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NAVAL POSTGRADUATE SCHOOL
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THESIS

COST-BENEFIT ANALYSIS FOR OUTSOURCING MEDICAL TREATMENT FOR ALL ACTIVE DUTY MEMBERS ON THE MONTEREY PENINSULA

by

Darryl M.Toppin

September 1998

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Due to downsizing, many activities within the Department of Defensehave turned to outsourcing as a means to complete their given missions with their shrinking or limited resources. The primary objective of this thesis was to analyze the various outsourcing options available to California Medical Detachment to provide medical services for active duty personnel on the Monterey Peninsula. Three alternative options were identified and evaluated in terms of five criteria: Cost, Accessibility, DoD control, Customer Service and flexibility of System Processes. To address these issues, interviews were conducted with key personnel familiar within the command structure of CMD and the Presidio of Monterey Health Clinic (POMAHC). Financial documents and policy statements were reviewed. The findings were that the current system of providing care through POMAHC was the most practical option in accordance with the five criteria.

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COST-BENEFIT ANALYSIS FOR OUTSOURCING MEDICAL TREATMENT FOR ALL ACTIVE DUTY MEMBERS ON THE MONTEREY PENINSULA

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ABSTRACT

Due to downsizing, many activities within the Department of Defense have turned to outsourcing as a means to complete their given missions with their shrinking or limited resources. The primary objective of this thesis was to analyze the various outsourcing options available to California Medical Detachment to provide medical services for active duty personnel on the Monterey Peninsula. Three alternative options were identified and evaluated in terms of five criteria: Cost, Accessibility, DoD control, Customer Service and flexibility of System Processes. To address these issues, interviews were conducted with key personnel familiar within the command structure of CMD and the Presidio of Monterey Health Clinic (POMAHC). Financial documents and policy statements were reviewed. The findings were that the current system of providing care through POMAHC was the most practical option in accordance with the five criteria.

TABLE OF CONTENTS

I INTRODUCTION

A. PURPOSE

This thesis provides a detailed presentation of options available to the California Medical Detachment (CMD) to fulfill the mission of providing medical care to all active duty personnel on the Monterey peninsula. This thesis identifies the costs and benefits associated with the different methods available to the Department of Defense in providing medical care to all active duty stationed on the Monterey peninsula only. Specifically, the possibility of reducing cost through privatization or transferring the monetary and non-monetary cost and responsibilities to non-Department of Defense (DoD) agencies are examined.

B. BACKGROUND

The Base Realignment and Closure Commission's (BRAC) decision to close Fort Ord led to the closure of Silas B. Hays Military Hospital, the only Military Treatment Facility (MTF) with inpatient/outpatient services and specialized care capabilities in central California. In addition, the closure of two local area Primus clinics in 1994 further diminished the availability of medical care to the military on the Monterey Peninsula. In 1993, the California Medical Detachment (CMD), Monterey Bay region was established to provide health services for active duty on the peninsula. CMD is responsible for health care administration at the Presidio of Monterey Army health clinic (POMAHC) and any supplemental care beyond the capabilities of the POMAHC. CMD's mission is to provide outpatient

and inpatient care to active duty service members. Inpatient care for active duty personnel is provided either through the nearest military hospital, David Grant Hospital at Travis Air Force Base, which is over 100 miles away, or through contracted arrangements with local hospitals. Outpatient care for active duty members is provided at the POMAHC, at David Grant or by local civilian physicians for certain specialties. CMD uses the same local civilian specialty providers that the managed-care contractor, AETNA, uses in the health care programs for active duty dependants and retirees as prescribe by Civilian Health and Medical Program of the Uniform Services (CHAMPUS).

CHAMPUS was originally designed to provide comprehensive health care services to the dependents of active duty members, retirees and their eligible family members. A beneficiary shares with CHAMPUS the total cost of each procedure or visit to the civilian health care provider. CHAMPUS has a ceiling established for each type of allowable service. This ceiling is called a Champus Maximum Allowable Charge (CMAC) for a specific area. The CMAC is determined by the lowest of the actual billed charge, the national prevailing charge for a particular procedure adjusted by a local geographic factor and the maximum allowable prevailing charge established by applying the Medicare economic index. (CHAMPUS, Section 1.1, Revision 4 pg. 1.1.1)

CHAMPUS beneficiaries can choose from three health care plans TRICARE PRIME, TRICARE EXTRA, or TRICARE STANDARD. The differences between these programs are the percentages of cost sharing assumed by the beneficiary and the choice of physician. TRICARE PRIME is the least expensive options

available to the beneficiary. The beneficiary must enroll in the TRICARE PRIME and choose a Primary Care Manager (PCM) from an authorized network provider. There is a minimal co-payment for each medical visit, but it is not a deductible or cost-sharing. The payments are not procedural based, but rather a surcharge for administrative cost. The PCM is responsible for providing all medical care within their capabilities, all other treatments must be referred to specialists. TRICARE EXTRA and TRICARE STANDARD both require an annual deductible. There is no enrollment requirement and the beneficiary can change between the programs at anytime. A beneficiary using TRICARE STANDARD must pay 20 percent of the CMAC for services. If they are not using a network provider, they must also pay the amount above the CMAC to cover the provider's charge up to one hundred fifty percent of the CMAC. A beneficiary using TRICARE EXTRA must choose a network provider and pay 20 percent of the CMAC for services. In 1994, the Department of Defense (DoD) selected Aetna Government Health Plan over Foundation Health Plan (FHP) as the prime contractor to manage the TRICARE programs in California and Hawaii. Aetna was responsible for contracting and negotiating fees with civilian providers, educating both providers and beneficiaries of the changes from the FHP programs and ensuring that quality health care was being provided to the beneficiaries. Conversely, even though active duty members are not eligible for medical services under the TRICARE umbrella, the contract between the Department of Defense and Aetna allows for the active duty service member to utilize the preferred providers when a situation mandates. The only exception is

that the active duty member is not responsible for any deductibles, cost-sharing or co-payments. CMD pays in full up to the allowable CMAC negotiated by Aetna with the local providers.

POMAHC is strictly an outpatient facility. It houses a pharmacy, limited laboratory and x-ray capabilities, and a separate dental treatment center. It provides sick call, primary care and limited acute care to active duty service members within the catchment area. The facility is staffed by nine Army officers: six physicians, two of which are field surgeons and the others family practitioners; one physician's assistant, one army surgical nurse and one field medical assistant. The staff also includes fifteen enlisted personnel: one clinical non- commission officer (NCO), one medical supply NCO, two CBT medically trained NCOs, two Radiological specialists, four CBT medical specialists, one lab specialist, two pharmaceutical specialists, one medical NCO and one medical specialist. Twenty civilian personnel also work at the facility: one Pharmacist (GS-12), one Occupational health nurse (GS-11), one clinical nurse (GS10), one social worker assistant (GS-08), one contract representative (GS-07), two practical nurses (GS-06), 2 medical record technicians (GS-05), three nurses assistants (GS-04), five medical clerks (GS-04), one psychologist (GS-09) and one medical technologist (GS-10). In addition, there is a Navy medical administrative unit (NMAU) attached with a Navy lieutenant as the officer in charge (OIC), six enlisted personnel and two civilian staff members to assist the large component of Navy personnel in the area. CMD also has an orthopedic physician from Travis Air Force Base at the clinic bi-weekly and a contracted

civilian orthopedic physician weekly. A female health clinic is held once a month by a nurse practitioner from Naval Air Station (NAS) Lemoore. A neurologist, dermatologist and other specialists are contracted on an as needed basis to practice at the clinic. There is an on call physician for emergency care after hours. The clinic also has the capability to provide ambulance service to the DoD population. Presently this capability is not used however, since the driver position is vacant. The clinic operates from 0630 to1630 during the week and from 0800 to 1000 on Saturdays for sick call only. It is closed on Sundays and Federal holiday.

Health care delivery on the Monterey peninsula is made up of the major components diagrammed in Figure I.

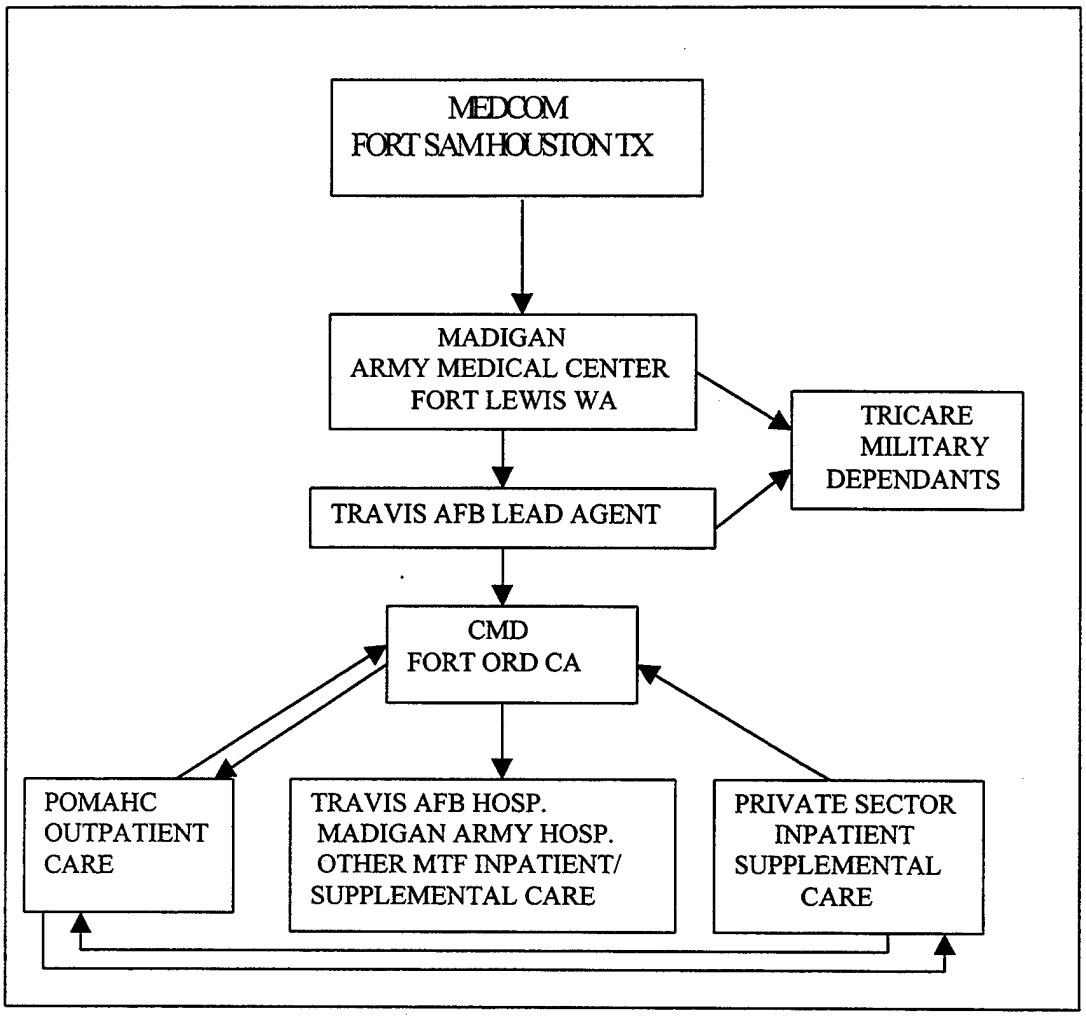

Figure 1.

Army medical command (MEDCOM) has overall responsibility for all army medical centers, hospitals and clinics worldwide. It is also responsible for providing medical care to all service members and their dependants that fall under its geographic areas of responsibility.

Madigan Army Medical Center, located in Fort Lewis, Washington has overall responsibility for all Military Treatment Facilities (MTF) and Tricare networks providers in Alaska, California, Hawaii, Idaho, Nevada, Oregon and Washington. (Tricare is secondary to the focus of this thesis.) Military medical

care facilities areas of responsibility are broken up into 14 regions worldwide. Each region has a lead agent that has financial and administrative responsibility for all MTF's within their regions. The POMAHC is in region 10 and falls under Travis AFB.

California Medical Detachment (CMD) is responsible for the administrative and financial control of the daily operations at the POMAHC. The average daily procedure for providing care to the active duty service members is as follows: The service members report to sick call, emergent care or a routine walk-in appointment for medical attention. If the prescribed treatment is within the capabilities of the primary care providers, the service member is treated and their medical record updated. If the prescribed treatment is beyond the capabilities of primary care providers, a referral is sent to the Tricare manager to decide where and when the service member can be seen. There are three options open to the Tricare manager: (1) Send the member to a local network provider. (2) Send the member to a MTF with the needed capabilities or (3) if the care needed is of the non-urgent type, have the service member see the next scheduled provider on the circuit rider program. The circuit rider program is a sharing of resources by MTF's that allows for needed specialty providers to travel to other MTF's as needed.

If the member is sent to a local network provider, he/she is evaluated and treated. A paper copy of the diagnosis and treatment is sent back to update the member's records at the POMAHC. A bill is generated by the network provider and sent to CMD's active duty claims department. CMD then fills out a voucher

and sends it to MEDCOM. MEDCOM records the transaction and forwards the voucher to Defense Finance and Accounting Service (DFAS) in Rome, New York. DFAS then issues a check to the network provider.

In cases of emergencies, where a referral was not obtained for inpatient/supplemental care, the diagnosis and treatment provided is also mailed to the POMAHC, but the bill is first sent to Palmetto, South Carolina to Foundation Health Federal Services (FHFS), Government Billing Agency (GBA) for processing. It is then sent to CMD and follows the identical path as referred outpatient care for payment.

If the member is sent to another MTF, the member takes his or her record to the MTF. Diagnosis and treatment can then be updated immediately by the MTF. The records are then hand carried by the member back to the POMAHC. Payments for treatments between different services are transferred from one account to the other at the MEDCOM level.

C. RESEARCH QUESTIONS

1. Primary Research Question

What are the costs and possible benefits to California Medical Detachment (CMD) in outsourcing all medical treatment currently available at the Army medical clinic, Military Treatment Facility (MTF) at the Defense Language Institute (DLI).

2. Secondary Research Questions

a. What is the current cost of operating the POMAHC?

b. What are the alternate costs of providing medical treatment for active duty through the civilian sector in accordance with Department of Defense policies?

c. What, if any, are the non-financial costs and benefits of outsourcing?

D. SCOPE

The scope of this thesis is to present a cost-benefit analysis of outsourcing Medical treatment for all active duty on the Monterey Peninsula only. The analysis presented in this thesis should not be applied to other DoD agencies or locations. These costs and benefits are presented in both financial and non-financial format. This thesis does not quantify the non-financial data.

E. METHODOLOGY

1. Data collection

This thesis was predominantly accomplished through interviews with the managed-care supervisor at the California medical detachment (CMD) and the administrative managers at the Presidio of Monterey Army health clinic (POMAHC). Historical financial data and administrative documentation were provided by the CMD and the POMAHC.

2. Analysis

The data collected was used for both quantitative and qualitative analysis. Different options and associated costs were analyzed with respect to costs and benefits to CMD, feasibility and customer satisfaction. The results were

then compared and the best methods selected as a recommended course of action.

F. ORGANIZATION

Chapter II determines the actual costs and the components that contribute to the costs of operating the POMAHC.

In Chapter III multiple methods of delivering medical care to the active duty population are identified and projected costs estimated in order to analyze and determine the best possible course of action.

Chapter IV further analyzes the non-financial costs and benefits inherit to each method identified in chapter III.

Chapter V provides conclusions and recommendations in answering the primary and secondary research questions.

G. BENEFITS OF STUDY

This thesis provides relevant financial and non-financial data that serve as a starting point for the CMD in the event that a contingency arises where the Department of Defense can no longer provide medical care to the active duty population under the current situation. It identifies the basis on which further study can be implemented and realistic financial estimates can be made.

II. POMAHC'S OPERATING COST

This chapter presents the actual cost of operating the POMAHC during the fiscal years of 1996 and 1997.

A. SOURCE OF COST DATA

The data was collected from CMD's comptroller and represents the operating funds in an open allotment account allocated from Operating and Maintenance (O & M) dollars by Madigan Army Medical Center at Fort Lewis, Washington.

B. COST CATEGORIES

There are many components that contribute to the cost of operating the POMAHC. These components are separated into different categories. The categories used in this thesis are civilian payroll, supplemental care, ambulance service, administrative and medical related supplies, support contracts, base operations, travel and civilian medical contracts.

C. NON-OPERATING COST

This thesis does not consider military payroll and physicians training costs. Military payroll is not used due to the fact that military personnel are paid out of a separate account that is not charged back to CMD. Therefore, CMD is not responsible for providing or executing a budget for military personnel. From CMD's perspective, military payroll will not change if the POMAHC closes.

Physicians training costs are also not used, based on the assumption that these cost were fully paid for through the Army's medical training program and are not allocated to each command throughout the physicians military career.

D. DESCRIPTION OF COSTS

Civilian payroll consists of hourly and salaried civilian employees. Expenditures are not tracked by regular and overtime wages, but strictly by totals. Supplemental care consists of all specialized care referred to civilian providers for evaluation and treatment and reimbursable costs to the MTF at Travis AFB, David Grant Medical Center (DGMC) for all active duty referred to Travis for specialized care. CMD is required to reimburse DGMC for inpatient care provided only, at a flat rate of $8.00/day/member. Ambulance service consists of emergency care and transport provided by local private companies contracted by the city of Monterey. Supply mainly consists of pharmaceuticals (prescription drugs and medical supplies) and administrative supplies. Support contracts consists of janitorial services, local laboratory services beyond the capabilities of the POMAHC's lab, medical waste disposal, copier maintenance, and the after hours answering service. These are paid for by contractual agreements.

Base operations is also paid for by contractual agreement. Base operations consists of laundry services, communications (telephone, faxes, message traffic and Internet services), refuse (daily trash pickup and disposal), civilian personal support (CPO) consisting of administrative services and other

human resource activities, government support activity (GSA) vehicles maintenance and fuel, and utilities.

Travel consists of two main factors: (1) temporary duty assignment (TDY) costs, which consist of the actual round trip travel costs, lodging costs and meals costs for physicians from David Grant Hospital at Travis Air Force Base and, (2) the costs associated with transporting service members to David Grant Hospital for specialized care. Civilian medical contracts are individual contracts for civilian physicians to provide care to active duty members. Contracts are usually for optometry, physical therapy, psychiatry, and orthopedics. Services are usually paid for by the hour or on a per patient basis.

E. COST BEHAVIOR (FIXED VS VARIABLE)

The cost components for the operating budget of the POMAHC fall under two types of cost behaviors, fixed and variable. Support contracts and Base operations are the components that are fixed costs on a yearly basis, due to the fact that they are negotiated and specified on a two year contract for the fiscal years 1996 and 1997 (FY96 and FY97). However, they are subject to change upon contract renewal and their actual amounts will tend to be adjusted to reflect changes in patient volume and overall resource consumption. All other cost components are labeled as variable costs since they vary depending on the volume of medical services provided. Civilian payroll varies on actual hours worked. Supplemental care varies on the number of patients referred. Ambulance service varies on the number of patients transported. Supply varies

on the number of patients seen or on actual usage based on the type of supplies (medical vs administrative). Travel varies on the actual trips taken and Civilian medical contracts vary on actual patients seen.

F. AMOUNTS

The following expenditures are listed by component and amounts for 1996 and 1997.

COMPONENT	1996	1997
Civilian Payroll	$982,000	$640,000
Supplemental Care	$970,000	$430,000
Ambulance service (local)	$750,000	$750,000
Supply	$350,000	$552,000
Support Contracts	$184,900	$184,900
Base Operations	$ 73,300	$ 73,300
Travel	$ 32,000	$ 29,500
Civilian Medical Contracts	$ 0	$346,327
Totals	**$3,342,200**	**$3,006,027**

Table I

The following is a breakdown of the individual items by cost in 1997 for Civilian Medical Contracts and Support Contracts:

CIVILIAN MEDICAL CONTRACTS (1997)	
Physical Therapy	$119,491
Optometrist	$90,996
Psychiatrist	$52,000
Orthopedic Surgeon	$45,500
Orthodontist	$38,340
Totals	**$346,327**

Table II

SUPPORT CONTRACTS (1997)	
Laboratory Services	$128,000
Janitorial	$ 36,000
Copier Maintenance	$ 16,000
Evening Answering Service	$ 2,850
Medical Waste	$ 2,047
Totals	**$ 184,900**

Table III

G. EXPLANATION OF YEARLY CHANGES

As noted in the Table 1, there are some major differences within the civilian payroll, supplemental care, supply and civilian medical contract components from 1996 to 1997. These major differences can be attributed to individual factors within each component. The factor causing the differences in civilian payroll from 1996 to 1997 is the reduction of civilian personnel employed during that period. The major cause of the reduction was transfer or separation of personnel.

The large change in the supply component is due to the transfer of supplies from a closing facility to the POMAHC. When one of the military clinics in Oakland was closed, all viable supplies, primarily pharmaceuticals, were transferred to Monterey. This caused a sharp drop in expenditures for FY 96. The POMAHC was able to re-stock the pharmacy at a much-reduced cost. The rise in expenditures for supply in FY 97 was due to the normal replacement cost of the consumed supplies.

The civilian medical contracts and supplemental care components offset each other. This is due to the fact that there were no civilian medical contracts awarded in 1996 and subsequently a large supplemental care expenditure of $970,000. In 1997, there was an expenditure of $346,300 for civilian medical contracts. This caused a reduction in the supplemental care expenditure for 1997. Even though the offset is not dollar for dollar, it still represents substantial net savings between the two components.

Chapter III further discusses these aspects and additional savings between civilian medical contracts and supplemental care.

III. POSSIBLE OPTIONS

A. INTRODUCTION

Due to the draw down in active duty manning levels, and the upwardly spiraling costs of delivering and managing medical treatment for the Department of Defense and possible future constraints, alternative methods must be investigated now to ensure the continued capability by the DoD to provide medical care/treatment to active duty personnel in all possible contingencies. This chapter presents the possible options available and the cost associated with the individual choices for California Medical Detachment (CMD) to effectively manage the delivery of health care to the active duty population now served by the POMAHC. The options are (1) Continue with the current configuration. (2) Close the POMAHC and outsource all treatment to the Veterans Administration (VA) clinic at Fort Ord. (3) Procure a full Enrollment Based Capitation (EBC) from a contracted provider. (4) Outsource to Local Network Providers under a Health Maintenance Organization (HMO) system, and (5) Create a hybrid of civilian or VA physicians with a military staff housed in the POMAHC.

There are indirect overhead costs associated with options 1, 2 and 3. Examples are CMD's personnel costs such as salaries, medical, travel and pensions. These expenditures data were obtained from the CMD's comptroller. The allocation of these costs to the POMAHC's overall operating expense is applied through a percentage of total population (13,000 active duty members) served by CMD in conjunction with the POMAHC's population (7000 active duty

members), which amounts to 54%. This 54% is applied to CMD's total overhead costs for managing the POMAHC.

It is also important to note that any potential real dollar savings would be realized mainly from the CMD's perspective and may or may not necessarily apply to the Department of Defense. Outsourcing the services that the POMAHC provides would save CMD budgeted funds in the civilian payroll, supply, support contracts and base operations components. The DoD would realize real dollar savings provided the Presidio of Monterey re-allocates base services to remaining tenants and effectively monitors and accurately traces these services to the individual tenants.

These options are evaluated based on the monetary costs to CMD and the types and level of care provided.

B. STATUS QUO

The first option is to keep the current system of providing local access to primary medical care for the active duty member and controlling the cost of supplemental care, while efficiently managing the Department of Defense's resources available to the POMAHC's unit commander and the managed care supervisors at CMD. Under this option the POMAHC provides primary medical care (outpatient only). All other levels of care are provided through supplemental inpatient and outpatient care from David Grant Medical Center (DGMC) at Travis AFB and local Foundation Health Federal Systems (FHFS) network providers

from the Tricare system. Emergent care is provided from the closest fully capable medical facility to the location of the emergency.

The operating cost of running the POMAHC for fiscal years 1996 and 1997 were $3,342,200 and $3,006,327 respectively. The additional overhead costs applied to the POMAHC's operating cost is 54% of CMD's total operating budget which are $657,800 for 1996 and 1997. At 54% across the board allocation from all personnel costs components the totals are $355,212 for 1996 and 1997. This $355,212 would represent a saving in total overhead cost to CMD if the POMAHC is shut down and a Full EBC is purchased. These savings would not be applicable to any other option. The overall cost for managing the POMAHC when CMD's personnel costs are added into the equation is **$3,697,412** for 1996 and **$3,361,539** for 1997. Based on the reduction of expenditures for supplemental care from 1996 to 1997, CMD has decided to expand the circuit rider program, where specialist physicians from other military treatment facilities visit the POMAHC on a regular or as needed basis to provide specialty care to the local active duty members. With these changes taking effect, the overall costs for operating and managing the POMAHC should be significantly reduced. Actual projected costs have not been calculated for the upcoming fiscal year.

C. PARTIAL EBC CONTRACT

The second option available to the Department of Defense is to close the POMAHC and outsource all medical treatment to the Veterans Administration (VA) clinic located at Fort Ord in Seaside, California, based on the stipulations of the current VA contract with California, Nevada, Oregon and Washington states. These states make up Regions 9,10 and 11 of the Department of Defense Health Services Areas (HSAs). Under this option the VA would be responsible for providing all outpatient primary care and limited supplemental care for various specialties. Any treatment beyond the limits set in accordance with the contract would be the responsibility of CMD to delegate how and where the active duty member would obtain treatment. The options for supplemental care open to CMD under this option would be referrals to DGMC, VA or local Private sector providers. Emergent care is provided from the closest fully capable medical facility to the location of the emergency.

All VA hospitals abide by the following rule. Provided that the service member is enrolled with that particular VA hospital or clinic, the VA will provide primary medical care at an Enrollment Based Partial Capitation (EBPC) of $20.00 per person per month. Appendix B Contains a copy of the existing EBPC with the VA hospital in Palo Alto, CA. For the 7,000 active duty personnel stationed in the Monterey Peninsula area this would come to a total of **$1,680,000** per year. It is important to note that this is for outpatient primary care only. By definition, primary outpatient care consists of 24-hour available medical care, two hours each morning are set aside for active duty sickcall Monday through Saturday, and laboratory work within the facilities capabilities. See Appendix A for a

complete definition. The responsible managed care supervisor or an assigned "gatekeeper" must authorize all other laboratory work beyond the facilities capabilities. A gatekeeper is a managed-care professional that tracks, traces, authorizes or denies requests for supplemental care for regional active duty members. X-rays and magnetic resonance imaging (MRI) are also part of the contract.

In addition, each active duty member that falls under the VA contract can be referred to specialty care by the primary care provider for five specialty visits per year to each area of specialized care, e.g., five optometry visits, five dermatology visits, five orthopedics visits, etc. There are also provisions for four psychiatry visits as an individual or in group sessions and five visits with a psychologist or social worker, not to exceed nine visits per person per year. Additionally, there are eight physical therapy visits per person per year permitted under the contract See Appendix B for actual limits in all categories. The limits to these visits are a controlling factor, used to ensure the service members are receiving the best possible care at all times, and to provide CMD with a readily available management tool to audit or investigate as the situations merit. Repeated visits or excessive visits to one particular specialty may raise a red flag to the managed care supervisor, who may take further action by referring the service member to a military treatment facility for further evaluation by a military physician. Any referrals beyond these limits are not part of the contract, but are referred back to CMD's responsibility for payment at a rate of 85 percent of the Champus Maximum Allowable Charge (CMAC). If the active duty service

member requires inpatient treatment, the primary care provider at the VA must refer the service member, even if the referral is to the very same VA facility or a civilian facility.

The managed-care supervisor in non-emergency cases must first authorize the inpatient referral. The cost of prescribed treatment is also at 85 percent of the CMAC for each procedure. The estimated cost for supplemental care (which is made up of civilian, VA and MTF specialized care, and inpatient care) would be based on the number of cases seen and different types of procedures performed. Based on historical data, the actual expenditures for supplemental care and ambulance services for fiscal years 1996 and 1997, the amount for supplemental care would range from $430,000 to $970,000 and the amount for ambulance services is estimated at $750,000. Civilian payroll at the POMAHC would no longer be a factor. Nor would supply, support contracts, base operations, travel and civilian medical contracts. CMD would realize an estimated **$1,896,777** in savings by deleting these costs components from their annual budget. The total estimated expenditures for this option using the average costs over fiscal years 1996 and 1997 for supplemental care ($700,000), ambulance service ($750,000) and CMD's overhead ($355,212) in conjunction with the partial EBC rates ($1,680,000) as costs component would be **$3,485,212.**

D. FULL EBC CONTRACT

The third option is to outsource all primary, supplemental and emergency care to a contracted provider on full Enrollment Based Capitation (EBC). Under this type of contract, the contractor would be solely responsible for providing all

facets of medical care to the active duty member: primary care, supplemental care and emergent care at the exclusive cost to the contractor. This means that there would be no DoD gatekeepers, all charges to the contractor would be on a procedural basis and not regulated by CMAC, and the active duty member's medical readiness status would no longer fall under the control of a DoD agency. This contract requires the contractor to assume all workloads previously handled by the POMAHC, David Grant Medical Center at Travis AFB and all civilian supplemental care provided by the Foundation Health Federal Systems (FHFS) network of providers for the Monterey peninsula active duty population. FHFS is the designated federal medical contractor for Region 10 that currently manages Tricare for the DoD.

Based on the current contract the Department of Defense has with the Veterans Administration in Reno, Nevada, for a full EBC, the cost would be at a baseline of $100.00 per person per month. For the POMAHC's population, it would be a total of **$8,400,000** per year, a ratio of 2.6 times the current costs to operate the POMAHC. To accomplish this, the contractor would have to utilize the current building that houses the POMAHC, or have the VA clinic at Fort Ord provide primary care. The contractor would also have to negotiate separate contracts with the community hospital of the Monterey Peninsula (CHOMP) to provide inpatient care and utilize supplemental care providers in a similar manner as described in the first option. This would be done at the contractor's expense and would not be allocated to any DoD agency. The VA in Reno is the only Federal treatment facility available. A federal facility is best suited for the

military's requirements. The VA has similar documentation practices, it is familiar with the military environment and population, and most importantly it allows for flexibility within the contract that would be unavailable with a civilian contractor.

It is important to note that even though $100 per person per month seems rather expensive, Congress has actually allocated a ceiling of $150 per person per month, which comes to $1800 per person per year or $12,600,000. In addition, due to the low population of 200 active duty members in the Reno area, the $100 capitation fee was deemed acceptable for the extensive level of local care provided. It seems reasonable to assume that full Enrollment Based Capitation for the POMAHC's population could be negotiated at a substantially lower rate due to the higher volume. Under this contract, CMD would realize an average cost savings in all costs components and CMD's overhead at an estimated savings of **$3,529,475.**

E. LOCAL NETWORK PROVIDERS

Under this option the network provides would provide primary medical care and CMD would be responsible for providing supplemental care from DGMC, the VA and private sector providers. Emergent care is provided from the closest fully capable medical facility to the location of the emergency.

Outsourcing medical care to the local network providers is not a viable option presently because of two main factors. First, the market for local providers is already saturated at a patients to physician ratio of 2000 to 1, and introducing an additional 7,000 active duty personnel would be impractical. Secondly, the administrative services and logistical support would be almost

impossible to effectively track and maintain on a daily basis. For example, transportation would have to be provided for the majority of junior personnel at the Defense Language Institute to and from the local network providers, and medical records would have to be updated daily from multiple outside sources. It would also increase the opportunity cost of additional time away from classes and work for the active duty members. The total cost would be an estimate based on historical data of workloads for the POMAHC multiplied by the corresponding CMAC, transportation cost and pharmaceutical cost due to the closing of the Pharmacy at the POMAHC. A total cost estimation for this option is unavailable due to the proprietary nature of the data needed to calculate this figure. It is important to note that the contractor for the full EBC contract may face the same problem of saturation of the provider market, but it is totally up to the contractor to fulfill the requirements of the contract.

F. HYBRID STAFFING

The final option is to staff the POMAHC with civilian physicians, while maintaining a military/civil servant support staff. Under this option, the provision of medical care would be identical to the current system. Upon request a contractor would staff the POMAHC with civilian physicians. The Department of Defense would then be responsible for the transportation costs for the relocation of the physicians and would pay their salaries and all administrative costs to the contractor for workloads taken by the civilian physicians. Since this option is a wartime contingency that is based on the needs of the government and not on

cost effectiveness, it is the opinion of some managed care personnel that the DoD would be at a disadvantage during contract negotiations for this contingency. Therefore, it is not considered as a viable cost reduction model. There are no current contracts written for this contingency and no historical data in which to estimate a total cost to CMD or the DoD.

IV. NON-FINANCIAL BENEFITS & COSTS

A. INTRODUCTION

This chapter presents the possible non-financial benefits and costs associated with the different outsourcing options. Some of these benefits and costs are related to more than one of the options described in Chapter III.

B. APPROACH

Interviews were conducted with the Commanding Officer of CMD, the Managed Care Supervisor and the claims department personnel at CMD. They deem four criteria as absolutely essential to completing their assigned mission of providing medical care to the active duty population: (1) The active duty members' accessibility to medical care, (2) CMD's ability to maintain control of the level and quality of care provided to the active duty population, (3) The level of customer service as measured by quality of care and time spent waiting for medical care, and (4) The System processes such as the provider payment system and contracts that allow for modifications without penalty clauses.

C. CRITERIA

1. Accessibility

Accessibility is important to the active duty member on the Monterey peninsula because of the concentration of active duty personnel within the small confines of the area. This means that proportionally there will be a greater number of personnel demanding medical treatment at any given time than in

areas of low concentration. A large catchment area has been set forth by Congress (40-mile radius), which identifies the area where medical care must be established in relation to the main military population center, the active duty members have requested medical treatment as close to their places of work as possible. This request falls under the accessibility and customer satisfaction criteria. This conclusion was taken from the Customer Satisfaction CMD Survey- How far would you and your family be willing to travel in order to obtain medical treatment? The choices were (a) 0-5 miles, (b) 5-10 miles (c) 10- 15 miles (d) 15 or more miles? The overall response was 43% chose (b), 26% chose (a), 22% chose (c) and 9% chose (d). The 5-10 miles range was the most popular choice.

2. Control

CMD's ability to maintain control of quality and level of care was deemed important because of readiness and budget constraints. It is CMD's sole responsibility to maintain the highest state of medical readiness or deployability of the active duty population. This is an essential part of CMD's mission statement. Financial efficiency is also very important, because of the escalating cost of providing medical care to all active duty members. CMD can obtain, track and procure more cost efficient medical treatment, than most private sector contractors, by utilizing the Foundation Health Federal System (FHFS), which locates, screens, qualifies and maintains all network providers in the federal system. FHFS provides all DoD treatment facilities with a Network Adequacy Report by regions. This allows CMD to effectively and efficiently shop around for quality and financially reasonable medical care. Financial and quality control is

especially important in contracts between DoD and the private sector medical contractors, in order to reduce escalating modification penalties and to ensure the contractor is not compromising the quality of care provided to the service member in order to reduce cost. It is important to remember that private sector contractors are in the business of providing medical care for a profit. It is reasonable to conclude that profit margins are their priority and thus dictate policy decisions. Their profit margins maybe dictated by how much their costs are reduced against the capitation rates. Private sector contractors have individual contracts with different providers in their networks. This allows them to incur variable costs or different levels of care based on price. The quality of the care may be difficult to determine or unacceptable to the DoD if the ability to control these aspects are not in the contract.

3. Customer Service

Customer service is deemed important for two reasons, morale and retention. As mentioned before, customer service is measured in terms of perceived quality and time spent in obtaining medical care.

POMAHC provides immediate attention in the form of sick call, in contrast to the existing Tricare or HMO systems where there is usually a waiting period for the next available appointment for non-emergency care (sometimes three weeks or longer). This requirement was established through a personal survey conducted with 40 active duty officers at Naval Postgraduate School, 25 males and 15 females, all with dependants. The questions were: (1) What is the average time you spend waiting for non-emergency medical care at the

POMAHC? The dominant range was 30 to 45 minutes. (2) What is the average time your dependants spend waiting for non-emergent medical care in the Tricare system? The average time was 10 to 18 days. This question was deemed relevant because the Tricare system uses the same network providers the active duty population would have to use if that system is chosen as a replacement for the POMAHC. (3) What is your preference for a primary care provider, a military provider or a private sector provider and why? 72.5% or 29 responders chose a military provider because of the shorter wait times to be seen. 27.5 or 11 responders chose the private sector for level/quality of perceived care. (4) What is your preference for a specialty care provider, a military provider or a private sector provider and why? 77.5% or 31 responders chose private sector providers because of quality and expertise. 22.5% or 9 chose military provider because of quality and faster availability.

The data obtained from this survey and the Customer Satisfaction CMD survey were the quantifying measures used in the analysis for this criterion.

4. System Processes

There is an issue concerning the efficiency of system processes which mandates the implementation of a new system to allow for changes in the federal payment system currently in use and the adoption of non-penalty modifications to future contracts. The payment system needs to be changed because of the number of complaints received by CMD's claims department from local providers that accept active duty members as patients. In addition, FHFS provides an Annual Provider Satisfaction Survey that list, among other items, reasons given

by providers why they decided to stop accepting active duty members. This report is a national survey and is broken up by regions. The report states that 50% of the providers discontinue accepting active duty members due to the complicated payment process and untimely payment. 30% are dropped due to non-compliance with FHFS standards of care, and twenty percent (20%) are due to saturation of practice, moving or retired out of business. The changing of this process is very important because Monterey has a finite amount of providers that accept active duty members and keeping them onboard is a high priority for CMD. If CMD continues to lose providers, active duty members will be forced to travel farther for supplemental medical treatment in the private sector or to travel to Travis Air force base for specialty care.

Using a provider not sanctioned by FHFS is not allowed in almost all cases to avoid substandard care being delivered. Non-penalty modifications are needed in order to keep down the costs of services not written into the original contract. There are contracts, which are somewhat narrowly specified, and there are situations that do not fit those specifications, which then require a modification to the existing contract. Modifying these contracts has become a very costly process. Presently, this is the area in which private sector contractors make the highest profit margins. Based on interviews with the managed care supervisor at CMD and a report published by the lead agent for Region 10, the total amount charged by various contractors within the region is $150,000,000 in modification charges.

D. OPTIONS ONE AND TWO: KEEPING THE POMAHC OPERATIONAL & CONTRACT WITH THE VA

The only difference between options one and two is the VA has a preset number of supplemental visits to send service members to prior to receiving approval from CMD (see Appendix B). There are three benefits inherent in option one and two.

First, the active duty member maintains accessibility to all levels of medical care in the local area. With this accessibility, the active duty service member has a variety of choices on whom he or she sees pertaining to supplemental care. These choices really promote a better sense of customer satisfaction on behalf of the service member. In addition, these two options are considered the same because of their locations. The POMAHC and the VA clinic on Fort Ord are equidistant from most of the active duty population. Military members are housed on the Presidio of Monterey, La Mesa Housing, in the community and at Fort Ord.

Second, CMD maintains control of the quality of care provided to the active duty population. CMD is able to screen and effectively track supplemental care outsourced in order to assume that the service member is provided with the best medical care available. To accomplish this, CMD has the combined resources of the local MTF in option one, the VA clinic in option two and local specialty providers in both options.

Third, local availability of specialized military care such as anthrax vaccination is maintained. With the MTF or even the VA, these

special vaccinations can be administered locally. Medical boards for limited duty, medical discharges and/or flight physicals can also be accomplished locally. This fulfills the need for customer satisfaction and accessibility to all levels of care, even those inherent to the military culture.

The cost associated with options one and two is that some civilian providers are hesitant to accept active duty members as patients due to the inefficient payment system the government employs. The system is complicated to use and difficult to track. The Defense Finance and Accounting Service (DFAS) pays all civilian providers. DFAS is responsible for the timely payment of all contracts between the DoD and any contractors. Presently DFAS sends payment to the civilian providers without any type of documentation. The civilian providers are unable to balance their accounts because there are no names or social security numbers provided, no dates of when the service member received treatment or what procedures are being paid. The civilian provider must then call CMD and have them provide an itemized list with the needed information. Many civilian providers would rather do business with the contractor as the government's representative. This allows them to get paid on time, with the correct documentation and less paperwork because the contractor is not regulated by the same rules that control DFAS's payment policies.

E. OPTION THREE: FULL EBC

There are two benefits to option three. First, the actual accessibility it provides to the active duty members for medical care if the POMAHC is closed and a contract is unavailable with the VA.

Second, the flexibility within the contract, provided the contract is with the VA. Contracts with the VA can be reviewed monthly or at any interval requested by the government without modification charges. This would dramatically reduce expenditures in modification costs.

There are three costs associated with option three, they are based on the contingency that the POMAHC is closed and there is no contract available with the VA. The service member's access to locally provided care is again paramount in this configuration.

First, if local access were not available, due to the high patient to physician ratio (2000: 1) all active duty service members may be forced to travel outside the catchment area to obtain medical care. This would become very expensive in terms of travel costs, opportunity cost in terms of time away from work, school, and training.

Second, contracts with a civilian contractor may not have the necessary amount of flexibility to allow for modifications without substantial fees and penalties charged to the government.

Third, the loss of control by a DoD agency over the management of the service member's level of care, type of care, quality of care and locations of care providers. This cost is most associated with a contract between a civilian contractor and the government. In addition, there is a large possibility that the financial cost of this option may increase exponentially due to the closing of the POMAHC. The loss of this capability may be seen by a civilian contractor as an opportunity to gain higher profit margins upon contract renewal. In the future, the

demand for medical care could rise, but the POMAHC would not be operational to offset the negotiations with its capabilities or competitive offsets during the contract renewal. Due to the relatively small physicians market on the Monterey peninsula, the possibility of another contractor providing substantial market competition with different network providers would be low.

The effects of the costs and benefits described in this chapter can be reduced or intensified by changing the contract provisions or management policies. These changes are further discussed in Chapter V.

V. CONCLUSIONS AND RECOMMENDATIONS

This chapter presents conclusions and recommendations on whether it is cost-effective to outsource all military medical care of the Monterey Peninsula or to maintain the current system.

A. CONCLUSIONS

The purpose of this thesis is to provide a cost-benefit analysis of outsourcing medical care for the active duty population on the Monterey Peninsula. Financial and non-financial data were collected and compared to determine the actual and perceived costs and benefits to answer the primary and secondary questions of this study. The primary and secondary thesis questions were:

Primary

What are the costs and possible benefits to California Medical Detachment (CMD) in outsourcing all active duty medical treatment in the Monterey Peninsula area?

Secondary

(1) What is the current cost of operating the POMAHC? The current cost is calculated at $ 3,697,412 for 1996 and $3,361,539 for 1997.

(2) What are the alternative costs of providing medical treatment for the active duty through other than DoD agencies? The alternative costs are the higher financial expenditures, possible customer dissatisfaction with replacement systems and possible lower readiness levels. Larger financial expenditures in all

options other than the current configuration. The cost for the partial EBC is $3,596,212 to $4,166,212. For the Full EBC the cost is $8,400,000 and the cost for Local Network Providers and Hybrid staffing was unattainable due to the proprietary nature of the data and no set model to analyze.

What are the non-financial costs and benefits in outsourcing active duty medical care? The non-financial costs and benefits were assessed based on four criteria: (1) Accessibility. (2) Control. (3) Customer Service and (4) System Processes.

Accessibility to all levels of medical care is maintained in all viable options presented based on the configurations described. Option one is the best choice to fulfill the requirements of this criteria.

The possible loss of control of the quality and level of care received by the active duty member in option three was important due to medical readiness, deployability and fiscal constraints. Control was best maintained in options one and two.

Customer service was deemed a priority for morale and retention reasons. The active duty members listed quality of care and time spent waiting for medical treatment as paramount components for satisfactory customer service. Customer service was paramount in all options, but may be subject to change in terms of distance traveled to obtain medical care in option three as a cost reduction measure by the contractor. Options one and two are evaluated as equally best choices to fulfill this requirement.

The complicated payment process and inflexible contracting used by the DoD in options one and two were system processes that needed changes in order to better assist the process of providing medical treatment to the active duty population. This criteria does not apply to option three due to the type of contract option three falls under. Providers would be paid by the contractor and not subjected to DFAS procedures and policies, and the contract would be inclusive for all types of medical care under a full EBC.

B. RECOMMENDATIONS

First, based on the financial data and the non-financial assessment points presented, the recommendation is to keep the POMAHC operational. In addition, it is possible to improve on the operational efficiency of running the POMAHC by implementing some cost reducing processes and systems.

Second, an additional recommendation is to maintain the current system of providing primary medical care to the active duty population at the POMAHC and supplemental care through various other sources, while employing cost reducing procedures and practices. There are many management information systems available to the commanding officer of the POMAHC that would assist in efficiently managing the available resources.

CMD can further reduce the cost of operating the POMAHC by fully implementing the existing management information systems at the POMAHC. Resource Analysis and Planning System (RAPS) provides projected workloads and resource utilization to better assist in the purchasing of medical supplies and pharmaceuticals. Composite Health Care System (CHCS) provides patient level

clinical data with Direct Care facilities. CHCS allows the physicians to use standardized patient care management procedures and successful past practices in resource utilization. Ambulatory Data System (ADS) was recently implemented at the POMAHC. This system provides outpatient level data from CHAMPUS or Direct Care facilities. It is also used for utilization analysis, research and planning. ADS has not been implemented for a sufficient period to decisively measure its impact on procedures at the POMAHC.

Every military treatment facility is required by the Joint Commission of Accreditation, Healthcare Organizations (JCAHO) to identify weaknesses and have continuous plans for improvement. Through the use of Focused Measures of the Military Health Services System Performance Report Card, the JCAHO can measure the performance of each military service in terms of access, quality, utilization, health behavior and health status. This allows the services to compare practices and adopt the successful ones to upgrade their services. Customer satisfaction is also a priority that must be constantly improved. It is not only important to provide quality care, but it must be perceived by the POMAHC's population as high-quality and compassionate care.

These management tools can reduce the level of autonomy that the POMAHC's physicians currently operate under and provide information to institute guidelines and feedback to the physicians about workload practice patterns and resource consumption. The result should be an increased capacity to effectively manage all levels and types of resources and reduce costs.

APPENDIX A

CMHJ-CMD
23 February, 1998

INFORMATION PAPER

Subject: VA/DOD Primary Care Capitation Reimbursement Agreement

1. PURPOSE: To provide Sick Call, Primary Care, and 24 hour Acute Care to the Active Duty member within the HA time and distance standards for primary care.

2. FACTS:

a. Due to the number of BRAC actions within DOD, many units have been left without military medical services within an acceptable commuting distance for primary care. This has resulted in an increase in the number of service members being referred to health care from the civilian community, which increases DOD health care costs. VA Capitation ($28 per AD member per month) versus fee for service from the civilian community could provide Quality medical care from a local source, and control escalating DOD Supplemental Care costs

b. Services Included: Medical
- Physician/Extender Services
- Diagnostic Clinical Lab Tests
- EKGs, EEGs, and related non-invasive procedures as VA PCM prescribed
- Pharmacy prescriptions as prescribed by VA staff
- Physical Therapy services as prescribed by VA staff
- Routine (stock) prosthetics
- Mental Health Services for acute conditions
- Limited Specialty Care as prescribed by VA staff

c. Services Included: Dental
- Dental Examination - Once per year
- Two Bitewing x-rays - Once per year
- Prophylaxis (teeth cleaning) -- Twice per year

3. PROJECT HIGHLIGHTS
   a. Reduced cost through VA Capitation
   b. Enhanced Unit Medical Readiness
   c. A VA/DOD contract already in place --. No cost for modifications
   d. Portability -nationwide

e. Lead Agent/Regional Service MTF oversight
f. Flexible - All DOD services currently use some VA services
g. Rapid implementation -contracts a ready in place in California
h. DOD Gains – Federal $ remain in Federal Programs, Local Access to Quality Care, Management of Care, Controlled Cost.
i. VA Gains - New revenue base, Younger Training & Education Program Resources, Expansion for Survival.

4. CONCLUSION/RECOMMENDAI'ION: DOD-WIN/WIN-VA, in our headlong rush to implement (outsourcing) Managed care contracts, we must not forget to continue to look for opportunities to provide better service to our health care beneficiaries and reduce costs.

APPENDIX B

Amendment to VA/D D Agreement 95/FRS/0241

General Provisions is amended to include the following:

1. California Medical Detachment (CMD) has, due to various base closures, the need for Primary Care (sick call clinic) services for active duty Army personnel who will remain outlying areas. These services are available from VA Palo Alto Health Care System at the following locations:

- VA Palo A to Health Care System, (VAPAHCS), 3801 Miranda Ave., Palo Alto, CA
- VAPAHCS, Livermore Division, 4951 Arroyo Road, Livermore, CA
- VA Clinic of San Jose, 80 Great Oaks, San Jose, CA
- VA Clinic, San Joaquin Gen. Hospital, 500 W. Hospital Road, French Camp. CA
- VA Clinic, Modesto, CA (opening soon)

2. The CMD will be responsible for identifying the active duty members and keeping VA staff informed of eligible personnel.

3. Records of individual patients will be created and retained at the respective locations with appropriate copies to be provided to CMD.

4. Special documentation requirements of the CMD will be adhered to by VA staff and documents routed as instructed. The CMD will assume responsibility for providing training to VA staff regarding the nature and use of any such forms.

5. Billing will be prepared monthly by VA and submitted to the indicated DoD billing address.

6. All active duty personnel treated at VA will be entered into VA's decentralized hospital computerized program (DHCP) patient registry for purposes of record keeping and workload tracking. As VA automates its medical record process, the records for active duty personnel will also be automated.

7. DoD Health Benefits Advisor. The CMD may consider placement of a health benefits advisor (HBA) onsite at VA to facilitate the treatment and referral of active duty personnel. The advisor will determine whether the active duty personnel

remain at VA for excluded services for the referred elsewhere. The HBA will also serve as an additional liaison to the CMD. VA agrees to provide the HBA with an appropriate workspace, telephone and computer access. The final determination of appropriate cost will be negotiated between VA and CMD.

8. Disputes. Any disputes arising from this agreement will be resolved between VA and CMD. Disputes will be minimized by routine and close cooperation between the representative of the VA and CMD.

10. Description of Services Provided by VA:

10.1. Sick Call: VA will provide "sick call" medical services every weekday from 8-00 a m. until 10:00 a.m. A specific sick cal1 clinic will not be provided on holidays or weekends. During the sick call clinic, active duty personnel will be seen on a priority basis. However, this will not disrupt eligible veterans as they will not use the sick call clinic.

10.2. Urgent Care: VA will provide urgent care services on a walk-in basis 24 hours each day, 365 days per year at the Palo Alto division. Except during the schedule sick call clinic, walk-in active duty personality will be seen in the evaluation and admissions unit. The active duty personnel will be prioritized on the basis of clinical urgency and will be seen secondary to eligible veterans. If a long wait is anticipated, the active duty member will be offered a schedule clinic visit time doing the next sick call clinic, provided their condition is not urgent or emergent. All active duty personnel seen in the evaluation unit will be triaged, as are eligible veterans, to determine the nature of their condition and urgency of the problem.

10.3. Specialty Clinic Referrals: as required, active duty personnel will be referred from the sick call clinic or from the evaluation unit to specialty clinic for follow-up. The referral for followed care must be concurred with by one of VA's primary physicians assigned to the follow the active duty population. Specialty clinic appointments will be made in a timely manner based upon the patient's clinical need as determined by the primary referring physician.

11. Capitation Reimbursement Basis:

11.I VA will provide the sick call clinic services on a capitated basis for the active duty personnel. The capitation price will be assessed monthly and applied only to the actual number of active duty personnel who were identified by the CMD

representative as having potential access to VA services. This methodology allows for variation in the active duty members as personnel are transferred in it out of the area.

11.2. Services included in the Capitated Rate:

- All professional services, to include physicians and physician extenders.
- All diagnostic clinic laboratory tests as prescribed by VA staff. (Excludes HIV testing).
- Routine non-invasive radiology diagnostic procedures as prescribed by VA staff (includes MRI and CT).
- EKG's, EEG's and related non- invasive procedures as prescribed by VA staff.

  Pharmacy prescriptions as prescribed by VA staff. These prescriptions will be given only to the extent determined to be necessary for the treatment of the condition. Chronic conditions requiring medication of a long-term basis will be referred to the CMD health benefits adviser (NO MAINTENANCE MEDS).
- Physical therapy services as prescribed by VA staff.
- Routine (stock) prosthetic items as prescribed by VA staff.

Examples include braces, crutches, and canes. Durable medical equipment and oxygen supplies are not included but will be made available at VA cost if requested by DoD HBA.

- Patient education materials as prescribed by VA staff.
- Mental health services. All mental health services needs will be prescribed by VA staff at will be covered for acute conditions only. Specifically, VA will provide psychiatric emergency evaluations and necessary counseling sessions up to four (4) individual sessions, five (5) group sessions, or a combination of the above not to exceed nine (9) sessions. For additional mental health services, patients will be referred to military facilities or followed by VA at CAMPUS allowable rates.

NOTE: All of the above are only to be provided as prescribed by VA staff assigned as primary care clinicians for the active duty personnel. The services under the capitated agreement shall be provided through the sick call clinic, evaluation unit, or in a specialty clinic based upon appropriate referral.

12. Capitated Rate and Estimated Reimbursement:

12.1 VA will provide the above-included services at the capitated rate of $20.00 per active duty member per month or $240.00 per active duty member annualized. The number of covered active duty members on average per month is estimated to be 150 in San Jose, 300 in Livermore, 150 in Stockton, unknown in Palo Alto and unknown in Modesto at this time.

12.2. Active duty members are authorized a maximum of five (5) specialty visits under the capitated rate. If authorized by CMD HBA, any specialty visits beyond five will be charged at 85 percent of CMAC.

12.3 VA will routinely monitor the utilization of its services to the active duty personnel and will provide its utilization information to the CMD. The rate and service components will be reviewed at six months following the beginning of this agreement and, if necessary, the agreement will be amended based upon utilization experience and cost incurred.

12.4. Dental services. Dental services will be provided, where available, at the capitated rate of $8.00 per active duty member per month. Services included in this rate:

- One (1) annual exam to produce a treatment plan. Treatment plans will be forwarded to CMD for approval.
- Two (2) pleadings per year.
- One (1) panorax

13. Services not covered under the capitated rate: unless noted above, any other services provided will not be considered to be under the capitated rate, but will be provided to the active duty personnel by VA staff if the VA offers the service. Below are significant and specific exclusions that VA will provide for additional cost reimbursement.

- Mental health services: Individual therapy $65.00 per session
  Group therapy $50.00 per session
  Family Group therapy $50.00 per session

- Ambulance or other transportation services.

14. Inpatient services: If required and authorized by CMD HBA, inpatient services
will be provided at 85% of the CMAMPUS area rate.

APPENDIX C

September 1997

VA RENO MANAGED CARE SUPPORT AGREEMENT

SECTION 1
This agreement is for assisting the lead agent/Military Treatment Facility (MTF) Commanders/Geographically Separated Unit (GSU) commanders in coordinating health care delivery in the non-catchment areas. This agreement seeks to improve access to quality health care via optimal use of the VA medical facilities and services.

SECTION 2
This agreement will require development, implementation and operation of the health care delivery and support system for the Nevada Air National Guard active duty members residing in the state of Nevada and California. The agreement shall be referred to as the Managed Care Support Agreement. The managed-care support concept focuses on connecting in Nevada Air National Guard's direct patient care system with a civilian and VA network of professional providers to fully support the needs of all individuals eligible to received services to the Military Health Services System (MHSS).

SECTION 3
VAMC Reno will become the primary, unless elsewhere stipulated or excluded, health care provider for Nevada Air National Guard active duty members with third party responsibility for authorized and/or the emergent community health care. Unless otherwise authorized by the VA, community care is limited to that originally authorized or until VA care can be accessed in an emergent situation. Necessary adjunct service requirements for example, utilization and quality management activities, public relations, appointments setting, patient advocacy and records management will be an inclusion in this arrangement.

The proposed sole health care provider arrangement, a HMO-like system, will be referred to as the Managed Care Support Agreement (MCSA). Beneficiaries will be enrolled in a managed-care program, which provides standard benefits and enhanced primary and preventive benefits. MCSA will require beneficiaries to use the MCSA manager (152nd MDS Senior Health Technicians) to obtain authorization for enrollment in VAMC Reno's program.

SECTION 4

The VAMC Reno shall furnish all necessary personnel, materials, facilities and other services (unless otherwise specified) to accomplish the delivery of comprehensive health care delivery and support services required to enrolled Nevada Air National Guard active duty members. The VAMC Reno shall provide access medically required specialists who fulfill requirements elsewhere in this agreement. The VAMC Reno shall ensure that the number and mix of primary and specialty providers is it adequate to satisfy demand and to ensure access to all necessary types and levels of primary care. Emergency services shall be available and accessible within the service area 24-hour a day, seven days a week. Established customer service standards will ensure timely an effective care, informed health-care decisions, courteous and dignified treatment and our support of the Nevada Air National Guard mission. VAMC Reno will provide a clinical inventory, which establishes the health care provider parameters of this agreement.

VAMC Reno will provide operational and administrative support services which will include: enrollment, marketing, community access, utilization management, claims processing and support services.

SECTION 5

VAMC Reno's basic medical benefits package and customer service standards

will include:

- Assignment to a singular primary care team.
- Urgent services available 24 hours a day/7 days per week on an unscheduled basis in our triage units.
- Primary care team available by phone during regular hours for sick call instructions and / or advice.
- Routine general medical appointments available when required within one week.
- Seen within 30 minutes of schedule appointment times.
- New prescriptions dispensed within 60 minutes of drop-off. Chronic refills will be handled after the initial fill by our centralized mailout pharmacy in Los Angeles.

- Provisions of dental services, which includes annual cleaning and examination.
- Scheduling and payment responsibility for authorized at ambulatory community specialty services not available at VAMC Reno.
- Third party payer responsibility for emergent services in the community, if DoD facilities or VAMC Reno's triage area were not reasonably all clinically available.
- Will be responsible for local stabilization special mode travel for beneficiaries who require specialized inpatient services not available at VAMC Reno.
- Preventive health and health education visits will be provided through the primary care team with appointments available within four weeks.
- Designated customer service representative for the enrollee who is not a member of the patient care team. The representative will be community service specialists who is familiar with DoD needs and concerns.

Agreement stipulations:

1. Non-emergent community services must be authorized by their primary VA physician or designee.
2. Specialized inpatient services not available at VAMC Reno will be referred to David Grant medical center at Travis AFB as a DoD beneficiary. If necessary services are not available at Travis, MCSA manager has disposition and authorization responsibility.
3. If Air Ambulance services are required for transport to Travis Air Force Base or another DoD facility, military air evac should be the option of first choice.
4. Require that enrollees on temporary duty outside the Reno catchment area utilize DoD facilities if available. If not available, their primary VA physician must authorized any community health-care or care at an available VA facility.
5. Community specialty consultation, testing and / or treatment must be authorized by their primary VA physician. Choice will be limited to those communities health care providers or organizations that are part of our contracted network.
6. The VA's DoD coordinator and the Air Guard's MCSA Manager have the authority to result health care, financial or delivery issues that result from unusual, special or "not covered in the agreement" situations. Air Force and VA top management will be advise and/or consulted as appropriate.
7. The Air Guard Flight Surgeon will be consulted and approve treatment plans
   to include medications for all air crew members.
8. The need for emergency care is defined as an illness or injury that is a direct threat to life, limb or sight. When any of these

conditions are met the Air Guard member should seek medical care at the nearest medical treatment facility. In time permits, the client's primary care physician or the triage staff should be contacted for advice and/or assistance.

Agreement Exclusions:

1. Obstetric consultation and /or treatment
2. Infertility studies and / or treatment.
3. Health-care required while outside the continental United States.

Note: enrollees with an exclusionary need will be referred back to the 152nd Medical Squadron for disposition.

The Reno VA will directly referred potential Medical Evaluation Boards (MEB) candidates to the152nd Medical Squadron in a prompt manner for determination of fitness for duty. The Senior Health Technician will attend all team, departmental council meetings which pertain to any care provided for The Nevada Air National Guard active duty members.

SECTION 6

PAYMENT FOR SERVICES -- the Military Health Service System (MHSS) transitioned to capitation based resourcing, effective FY 94. Accordingly, a fixed amount per person is provided by the Air National Guard to VAMC Reno at the beginning of the fiscal year to pay for all health services provided to eligible beneficiaries. Under the terms of this agreement, the 77th Medical Squadron will pay the Reno VA $1,207.50 per covered beneficiary per year to provide all health services outlined in section 1 -- 5 of this agreement. Historical utilization rate for 110 eligible personnel covered by this agreement are reflected in appendix II. Utilization rates for FY 97 remained in the same general range since the original agreement and modification is not required. VAMC Reno will not a responsible for catastrophic care required by a covered beneficiary, which is defined as an incident of significant illness/injury where hospitalization/associated medical services would exceed $5000.00 per incident of non-federal care. Such cases would revert to the 77th Medical Squadron to process under the guidelines of AFI 41-101, Obtaining Civilian Medical and Dental Care. In addition, there is a Cap on VAMC Reno's overall non-federal care costs of $50,000 per year. Once this Cap reached, all subsequent required non-federal care would revert to the 77th Medical Squadron to process.

SECTION 7

USE of VA RESOURCES -- services provided under this agreement will not adversely affect the range of services, accessibility, or quality of care provided to VA beneficiaries: will not interfere with existing sharing

agreements between the Reno VA and other federal agencies; will promote cost efficiencies, and will fully complement the Department of Defense managed-care program.

SECTION 8
RECONCILLATION OF FUNDS -- annually during the month of July Reno VA and the Nevada Air National Guard will meet and reconcile financial accounts. The VA is provided funding for an estimated number of personnel at the beginning of each fiscal year. In mid-July, the VA and Air Force will compare the actual number of enrolled members per month with the paid amount. If the number of enrollee's is the less than the number funded at the beginning of the agreement, the VA will refund the respective service the amount due. If the number of enrolled members is greater than the number funded at the beginning of the year, the service will pay the VA the amount due.

SECTION 9
MODIFICATION or TERMINATION -- either the Nevada Air National Guard or the Reno VA may propose amendments modifying this agreement and anytime. Before any amendment will become effective both parties must agree in writing to the modification. The effective date of any amendments will be the date agreed-upon and specified in the amendment, or, if no date is specified, the date upon which officials representing both parties have agreed in writing to the amendment. Either party may terminate this agreement in its entirety upon 30 days notice in writing to the other party.

SECTION 10
EFFECTIVE DATE AND RENEWAL -- they effective date of this initial agreement is on or after October 1, 1995. It is to be renewed annually at the local level on October 1 of each fiscal year. Modifications to the basic benefits package, customer service standards and / or capitation rate is allowable during the renewal process.

LIST OF REFERENCES

Ft. Ord and Silas B. Hays Hospital Closure --Lessons Learned, Study Report, March 1, 1995.

Monterey Regional Health Resources Strategy – Study Report, April 25, 1994.

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Interview between D. Tompkins, CMD's Managed Care Supervisor, and author February 26, March 10, June 4,1998.

Interview between L. Vanderpool, CMD's Comptroller, and author February 26, March 10,1998.

Interview between Colonel Weine, CMD's Commanding Officer, and author February 26, 1998.

Interview between LT. Jacobson, OIC of POMAHC's Naval Administrative Unit, and author March 17, 1998.

Interview between H. Brown, MEDCOM's Resource Management personnel, and author Aug 7, 1998.

Interview between LT. Broyer, David Grant Medical Center Resource Management Personnel, and author Aug 7, 1998.

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