMUS/NAVCARE contracts in the way in which services are defined and in the charges that the government and contractor agree to for such services. For the most part, physician, paraprofessional, laboratory, radiology, and pharmacy services are included in the basic per-visit charge, although some contracts deal with prescription refill and handling charges separately.

In this analysis, we used a program-wide average cost to the government for a PRIMUS/NAVCARE visit, derived from actual FY89 utilization levels and actual FY89 contractor payments. We prorated start-up costs charged to the Government over a five-year period, and included one year's share in the FY89 payments used for this calculation.

d. CHAMPUS Unit Costs

We estimated both the total CHAMPUS-Equivalent Cost and the government's share of the total CHAMPUS-Equivalent Cost of the services received by patients in PRIMUS/NAVCARE clinics. The first step in estimating the CHAMPUS-Equivalent Cost of a PRIMUS/NAVCARE visit was to identify and encode all procedures reflected in the sample of medical records from PRIMUS Killeen and PRIMUS Omaha. During this step, the number of medications dispensed or prescribed during each visit was also noted, as was the age of the

patient. At the completion of this step, two listings were generated of all CPT-4 codes that had been encountered -- one for visits by patients in the pediatric age group and another for adults.

Next, we calculated the national average CHAMPUS total billed charges associated with each procedure code.[1] We then adjusted the FY88 CHAMPUS-Equivalent Costs for inflation using the professional medical services component of the CPI because the PRIMUS/NAVCARE and MTF counterparts were to be derived from FY89 data.[2]

The next step was to apply the unit cost estimate for medications -- $7.02 -- to the respective medication amount. We then summed procedure and medication costs for each visit and averaged across demographic cells.

The last step before calculating the CHAMPUS-Equivalent Cost of a given PRIMUS/NAVCARE visit was to add an estimate of CHAMPUS claims processing costs. This is necessary because the administrative component of a PRIMUS/NAVCARE visit is included

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[1] We used national rather than regional or local average charges due to data availability. These data were extracted from the OCHAMPUS report entitled, "CHAMPUS Outpatient Services for Care Received in Fiscal Year 1988 for All Catchment Areas Combined" (OSCR), which lists each CPT-4 code encountered during the year by CHAMPUS claims processors. For each code, the OSCR reports the number of occurrences and three costs: (1) total billed charges; (2) CHAMPUS allowable costs (i.e., the lesser of billed charges or the CHAMPUS prevailing rate); and (3) actual government-paid costs. Because this report does not distinguish between beneficiary categories, we chose the first of these costs and later applied beneficiary- category-specific ratios of total charges to government costs, allowing us to develop separate government unit costs for active duty dependents and retirees.

[2] Between 1988 and 1989, the professional medical services component of the Consumer Price Index increased by 6.5 percent.

in the PRIMUS/NAVCARE charge while CHAMPUS claims processing costs are not included in the OCSR report.[1]

Finally, because beneficiaries pay part or all of the costs of a CHAMPUS visit, we needed to calculate the government's share of the total cost. We did this by calculating the beneficiary type-specific ratio of government-to-total costs based upon medical visit costs in the CHAMPUS Cost and Workload Report in FY89.

e. MTF Unit Costs

The procedure for estimating what the typical PRIMUS/NAVCARE visit would cost to provide at an MTF involved the following two steps:

- estimate the MTF marginal cost of providing a typical MTF primary care visit; and
- adjust this cost for differences in complexity between the typical MTF primary care visit and the typical PRIMUS/NAVCARE visit.

Our estimate of the MTF marginal cost of providing typical MTF primary care visits was taken from the OASD(HA) RAPS model. We adjusted for differences in complexity by comparing the average CHAMPUS-Equivalent Cost in our sample of MTF primary care visits with the average CHAMPUS-Equivalent Cost of our sample of typical PRIMUS/NAVCARE visits. The ratio of these costs constitutes a case mix adjuster whose value reflects the complexity of MTF visits relative to PRIMUS/NAVCARE visits. Once this case mix adjuster was computed, the RAPS model MTF marginal cost estimate was divided by the adjuster to form an estimate of the marginal MTF cost of providing a typical PRIMUS/NAVCARE visit.

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[1] For FY 89, the OCHAMPUS budget included $73.9 million for FI administrative costs to process approximately 11.7 million claims for an average of $6.34 per claim. However, the claim is an administrative unit, not a unit of health care utilization. Using the CHAMPUS Statistical Phase Back Report we estimate that one outpatient visit generates approximately 0.66 claims for outpatient professional services or drugs. Thus we estimate average claims processing costs per visit to be $6.34 x 0.66 or $4.15.

This process was actually carried out separately for children and adult patients. Our final estimated MTF marginal cost for providing the typical PRIMUS/NAVCARE visit was computed as the weighted average of the adult and child marginal costs, using the mix of adults and children in our PRIMUS/NAVCARE sample as weights.

2. Limitation of the Analysis

It should be emphasized that the MTF and CHAMPUS unit costs developed under this methodology represent the cost of providing the set of services associated with the typical PRIMUS/NAVCARE visit. Because of varying practice patterns and financial incentives, this may be quite different from the unit cost of the care that would actually be provided to the typical PRIMUS/NAVCARE patient at an MTF or under CHAMPUS. As discussed above, PRIMUS/NAVCARE clinics are paid a fixed amount per regular visit, regardless of the procedures performed, and thus there is an incentive to minimize procedures. CHAMPUS physicians, on the other hand, have a financial incentive to maximize the number of profitable services. MTF incentives would appear to be more neutral. Thus, one would predict that the actual cost of providing an MTF or CHAMPUS visit to the typical PRIMUS/NAVCARE patient would exceed these unit cost estimates because of differences in services provided, particularly in the case of CHAMPUS.

Using the medical record samples, we attempted to determine whether MTFs conducted more procedures than PRIMUS/NAVCARE patients with similar presenting diagnoses. Our findings were inconclusive. We were unable to conduct a similar analysis of CHAMPUS care due to the absence of medical record data.

3. Results

Using this methodology, we found that the average cost of a PRIMUS/NAVCARE visit in FY 89 was $48.52 (see Exhibit III-4). Controlling for case mix, we found that this was

EXHIBIT III-4

AVERAGE COSTS PER VISIT, ADJUSTED FOR CASE MIX, FY89[a]

Visit Type	Average Cost[b]	Percent of PRIMUS/ NAVCARE Cost	Savings Relative to PRIMUS/ NAVCARE
PRIMUS	$48.52	100%	--
CHAMPUS Charges	$51.81 ± $2.04	107% ± 4.2%	-$3.29
CHAMPUS Government Costs	$38.52 ± $1.43	79% ± 3.0%	$10.00
MTF	$33.60 ± $3.36	69% ± 10%	$14.92

a Note that the unit costs represent the CHAMPUS cost of providing services done in PRIMUS/NAVCARE centers; this may not represent the actual cost of a CHAMPUS visit because of the incentives to increase services in CHAMPUS visits.

b ± values at 95% confidence level.

somewhat less than the average total CHAMPUS charges for similar primary care visits in that year ($51.81 in FY 89). We found that the average cost of a PRIMUS/NAVCARE visit was higher than the average government cost of a CHAMPUS visit ($38.52). The government cost of a CHAMPUS visit is lower than total charges because of beneficiary cost sharing, payments by other insurance, and any amount in excess of CHAMPUS allowable charges.[1] We also found that the average cost of a PRIMUS/NAVCARE visit was significantly higher than the estimated cost of a similar MTF primary care visit ($33.60).

[1] However, we note that unit costs represent the CHAMPUS cost of providing services done in PRIMUS/NAVCARE centers; this may not represent the actual cost of a CHAMPUS visit because of the incentives to increase services in CHAMPUS visits.

B. TOTAL COSTS

To what degree have PRIMUS/NAVCARE centers increased aggregate costs? As discussed above, almost everyone interviewed as part of this report believed that because access has increased, aggregate government costs have also increased. The additional costs to the government of providing PRIMUS/NAVCARE visits depends upon the unit costs of PRIMUS/NAVCARE visits relative to MTF and CHAMPUS visits as well as the impact of PRIMUS/NAVCARE on MTF and CHAMPUS utilization.

For costing purposes, it is convenient to subdivide PRIMUS/NAVCARE visits into three categories:

- those that were previously provided by an MTF;
- those that were previously paid for under CHAMPUS; and
- "new" visits.

Based upon our unit cost analysis, we estimate that every visit shifted to PRIMUS/NAVCARE from MTFs and CHAMPUS increases government costs by about $10-$15. New visits increase costs by about $49 each.

In FY89, there were a total of about 1.5 million PRIMUS/NAVCARE visits. Based upon our analysis of the impact of PRIMUS/NAVCARE on MTF visits, we estimate that roughly 660,000 of these visits were shifted from local MTFs. Of the remaining 840,000 visits, our rough estimate is that 170,000 were shifted from CHAMPUS. This estimate is based upon observing local CHAMPUS utilization before and after the opening of selected PRIMUS/NAVCARE clinics.

The implications of these estimated unit cost and utilization effects are summarized in Exhibit III-5. As can be seen, we estimate that the net increase in government costs is $44.1 million or an average cost of $29.40 per PRIMUS/NAVCARE visit. In other words, DoD spent

EXHIBIT III-5

NET COST TO GOVERNMENT OF PRIMUS/NAVCARE PROGRAM

Type of Visit	Number of Visits	Increased Cost Per Visit	Total Increased Cost
Visits Shifted from MTF	660,000	$14.92[a]	$9.8 M
Visits Shifted from CHAMPUS	170,000	$10.00[b]	$1.7 M
New Visits	670,000	$48.52[c]	$32.5 M
Total	1,500,000	$29.40[d]	$44.1 M

[a] Difference in cost per visit between MTF and PRIMUS/NAVCARE.

[b] Difference in cost per visit between CHAMPUS government cost and PRIMUS/NAVCARE.

[c] Average cost of a PRIMUS/NAVCARE visit.

[d] Calculated by dividing $44.1 million by 1.5 million visits.

$71.5 million on the PRIMUS/NAVCARE system in FY 89; $44.1 million of this total would not have occurred if care had been provided exclusively at MTFs or through CHAMPUS. Part of this $44.1 million is due to the increased number of visits and part is due to the higher cost of PRIMUS/NAVCARE clinic visits relative to CHAMPUS and MTFs. Even if one assumed that all the PRIMUS/NAVCARE visits would have occurred at CHAMPUS or MTFs (i.e., that none of the visits were new), the average cost per visit would have increased by $10-15 and total costs would have increased by $15 to $23 million.

As noted above, much of this cost increase was for care that would not have been received otherwise. Much of the care was also for preventive, primary care services which may be cost effective if they prevent more costly outpatient and/or inpatient care. This increased aggregate cost is viewed as an expected outcome by many in the Services.

Because the goal of PRIMUS/NAVCARE was to improve access, there was bound to be some cost associated with the attainment of this goal.

As discussed in the analysis of unit costs, these results may overstate the additional costs of the PRIMUS/NAVCARE program. To the degree that CHAMPUS or MTF physicians provide more services per visit than in PRIMUS/NAVCARE visits, the additional costs per visit of a PRIMUS/NAVCARE visit presented here may be too high. In addition, PRIMUS/NAVCARE clinics are more likely to refer patients to the MTF than CHAMPUS physicians. Consequently, patients who use PRIMUS/NAVCARE clinics may have lower costs for specialty care -- an effect not measured here.

V. QUALITY OF CARE

An in-depth analysis of the quality of care at PRIMUS/NAVCARE clinics was beyond the scope of this study. However, as part of this report, a physician consultant evaluated the adequacy of selected PRIMUS/NAVCARE quality assurance (QA) plans and activities. We also addressed quality issues in site visit discussions with MTF commanders and physicians and considered the results of PRIMUS/NAVCARE patient satisfaction surveys.

A. QUALITY ASSURANCE PLANS

PRIMUS/NAVCARE contractors are typically required to propose a QA plan that conforms to the requirements of the parent military hospital and to the guidelines of the Joint Commission on Accreditation of Health Care Organizations (JCAHO). In order to assess the adequacy of PRIMUS/NAVCARE QA plans, as part of this report an experienced QA physician (who also directs the DoD Civilian External Peer Review Program) reviewed the following documents:

- Services' regulations governing quality assurance/risk management (QA/RM), provider credentialing, and clinical privileging;
- the quality assurance requirements in a sample of PRIMUS/NAVCARE contracts; and

- a sample QA plan from each of the four PRIMUS/NAVCARE contractors.

The quality expert found that all of the service QA documents and contractor QA plans are written within the framework of traditional QA systems. That is, their implicit and explicit goal is to measure quality, find substandard quality, and improve it primarily through "corrective actions" aimed principally at various health care providers. This expert found that there was variation in the overall quality of these documents, but that they were generally acceptable as QA plans. Health care QA is now moving away from this traditional approach toward a philosophy of "continuous improvement." However, this movement is in its early stages and thus the traditional QA model is in line with current practice.

B. SITE VISIT FINDINGS AND PATIENT SATISFACTION

Site visits conducted as part of this report took us to clinics of each of the Services and three of the four PRIMUS/NAVCARE contractors. In these site visits, we spoke with MTF commanders, as well as the military doctors whose areas of responsibility were more focused on primary care or emergency services and who, therefore, interact more closely with contractors' medical staffs. On the whole, they were impressed with the medical practices at PRIMUS/NAVCARE clinics and, of equal importance, with the competency of PRIMUS/NAVCARE physicians.[1]

While our visits to Fort Hood, Offutt, and Charleston provided information on the quality of care at these PRIMUS/NAVCARE clinics, it was too early to make this assessment at the PRIMUS center at MacDill. Instead, the COR's comments on quality of care at this site were based on the contractor's proposed quality assurance program as presented in their proposal.

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[1] This is consistent with previous studies that showed a higher proportion of PRIMUS/NAVCARE physicians to have post-graduate training in a primary care specialty and to be board-certified or eligible in their specialty compared to military physicians.

The CORs/COTRs at each site are responsible for a series of audits of the PRIMUS/NAVCARE clinic. While there is some variation across sites, these audits typically include a review of CPR certification, equipment inspection, compliance with Service regulations regarding medical record documentation, review of provider licenses and credentials, an examination of the minutes of the quality assurance committee meetings to ascertain whether all identified problems were addressed and resolved, and a review of the prescriptions and consultations issued. They also review patient satisfaction surveys and complaints, and share any identified concerns with the contractor. Through beneficiary feedback, monthly audits, and first-hand observations, the CORs/COTRs have identified a few operational and staffing problems. For example, one physician had deficient English-language skills and patients complained of another's bedside manner. In another case, a radiology technician was not performing adequately and did not respond to additional training. Such accounts were, however, anecdotal in nature, and in each case the situation was resolved by the contractor to the satisfaction of the government. In fact, the CORs/COTRs from our site visits noted that the PRIMUS/NAVCARE contractors are responsive to any comments or problems presented by the COR/COTR. In addition, the COR/COTRs thought highly of the contractor's quality assurance programs and of the overall operations of the clinics.

The responsiveness of the contractors may help to explain the high level of satisfaction that PRIMUS/NAVCARE patient surveys have shown since the program's inception. Most recent of these, and the broadest, is the Navy-wide 1990 Annual Patient Evaluation of NAVCARE Clinics, which questioned patients' views on NAVCARE facilities, staff, and ancillary services. Overall, 92 percent of patients rated NAVCARE clinics outstanding, excellent, or satisfactory. Results are similar for the Air Force, which surveys satisfaction on a

local basis, and the Army, which now includes PRIMUS under the umbrella of its general MTF outpatient satisfaction survey.

Findings from our site visits indicated that the MTF medical staff at the three established PRIMUS/NAVCARE sites agreed that the quality of the medical services provided was high. In some cases, MTF staff members stated that a clinic's quality assurance program was more thorough than that of the MTF. In those cases where we were told of weaknesses on the part of the contractor, the complaints focused on a lack of compliance with Service procedures for documenting medical records (typically a problem when a new provider came on board at the clinic and usually resolved soon thereafter) or, in one instance, a complaint that the clinic referred inappropriate cases to the MTF emergency room.[1]

Each of the clinics visited had a quality assurance program in place, although, as discussed above, the clinic at MacDill was still developing its program at the time of our visit. The contractors rely on a combination of procedures including peer reviews; focused reviews; reviews of consultations (particularly to see if consulting physician reports have been returned), prescriptions, and ambulance transfers; monitoring and evaluation programs; reviews of radiology readings and cases with abnormal lab results; patient surveys and other mechanisms to assure high quality care. Those sites administering patient satisfaction surveys indicated a high level of satisfaction across clinic patients, with satisfaction levels typically in the 90 percent or higher range.

In some ways, PRIMUS/NAVCARE clinics have exceeded those contractual requirements designed to promote high quality care. For example, some of the clinics are required to apply for JCAHO accreditation within one year of opening. Of the three clinics that had been open for any length of time, two had received JCAHO accreditation (and one of

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[1] The medical director at the PRIMUS/NAVCARE clinic in question mentioned anecdotally that the clinic sometimes had to refer patients to the ER when it was after-hours for the appropriate MTF clinic.

these had received a special commendation from the JCAHO). In addition, the clinics are required to hire physicians who are board-eligible; many if not most of the clinics' physicians were board-certified.

While a strong QA plan does not guarantee equally strong execution, it does increase the prospects for satisfactory results. Prospects are further raised by close supervision on the part of the MTF and a climate of cooperation between PRIMUS/NAVCARE and MTF medical staffs. If patient satisfaction is any indicator, PRIMUS/NAVCARE clinics have reallzed these prospects, and the goal now is to maintain this success.

ACRONYMS AND ABBREVIATIONS

AFB	Air Force Base
AH	Army Hospital
CAPS	CHAMPUS Actuarial Projection System
CHAMPUS	The Civilian Health and Medical Program of the Uniformed Services
COB	Coordination of Benefits
COR	Contracting Officer's Representative
COTR	Contracting Officer's Technical Representative
CONUS	Continental United States
CPT-4	Current Procedural Terminology, Fourth Edition
DEERS	Defense Enrollment Eligibility Reporting System
DMIS	Defense Medical Information System
DoD	Department of Defense
ER	Emergency Room
FY	Fiscal Year
IG	Inspector General
JCAHO	Joint Commission on the Accreditation of Health Organizations
MEPRS	Medical Expense and Performance Reporting System
MHSS	Military Health Services System
MTF	Military Treatment Facility
NAVCARE	Navy Cares
NH	Navy Hospital
OCHAMPUS	Office of the Civilian Health and Medical Program of the Uniformed Services
OSCR	CHAMPUS Outpatient Services for Care Received in Fiscal Year 19XX Report
PCM	Primary Care Manager
POC	Point of Contact
PRIMUS	Primary Care for the Uniformed Services
QA	Quality Assurance
RAPS	Resource Analysis and Planning System