DEPARTMENT OF DEFENSE

AUDIT REPORT

PRIMARY CARE FOR UNIFORMED SERVICES AND NAVY CARES PROGRAMS

No. 90-012

December 6, 1989

Office of the Inspector General

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
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MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
COMPTROLLER OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF THE ARMY (FINANCIAL MANAGEMENT)
ASSISTANT SECRETARY OF THE NAVY (FINANCIAL MANAGEMENT)
ASSISTANT SECRETARY OF THE AIR FORCE (FINANCIAL MANAGEMENT AND COMPTROLLER)
OFFICE OF THE SURGEON GENERAL, U.S. ARMY
OFFICE OF THE DIRECTOR OF NAVAL MEDICINE/SURGEON GENERAL OF THE NAVY
OFFICE OF THE SURGEON GENERAL, U.S. AIR FORCE

SUBJECT: Report on the Audit of Primary Care for the Uniformed Services and Navy Cares Program (Report No. 90-012)

This final report on the Primary Care for Uniformed Services (PRIMUS) and Navy Cares (NAVCARE) programs is provided for management's information and use. The audit was made at the request of the Committee of Conference on House Joint Resolution 395 in House Report 395. The objectives of the audit were to inspect PRIMUS and NAVCARE facilities and to evaluate management of the facilities and contracting processes, to evaluate budgeted and actual costs of the clinics and compare such costs with the CHAMPUS program, and to evaluate the level of care offered by the clinics and contracts. The audit was a joint effort of the Offices of the Assistant Inspectors General for Auditing and Inspections, and was made from April 1988 to November 1988. The Office of the Inspector General for Inspections issued a report on September 1, 1988. In FY 1988, 23 PRIMUS and NAVCARE clinics were in operation and cost approximately $40 million. At the time our audit was completed, DoD had plans to increase the number of clinics to 57 by the end of FY 1992.

Overall, the PRIMUS and NAVCARE clinics had increased access to family health care for qualifying recipients. With the exception of waiting times, recipients were generally happy with the health care service, but without DoD-wide objectives and goals, management cannot measure the effectiveness and efficiency of the PRIMUS and NAVCARE programs. Furthermore, without a formal method of determining family health care needs and the most cost-effective approaches to servicing these needs, the economies of PRIMUS and NAVCARE cannot be determined. The audit identified

instances where the placement of PRIMUS and NAVCARE clinics and the services offered have not provided the most cost-effective approach to serving family health care needs. In addition, without improvements in the Quality Assurance Program, the potential exists that unacceptable health care services will not be identified in Army and Air Force PRIMUS clinics, and the Government will not receive the level of service it paid for. The overall results of the audit are summarized in the following paragraphs, and the details and audit recommendations are in Part II of this report. Appendixes A through D answer questions or provide data specifically requested by Congress.

The PRIMUS and NAVCARE program objectives and goals were not formalized to comply with the congressional mandate and were not consistent among the Military Departments. As a result, DoD could not determine if the programs were achieving the desired results in a cost-effective and efficient manner. We recommended that the Assistant Secretary of Defense (Health Affairs) establish DoD-wide objectives and goals for the PRIMUS and NAVCARE programs that are consistent with the intent of Congress, and that a DoD-wide tracking system be developed to monitor the programs' achievements (page 9).

The Department of Defense did not perform sufficient analyses to determine the best alternatives for serving their outpatient needs. As a result, the Military Departments opened PRIMUS or NAVCARE clinics that did not provide the most cost-effective alternatives for outpatient medical care. We recommended that the Army Health Services Command, the Naval Medical Command, and the Air Force Surgeon General develop methods and perform analyses to determine how their outpatient needs can best be served in terms of quality, efficiency, convenience, and cost (page 13).

The PRIMUS Quality Assurance Program did not ensure that when an unacceptable level of care occurred, it would be identified and corrected in a timely manner. As a result, the Government could be held liable for harm to recipients due to unacceptable health care. In addition, the Government did not receive the level of service it contracted for. We recommended that the Army and the Air Force develop appropriate quality assurance guidelines for staffing and monitoring the PRIMUS programs, establish uniform and enforceable Performance Requirements Summaries to evaluate contractor performance, and train all Contracting Officers' Representatives (page 21).

The PRIMUS and NAVCARE programs were not evaluated in the Military Departments' Internal Management Control Programs (IMCP's) under the Federal Managers' Financial Integrity Act. As a result, internal controls were inadequate to protect the PRIMUS and NAVCARE programs from waste, fraud, and mismanagement. We recommended that the Army, the Navy, and the Air Force include the PRIMUS and NAVCARE programs in their IMCP's and provide

applicable guidance and training to the senior- and mid-level management officials responsible for the PRIMUS and NAVCARE programs (page 29).

The audit identified internal control weaknesses as defined by Public Law 97-255, Office of Management and Budget Circular A-123, and DoD Directive 5010.38. Controls were not established or effective to develop adequate program objectives and goals, to select the sites and services to be performed, to ensure that quality care was provided, and to include the PRIMUS and NAVCARE programs in the IMCP of the Military Departments. We have determined that monetary benefits will not be realized by implementing the recommendations; however, all recommendations in this report, if implemented, will correct the weaknesses. Therefore, the senior officials responsible for internal controls within the Office of the Assistant Secretary of Defense (Health Affairs) and the Army, the Navy, and the Air Force will be provided a copy of the final report.

The Assistant Secretary of Defense (Health Affairs) concurred with Recommendations A.1. and A.2. Appropriate DoD-wide objectives and goals and a tracking system will be implemented 90 days after a health care consultant makes recommendations in an interim report due December 31, 1989. The Assistant Secretary of the Air Force (Manpower and Reserve Affairs) nonconcurred with the recommendation addressed to the Assistant Secretary of Defense (Health Affairs) to establish DoD-wide objectives and goals and a tracking system, stating that the program was a Service initiative, not a Congressional demonstration project or a DoD-wide health care program.

The Surgeon General of the Army, responding for the Assistant Secretary of the Army (Manpower and Reserve Affairs) concurred with Recommendation B but did not identify specific corrective actions or dates of completion. The Assistant Secretary of the Navy (Manpower and Reserve Affairs) did not state whether the Navy concurs or nonconcurs with Recommendation B to develop methods and perform analyses to determine how outpatient needs can best be served in terms of quality, efficiency, convenience, and cost. The Navy provided a proposed corrective action in its response to Recommendation B but did not provide a completion date. The Assistant Secretary of the Air Force (Manpower and Reserve Affairs) concurred with Recommendation B and plans to develop a model for analysis of outpatient needs by January 1992. The Army is requested to provide its proposed corrective action and a completion date when responding to the final report. We ask that the Navy provide its concurrence or nonconcurrence with Recommendation B and give a completion date for its proposed corrective action when responding to the final report.

The Assistant Secretary of the Army (Manpower and Reserve Affairs) concurred with Recommendations C.1., C.2., and C.3. The Assistant Secretary of the Air Force (Manpower and Reserve

Affairs) concurred in full or in part with Recommendations C.1., C.2., and C.3. Based on management comments, we have revised our Recommendation C.2. to recommend that the Air Force develop uniform and enforceable Performance Requirements Summaries to evaluate a contractor's performance or use other contract initiatives to ensure that the Government receives the service for which it contracts. The Air Force proposed that for future acquisitions of PRIMUS clinics, a fixed-price award fee-type contract be used, to motivate contractors to perform above the minimum standards of the contract to earn monetary rewards. For Recommendation C.1., the Army did not provide a date when its revised surveillance instruction was completed and sent to its PRIMUS sites. Therefore, the Army is requested to provide the completion date when responding to the final report.

The Assistant Secretary of the Army (Manpower and Reserve Affairs) concurred with Recommendations D.1. and D.2. Although the Assistant Secretary of the Navy (Manpower and Reserve Affairs) did not concur or nonconcur with Recommendations D.1. and D.2., we accept the proposed corrective actions for Recommendations D.1. and D.2. as responsive and demonstrating concurrence. The Assistant Secretary of the Air Force (Manpower and Reserve Affairs) concurred with Recommendations D.1. and D.2. However, the Army and the Air Force did not provide a target date for including their PRIMUS programs in their Internal Management Control Program (IMCP); this is needed to ensure that the internal controls are adequate to protect PRIMUS from waste, fraud, and mismanagement. Also, the Army did not provide a target completion date for implementing PRIMUS in its IMCP and the completion date for providing IMCP training. Therefore, we ask the Army and Air Force to provide a target completion date for including PRIMUS in their IMCP, and we ask the Army to give a completion date for providing IMCP training when responding to the final report. The full text of management comments are in Appendix E through Appendix H.

The cooperation and courtesies extended to the auditors during this audit are appreciated. A list of the audit team members is in Appendix J. This report contains no claims of potential monetary benefits. If you have any questions concerning this final report, please contact Mr. Robert Coffey at (202) 694-2397 (AUTOVON 224-2397) or Mr. Christian Hendricks at (202) 694-9160 (AUTOVON 224-9160).

Copies of the final report are being distributed to the activities shown in Appendix K.

DoD Directive 7650.3 requires that all audit recommendations be resolved within 6 months of the date of the final report. Accordingly, final comments on the unresolved issues in this

report should be provided to us within 60 days of the date of this memorandum. The responses should describe the corrective actions taken or planned, the completion date for actions already taken, and the estimated dates for completion of planned actions.

Stephen A. Trodden
Assistant Inspector General
for Auditing

Enclosure

cc:
Secretary of the Army
Secretary of the Navy
Secretary of the Air Force

REPORT ON THE AUDIT OF
PRIMARY CARE FOR UNIFORMED SERVICES
AND NAVY CARES PROGRAMS

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Prepared by:
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REPORT ON THE AUDIT OF PRIMARY CARE FOR UNIFORMED SERVICES AND NAVY CARES PROGRAMS

PART I - INTRODUCTION

Background

In the Omnibus Defense Authorization Act of 1984, Congress directed DoD to conduct studies and demonstration projects to improve the access, quality, efficiency, and cost-effectiveness of health services. In November 1984, the Army Surgeon General initiated a demonstration project to establish a contractor-owned, contractor-operated (COCO) primary care center to provide primary and family practice medical services to eligible beneficiaries. The demonstration project was called Primary Care for the Uniformed Services (PRIMUS). The original objectives of the program were to increase access and convenience, improve cost competitiveness with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and increase patient satisfaction.

In March 1987, the Secretary of the Navy approved the establishment of a Naval health care center, designated the Navy Cares (NAVCARE). The Air Force approved a demonstration project in October 1987, also called PRIMUS.

Both PRIMUS and NAVCARE operations offer the following services:

- PRIMUS and NAVCARE facilities are open 365 days a year, from 7:00 a.m. until 8:00 p.m. on weekdays and from 7:00 a.m. until 2:00 p.m. on weekends and holidays.

- All eligible active duty and retired military personnel and families enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) are entitled to use the facilities.

- Appointments at the PRIMUS and NAVCARE facilities are not necessary, and charges for visits are paid for by the Government at no cost to the patient.

- Episodic illnesses and minor injuries are treated at the facilities, while life- and limb-threatening conditions are referred to the responsible Medical Treatment Facility (MTF).

- The facilities provide basic laboratory, X-ray, and pharmaceutical services on-site.

- Licensed and credentialed physicians and staff provide medical care.

- The facilities' other services include mammography screening, school-related physical examinations, immunizations, and follow-up care for acute chronic conditions such as hypertension, allergies, and diabetes.

Each Military Department issued an advertised Request for Proposal for operating the COCO facilities. The selection of the winning vendor was based on a point system where competing vendor proposals were subject to a technical and cost evaluation. The contracts were generally for a 1-year term with four 1-year options, to be exercised at the Government's discretion. The contracts provided for a fixed number of patient visits for a fixed price, with options to increase the level of patient visits at predetermined levels up to a maximum of 48,000 visits per clinic, per year. Start-up cost per clinic ranged from $33,500 to $670,000, and was funded by the Government at minimum risk to the winning vendor. As of FY 1988, 3 contractors had 23 clinics in operation (13 PRIMUS and 10 NAVCARE).

The Health Services Command (HSC) in San Antonio, Texas, with oversight from the Army's Office of the Surgeon General, manages the Army PRIMUS program. HSC is responsible for overall management, contracting, and budget formulation. Each MTF, through its commanding officer and contracting officer's technical representative, is responsible for the day-to-day operations of the clinic and for reporting these operations to HSC.

The Commander, Naval Medical Command in Washington, D.C., manages the NAVCARE program. The Naval Regional Contracting Center, Philadelphia, Pennsylvania, contracts for the clinics with contract monitoring and administrative support from Naval Medical Materiel Support Command, Fort Detrick, Maryland. The Navy's MTF's have the same responsibilities and duties as the Army's MTF's.

The Air Force Surgeon General's Office manages the Air Force PRIMUS program, and contracts are processed through the 3303rd Contracting Squadron, Randolph Air Force Base, Texas. Medical Logistics, Office of the Surgeon General, at Brooks Air Force Base, San Antonio, Texas, provides administrative and technical support for the PRIMUS program. The Financial Management Division, Office of the Surgeon General at Bolling Air Force Base formulates and controls the budgets of Air Force PRIMUS clinics. The Air Force's MTF's have the same responsibilities and duties as the Army's MTF's but report to the installation's contracting office.

Objectives and Scope

Our audit objectives, as requested by the Committee of Conference on House Joint Resolution 395 in House Report 395, were to inspect PRIMUS and NAVCARE facilities and to evaluate their management and contracting processes; to evaluate budgeted and actual costs of the clinics and compare these costs with the CHAMPUS program; and to evaluate the level of care offered by the clinics and contracts. We also evaluated the internal controls to determine their effectiveness in achieving program objectives and goals.

The project was a joint effort of the Office of the Assistant Inspector General for Auditing and the Office of the Assistant Inspector General for Inspections. An inspection report was issued on September 1, 1988, and the results of the report are in the "Prior Audit Coverage" section of this report.

We selected a sample of 9 of the 23 PRIMUS and NAVCARE clinics in operation in FY 1988. This sample included four Army and four Navy clinics and one Air Force clinic. We evaluated new and old clinics (old clinics had been in operation for more than 1 year) and their controlling MTF's. For each MTF visited, we evaluated the management oversight and internal controls in place to achieve program objectives and goals for PRIMUS and NAVCARE.

We evaluated all applicable policies and procedures concerning PRIMUS and NAVCARE programs as issued by the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) and the Military Departments. We also reviewed the policies of the Joint Commission on Accreditation of Health Care Organizations, on which contract requirements concerning quality assurance were based. To establish objectives and goals, to select sites and services, and to determine whether PRIMUS and NAVCARE programs were included in Internal Management Control Programs, we held discussions with officials from the Army, Navy, and Air Force contracting offices; the Army Health Services Command; the Naval Medical Materiel Support Command; and the Surgeon General's Office of each Military Department. To evaluate contract oversight and quality assurance, we interviewed PRIMUS and NAVCARE Contracting Officers' Representatives (COR's) and reviewed their files.

We held discussions with contractor personnel at each clinic in order to determine the level of quality assurance and control exercised by the contractor. To test contractor quality control, we reviewed personnel files randomly selected from personnel rosters at each clinic and checked to see if credentials were verified by the contractor.

To identify and evaluate budgeted and actual costs of the programs, we reviewed budget and cost data from inception of the original Army PRIMUS demonstration project in FY 1985 through

FY 1988. We obtained information from three sources: the budget and summary cost figures from the command level of each Military Department, the cost data provided by the COR's of each clinic, and the DD Form 250, Material Inspection and Receiving Report, from PRIMUS and NAVCARE contractors. We then compared the budget to the actual costs to determine whether the budgeting process for PRIMUS and NAVCARE programs was adequate.

To determine the cost-effectiveness of the PRIMUS and NAVCARE programs as opposed to CHAMPUS costs, we visited the CHAMPUS office in Aurora, Colorado. There, we held discussions with the director and staff members to develop a costing methodology for using CHAMPUS reimbursement prices to set prices for PRIMUS and NAVCARE services, and to review other CHAMPUS programs for military health care alternatives.

We compared costs per visit at the MTF outpatient clinic, the PRIMUS and NAVCARE clinics, and CHAMPUS. MTF costs were obtained from the Medical Expense and Performance Report for the third quarter of FY 1988. The average cost per PRIMUS and NAVCARE clinic visit was based on start-up costs and payments to the vendor for FY 1988. CHAMPUS costs were computed using the associated costs for medical procedures from a random sample of cases at two PRIMUS clinics. Because CHAMPUS cost figures for FY 1988 were unavailable at the time of our audit, FY 1987 cost figures were used. The "Physicians' Current Procedural Terminology" codes were used to identify the procedures, and the "CHAMPUS Outpatient Services for Care Received" cost reports for FY 1987 were used to identify the Government cost. We compared our computed CHAMPUS cost with the average CHAMPUS cost per visit (by diagnostic category) that DoD used to justify the PRIMUS and NAVCARE programs.

At each clinic, a sample of FY 1988 patient visits was selected to verify the billing process, to document who was receiving the service, and to identify the types of services being provided. A sample of 5,464 patients' visits was selected from a total of 204,078 visits available at the time of our review. The sample was randomly selected, with the exception of San Diego NAVCARE II. This clinic had been operating for only 11 days at the time of our visit, so we reviewed all records.

The audit identified internal control deficiencies as defined by Public Law 97-255, OMB Circular A-123, and DoD Directive 5010.38. Controls were not established or effective for developing adequate objectives and goals, selecting the sites and services to be performed, or ensuring that quality care was provided. In addition, the PRIMUS and NAVCARE programs were not included in the Internal Management Control Programs of the Military Departments.

This program audit was made in accordance with auditing standards issued by the Comptroller General of the United States as implemented by the Inspector General, DoD, and accordingly

included such tests of the internal controls as were considered necessary. The audit was conducted from April 1988 to November 1988 and covered transactions that occurred in FY 1988. Activities visited or contacted are listed in Appendix I.

Prior Audit Coverage

A Congressional Budget Office Study, "Reforming the Military Health Care System," released in January 1988, concluded that a balanced approach, involving various health care initiatives and increased cost-sharing, could improve the military health care system. More civilian-run outpatient clinics would improve the direct care system's capabilities and increase satisfaction among beneficiaries.

The United States General Accounting Office (GAO) issued a report entitled, "DoD Health Care, Implications of Outpatient User's Fee for Non-Active Duty Beneficiaries," Report No. GAO/HRD-8677BR, (OSD Case No. 6986), in July 1986. This report estimated that a $5 or $10 user fee would result in a net revenue of between $231 million and $467 million per year or between $700 million and $1.5 billion, respectively, over a 5-fiscal year period. GAO could not determine what the user's fee would be, when compared to the charge paid by CHAMPUS beneficiaries. GAO suggested that DoD make a study to establish specific objectives for a user fee program and determine the fees needed to accomplish these objectives. DoD opposed user fees, citing morale and troop retention problems. DoD agreed to conduct a feasibility study in FY 1987. Plans for the project were suspended indefinitely when the House and Senate Armed Services Committees passed versions of the FY 1988 authorization bill that included a 2-year prohibition on imposing fees for outpatient medical and dental care received at MTF's.

The Navy Inspector General released an inspection report, "NAVCARE Clinics Site Visits," October 16, 1987. The Navy concluded that the four NAVCARE clinics were operating satisfactorily. However, the Navy found that the contract's statement of work did not adequately describe the work to be performed by the contractor; accurate, clear, or timely guidance for contract administration was not provided, and the overall responsibility or accountability for the clinics was not assigned; resources to administer and monitor the NAVCARE project were not adequate; credentialing programs at NAVCARE clinics were not in compliance with the contract; and the military population was not adequately informed about the level of care provided by the NAVCARE clinics. The Navy Inspector General recommended that the Commander, Naval Medical Command revise the 1988 NAVCARE contract specifications and modify the 1987 contract to ensure that major deficiencies were corrected. The Commander, Naval Medical Command concurred with the recommendation and developed a management action plan that was to be implemented in

November 1988, and if followed, would improve NAVCARE operations. By the end of our audit, the contract had been modified and the Navy was implementing instructions that govern the NAVCARE program.

The Office of the Assistant Inspector General for Inspections issued "Report of the Inspection of Primary Care for the Uniformed Services (PRIMUS) and Navy Cares (NAVCARE) Programs," on September 1, 1988. The report presents the inspection and evaluation of the current and proposed PRIMUS and NAVCARE facilities and contracts directed by the Committee of Conference on House Joint Resolution 395 in House Report 395. The report was issued to identify problem areas that were serious enough to warrant early management attention.

The OAIG for Inspections found that beneficiary access to health care has improved significantly, and that the Army and the Navy have made significant improvements in the terms, conditions, language, and enforceability in the second set of PRIMUS and NAVCARE contracts. However, improvements were needed due to weaknesses in the contract administration process and a lack of oversight by the Office of the Secretary of Defense.

Contract administration lacked sufficient resources and was ineffective. Weaknesses included lack of contract officers' involvement, ineffective and inconsistent staffing and training of COR's, and a lack of standardized quality assurance guidelines to review and assess contractors' performance. The report stated that as a result, the Government may have paid for health care services that were either inadequate or not provided. The OAIG for Inspections also found evidence of PRIMUS and NAVCARE contractors overcharging and erroneously billing the Government for health care services. In addition, some clinics lacked DEERS equipment to validate patients' eligibility for health care.

The OAIG for Inspections report concluded that "as a result of no OSD oversight, there was no institutionalized effort to take advantage of the lessons learned." The report also stated that although the primary health care provided by the PRIMUS and NAVCARE programs is essentially the same, the Military Departments managed the programs independently, resulting in a duplication of effort. There was no central clearing house responsible for collecting, analyzing and disseminating "lessons learned."

No recommendations were made in the OAIG for Inspections report, and no response was required. We studied the same issues, and they are addressed in Part II of this report.

Other Matters of Interest

The issue of implementing user fees for military health care has been controversial for some time. Although the objectives of this audit did not specifically include a review of the

feasibility of implementing a user fee at PRIMUS and NAVCARE clinics, the congressional committee asked that we consider this issue.

As previously mentioned in the prior audit coverage, GAO's report of July 1986 recommended that DoD conduct a feasibility study to determine if a user fee should be implemented. Such a study was never undertaken, however, because the FY 1988 authorization bill prohibited user fees for 2 years.

We reviewed other studies conducted by the Congressional Budget Office, the ASD(HA), and the HSC. All of these studies stated that user fees for military health care might reduce the overuse of facilities. Overuse, in this case, refers to unnecessary patients' visits. It is not intended to suggest that facilities always operate at full capacity. The studies, however, did not present any data to support such a conclusion.

The study by HSC was made in 1979 and updated in 1983. This study dealt primarily with the additional collection costs that user fees would incur. The study presented time and cost analyses for collecting fees (37 minutes and an average cost of $5.28 per collection). The study concluded that any cost reduction resulting from user fees must be weighed against increased collection costs.

Subsequent to our review in December 1988, the Office of Management and Budget (OMB) proposed that a health care user fee plan be included in the DoD budget for FY 1990. This plan would include the PRIMUS and NAVCARE programs. The Secretary of Defense opposed this proposal and stated that the budget proposal would not include a user fee plan. Discussions with officials from the Office of the Comptroller of the Department of Defense highlighted the political nature of this issue. Congress will probably make the final decision on whether to include the user fee plan in the FY 1990 budget.

Our review of this issue, including prior studies, indicates that available data do not support any conclusion on the effect of a user fee on PRIMUS and NAVCARE use. We cannot make any recommendation concerning the impact that user fees would have on reducing unnecessary visits at the PRIMUS and NAVCARE clinics in order to reduce costs.

PART II - FINDINGS AND RECOMMENDATIONS

A. Program Objectives and Goals

FINDING

The Primary Care for the Uniformed Services (PRIMUS) and Navy Cares (NAVCARE) program objectives and goals were not formalized to comply with the congressional mandate and were not consistent or monitored within the Military Departments. These conditions existed because the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) had not established a policy for this DoD-wide program or monitored its results. As a result, DoD could not determine whether the programs were achieving the desired results in a cost-effective and efficient manner.

DISCUSSION OF DETAILS

Background. The Omnibus Defense Authorization Act (the Act), 1984, outlines the objectives for new health care initiatives such as the PRIMUS and NAVCARE programs. Specifically, the Act states that new health care initiatives are to be designed to improve the quality, efficiency, convenience, and cost-effectiveness of health care services.

The Federal Managers' Financial Integrity Act (FMFIA) of 1982, as revised, requires that new programs establish objectives and goals and be monitored to protect against fraud, waste, mismanagement, and misappropriation and to ensure that programs are effectively and efficiently managed. DoD Directive 5010.38, "Internal Management Control Program," April 14, 1987, established the FMFIA program in DoD.

As of November 1, 1988, PRIMUS and NAVCARE are ongoing programs within the Military Departments. The PRIMUS and NAVCARE programs have been funded in the Military Departments' annual budgets since FY 1985. DoD Directive 5136.1, "Assistant Secretary of Defense (Health Affairs)," October 5, 1984, states that ASD(HA) is responsible for overall supervision of the health affairs of the Department of Defense. More specifically, the ASD(HA) is responsible for developing policies, guidance, plans, and standards for DoD health care programs and for monitoring their compliance.

Program Objectives and Goals. PRIMUS and NAVCARE objectives and goals are not formalized, consistent, monitored, or in full compliance with congressional mandate. The ASD(HA) and the Military Departments have not issued directives outlining the objectives and goals of the program. The Military Departments have identified broad objectives instead of quantifiable goals. Examples of quantifiable goals would be reducing CHAMPUS costs by 5 percent or providing services at lower cost than the Medical Treatment Facilities (MTF's).

To evaluate the PRIMUS and NAVCARE program, we reviewed applicable directives and project files of the ASD(HA) and the Military Departments. We met with officials from ASD(HA), the Surgeon General's office of each Military Department, the U.S. Army Health Services Command, the U.S. Naval Medical Command, and applicable MTF's to discuss the process, the adequacy of objectives and goals, and documentation supporting the program results.

On January 12, 1984, the Army Surgeon General approved the Satellite Primary Care Concept as a demonstration project to be performed in the Washington, D.C., area during the 1984 calendar year. In a memorandum to the U.S. Army Health Services Command, the Surgeon General stated that the Army had been under pressure from DoD and Congress to "reduce the CHAMPUS costs and recapture the CHAMPUS work load." The Surgeon General stated that the goals of the demonstration project were "to improve access, reduce CHAMPUS growth, and to develop a satellite primary care framework or program model that can be used elsewhere." As of November 1, 1988, this memorandum contained the only formalized objectives and goals of the Army program; however, the memorandum did not make any reference to congressional objectives for quality, cost-effectiveness, or efficiency.

In FY 1986, the Navy instituted its NAVCARE program and based it on the Army's PRIMUS program. On March 31, 1986, the Assistant Secretary of the Navy (Manpower and Reserve Affairs) (ASN[M&RA]) issued a memorandum that established a working group to set up PRIMUS-type clinics within the Navy. In the memorandum, ASN (M&RA) stated that the Navy could benefit from such clinics through increased access to care, reassignment of medical officers to other areas of greater need, and increased overall efficiency of health care delivery. In addition, the clinic could fill a vital role as a temporary measure or possibly as a permanent cost-effective means for the Navy to "take care of its own."

The ASN (M&RA) memorandum represents the Navy's only written objectives and goals for the NAVCARE program, but it was not effectively communicated to all parties concerned, and the objectives did not address the quality of care or define goals by which to measure the program.

On January 15, 1987, the Air Force stated its objectives and goals in a concept paper. In the paper, the Director, Medical Plans and Resources, Office of the Surgeon General, stated that the primary purpose of this effort was to "improve the accessibility to primary care medical services for the military beneficiaries." The Director also stated that implementation of this program would increase patient satisfaction and convenience, provide cost savings to the Government and the patient, and provide service at a level of quality that is consistent with the MTF's. While these objectives agreed with the congressional mandate, the Air Force did not identify the goals by which to measure them.

The ASD(HA) also did not monitor the program and consequently had no data to support the results of the program. In monitoring their programs, the Military Departments focused on reporting the number of persons served and the type of services provided. As a result, the PRIMUS and NAVCARE reports only reflected that more health care services had been provided. The Military Departments did not collect detailed cost data or evaluate the cost-effectiveness or efficiency of the program.

There was also a lack of effective budget monitoring by the Military Departments. We identified a number of budget overruns for FY 1988 in 9 of the 23 clinics due to laxity of budget monitoring (Appendix A). Furthermore, the audit disclosed that there were no written contingency plans to prevent or control budget overruns at a given clinic. The Military Departments, however, did delay opening several new clinics to reduce potential budget overruns.

The applicable MTF commanders had implemented a Quality Assurance Program to monitor the quality of the care provided at clinics under their control. Improvements in staffing, training, and guidance had been proposed to enhance the quality of care provided, as discussed in Finding C.

Conclusion. There were no formalized objectives or goals for the PRIMUS and NAVCARE programs because ASD(HA) had not established PRIMUS and NAVCARE policies or instituted a system for monitoring program results. The quick implementation of the program prevented ASD(HA) and the Military Departments from establishing sound internal controls. Without objectives and quantifiable goals, DoD had no criteria to evaluate the effectiveness and efficiency of the PRIMUS and NAVCARE programs. Without effective monitoring, the program is subject to fraud, waste, and mismanagement. Congress and management need sufficient and relevant data to support decisions to expand, modify, or cancel the program.

RECOMMENDATIONS FOR CORRECTIVE ACTIONS

We recommend that the Assistant Secretary of Defense (Health Affairs):

1. Establish DoD-wide objectives and goals for the Primary Care for Uniformed Services and Navy Cares programs that are consistent with congressional intent.

2. Develop a DoD-wide tracking system to monitor the programs' achievements and results.

MANAGEMENT COMMENTS

The Assistant Secretary of Defense (Health Affairs) concurred with Recommendations A.1. and A.2. A leading health care consultant has been hired to review the Primary Care for Uniformed Services and Navy Cares programs to ensure that DoD-wide objectives and goals are implemented and to identify the appropriate data sources and methodology for the programs' DoD-wide tracking system. An interim report from the contractor is due December 31, 1989, with the final evaluation due December 31, 1990. Both reports will be sent to Congress. The DoD-wide objectives and goals for the program and the tracking system will be implemented within 90 days of the contractor's interim report date of December 31, 1989.

B. Site Selection and Services

FINDING

The Department of Defense did not perform sufficient analyses to determine the best alternatives for servicing outpatients' needs. This condition existed because methods were not developed for determining how to best serve outpatients' needs in terms of quality, efficiency, convenience, and cost. As a result, the Military Departments selected locations and opened Primary Care for Uniformed Services (PRIMUS) or Navy Cares (NAVCARE) clinics that did not provide the most cost-effective alternatives for outpatient medical care.

DISCUSSION OF DETAILS

Background. The Department of the Army initiated cost containment demonstration projects to reduce Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) costs and recapture the CHAMPUS work load. On January 12, 1984, the Office of the Surgeon General (OTSG) approved a prototype clinic to operate in the Washington, D.C., area. The first clinic was opened in Fairfax, Virginia, on October 1, 1985. The clinic was considered a success, and three additional clinics were approved for opening -- two in Northern Virginia and one in Georgia. The Northern Virginia clinics opened in November 1986 and December 1986, while the Georgia clinic opened in January 1987. At the end of our audit, the Army had opened 10 clinics and planned to open 26 more clinics by the end of FY 1992.

The Navy followed the Army's prototype with only minor changes and opened its first clinic in Jacksonville, North Carolina, on December 3, 1986. Clinics opened in Florida and Virginia later in the same month. At the end of our audit, the Navy had 10 clinics in operation and planned to add 2 clinics each year through 1992. During our audit, Navy officials stated that in establishing future clinics, contractors would be required to use Government-owned facilities instead of contractor-owned facilities.

The Air Force also followed the Army's prototype. The first Air Force clinic opened on August 24, 1988, in Omaha, Nebraska. Two more clinics opened the following month in Arizona and California. At the end of our audit, the Air Force had 3 clinics in operation with plans for 13 additional clinics by the end of FY 1994. A list of all clinics opened by the end of FY 1988 is in Appendix A.

Selection Process. The Military Departments lacked documentation to support their selection of the current clinic locations and their claims of the cost-effectiveness of services and the number of beneficiaries to be serviced.

Army. No documentation was found to justify locating the first clinic in Northern Virginia. Managers agreed that the location was probably selected for political reasons: its proximity to the Pentagon and visibility to Congress. The Army also could not provide any documentation for its selection of the other nine locations for clinics.

The Office of the Surgeon General selected the sites for the initial 10 clinics. When the program was transferred to the U.S. Army Health Services Command (HSC) in April 1987, the HSC developed criteria for locating the next 16 clinics. After the initial 10 clinics were operating, the HSC planned to expand the clinics at a rate of 4 clinics per year through FY 1992, for a total of 26 clinics. Criteria for the economic analysis of sites included (by priority) CHAMPUS costs, the number of anticipated clinic visits, active duty and family member population, retiree population, efficiency of the nearest MTF, and number of patient appointments that can be accommodated.

HSC's only documentation for its decisions was a prioritized listing that considered CHAMPUS costs a key factor for selecting the next 16 locations. However, high CHAMPUS costs were not consistently applied as selection criteria. For example, if high CHAMPUS costs were the principal criteria, Fort McPherson, Georgia, should have been one of the first locations for a PRIMUS clinic in FY 1989. However, no clinic was planned for Fort McPherson until FY 1991. The Fort Lewis, Washington, statistics showed high CHAMPUS costs, yet the Army planned to open two clinics in Fort Sill, Oklahoma, which has lower CHAMPUS costs, before opening a clinic at Fort Lewis.

Analyses were insufficient to determine what services should be available at specific clinics. For example, the Army did not determine which clinics should perform physical exams for school sports as a contractor-provided service. If school sports physicals cost less at the MTF, all beneficiary athletes who need school-related physicals should be examined at the MTF. Also, HSC did not perform sufficient analyses to determine the number of visits the contractor should be guaranteed, or the amounts that the MTF should budget for the program.

Navy. The Navy locations were based on the requirements of the Assistant Secretary of the Navy (Manpower and Reserve Affairs) (ASN [M&RA]), and no formal studies were made. However, the Navy surveyed ZIP Code locations within the predetermined cities to learn which would serve the largest number of personnel. The Navy claimed to base its decision on the results of surveys, using the following criteria to select NAVCARE clinic sites:

- locations having the greatest need, such as areas with major concentrations of both active duty and retired Navy and Marine Corps families, or MTF's that lacked resources to meet the demand for primary care services;

- congressional and other concerns;

- proximity of sites to Naval hospitals (for specialty clinic referrals); and

- number of beneficiaries being referred to CHAMPUS.

The Navy could not provide any documentation showing that the criteria were applied or that any analysis was made to determine site selection other than the list provided by the ASN(M&RA). Likewise, the Navy had no documentation that any analysis had been made to determine specific services or the number of visits each clinic would provide.

Air Force. The Air Force Surgeon General requested input from its MTF's to determine where to place the PRIMUS clinics. The stated site selection criteria (by priority) were as follows:

- support a large active duty population;

- show evidence of excess demand, such as appointment backlogs, clinic overcrowding, and history of complaints of access;

- have an existing or projected shortfall of primary care providers;

- exhibit high CHAMPUS costs and volume;

- be within an Air Force hospital catchment area;

- have Major Command and Surgeon General concurrence and local Air Force base support;

- avoid competition with planned Army and Navy clinics; and

- have local civilian resources, such as providers and leasable facilities, available to support operation of PRIMUS clinics.

The Air Force did not consider active duty population and demand as the most important selection factors, but emphasized sites with Major Command and Surgeon General concurrence and local base support. As a result, the sites selected may not have had the most need. For example, at least eight installations where clinics were not planned had higher active duty populations than installations that were selected. Wright-Patterson Air Force Base (AFB) was 12th on the PRIMUS priority listing, with an active duty population that was higher than at least 3 of the first 5 clinics selected. Also, direct care data indicated that

Wright-Patterson AFB had more direct care visits than four of the first five locations selected. No documentation showed the Air Force adequately determined the type of services to be offered or the number of visits to be provided at each Air Force PRIMUS clinic. Therefore, in our opinion, the Air Force may have identified requirements that were not needed or were less critical than others.

Need for Documented Analysis. An analysis methodology is needed to determine the costs for similar treatment from all available sources in order to make the best decisions for allocating health care resources. Office of Management and Budget (OMB) Circular A-76, (the Circular), "Performance of Commercial Activities," August 4, 1983, requires that Government commercial-type activities compare in-house costs to the contractor costs when determining where the Government's needs can best be served. The Circular sets forth procedures for determining whether commercial-type activities should be performed under contract with commercial sources or with in-house sources using Government facilities and personnel. The PRIMUS and NAVCARE programs should have been considered commercial-type activities and the contract should have been awarded according to the Circular. Even if the services provided by the PRIMUS and NAVCARE clinics were not considered commercial-type activities, sound business practices required that the same type of cost evaluation and comparison for in-house and contractor-operated primary care should be used in every catchment area.

The Military Departments lacked clear criteria and processes for site or service selection. To meet the congressionally-mandated audit objectives, we developed a methodology to determine the effect of the clinic selections. At each of the sites visited, we selected random samples of patients' records to determine the users of the clinics and diagnostic categories of visits for FY 1988, as shown in Appendixes B and C.

The Medical Expense and Performance Reporting System (MEPRS) for the first three quarters of FY 1988 was used as the best available data to determine an average cost per visit at the MTF Primary Care outpatient clinics. The CHAMPUS office provided data and helped us develop methods for determining the average cost for an outpatient visit, based on the procedures performed and the fees that PRIMUS and NAVCARE contractors would be reimbursed using the CHAMPUS rate structure. To determine the actual treatment procedures at PRIMUS and NAVCARE clinics, we sampled 160 visits at each of the two Northern Virginia PRIMUS clinics. CHAMPUS data were not available for FY 1988. Therefore, we used cost data for FY 1987, which CHAMPUS estimated to be 10 to 11 percent lower than FY 1988 costs. Details are in Appendix D.

Cost Comparisons of PRIMUS, NAVCARE, MTF and CHAMPUS. The PRIMUS and NAVCARE clinics were more costly alternatives for providing primary outpatient health care. Eight of the eleven

12/ Costs for specific procedures were obtained from a random sample selected at PRIMUS clinics at Woodbridge, Virginia and Fairfax, Virginia. Procedures provided in the selected patient records were coded by CPT-4 code. The CHAMPUS report of each catchment area was used for the cost of each of these procedures. The cost for each prescription filled was added to the cost per prescription at the Medical Treatment Facility.

13/ CHAMPUS Average Cost by Diagnostic Category. The amount shown is the average cost per visit from the "CHAMPUS Health Care Summary by Primary Diagnosis" report for each of the selected categories used in the sample above.

clinics reviewed showed a higher average cost per visit at the clinics than at the sponsor MTF's. Of the remaining three, two NAVCARE clinics had lower costs because the sponsoring MTF's had moved into new facilities during our audit, raising the MTF's overhead costs.

The MTF costs developed in our evaluation were also higher than they should have been because the scope of practice at MTF's was considerably greater than at the PRIMUS and NAVCARE clinics. For example, outpatient surgery was performed in MTF outpatient clinics and not at PRIMUS and NAVCARE. In the time allotted, we could not reconstruct the costs for PRIMUS- and NAVCARE-type services performed at the MTF. Such a comparison is necessary to determine the actual costs. Also, the MTF cost analysis should consider the incremental cost of providing the service when comparing the costs to that proposed by the PRIMUS and NAVCARE contractors. Specifically, the incremental costs would consider the direct costs (supplies, pharmaceuticals, etc.) and any additional staffing or overhead costs needed to provide the additional service.

CHAMPUS costs also appeared to be less than PRIMUS and NAVCARE costs. Because of the differences in the scope of practice, the comparison of average CHAMPUS costs by diagnostic category with the PRIMUS and NAVCARE cost per visit, which was used to justify the PRIMUS and NAVCARE programs, is not valid. We computed the actual CHAMPUS costs that would be authorized to a civilian medical provider by converting the procedures at the Northern Virginia PRIMUS clinics to the Government-authorized price paid for a given procedure, using Current Procedure Terminology (CPT-4) codes. The CPT-4 codes are used by all civilian medical providers for billing services. Our computed average of CHAMPUS procedures for the services actually provided was almost half the average CHAMPUS cost per visit used to justify the contract costs and was less than the contractor fees paid. This comparison is shown in Appendix D (page 3 of 9).

PRIMUS and NAVCARE Work Load. The Military Departments did not perform adequate studies to determine the total number of visits for any of the PRIMUS and NAVCARE clinics. Studies should have projected the need of the catchment area receiving the clinic minus the capacity of the MTF to determine how much service to contract for. Our analysis identified problems with clinic capacity. Clinics had unused visits in their contracts; at the Oakland NAVCARE clinic, 41 percent of the guaranteed visits were unused, and at the Salinas PRIMUS clinic, 37 percent of the visits were unused. Other clinics had more visits than the number of visits named in the contract terms: the Omaha PRIMUS clinic had 33 percent more visits than were allotted in the contract, and the San Diego NAVCARE I clinic had 5 percent more visits. Unused visits are contractually required to be paid, and overdemand affects the number of services available to be purchased in the option years because future contracted service options must be exercised to meet the demand. Also,

personnel at the MTF's stated that after PRIMUS and NAVCARE clinics opened, outpatient work loads had not decreased and in some cases had increased. Further study of the catchment area's population and needs is necessary during the site selection process because the number of visits contracted for and the mix of services the contractor provides affect the total cost to the Government.

The current 23 PRIMUS and NAVCARE clinics had not served the medical needs of their beneficiaries cost-effectively. Opportunities to procure medical resources in the most cost-effective manner were lost because studies were not made when selecting what services were needed in each catchment area and who could provide the services at the least cost to the Government. If documented management studies are made, cost-effective decisions can be made when selecting future sites and services for PRIMUS and NAVCARE clinics.

RECOMMENDATION FOR CORRECTIVE ACTION

We recommend that the Commander, U.S. Army Health Services Command, the Commander, U.S. Naval Medical Command, and the Air Force Surgeon General develop methods and perform analyses to determine how their outpatient needs can best be served in terms of quality, efficiency, convenience, and cost.

MANAGEMENT COMMENTS

The Assistant Secretary of the Army (Manpower and Reserve Affairs) concurred with Recommendation B. The U.S. Army Medical Department's health care needs are continually analyzed, and the methodology is utilized and improved as new techniques and technology are identified.

The Assistant Secretary of the Navy (Manpower and Reserve Affairs) did not concur or nonconcur with Recommendation B. The Navy stated that the Bureau of Medicine and Surgery recently acquired the Retrospective Case Mix Analysis System which will augment human experience to ensure that quality, efficiency, convenience, and cost are measurable and inherent characteristics in decisions regarding the establishment or disestablishment of health delivery facilities.

The Assistant Secretary of the Air Force (Manpower and Reserve Affairs) concurred with the recommendation. The Air Force will develop a model for analysis of how its outpatient needs can best be served as part of the Air Force Catchment Area Management (CAM) demonstration projects. The CAM demonstration projects are scheduled for fiscal years 1990 through 1992, and will be independently evaluated by the Rand Corporation. No additional Air Force PRIMUS sites have been budgeted prior to that completed demonstration. Implementation of the corrective action is estimated to be January 1992.

AUDIT RESPONSE TO MANAGEMENT COMMENTS

The Assistant Secretary of the Army (Manpower and Reserve Affairs) comments to Recommendation B are not considered responsive. The Army has not identified the methods or procedures it has developed to ensure that the Primary Care for Uniformed Services (PRIMUS) clinics provide the best service in terms of quality, efficiency, convenience, and cost.

C. Quality Assurance Program

FINDING

The Primary Care for Uniformed Services (PRIMUS) Quality Assurance Program did not ensure the identification and timely correction of unacceptable health care service. The weaknesses in the program were due to inadequate staffing and training, inadequate guidance and contract provisions, and a lack of oversight by the contracting officers and DoD management. As a result, the Government could be held liable for harm to the patients who receive unacceptable health care. In addition, the Government did not receive the level of service for which it contracted.

DISCUSSION OF DETAILS

Background. The contracting officer ensures that the Government receives the services required by the contract. The contracting officer also has the authority to initiate legal action to ensure that the contractor performs in accordance with contract specifications for quality, cost, or schedules. The contracting officer, however, delegates this authority and the responsibility for day-to-day review of the contractor's activities to a representative, who is referred to as the contracting officer's representative (COR), the contracting officer's technical representative (COTR), or the quality assurance evaluator. Generally, the commander of the servicing medical treatment facility (MTF) recommends to the contracting officer an individual from his staff to perform these duties.

Contract administration for health care service is evaluated through a Quality Assurance Program (QA Program). The QA Program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The requirement to establish a QA Program is outlined in the Joint Commission on Accreditation of Health Care Organizations (the Joint Commission) "Ambulatory Health Care Standards," which DoD has adopted. The PRIMUS and Navy Cares (NAVCARE) programs allow contractors to institute their own QA Programs using the Joint Commission's standards. QA Programs are ongoing and must be integrated into the contract administration process in order to be effective.

The COR evaluates the contractor's performance using the QA Program surveillance plan. The plan describes the objectives, organization, scope, and procedures for evaluating the quality of the services provided and the contractor's compliance with the contract terms. The surveillance plan provides guidelines for evaluating the quality of care provided by the contractor, including physicians' credentials for performing services, compliance with prescribed medical treatments, and standards for laboratory equipment operation. These control techniques for

increasing the quality of care are also part of the contractors' QA Program. In addition, the plan has quality control guidelines for ensuring that the contractor complies with cost and schedule requirements, such as a clinic's hours of operation; time frames for patient triage, registration, and dispensing medication; quantities of pharmaceutical stock on hand; and verification of bills.

When a contractor does not perform within the acceptable limits of the contract, the performance requirements summaries (PRS) contained in the contract are used to assess penalties. The PRS identifies the performance criteria and the dollar amounts for which the contractor will be fined for nonperformance. The contracting officer has sole authority to assess equitable adjustments on the contractor.

We reviewed the audit work of the Naval Inspector General; regulations, instructions, and directives of the Military Departments for contract administration; policies and procedures of the QA Program and the Joint Commission; and the contracts and related files of the contracting officers, COR's, and contractors. We also reviewed the COR's assessment and surveillance criteria, the contractor's QA Program, and the contracting officer's oversight and monitoring of the COR surveillance efforts. We interviewed officials representing the MTF and the contracting officers, COR's, and contractors to discuss the QA Program and the surveillance plans. We made these reviews to determine the compliance and effectiveness of QA Program processes and procedures, the staffing and training levels, and the overall commitment to the program.

Quality Assurance Program. The PRIMUS QA Program did not adequately ensure identification and timely correction when an unacceptable level of service occurs. Also, it did not effectively ensure that the Government receives the level of service for which it contracts. The QA Program consists of the quality assurance (QA) and Quality Control (QC) processes. The QA evaluates the quality of care provided and the QC evaluates the level of service provided. A discussion of these processes follows.

Quality Assurance. Improvements were needed in the QA process to ensure that quality care is provided. The PRIMUS QA process requires the COR to evaluate the contractors' QA Programs. At the clinics we visited, PRIMUS contractors were not implementing the QA Program cited in the contract. The contractors' QA Programs addressed problems after they occurred instead of continually monitoring the quality of care provided to prevent problems from occurring. The Joint Commission requires that monitoring and evaluation include the ongoing examination of care provided, identification of deficiencies in that care, and necessary improvements in the quality of care. PRIMUS contractors' QA committees apparently did not exist to prevent problems from occurring. For example, in one clinic, the COR and

the MTF's quality assurance chief found that the contractor had no standard criteria for evaluating patients' records on a daily, weekly, or monthly basis. When the contractor was notified it took the necessary corrective action. In our opinion, if the contractor had implemented an effective QA Program, this condition could have been solved prior to the COR analysis.

Credentialing of clinic medical staff is one of the key controls of the contractor's QA Program. This area is important because credentials (education, training, professional conduct, current medical license, etc.) indicate the professional qualifications of clinic personnel. These credentials indicate what services (privileges) the medical professional can provide. This area also affects the quality of care because privileges define the scope of practice and level of services a health care provider may perform. Credentials and approved clinical privileges for contracted health care providers were not made available for the COR's review as provided for in the contracts. We found this condition at every PRIMUS and NAVCARE clinic visited. However, only the Navy COR's reported it to the contractors. For example, a Navy COR identified a NAVCARE clinic where nurse practitioners were prescribing and dispensing drugs. Nurse practitioners are not licensed to prescribe drugs, and doing so may be considered an illegal act. Also, a nurse practitioner's background and training usually does not provide the expertise needed to effectively and safely prescribe drugs.

The Army and the Air Force did not provide adequate guidance in their COR's QA Program surveillance plan to evaluate the contractors' performance. The Joint Commission's standards require quarterly inspections by teams of Government health care professionals to monitor contractors' efforts to ensure that quality care is provided. The results of the quarterly inspections to evaluate contractor performance were documented; however, there were no established evaluation and reporting criteria to determine if all requirements were met. In the Army, two of seven quarterly PRIMUS inspections were not performed when required, and three of seven quarterly inspections were performed separately by health care professionals (radiologists, laboratory technicians, and pharmacists) at various times instead of as a team. The Air Force had no requirement to perform quarterly inspections. The Navy's quarterly inspections were consistent and performed in a timely manner.

Quality Control. Quality control techniques needed improvements to ensure that the contractor is paid for the level of service provided as required by the contract. A process for verifying PRIMUS bills did not exist in the surveillance plans for the Army and the Air Force. The Navy's surveillance plan required the COR to validate the contractors' bills. The Navy selected billings for review based on the volume of visits, and the Navy's bill verification process showed that the level of review by the three COR's varied, with one COR reviewing almost 100 percent of the bills. Two of the four Army COR's we visited

approved the contractors' reimbursement requests (DD Forms 250) without verifying their accuracy. At the other two clinics, the COR's used their own verification techniques to review bills. At the Air Force PRIMUS location, the COR was not required to validate the contract as billed. At the time of our review, the bills were forwarded to another site for payment.

For the 9 sites visited during the audit, we selected 5,464 patients' visits from a universe of 204,078 for FY 1988 to determine the effectiveness of the bill verification process. Each patient's visit was reviewed to determine whether it was authorized, not duplicated, and if the fee charged was appropriate for a full visit, a short visit, a prescription refill, or another special billing rate established in the contract. Our test of the billings for the PRIMUS and NAVCARE locations based on a sampling plan with a 90-percent confidence level showed a frequency rate of 0 to 9 percent for billing error. The loss from billing errors was $900,000 for DoD in FY 1988.

Contractor Accountability. PRIMUS contractors were not being held accountable for noncompliance with contract provisions. This occurred because the Army and the Air Force had not incorporated in their contracts criteria for performance requirements summaries (PRS) and associated penalties for nonperformance of contract terms and conditions. Our review identified several areas of contractor nonperformance; contractors were not held accountable for discrepancies in credentialing and contractor's accreditation by the Joint Commission on Accreditation of Health Care Organizations.

The Navy had always included performance requirements summaries (PRS) in its contracts, but the contracting officer determined that the PRS were not enforceable until changes were made in NAVCARE contracts in July 1988. At one NAVCARE location, the COR had identified PRS assessments of $284,000 against the contractor for the period March 1987 through June 1988; however, the Navy had no plans to collect the assessments for inadequate service that occurred prior to June 1988. Based on our analysis of the deficiencies identified by the Navy COR's at two NAVCARE clinics for the period May 1988 through July 1988, we determined that the Navy's process for identifying and reporting contractor deficiencies is effective. Therefore, we believe the assessments made were based on the contract terms and conditions and should have been collected if the PRS provisions in the contracts were enforceable.

In July 1988, the Navy also implemented a new process to resolve contractor deficiencies noted by the COR's. The new process will increase the likelihood that contractor fines will be assessed. We found that the weaknesses in contract provisions, PRS guidance, and access to the contracting officer have been resolved. The Navy COR's identified $457,000 in PRS deductions from July 1988 to September 1988 because contractors did not

comply with the terms and conditions of the contracts. Contractor deductions were due to inadequate staffing, an ineffective QA program, and untimely and ineffective treatment of patients.

Army and Air Force Programs. Weaknesses in the Army and Air Force QA Programs were due to inadequate staffing, inadequate oversight and monitoring, and inadequate guidance to measure contractors' performance. COR's also were not trained in monitoring health service contracts.

The Army and Air Force COR's were understaffed, and the skills necessary to perform the function were undefined. Neither the Army nor the Air Force had developed measures of the level of effort necessary to effectively administer the PRIMUS contracts. Consequently, COR's did not have adequate resources to perform the required function. In the Army and the Air Force, COR functions were assigned as collateral duties. For example, one Army COR was responsible for three clinics and was also the MTF patient administrator. No guidelines delineated the category or level of experience necessary for appointment as a COR. Typical Army and Air Force COR's had little of the clinical background needed to verify required QA Programs. In contrast, the Navy staffed its COR function with nurses from the servicing MTF.

The COR's surveillance efforts were not effectively monitored by the contracting officers who were responsible for ensuring that the Government receives the services for which it contracts. Contracting officers did not have day-to-day contact with COR's, and at the time of our audit had not evaluated any of the COR's activities. During the audit, the MTF's were evaluating the COR's annually. The Army's PRIMUS Project Director at Health Services Command also began reviewing the COR's surveillance efforts at the end of our field work, and the contracting officer planned to review the COR's activities in FY 1989.

Contracting officers and major medical commands did not issue enough guidance to the Army and the Air Force COR's. The COR's were given limited guidance on procedures (such as how to coordinate and perform a quarterly inspection with health care professionals from the MTF or how to verify the contractor's bill) for evaluating contractors' performance. We found no procedures to ensure that such processes were documented or consistently applied among the COR's. The Navy COR's performed quarterly inspections and other surveillance efforts in a timely and consistent manner because the requirement and process were well-defined. The Navy used PRS criteria that provided an effective control to evaluate the contractor and to ensure uniformity in the COR process.

The Army and the Air Force did not train their COR's in administering health service contracts. However, at the end of our audit, the Army was taking steps to develop a COR training

course. During our audit, the Navy redesigned its COR training program to address issues specific to the NAVCARE program.

Conclusion. Without effective QA Programs, the Government may not receive the quality and level of service it paid for. Because performance requirements summaries (PRS) were inadequate, contractors were not penalized for breaches of the contract terms or discouraged from providing inadequate and potentially dangerous health care service. The Navy COR's identified $456,000 PRS deductions from July 1988 to September 1988. PRIMUS sites are served by the same contractors as NAVCARE; therefore, the Army and Air Force should have PRS deductions similar to the Navy's. We did not note any variations in the level of contractors' efforts that would warrant a different conclusion. We noted billing errors representing a loss to DoD of $900,000 in FY 1988, indicating that the Government is paying more than it should.

The need for effective contract administration is critical in health care, since unacceptable health care increases the risk of harm to recipients. When the quality of care is questionable, the Government is at risk because of the "deep pocket" litigation theory, where the injured sues the one most likely to pay. This situation may occur even though the Government holds the contractors liable in the contract for the services they provide. In one instance, a contractor called its clinic a Government entity to avoid state licensing. This misrepresentation was done to avoid the cost of the license and to avoid state oversight. When the Government's QA Programs are not effective, the potential for liability increases. Specifically, when the Government does not ensure that clinic personnel perform within their normal scope of practice and clinical privileges, the potential exists for improper diagnosis of patients, errors in medication, and malpractice. For example, during our audit, several errors in medication occurred when unqualified clinic personnel dispensed drugs.

RECOMMENDATIONS FOR CORRECTIVE ACTION

We recommend that the Commander, U.S. Army Health Services Command and the Office of the Surgeon General, Air Force:

1. Develop appropriate guidelines for staffing, monitoring, and inspecting the Primary Care for Uniformed Services clinics.

2. Develop uniform and enforceable performance requirements ummaries to evaluate contractors' performance or other contract ntiatives that ensure the Government receives the services for hich it contracts.

3. Develop and implement a training course for contracting fficer's representatives.

MANAGEMENT COMMENTS

he Assistant Secretary of the Army (Manpower and Reserve ffairs) concurred with Recommendations C.1., C.2., and C.3. To plement Recommendation C.1., the Army revised its Primary Care or Uniformed Services (PRIMUS) surveillance plan and distributed to all PRIMUS sites. Also, the manpower staffing requirements ere established on October 1, 1985, for the operation and rveillance of PRIMUS contracts. The Army concurred with ecommendation C.2. and has developed performance requirements ummaries (PRS) for all PRIMUS contracts. By the second quarter fiscal year 1990, PRS will be implemented in all PRIMUS ntracts and will be required for all future PRIMUS contracts. implement Recommendation C.3., the Army required training for s contracting officer's representatives and sent its PRIMUS R's to an Army training course. In addition, the U.S. Army gistics Management Center has designed a workshop to supplement IMUS COR training. The first PRIMUS COR workshop was conducted November 15-18, 1988; the workshop and will be conducted nually.

e Assistant Secretary of the Air Force (Manpower and Reserve fairs) concurred in full or in part with Recommendations C.1., 2., and C.3. The Air Force partially concurred with commendation C.1. because the audit reviewed its Primary Care r Uniformed Service (PRIMUS) program when it had been erational for only three weeks. The Air Force is evaluating s PRIMUS clinic guidelines for consistency and propriateness. The review is expected to be completed by vember 1989 and the procedures standardized by January 1990. e Air Force concurred with exception with Recommendation C.2. d recommended an alternative action to ensure that the ntractor provides the level of service contracted for. The Air rce proposed that fixed-price award fee-type contracts be used r future acquisitions of PRIMUS clinics. This type of contract tivates the contractor to perform above the minimum standards the contract to earn monetary reward. The Air Force will use ard fees and the quality assurance surveillance plan to monitor ntractors' performance. The Air Force concurred with commendation C.3. and will hold a joint Army and Air Force aining course for contracting officer's representatives in tober 1989 or November 1989. Additional training courses will scheduled as needed.

AUDIT RESPONSE TO MANAGEMENT COMMENTS

The proposed corrective actions of the Assistant Secretary of the Air Force (Manpower and Reserve Affairs) for Recommendations C.1. and C.2. are considered responsive. For Recommendation C.2., we have revised our recommendation to allow for contract initiatives that ensure that the Government receives the service for which it has contracted.

Internal Management Control Program

FINDING

Primary Care for Uniformed Services (PRIMUS) and Navy Cares CARE) programs were not evaluated in the Military rtments' Internal Management Control Programs (IMCP's). This ition occurred because the Military Departments were not e of the program's annual review requirement. As a result, rnal controls were inadequate to protect the PRIMUS and ARE programs from waste, fraud, and mismanagement.

DISCUSSION OF DETAILS

Background. The Federal Managers' Financial Integrity Act IA) of 1982 requires each executive agency to evaluate its ems of accounting and administrative control in accordance Office of Management and Budget (OMB) guidelines and report ally to the President and the Congress. The Office of gement and Budget revised Circular A-123 (OMB Circular), ernal Control System," August 1986. The OMB Circular ires the head of each department and agency to establish and tain adequate systems of internal control. Agencies shall blish a system to provide reasonable assurance that rnment resources are protected against waste, fraud, anagement, and misappropriation, and that new programs are ctively and efficiently managed to achieve the goals of the cy. DoD Directive 5010.38, "Internal Management Control ram," April 14, 1987, established the DoD program for rnal management control. The DoD Directive incorporates the irements of the FMFIA, and the OMB Circular gives policies procedures and assigns responsibilities to the DoD onents.

PRIMUS and NAVCARE programs, as an extension of the atient services provided by Medical Treatment Facilities 's), are part of the overall DoD health care program. The ion of the health care programs is critical to DoD. Given r $42 million budget for FY 1988 and current and projected th, PRIMUS and NAVCARE should be considered an assessable . An assessable unit is defined as a program or nistrative function within an organization capable of being luated by internal control risk assessment procedures, rnal management control reviews, or other types of internal rol evaluation. The internal management control program CP) should entail a review of the internal controls involved the management of the PRIMUS and NAVCARE program. In ition, areas for review should include contract administration the vendors' internal controls as they relate to compliance n the contract.

During the audit, we interviewed officials from the Surgeon General's office of each of the Military Departments, the U.S. Army Health Services Command, the U.S. Naval Medical Command, and selected MTF's to discuss their IMCP's for the PRIMUS and NAVCARE programs. At each MTF where the clinics were located, we asked internal management control coordinators and the contracting officer's representative to provide documentation indicating that PRIMUS or NAVCARE programs were reviewed under the requirements of the OMB Circular.

Control Assessment Needed. The PRIMUS and NAVCARE programs were not included in the IMCP's at the Military Department level or at the local MTF level. Thus, no assessment of the internal controls was made. During our audit, we found no evaluation of the PRIMUS and NAVCARE programs as individual entities or as part of the outpatient program in an MTF. The evaluations were not made because the internal management control coordinators at the major medical command and MTF's were not told to incorporate the PRIMUS and NAVCARE programs into their IMCP's. This condition also existed because the Military Departments and local MTF managers were not aware of the requirements of the IMCP's.

Training Needed. In order to effectively implement an IMCP, PRIMUS and NAVCARE managers must be trained in the requirements of the FMFIA and the OMB Circular. OMB guidelines state that training should be provided to senior-level and mid-level managers to make them aware of their responsibilities under FMFIA and the OMB Circular. In "Guidelines for the Evaluation and Improvement of the Reporting of Internal Control Systems in the Federal Government," December 1982, OMB identified a detailed seven-step approach for evaluating and reporting internal controls. PRIMUS and NAVCARE managers should be trained in the internal control evaluation process.

This report has identified internal control weaknesses that need to be corrected. Without an evaluation of the PRIMUS and NAVCARE internal controls, DoD has no assurance that the program is protected against waste, fraud, and mismanagement and is meeting its objectives and goals. Specifically, the weaknesses and proposed recommendations for establishing and monitoring the objectives and goals, for developing a process for identifying outpatient requirements, and for ensuring that quality service has been provided are discussed in Findings A, B, and C, respectively, and corrective actions should be monitored in the Military Departments' IMCP's.

RECOMMENDATIONS FOR CORRECTIVE ACTION

We recommend that the Commander, U.S. Army Health Services Command; the Commander, U.S. Naval Medical Command; and the Air Force Surgeon General:

1. Include the Primary Care for Uniformed Services and Navy es programs in the Internal Management Control Review program.

2. Provide guidance and training to senior- and mid-level agement officials involved in the Primary Care for Uniformed vices and Navy Cares programs.

MANAGEMENT COMMENTS

Assistant Secretary of the Army (Manpower and Reserve airs) concurred with Recommendations D.1. and D.2. The Army ted that Primary Care for Uniformed Services (PRIMUS) would be luded in the Internal Management Control Program, and that mand training for personnel in the Army PRIMUS program would lude IMCP guidance.

Assistant Secretary of the Navy (Manpower and Reserve airs) did not concur or nonconcur with Recommendations D.1. D.2. The Navy Cares (NAVCARE) program will be included in Bureau of Medicine and Surgery management control inventory an assessable unit under the functional category "Support vices" by October 31, 1989, in preparation for the Fiscal r 1990 Management Control Review Cycle. In addition, on ember 8, 1988, contract administration was directed for review Naval Medical Command (now Bureau of Medicine and Surgery) ivities. This included contract renewal procedures, quality urance review procedures, personal services contracting, and lth services contracting. The Navy provided management trol training to Echelon II and subordinate program rdinators between October 17, 1988, and March 23, 1989. ivity coordinators train senior and mid-level managers as ded.

Assistant Secretary of the Air Force (Manpower and Reserve airs) concurred with Recommendations D.1. and D.2. The Air ce officials stated that if including their Primary Care for formed Services (PRIMUS) program in the Internal Management trol Program (IMCP) is mandated as outlined in Recommendation ., they will comply. The Air Force also agreed to ensure by uary 1990 that IMCP guidance and training are provided to propriate management officials involved in the PRIMUS programs.

AUDIT RESPONSE TO MANAGEMENT COMMENTS

corrective actions proposed by the Assistant Secretary of the y (Manpower and Reserve Affairs) for Recommendations D.1. and 2. are considered responsive. These actions ensure that the y Cares program is included in the Internal Management Control gram and that the appropriate management officials are ained.

Clinics		Clinic Opening Date	Pre Imp Cost 3/	Budgeted Cost	Total Cost	Budgeted Variance	Total Visit	Cost Per Visit
Army								
Ft. Belvoir, VA (Burke)			$ 0	$ 2,944,500	$ 2,651,400 4/	$ 293,100	65,841	$ 40
Ft. Belvoir, VA (Fairfax)			0	2,944,500	2,651,400	293,100	66,912	40
Ft. Belvoir, VA (Woodbridge)			0	3,926,000	3,535,200	390,800	89,026	40
Ft. Benning, GA		04/30/88	83,109	1,303,000	1,396,109	(93,109)	19,067	73
Ft. Bragg, NC		05/02/88	97,614	1,310,000	1,519,614	(209,614)	27,764	55
Ft. Stewart, GA			0	2,502,000	2,499,000	3,000	52,926	47
Ft. Ord, CA (Presidio of Monterey)			0	1,659,080	879,320	779,760	17,112	51
Ft. Ord, CA (Primus of Salinas)		06/01/88	268,530	523,920	546,210	(22,290)	5,431	101
Ft. Hood, TX (Killeen)		06/04/88	33,393	966,720	1,018,557	(51,837)	20,439	50
Ft. Hood, TX (Copperas Cove)		06/04/88	33,843	857,280	907,479	(50,199)	17,421	52
Totals			$516,489	$18,937,000	$17,604,289	$1,332,711	381,939	
Navy								
Jacksonville, NC	Navy Care I		$ 0	$ 2,663,000	$ 2,752,466	$ (89,466)	64,037	$ 43
Jacksonville, FL	Navy Care I		0 0	1,566,000	2,134,804	(568,804)	43,821	49
Norfolk, VA	Navy Care I		0	2,681,000	2,816,328	(135,328)	74,438	38
San Diego, CA	Navy Care I		0	3,113,000	3,557,655	(444,655)	87,855	40
Charleston, SC	Navy Care II	07/08/88	607,971	1,456,000	1,591,154	(135,154)	17,572	91
Long Beach, CA	Navy Care II	07/13/88	652,479	1,626,000	1,367,946	258,054	8,040	170
Norfolk, VA	Navy Care II	07/07/88	668,074	1,843,000	1,565,259	277,741	14,358	109
Oakland, CA	Navy Care II	07/19/88	650,814	1,553,000	1,096,661	456,339	6,478	169
Oceanside, CA	Navy Care II	07/12/88	530,111	1,456,000	1,335,472	120,528	9,556	140
San Diego, CA	Navy Care II	07/12/88	502,270	1,818,000	1,394,568	423,432	11,069	126
Totals			$3,611,719	$19,775,000	$19,612,313	$ 162,687	337,224	
Air Force								
Offutt Air Force Base (AFB), NE		08/24/88	$ 523,983	$1,300,000	$ 712,934	$ 587,066	7,604	$ 94
Davis-Monthan AFB, AZ		09/01/88	433,484	1,300,000	555,806	744,194	3,354	166
March AFB, CA		09/02/88	657,957	1,300,000	825,675	474,325	2,968	278
Totals			$1,615,424	$3,900,000	$2,094,415	$1,805,585	13,926	

See footnotes at end of chart.

PRIMUS/NAVCARE BUDGETED AND ACTUAL COSTS SUMMARY (Continued)

Cost Analysis for FY 1987 by Service

Clinics		Clinic Opening Date	Pre Imp Cost	Budgeted Cost	Total Cost	Budgeted Variance	Total Visits	Cost Per Visit
Army								
Ft. Belvoir, VA (Burke)		12/02/86	$ 405,272	$2,250,000	$ 3,135,208 4/	$ (885,208)	51,960	$60
Ft. Belvoir, VA (Fairfax)			0	2,250,000	3,560,786	(1,310,786)	68,814	52
Ft. Belvoir, VA (Woodbridge)		11/11/86	405,272	2,250,000	4,203,443	(1,953,443)	73,871	57
Ft. Benning, GA			0	0	0	0	0	0
Ft. Bragg, NC			0	0	0	0	0	0
Ft. Stewart, GA		01/20/87	354,000	2,250,000	2,134,393	115,607	33,776	63
Ft. Ord, CA (Presidio of Monterey)		06/13/87	207,225	0	0	0	0	0
Ft. Ord, CA (Primus of Salinas)			0	0	0	0	0	0
Ft. Hood, TX (Killeen)			0	0	0	0	0	0
Ft. Hood, TX (Copperas Cove)			0	0	0	0	0	0
Totals			$1,371,769	$9,000,000	$13,033,830	$(4,033,830)	228,421	
Navy								
Jacksonville, NC	Navy Care I	12/03/86	$ 53,302	$2,063,750 5/	$1,532,484	$ 531,266	38,141	$ 40
Jacksonville, FL	Navy Care I	12/08/86	42,401	2,063,750	1,303,801	759,949	26,403	49
Norfolk, VA	Navy Care I	12/14/86	254,318	2,063,750	1,947,026	116,724	48,715	40
San Diego, CA	Navy Care I	12/15/86	308,702	2,063,750	2,177,068	(13,318)	46,894	46
Charleston, SC	Navy Care II		0	0	0	0	0	0
Long Beach, CA	Navy Care II		0	0	0	0	0	0
Norfolk, VA	Navy Care II		0	0	0	0	0	0
Oakland, CA	Navy Care II		0	0	0	0	0	0
Oceanside, CA	Navy Care II		0	0	0	0	0	0
San Diego, CA	Navy Care II		0	0	0	0	0	0
Totals			$658,723	$8,255,000	$6,960,379	$1,394,621	160,153	
Air Force								
Offutt AFB, NE			$ 0	$ 0	$ 0	$ 0	0	$0
Davis-Monthan AFB, AZ			0	0	0	0	0	0
March AFB, CA			0	0	0	0	0	0
Totals			$ 0	$ 0	$ 0	$ 0	0	$0

See footnotes at end of chart.

PRIMUS/NAVCARE BUDGETED AND ACTUAL COSTS SUMMARY (Continued)

Clinics		Clinic Opening Date	Pre Imp Cost	Budgeted Cost	Total Cost	Budgeted Variance	Total Visits	Cost Per Visit
Army								
Ft. Belvoir, VA (Burke)			$	$ 0	$ 0	$ 0	0	$ 0
Ft. Belvoir, VA (Fairfax)		10/01/85	661,561	3,650,000	3,400,400	249,600	70,409	48
Ft. Belvoir, VA (Woodbridge)			0	0	0	0	0	0
Ft. Benning, GA			0	0	0	0	0	0
Ft. Bragg, NC			0	0	0	0	0	0
Ft. Stewart, GA			0	0	0	0	0	0
Ft. Ord, CA (Presidio of Monterey)			0	0	0	0	0	0
Ft. Ord, CA (Primus of Salinas)			0	0	0	0	0	0
Ft. Hood, TX (Killeen)			0	0	0	0	0	0
Ft. Hood, TX (Copperas Cove)			0	0	0	0	0	0
Totals			$661,561	$3,650,000	$3,400,400	$249,600	70,409	
Navy								
Jacksonville, NC	Navy Care I		$ 0	$167,500 5/	$167,500	$ 0	0	$ 0
Jacksonville, FL	Navy Care I		0	167,500	167,500	0	0	0
Norfolk, VA	Navy Care I		0	167,500	167,500	0	0	0
San Diego, CA	Navy Care I		0	167,500	167,500	0	0	0
Charleston, SC	Navy Care II		0	0	0	0	0	0
Long Beach, CA	Navy Care II		0	0	0	0	0	0
Oakland, CA	Navy Care II		0	0	0	0	0	0
Oceanside, CA	Navy Care II		0	0	0	0	0	0
Norfolk, VA	Navy Care II		0	0	0	0	0	0
San Diego, CA	Navy Care II		0	0	0	0	0	0
Totals			$ 0	$670,000	$670,000	$ 0	0	
Air Force								
Offutt AFB, NE			$ 0	$ 0	$ 0	$ 0	0	$ 0
Davis-Monthan AFB, AZ			0	0	0	0	0	0
March AFB, CA			0	0	0	0	0	0
Totals			$ 0	$ 0	$ 0	$ 0	0	

See footnotes at end of chart.

PRIMUS/NAVCARE BUDGETED AND ACTUAL COSTS SUMMARY (Continued)

Cost Analysis for FY 1985 by Service

Clinics	Clinic Opening Date	Pre Imp Cost	Budgeted Cost	Total Cost	Budgeted Variance	Total Visits	Cost Per Visit
Army							
Ft. Belvoir, VA (Burke)		$ 0	$ 0	$ 0	$0	0	$0
Ft. Belvoir, VA (Fairfax)	10/01/85	661,561	661,561	661,561	0	0	0
Ft. Belvoir, VA (Woodbridge)		0	0	0	0	0	0
Ft. Benning, GA		0	0	0	0	0	0
Ft. Bragg, NC		0	0	0	0	0	0
Ft. Stewart, GA		0	0	0	0	0	0
Ft. Ord, CA (Presidio of Monterey)		0	0	0	0	0	0
Ft. Ord, CA (Primus of Salinas)		0	0	0	0	0	0
Ft. Hood, TX (Killeen)		0	0	0	0	0	0
Ft. Hood, TX (Copperas Cove)		0	0	0	0	0	0
Totals		$661,561	$661,561	$661,561	$0	0	
Navy							
Jacksonville, NC Navy Care I		$ 0	$ 0	$ 0	$0	0	$0
Jacksonville, NC Navy Care I		0	0	0	0	0	0
Norfolk, VA Navy Care I		0	0	0	0	0	0
San Diego, CA Navy Care II		0	0	0	0	0	0
Charleston, SC Navy Care II		0	0	0	0	0	0
Long Beach, CA Navy Care II		0	0	0	0	0	0
Norfolk, VA Navy Care II		0	0	0	0	0	0
Oakland, CA Navy Care II		0	0	0	0	0	0
Oceanside, CA Navy Care II		0	0	0	0	0	0
San Diego, CA Navy Care II		0	0	0	0	0	0
Totals		$ 0	$ 0	$ 0	$0	0	
Air Force							
Offutt AFB, NE		$ 0	$ 0	$ 0	$0	0	$0
Davis-Monthan AFB, AZ		0	0	0	0	0	0
March AFB, CA		0	0	0	0	0	0
Totals		$ 0	$ 0	$ 0	$0	0	

See footnotes at end of chart.

Clinics		Clinic Opening Dates	Budgeted Cost FY 1989	Budgeted Cost FY 1990	Budgeted Cost FY 1991	Budgeted Cost FY 1992
Army						
Ft. Belvoir, VA (Burke)		12/02/86	$ 2,250,000	$ 2,760,000	$ 2,760,000	$ 2,760,000
Ft. Belvoir, VA (Fairfax)		10/01/85	2,250,000	2,760,000	2,760,000	2,760,000
Ft. Belvoir, VA (Woodbridge)		11/11/86	2,250,000	2,760,000	2,760,000	2,760,000
Ft. Benning, GA		04/30/88	2,250,000	2,250,000	2,250,000	2,250,000
Ft. Bragg, NC		05/02/88	2,250,000	2,250,000	2,250,000	2,250,000
Ft. Stewart, GA		01/20/87	2,250,000	2,250,000	2,250,000	2,250,000
Ft. Ord, CA (Presidio of Monterey)		06/13/88	2,250,000	2,250,000	2,250,000	2,250,000
Ft. Ord, CA (Primus of Salinas)		06/01/88	2,250,000	2,250,000	2,250,000	2,250,000
Ft. Hood, TX (Killeen)		06/04/88	2,250,000	2,250,000	2,250,000	2,250,000
Ft. Hood, TX (Copperas Cove)		06/04/88	2,250,000	2,250,000	2,250,000	2,250,000
Totals			$22,500,000	$24,030,000	$24,030,000	$24,030,000
Navy						
Jacksonville, NC	Navy Care I	12/03/86	3,814,700	3,816,250	3,933,100	4,462,050
Jacksonville, FL	Navy Care I	12/08/86	3,814,700	3,816,250	3,933,100	4,462,050
Norfolk, VA	Navy Care I	12/14/86	3,814,700	3,816,250	3,933,100	4,462,050
San Diego, CA	Navy Care I	12/15/86	3,814,700	3,816,250	3,933,100	4,462,050
Charleston, SC	Navy Care II	07/08/88	3,814,700	4,084,000	4,205,600	3,888,467
Norfolk, VA	Navy Care II	07/07/88	3,814,700	4,084,000	4,205,600	3,888,467
Oakland, CA	Navy Care II	07/19/88	3,814,700	4,084,000	4,205,600	3,888,467
Oceanside, CA	Navy Care II	07/12/88	3,814,700	4,084,000	4,205,600	3,888,467
Long Beach, CA	Navy Care II	07/13/88	3,814,700	4,084,000	4,205,600	3,888,467
San Diego, CA	Navy Care II	07/12/88	3,814,700	4,084,000	4,205,600	3,888,467
Totals			$38,147,000 1/	$39,769,000 1/	$40,966,000 1/	$41,179,002 1/
Air Force						
Offutt AFB, NE		08/24/88	$ 2,800,000	$ 2,800,000	$ 2,800,000	$ 2,800,000
Davis-Monthan AFB, CA		09/01/88	2,800,000	2,800,000	2,800,000	2,800,000
March AFB, CA		09/02/88	2,800,000	2,800,000	2,800,000	2,800,000
Totals			$ 8,400,000	$ 8,400,000	$ 8,400,000	$ 8,400,000

See footnotes at end of chart.

PRIMUS/NAVCARE BUDGETED AND ACTUAL COSTS SUMMARY (Continued)

Budgeted Cost Summary for Contract Outyears

Clinics		Clinic Opening Dates	Budgeted Cost FY 1989	Budgeted Cost FY 1990	Budgeted Cost FY 1991	Budgeted Cost FY 1992
Navy						
Jacksonville, NC	Navy Care I	12/03/86	$ 3,814,700	$ 4,198,250	$ 4,331,850	$ 4,876,150
Jacksonville, FL	Navy Care I	12/08/86	3,814,700	4,198,250	4,331,850	4,876,150
Norfolk, VA	Navy Care I	12/14/86	3,814,700	4,198,250	4,331,850	4,876,150
San Diego, CA	Navy Care I	12/15/86	3,814,700	4,198,250	4,331,850	4,876,150
Charleston, SC	Navy Care II	07/08/88	3,814,700	4,084,000	4,205,600	4,742,233
Long Beach, CA	Navy Care II	07/13/88	3,814,700	4,084,000	4,205,600	4,742,233
Norfolk, VA	Navy Care II	07/07/88	3,814,700	4,084,000	4,205,600	4,742,233
Oakland, CA	Navy Care II	07/19/88	3,814,700	4,084,000	4,205,600	4,742,233
Oceanside, CA	Navy Care II	07/12/88	3,814,700	4,084,000	4,205,600	4,742,233
San Diego, CA	Navy Care II	07/12/88	3,814,700	4,084,000	4,205,600	4,742,233
Totals			$38,147,000 8/	$41,297,000 8/	$42,561,000 8/	$47,957,998 8/

See footnotes at end of chart.

Footnotes:

1/ PRIMUS - Primary Care for Uniformed Services
NAVCARE - Navy Cares

2/ Cost Analyses for FY's 1985 through 1988 represent the clinics' operating costs by Service and include the pre-implementation cost for clinic openings.

3/ Pre-Imp Cost - Pre-implementation cost (Start-up cost).

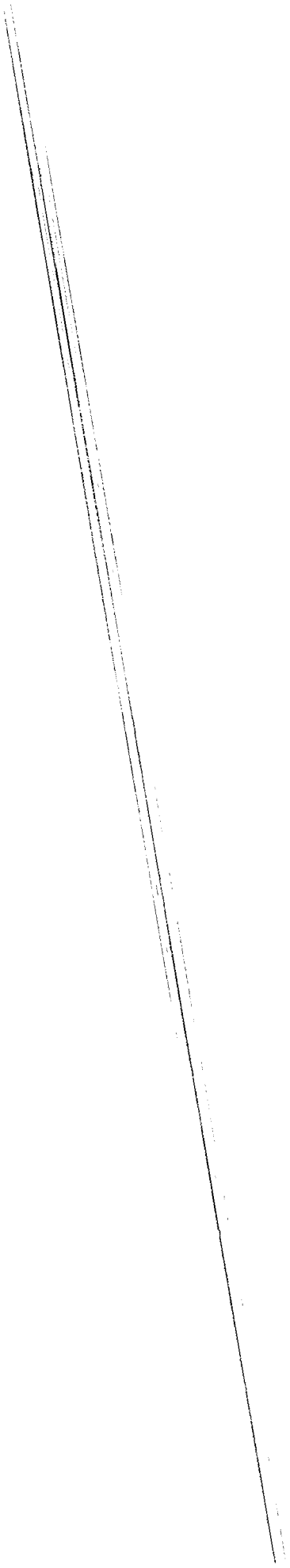
4/ The weighted average method was used in computing the actual cost in FY 1988 for all clinics with the exception of Fort Stewart, Fort Benning, and Fort Bragg, using the total visits column as the basis of the computation for "Army" only. The Army also used this reporting methodology in FY 1987.

5 The Navy's budgeted cost per clinic was computed by dividing the total cost reported by the Commander, Naval Medical Command by four, the number of clinics scheduled to open in FY 1986; however, the clinics did not open until FY 1987. Start-up costs were included in the FY 1986 and FY 1987 budgets.

6/ Budgeted cost summary for contract outyears, Fiscal Years 1989 through 1992.

7/ The amounts listed in the Navy's budget for FY 1989 through FY 1992 are all average amounts based on the total budget amounts as provided by the Naval Medical Command, Washington, DC. These figures represent the Navy's proposed budget for FY 1989 through FY 1992, provided Option I of the budget proposal is exercised, which is a "status quo" budget that requires reducing the services presently provided.

8/ These figures represent the budget amounts should the Navy exercise Option II of the budget proposal, which presents a "minimum funded package" that will maintain the clinics as they are presently functioning.



CHARACTERISTICS OF PRIMUS/NAVCARE PATIENTS [1/]
(DOD-WIDE)

	Percentage	Range of Precision [2/] (By Percent)
pes of Patients		
litary Sponsors (Active Duty & Retired)	16.73	(4.30) to 37.76
pendents of Sponsors (Active & Retired)	82.25	60.60 to 100.00
ient Unspecified	1.01	(5.02) to 7.04
y Status		
listed Active (Sponsors & Dependents)	52.06	24.37 to 79.75
listed Retired (Sponsors & Dependents)	13.63	(6.19) to 33.45
ficers Active (Sponsors & Dependents)	17.28	(2.53) to 37.09
ficers Retired (Sponsors & Dependents)	6.46	(7.35) to 20.27
classified Status	10.58	(7.64) to 28.80
niority		
nior Enlisted (Sponsors & Dependents) [3/]	11.83	(7.19) to 30.85
nior Enlisted (Sponsors & Dependents) [4/]	54.40	26.12 to 82.68
ficers (Sponsors & Dependents)	23.82	1.52 to 46.12
classified Rank	9.95	(7.77) to 27.67

otnotes:

This schedule represents the population serviced by Primary Care for iformed Services (PRIMUS) and Navy Cares (NAVCARE) Programs.

These percentages are based on a sample of 5,464 patient visits randomly lected from a universe of 204,078 at the 9 PRIMUS/NAVCARE clinics visited. are 90 percent confident that the true percentage will fall within the ated precision range. For example: under the category "types of patients," are 90 percent sure that the true number of patients who are military onsors, whether active duty or retired, will fall between 0.0 percent and .76 percent. Percentages that have approached zero are recorded as a gative percentage; percentages exceeding 100 are recorded as 100 percent.

Junior Enlisted (E-4 and below)

Senior Enlisted (E-5 and above)

PRIMUS/NAVCARE BREAKDOWN OF DIAGNOSTIC CATEGORIES [1/]

agnostic Category	Projected Percentage of total PRIMUS/NAVCARE Visits	Range of [2/] Precision (Percentage)
r, Nose, and Throat	33.40	5.88 to 60.92
necology	13.20	-6.66 to 33.06
sculoskeletal	8.56	-7.53 to 24.65
in	8.43	-7.73 to 24.59
alth Maintenance	6.68	-8.22 to 21.58
rdiovascular	3.11	-6.90 to 13.12

otnotes:

/ PRIMUS - Primary Care for Uniformed Services
NAVCARE - Navy Cares

/ These percentages were based on a sample of 5,464 patient visits randomly elected from a sample universe of 204,078 at the 9 PRIMUS/NAVCARE clinics isited. We are 90 percent confident that the true percentage will fall ithin the stated precision range. For example: for the category Ear, Nose, nd Throat, we are 90 percent confident that the true number of patient visits elated to ear, nose, and throat problems is between 5.88 percent and 60.92 ercent. Note: When negative percentages are stated, this means that the ercentage approaches zero, and should be indicated as such. Also, the ercentage figures do not total 100 due to the exclusion of several diagnostic ategories too small to statistically project to the universe.

COST COMPARISON OF PRIMUS/NAVCARE, CHAMPUS, AND MTF'S

Average Cost Per Visit Comparison [1]

Sample Clinic	Average Cost Per Visit at MTF [2]	Average Cost Per Visit CHAMPUS [3]	Average Cost Per Visit PRIMUS/NAVCARE [4]
Army			
Fairfax, VA	$35.38	$68.57	$ 42.28
Woodbridge, VA	35.38	68.57	40.85
Fort Bragg, NC	31.90	59.57	53.48
Presidio of Monterey, CA	47.81	70.18	56.30 [5]
Salinas, CA	47.81	70.18	66.73
Totals (Average)	$34.35	$65.35	$ 44.98
Navy			
NAVCARE I, San Diego, CA	$106.28	$61.70	$ 41.73
NAVCARE II, San Diego, CA	106.28	61.70	93.94
NAVCARE II, Oakland, CA	55.47	64.49	125.81 [6]
NAVCARE I, Portsmouth, VA	49.78	58.17	39.13
NAVCARE II, Portsmouth, VA	49.78	58.17	74.94
Totals (Average)	$ 70.81	$60.39	$ 48.97
Excluding San Diego	52.21	58.89	
Air Force			
Offutt, NE	$ 40.21	$65.65	$ 35.08

See footnotes on pages 7 through 9 of this chart.

COST COMPARISON OF PRIMUS/NAVCARE, CHAMPUS, AND MTF'S (Continued)

Average Cost Per Visit History [7/]

Army Clinics Opened 1987 or Before

Sample Clinics	Average Cost Per Visit
Fairfax, VA	$42.28
Woodbridge, VA	40.85
Average	$41.47
Army Clinics Opened 1988	
Fort Bragg, NC	$53.48
Presidio of Monterey, CA	56.30
Salinas, CA	66.73
Average	$55.87
Navy Clinics Opened 1987 or Before	
NAVCARE I, San Diego, CA	$41.73
NAVCARE I, Portsmouth, VA	39.13
Average	$40.54
Navy Clinics Opened 1988	
NAVCARE II, San Diego, CA	$ 93.94
NAVCARE II, Oakland, CA	125.81
NAVCARE II, Portsmouth, VA	74.95
Average	$ 91.86
Air Force Clinic Opened 1988	
Offutt Air Force Base, Omaha, NE	$ 35.08
Overall Average Initial Clinics	$ 41.05
Overall Average FY 1988 Clinics	$ 60.97

See footnotes at end of chart.

COST COMPARISON OF PRIMUS/NAVCARE, CHAMPUS, AND MTF'S (Continued)

Cost of PRIMUS/NAVCARE Using CHAMPUS Reimbursement Rates 8/

	PRIMUS/ NAVCARE Workload Percentage 9/	CHAMPUS Average by Procedures 10/	CHAMPUS Average by Diagnostic Category 11/
y			
, Nose, and Throat	32.54	$30.03	$ 48.41
ıecology	12.55	39.16	110.64
sculoskeletal	8.89	40.21	74.52
ın	8.88	28.04	48.89
·diovascular	3.14	26.91	61.69
Weight Average Army		$33.52	$ 65.35
y			
-, Nose, and Throat	32.54	$36.36	$ 43.30
ıecology	12.55	44.76	$105.30
sculoskeletal	8.89	42.65	69.34
in	8.88	31.43	45.85
rdiovascular	3.14	31.08	60.47
Weight Average Navy		$38.49	$60.39
r Force			
ır, Nose, and Throat	32.54	$21.38	$70.31
necology	12.55	27.77	72.91
sculoskeletal	8.89	35.85	57.24
in	8.88	19.51	55.83
rdiovascular	3.14	18.71	68.69
Weight Average Air Force		$24.62	$65.65

e footnotes at end of chart.

COST COMPARISON OF PRIMUS/NAVCARE, CHAMPUS, AND MTF'S (Continued)

Summary Cost Evaluation for FY 1988 [12]

Location and Procedures	CHAMPUS Average by Procedures [12]	CHAMPUS Average by Diagnostic Category [13]	Average Cost Per Visit PRIMUS [4]	Average Cost Per Visit PRIMUS [4]	Average Cost Per Visit MTF [2]
Fort Belvoir, Virginia			Fairfax	Woodbridge	
ENT Cost Per Visit	$30.40	$ 48.07			
GYN Cost Per Visit	40.37	120.25			
Musculoskeletal Cost Per Visit	40.63	80.45			
Skin Cost Per Visit	27.46	47.13			
Cardiology Cost Per Visit	26.81	61.60			
Total Average	$33.98	$ 68.57	$42.28	$40.85	$35.38
Fort Ord, California			Salinas Clinic	Monterey Clinic	
ENT Cost Per Visit	$34.00	$43.73			
GYN Cost Per Visit	39.16	90.22			
Musculoskeletal Cost Per Visit	47.71	88.39			
Skin Cost Per Visit	33.63	63.93			
Cardiology Cost Per Visit	31.55	64.04			
Total Average	$38.30	$70.18	$66.73	$56.30	$47.81
Fort Bragg, North Carolina					
ENT Cost Per Visit	$25.68	$ 50.29			
GYN Cost Per Visit	33.70	115.86			
Musculoskeletal Cost Per Visit	32.28	57.83			
Skin Cost Per Visit	23.04	35.59			
Cardiology Cost Per Visit	22.36	60.52			
Total Average	$28.29	$59.57	$53.48		$31.90
Army Average Cost Per Visit	$33.52	$65.35	$44.98		$34.35

Location and Procedures	CHAMPUS Average by Procedures 12/	CHAMPUS Average by Diagnostic Category 13/	Average Cost Per Visit NAVCARE I 4/	Average Cost Per Visit NAVCARE II 4/	Average Cost Per Visit MTF 2/
Oakland, California					
ENT Cost Per Visit	$36.47	$39.52			
GYN Cost Per Visit	44.60	69.97			
Musculoskeletal Cost Per Visit	41.10	78.44			
Skin Cost Per Visit	30.71	56.72			
Cardiovascular Cost Per Visit	30.62	67.98			
Total Average	$38.14	$64.49	$125.81	$55.47	
San Diego, California					
ENT Cost Per Visit	$41.53	$47.80			
GYN Cost Per Visit	50.82	85.25			
Musculoskeletal Cost Per Visit	49.63	70.96			
Skin Cost Per Visit	37.18	48.98			
Cardiovascular Cost Per Visit	36.06	63.14			
Total Average	$44.22	$61.70	$41.73	$93.94	$106.28
Portsmouth, Virginia					
ENT Cost Per Visit	$31.07	$ 39.01			
GYN Cost Per Visit	38.86	142.34			
Musculoskeletal Cost Per Visit	37.22	65.43			
Skin Cost Per Visit	26.40	40.82			
Cardiology Cost Per Visit	26.56	55.23			
Total Average	$33.12	$58.17	$39.13	$74.95	$ 49.78
Navy Average Cost Per Visit Excluding San Diego	$38.49	$60.39	$48.97	$ 52.21	$ 70.81

NOTE: San Diego costs are high because of the move to a new facility at the beginning of FY 1988.

See footnotes at end of chart.

COST COMPARISON OF PRIMUS/NAVCARE, CHAMPUS, AND MTF'S (Continued)

Summary Cost Evaluation for FY 1988 [12]

	CHAMPUS Average by Procedures [12]	CHAMPUS Average by Diagnostic Category [13]	Average Cost Per Visit PRIMUS [4]	Average Cost Per Visit MTF [2]
Offutt AFB, Nebraska				
ENT Cost Per Visit	$21.38	$70.31		
GYN Cost Per Visit	27.77	72.91		
Musculoskeletal Cost Per Visit	35.85	57.24		
Skin Cost Per Visit	19.51	55.83		
Cardiovascular Cost Per Visit	18.71	68.69		
Air Force Average Cost Per Visit	$24.62	$65.65	$35.08	$40.21

See footnotes at end of chart.

1/ All costs used in the Appendix D schedules are average costs per visit computed by dividing the total costs by the total number of visits. The total averages were computed in the same manner and are the weighted average of the total cost and total visits.

2/ Medical Treatment Facilities (MTF's). The third quarter year-to-date reports of the Medical Expense and Performance Reporting System (MEPRS) for fixed military medical and dental treatment facilities were used to determine the cost per visit for primary care clinics, pediatric clinics, and gynecology clinics. Adjustments were made by removing support costs that are not applicable to a contractor. The MEPRS costs were considered the best available data on which to base MTF costs for outpatient care. Comparison of the costs is limited because the scope of practice provided by MTF's is greater than at the PRIMUS/NAVCARE clinics; for example, MTF's perform outpatient surgery and treat serious illnesses. Costs at San Diego Naval hospital in FY 1988 ran higher than normal because of the move to a new facility. Patient loads were reduced, utilities were paid for both facilities, and clinics were closed for equipment moves.

3/ Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Costs. The average cost per visit is extracted from the CHAMPUS Health Care Summary by Primary Diagnosis report for October 1, 1986, through September 30, 1987, for each of the selected catchment areas and for five of the diagnoses selected by our samples as being the most frequently diagnosed at the PRIMUS/NAVCARE clinics. The care received was at a higher scope of practice than at the PRIMUS/NAVCARE clinics. It includes serious illnesses, injuries, and outpatient surgery by specialists, but does not include the cost of drugs. Cost data for FY 1988 are not available but are expected to be from 10 to 11 percent higher than the FY 1987 costs used here.

4/ Primary Care for Uniformed Services (PRIMUS) and Navy Cares (NAVCARE). We computed the average cost per visit by adding the amount disbursed for FY 1988, one-fifth of the site preparation costs, and some of the administration costs; and we divided the sum by the total number of visits for each clinic in FY 1988. The visits include prescription refills, immunizations, and short visits, which may unrealistically drive down the average cost.

5/ This amount may be unrealistically low, since the Army provided the facility, plant, equipment, utilities, and 4.5 staff years of uniformed personnel. A more realistic figure may be found at its sister clinic in Salinas, CA, where the contractor provides these items.

6/ Costs may be higher because unused guaranteed visits have not yet been paid for and are not included in the cost per visit.

7/ This schedule compares costs of the earlier PRIMUS/NAVCARE clinics to the costs of PRIMUS/NAVCARE clinics opened in FY 1988. The initial cost per visit at the clinics opened prior to FY 1988 causes the weighted average cost per visit to be misleading. This schedule was developed to determine the effect of the newer contracts. The newer contracts have all been awarded at a higher cost per visit. All of the initial contracts have been modified with higher costs that will be reflected in the cost to the Government in FY 1989.

8/ This schedule compares the average CHAMPUS cost by actual procedures performed in the PRIMUS/NAVCARE clinics to the average by diagnostic category that the Army used to justify the PRIMUS program.

A random sample was taken of procedures provided at two PRIMUS clinics at Woodbridge, Virginia and Fairfax, Virginia. The actual procedures provided and their appointed fees were coded by CPT-4 code from the fee reimbursement book for the catchment area, FY 1987 "CHAMPUS Outpatient Services for Care Received." Each diagnostic category was totaled and averaged by the number of visits represented in the sample to provide a weighted average cost. The cost of over-the-counter and prescription drugs provided to each patient was added to the average cost for providing prescriptions at the Medical Treatment Facility in each area. The CHAMPUS costs used were for FY 1987, which were 10 to 11 percent lower than those expected in FY 1989.

The sample was taken to determine at what level the scope of practice at the clinics differed from the scope of practice provided by the Medical Treatment Facilities and CHAMPUS providers. It was found that the average cost per visit, used previously to justify contract costs of the clinics, was related to a higher scope of practice than that provided at the PRIMUS/NAVCARE clinics, and therefore should not be considered a valid comparison.

9/ This column represents the work load percentage based on services provided at the Army PRIMUS Clinics.

10/ This column shows the average cost of the services provided by PRIMUS/NAVCARE based on the CHAMPUS reimbursement rate. Services included are office visits, the specific treatment procedures provided, and the cost of the prescription charges.

11/ This column shows the average cost of service for all procedures performed in a CHAMPUS diagnostic category.

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

21 AUG 1989

EALTH AFFAIRS

MEMORANDUM FOR INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Draft Report on the Audit of Primary Care for the Uniformed Services and Navy Cares Programs (Project No. 8FH-5014)

This memorandum responds to your draft report of June 26, 1989, which requested comments on two recommended Assistant Secretary of Defense (Health Affairs) corrective actions.

Recommendation 1. "Establish DoD-wide objectives and goals for the Primary Care for Uniformed Services and Navy Cares programs that are consistent with the original congressional intent."

Comment: Concur.

Corrective action taken: Specifically, to ensure that appropriate DoD-wide objectives and goals are implemented, OASD(HA) has determined that the essential first step is a thorough evaluation of the program. Accordingly, Lewin/ICF Incorporated, a leading health care consulting firm, was hired in April, 1989, to conduct an evaluation of the PRIMUS/NAVCARE program. This evaluation will address the four objectives outlined in the legislation authorizing new health care initiatives such as PRIMUS and NAVCARE programs. Specifically, Lewin/ICF is performing a thorough, independent assessment of the following four objectives:

- o Access (including convenience) to primary care
- o Relief of MTF overcrowding
- o Cost effectiveness (including efficiency)
- o Quality of care

Estimated dates for completion: An interim evaluation report will be provided by the contractor (and sent to Congress) by December 31, 1989. This report will contain baseline information and preliminary analysis of the issues. The final evaluation report will be provided by the contractor (and sent to Congress) by December 31, 1990. DoD-wide objectives and goals for the PRIMUS and NAVCARE programs will be established and disseminated within 90 days of the interim report date.

Recommendation 2. "Develop a DoD-wide tracking system to monitor the programs' achievements and results."

Comment: Concur.

Corrective action taken: Corrective action for this recommendation complements the action taken for Recommendation 1. Specifically, the contractor's evaluation process necessarily includes identifying requisite management and cost data. The evaluation's findings will suggest the appropriate data sources and methodology to be utilized in a DoD-wide tracking system.

Estimated dates for completion: A DoD-wide tracking system will be established and appropriate directives will be prepared within 90 days of the interim report date.

Thank you for the opportunity to comment on the draft report.

David Newhall, III
Acting

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO
ATTENTION OF

25 AUG 1989

DASG-IRO

ALCIDE M. LANOUE
Major General, MC
Deputy Surgeon General

MEMORANDUM THRU ~~CHIEF OF STAFF, ARMY~~
ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND RESERVE AFFAIRS)

31 AUG 1989
MERRILL
COL GS
Assistant Deputy for Military Fa
Policy & Equal Opportunity

FOR DIRECTOR OF FINANCIAL MANPOWER AND SECURITY ASSISTANCE PROGRAMS DIRECTORATE IG DOD

SUBJECT: Draft Report on the Audit of Primary Care for the Unified Services and Navy Cares Program (Project No. 8FH-5014)

1. This is in reply to your draft audit report project (8FH-5014). We have reviewed subject findings and recommendations and submit the enclosed comments. The Office of The Surgeon General has applied the necessary action to facilitate the implementation of the audit recommendations.

2. In closing, I would like to express our appreciation for giving me the opportunity to review the draft audit report. Should you require further information, please call Mr. Samih H. Helmy at 756-0285.

FOR THE SURGEON GENERAL:

Encl

ALCIDE M. LANOUE
Major General, MC
Deputy Surgeon General

CF:
SAIG-PA
OASD(HA)
HSC (IR)
DASG-RMZ
DASG-PTZ

U.S. Army Surgeon General Reply

Draft Report on the Audit of Primary Care for the Uniformed Services and Navy Care Program (Project Nc. 8FH-S014)

Finding A. Program Objectives and Goals. The Primary Care for the Uniformed Services (PRIMUS) and Navy Cares (NAVCARE) Program objectives and goals were not formalized to comply with congressional mandate and therefore not consistant or monitored within the Military Departments. These conditions existed because the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) had not established a policy for this DOD program or monitored its results. As a result, it could not be determined whether the programs were achieving the desired results in a cost effective and efficient manner.

Additional Facts. The implication in this report is that the PRIMUS program was solely directed by the DOD Authorization Act 1984. That assumption is simply not accurate. Congress and DOD tasked the services with the continuing objective to improve the access, quality, efficiency, and cost effectiveness of health service. The PRIMUS initiative was originally conceived at OTSG, and developed in accordance with existing regulations and policy guidance. The PRIMUS program quite simply was an expansion of existing health care contracting authority and has been executed IAW Federal Acquisition Regulations and U.S. Army regulations and service policy. OTSG established one clinic as a demonstration project to be tested in the Northern Virginia area.

Action taken---Recommendation A-1: Concur. PRIMUS is currently operated IAW existing DOD and Service policies. Implementation of objectives and goals at the ASD(HA) level would be redundant. However, the following objectives were implemented on 1 Oct 85 and are effective since then.

(1) Develop a primary care clinic that will provide primary care in a family practice mode at a cost that is competitive with CHAMPUS.

(2) Improve access to the Uniformed Services health care delivery system by locating the clinic at a site near the user population.

(3) Develop a contract model for a primary care clinic that can be reported and marketed to other catchment areas as appropriate.

(4) Reduce patient backlog for outpatient clinical services at DeWitt Army Community Hospital by providing medical services to the user population in a setting outside the hospital.

(5) Improve patient satisfaction with the health care system by providing a service that is operated for the convenience of the patient.

(6) Improve the AMEDD image with Congress, DOD, and the Army staff by demonstrating a willingness to try innovative health care delivery methods.

(7) Determine the acceptability of the satellite clinic concept with the intended user population.

Action taken---Recommendation A-2: Concur. A PRIMUS program tracking information is available through existing management systems established by the Army. The following criteria has been utilized since 1 Oct 85 to evaluate the success of the project:

(1) The cost of the average patient encounter in the clinic must be competitive with the CHAMPUS cost. This was to be determined by analysis of the data by DASG-RMP and HSC/Fort Belvoir MEDDAC. Utilization of the clinic must generate the requisite workload from the intended catchment area. The catchment area was defined by zip code utilizing demographic data from OCHAMPUS, the U.S. Bureau of Census, DEERS, and RAPS.

(2) The quality of care provided must be acceptable to the military medical manager and to the patient population supported. Standards of quality were established and reviewed by designated medical authorities. Patient satisfaction was to be measured by patient surveys. The clinic was to be considered successful after 80% of the patients surveyed indicated a willingness to return. The workload data and cost data from the clinic must be accepted by the decision making authority (Congress, DOD, TSO, HSC) for justifying the continuation and/or proliferation of the effort.

A. The planned evaluation was conducted by an evaluation panel including OTSG staff and DeWitt Army Community Hospital staff. Based upon positive evaluation results, especially improved access to health care services and enthusiastic patient response, two additional clinics in the Fort Belvoir catchment area were approved and funded by OTSG. In the meantime, a proposal for expansion of the number of clinics was staffed with the DA and DOD staff and included in the POM process. A PDIP was approved for the expansion of number of clinics to 26 facilities through FY 92.

B. Detailed cost and workload data pertaining to PRIMUS clinic operation has been continually collected from the first day of clinic start-up. This information is collected and reported in the same detail and channels as workload from any other Army medical treatment facility. At the MACOM level, PRIMUS workload statistics are separately reported at the command Quarterly Review and Analysis conference. The observation that the PRIMUS program is without effective monitoring is simply not accurate. Likewise, the allegation of a lack of effective budget monitoring is erroneous, at least for the U.S. Army. The figures on the chart on page 1 of Appendix A purport to reflect budget overruns at five U.S. Army PRIMUS sites. Tha budget variance at those sites reflects additional year end funding authorized those commands in recognition of patient health care needs. The additional funds were reprogrammed from other PRIMUS clinics and were not funds diverted from other programs to the PRIMUS program. As displayed on the referenced chart, total U.S. Army PRIMUS expenditures for FY 88 were $17.6M which were $1.3M under program. The PRIMUS program has proved to be extremely successful in meeting patient expectations and has never exceeded budget authorizations. The same budget constraints that pertain to all medical programs administered by the MEDDAC commander extend to management of the PRIMUS program. As an additional safeguard, specifications in all PRIMUS contracts prohibit the contractor from delivering PRIMUS services in excess of levels preapproved by specific delivery orders.

Finding B. Site Selection and Services. The Department of Defense did not perform sufficient analysis to determine the best alternatives for servicing their outpatients. This condition existed because methods were not developed for determining how to best serve outpatients' in terms of quality, efficiency, convenience, and cost. As a result, the Military Departments selected locations and opened Primary Care for the Uniformed Services (PRIMUS) or Navy Cares (NAVCARE) clinics that did not provide the most cost effective alternatives to the Government for outpatient medical care.

Additional Facts.

A. The audit report states there were not sufficient analyses made to determine what services should be available at specific clinics. In actuality, the scope of services approved for the program is ambulatory family practice which is reflected in all PRIMUS contracts. PRIMUS clinics are established as an element of the Uniformed Services direct health care program and organizationally established as another resource available to the MEDDAC commander. As the responsible manager, the MEDDAC commander has the discretion to direct the type of ambulatory services that will be provided by the contractor. For example, if the MEDDAC is well staffed with OB/GYN practitioners the commander may not authorize routine examinations in his PRIMUS clinic. Likewise, if there is a shortage of pediatricians in the MEDDAC, the commander may place an emphasis on utilization of his budgeted number of PRIMUS visits for the treatment of children. Other factors essential for the commander's decision making are the relative costs of similar services delivered in the MEDDAC or via CHAMPUS. The important point is that a PRIMUS clinic expands the MEDDAC's ability to provide primary care services and the MEDDAC commander has the authority to influence the mix of services provided. The variance in services available at different PRIMUS installations is reflective of the flexibility offered to the MEDDAC in meeting community needs. Analysis of the cost comparisons detailed by the auditors is difficult due to lack of details regarding the study methodology. However, several observations are either erroneous or misleading.

B. The audit report statement that "the scope of practice at the MTF is considerably greater than in PRIMUS clinics". For example, outpatient surgery is performed in MTF outpatient clinics and not in PRIMUS reflects a lack of understanding of military health care delivery. Outpatient surgery is not routinely performed in MTF outpatient clinics and is performed only on a limited basis in MTF specialty clinics. In actuality, the scope of practice reflected by the range of diagnostic categoriesd treated is greater in PRIMUS clinics than in the corresponding MTF clinic, i.e.,

General Outpatient Clinic, Acute Minor Illness Clinic, Army Health Clinics, etc. PRIMUS clinics are staffed by residency trained practitioners whereas most MTF primary care clinics are staffed by general practitioners without residency training.

C. The report states that all recently awarded PRIMUS contracts have been awarded at a higher price per visit. Fort Belvoir is the only site where a PRIMUS contract was resolicited for the same installation. The result of the new contract award was lower contract costs at all Fort Belvoir PRIMUS clinic locations:

	FY 86 Contract (Cost Per Visit)	FY 88 Contract (Cost Per Visit)
Fairfax Clinic	$48.74	$47.13
Burke Clinic	51.80	46.60
Woodbridge CIinic	51.80	45.14

All other contracts awarded in FY 88 with the exception of Fort Ord, an exceptionally high cost area, were awarded at a lower per unit cost than the original Fort Belvoir contract.

D. The FY 88 costs reflected in the audit report are not reflective of the average cost of a PRIMUS visit for a complete fiscal year. Pricing of a PRIMUS clinic visit is based upon a two tier system with the first 24K visits priced higher than those visits after the 24K volume level is reached. All FY 88 PRIMUS costs cited in the audit report for the six newly established clinics were based upon the under 24K visit volumn level. This was a one-time situation. An accurate comparison of PRIMUS costs must consider total cost based upon a budget volumn of at least 48K visits or whatever the actual volumn is for that particular clinic.

E. The methodology utilized in the report in calculating the cost of a PRIMUS visit if delivered by a CHAMPUS provider by the technique of applying CPT-4 codes and using the local CHAMPUS reimbursement rate is suspect and of questionable validity. Of concern is the significance of a 160 visit sample, and of more concern is the application of CPT-4 coding by individuals without specific training in use of the manual. CHAMPUS Fiscal Intermedicary Contractors require 4-6 months detailed training for their personnel before they are allowed to apply CPT-4 codes.

It's doubtful the IG learned this in one visit to OCHAMPUS. However, it is suspected that the lower cost of CHAMPUS Average by Procedure versus CHAMPUS Cost by Diagnostic Category was the result of "down-coding" and a failure to recognize the pricing implication of diagnosis that are classified as a PRIMUS "short" visit. "Short" visits in the Fort Belvoir and Fort Benning PRIMUS clinics are priced by the contractor at zero cost to the Governmrnt. Those visits should have been included into the average cost of a PRIMUS visit. Potential "down coding" in the report considered that a recognized problem with CHAMPUS billings by some practitioners is the practice of "up coding." A significant difference in the health care delivered by PRIMUS versus a CHAMPUS provider is that PRIMUS visits are audited by the Government to ensure accuracy of billing. There is not an established recurring mechanism for the audit of CHAMPUS outpatient visits. Furthermore, the report states in a footnote that CHAMPUS costs cited were FY 87 rates which were 10-11 percent lower than those expected in 1989. However. the estimate presented in the Appendix D price comparison chart does not reflect an inflationary adjustment which would constitute a fairer comparison with cited PRIMUS costs.

F. Concur in the use of the Uniform Chart of Accounts (UCA) cost as reflecting realistic MTF cost. However, the report did not consider support costs which were not considered applicable to a contractor. One of the support categories that was identified was police and fire protection provided by the installation. The contractor obviously incurs expense for police and fire protection for his facility and that expense is reflected in the contract price.

G. Following is a cost comparison of PRIMUS and MTF average cost per visit for FY 89. MTF figures reflect UCA costs for the primary care account BHA:

	PRIMUS (FY89)	MTF (2Q-FY 88)
Fort Belvoir	$ 45.92	$ 48.29
Fort Benning	48.21	45.54
Fort Bragg	45.82	38.41
Fort Hood	36.23	46.32
Fort Ord	52.26	55.47
Fort Stewart	48.44	55.35

Action Taken - Recommendations: Concur. U.S. Army Medical Department health care needs are continually analyzed with the methodology utilized improved as new techniques and technology are identified.

a. OTSG approved the establishment of the first PRIMUS facility after a detailed staff analysis that assessed CHAMPUS growth in the catchment area, primary care concept, location, professional and ancillary staffing, scope of services, utilization of the facility, facility requirements, and principles of practice. The selection of Northern Virginia for the first PRIMUS clinic was not arbitrary. The shortfall of primary care resources in the Fort Belvoir catchment area as well as high levels of CHAMPUS outpatient care were well established. In addition, cost containment was a major consideration in establishment of the PRIMUS program, however, a more immediate objective was to improve the AMEDD capability to provide primary health care services and patient access to care. Initial cost guidance was that the PRIMUS contract effort must be competitive with CHAMPUS. Independent government price estimates prepared in conjunction with the contracting effort indicated that costs would be lower than CHAMPUS as well as being competitive or lower than military MTF costs. OTSG, in conjunction with HSC, identified the locations for the initial ten clinics and the effort was coordinated with the DA staff and approved in the POM process. Upon transfer of the PRIMUS program from OTSG in April 1987, the Commander, Headquarters, U.S. Army Health Services Command (HSC) directed a revalidation of the sites selected for future expansion of the program based upon updated management information. The criteria addressed in the audit report is accurate. However, the auditors failed to understand application of the criteria by inferring that there was inconsistency in site selection by citing that Fort McPherson with high CHAMPUS costs was not identified as an initial site for a PRIMUS clinic. The report is likewise critical regarding the selection of Fort Sill with lower CHAMPUS costs for PRIMUS clinics over Fort Lewis.

b. Fort McPherson was not identified as the highest priority for a PRIMUS clinic because the facility does not have a supporting MEDDAC to serve as a PRIMUS referral source. Additionally, the workload consists primarily of retirees and their family members. Installations such as Fort Bragg, Fort Benning, and Fort Hood had greater number of active duty family members who were medically underserved. The availability of a supporting MEDDAC for PRIMUS facilities is important. The PRIMUS clinic as a primary care "gatekeeper" has a significant impact on channeling patients with "specialty" medical problems to the military MTF. If these patients are seen by providers in the civilian health care system, they are invariably referred to civilian specialty sources and thus increase the CHAMPUS bill. Fort Sill was scheduled for PRIMUS clinics before Fort Lewis due to new hospital constructicn at Fort Lewis and implementation of the Mission Oriented Medical Support (MOMS) program which has expanded the primary care capability at Fort Lewis. The observation that PRIMUS contracts should have been awarded under the provisions of OMB Circular A-76, Performance of Commercial Activities is unfounded. The A-76 program applies to conversion of operations from military to civilian and not to the expansion of existing programs.

Finding C. Quality Assurance Program. The Primary Care for the Uniformed Services (PRIMUS) Quality Assurance Program did not ensure the identification and timely correction of unacceptable health care service. The weaknesses in the program were due to inadequate staffing and training, inadequate guidance and contract provisions, and a lack of oversight by the contracting officers and DOD management. As a result, the Government could be held liable for harm to the patients who receive unacceptable health care. In addition, the Government did not receive the level of service for which it contracted.

Additional Facts. The statement that CORs did not have the skills necessary to perform the COR function is unfounded. No problems have been identified to reflect a lack of capability by either military or civilian CORs. The principal role of the PRIMUS COR is to perform administrative surveillance tasks to include billing verification and orchestrate the clinical surveillance which is performed by clinical personnel. The COR function is appropriately performed by a Medical Service Corps Officer. The contracting office is in constant contact with the CORs. The telephone logs reflect this. 12 site visits have been made by program office personnel and Contracting office personnel. The audit report notes billing errors representing a loss of $900,000 in FY 88 for DOD. No evidence is given to support this serious allegation. Likewise, there have been no incidents reported of medication errors occurring in Army PRIMUS clinics due to the dispensing of drugs by unqualified PRIMUS clinic personnel.

Action Taken - Recommendation C-1: Concur. Manpower staffing requirements have been established on 1 Oct 85 for the operation and surveillance of PRIMUS contracts. The PRIMUS surveillance plan has been revised and distributed to all PRIMUS sites. Quality control is the monitoring and evaluation process utilized by the contractor to ensure compliance with the terms of the contract. A quality control issue is the execution and effectiveness of the medical quality assurance program. The quarterly inspections is required by the Government prepared surveillance plan. The inspections may be conducted by inspectors with all participants performing surveillance at the same time. However, there is no requirement that all inspection team members be in the PRIMUS clinic at the same time. The important point is that all functional areas i.e. pharmacy, radiology, nursing, laboratory, etc., be inspected periodically by appropriately trained health care professionals who assess functional quality of the service as well as contractcr compliance with contract specifications.

Action Taken - Recommendation C-2: Concur. A PRS has been developed for all PRIMUS clinics. The contracting office is negotiating with the contractors for inclusion of the PRS in all contracts. By 2nd QTR FY 90, it is projected to have PRS in all PRIMUS contracts. A PRS will be included in all future RFP's for PRIMUS contracts.

A. The QA program requires all PRIMUS contractors to meet or exceed the medical quality assurance requirements of the JCAHO and U.S. Army. These plans were approved prior to the start of PRIMUS clinic operations. PRIMUS contractors conduct monthly QA meetings which address QA, risk management, and utilization review issues. These minutes are forwarded to the supporting MTF and are incorporated into the hospital QA program for surveillance and oversight.

B. Performance Requirement Summaries (PRS) were included in the initial PRIMUS contracts and were to be included in the FY 88contracts. However, DOD Acquisition Office guidance was received during the solicitation phase of the contract effort indicating that PRS should not be included in contracts. Over the objection of the PRIMUS program office, the FY 88 contracts were awarded without a PRS. DOD authorities subsequently changed their position and recommended the use of a PRS. The contracting office, HSC is currently negotiating with PRIMUS contractors for the inclusion of PRS in all PRIMUS contracts. PRIMUS CORs have use PRS as part of their surveillance efforts even though the document is not part of the contract. Manpower requirements have been established for the COR function at all PRIMUS sites in recognition of the manhours required to perform contract surveillance. Four of the six Army PRIMUS installations currently employ a full time PRIMUS COR.

Action Taken - Recommendation C-3: Concur. It has been an established policy that all PRIMUS CORs attend the US Army COR course. All CORs with the exception of those recently assigned have in fact attended the course. In addition, a COR workshop was conducted at HSC 15-18 November 1988 to augment instruction presented at the Army COR course. An additional workshop is planned for November 1989 at HSC. A COR course is conducted by the US Army Logistics Management Center. A COR workshop designed to supplenment instruction presented in the US Army COR course was presented for PRIMUS CORs during the period 15-18 Nov 88 at HSC. This will be an annual course.

Finding D. Internal Management Control Program. The PRIMUS and NAVCARE programs were not evaluated in the military departments Internal Management Control Program (IMCP). This condition occurred because the Military Departments were not aware of the programs annual review requirement. As a result internal controls were inadequate to protect the Program from waste, fraud and mismanagement.

Action taken. Recommendation D-1. The Federal Acquisition Regulations and Army Supplements thereto establish contract administration and contractor responsibility. Internal controls necessary for the protection of the government resources are adequate and provided IAW provisions of the FAR. Therefore PRIMUS should be included in the IMCP as it relates to Army Medical Department Facilities.

Action taken. Recommendation D.2. Concur. Guidance and training is included in every phase of command training, staff training and COR training for anyone involved in the Army PRIMUS program.

DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
WASHINGTON, D C 20350 1000

1 8 SEP 1989

MEMORANDUM FOR THE INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

Subj: DRAFT REPORT ON THE AUDIT OF PRIMARY CARE FOR THE UNIFORMED SERVICES AND NAVY CARES PROGRAM (PROJECT NO. 8FH-5014) - INFORMATION MEMORANDUM

In response to TAB A, TABs B and C are forwarded.

KENNETH P. BERGQUIST
Assistant Secretary of the Navy
(Manpower and Reserve Affairs)

TAB A - DODIG Draft Report
TAB B - Response to Findings B and D
TAB C - FY88 NAVCARE Statistics

Department of the Navy Response

to

Department of Defense Inspector General Report of 05 July 1989

on

Audit of Primary Care for the Uniformed Services
and
Navy Cares Program

FINDING B: Site Selection and Services

SUMMARY: The Department of Defense did not perform sufficient analyses to determine the best alternatives for servicing their outpatients' needs. As a result, the Military Departments selected locations and opened clinics that did not provide the most cost-effective alternatives to the Government for outpatient medical care. The Navy locations were based on the Assistant Secretary of the Navy (Manpower and Reserve Affairs) [ASN (M&RA)] mandate without formal studies being made. The Navy could not provide any documentation showing claimed criteria had been applied nor that any analysis was made to determine site selection other that the list provided by ASN (M&RA). Likewise, the Navy had no documentation that any analysis had been made to determine specific services or the number of visits each clinic would provide.

RECOMMENDATION: "We recommend that the Commander, U. S. Army Health Services Command, the Commander, U. S. Naval Medical Command, and the Air Force Surgeon General develop methods and perform the analyses to determine how their outpatient needs can best be served in terms of quality, efficiency, convenience, and cost."

DON POSITION: The Bureau of Medicine and Surgery recently acquired the Retrospective Case Mix Analysis System which will augment human experience to ensure quality, efficiency, convenience, and cost are measurable and inherent characteristics in decisions regarding establishment/disestablishment of healthcare delivery facilities.

The NAVCARE clinics are consistently monitored with reports on visits and expenditures submitted monthly by the Contracting Officer's Technical Representatives to the program manager through the technical manager. This report graphically portrays trends in growth.

The NAVCARE visits are structured in the contract with basic and optional quantities. The contractor is required to notify the contracting officer 60 days prior to utilization of 75 percent of

FINDING B: Site Selection and Services

DON POSITION (CONTD):

any visit category. The contractor must be issued a signed modification before exercising the visit quantities under the next option. Each NAVCARE contract is a firm, fixed price contract. Overruns are not payable under this type of contract.

The NAVCARE contract cost/visit methodology is based on the identification of a basic visit quantity and two to three optional quantities for each contract year. The basic quantity is normally costed at a higher rate per visit. It is in the basic quantity the contractor will recoup his fixed costs, associated variable costs, and profit. Optional quantities are therefore of a lower cost and normally contain only variable costs and profit. As visits are utilized throughout the year and optional quantities are authorized, the average cost per visit declines.

Using NAVCARE II in FY88 to portray the NAVCARE program compared to the cost of care through CHAMPUS and the local medical treatment facility is an inaccurate reflection of the program. NAVCARE II was in operation for only the last three months of FY88. In that short period of operation, NAVCARE II did not exceed the basic visit quantity, therefore, in FY88 NAVCARE II reflects a higher cost per visit than will be experienced in the out-years of the contract.

The gross applicability of CHAMPUS cost comparisons is questioned. Unlike CHAMPUS, NAVCARE cost per visit includes the cost of the total care provided (doctor's fee, laboratory, radiology, pharmaceuticals, etc.).

The inclusion of start-up costs in determining cost/visit results in an abnormally high ratio. Start-up costs should be spread over the life of the contract rather than confined to the first year.

Statistics maintained at the Bureau of Medicine and Surgery provide a different picture of the average cost per visit than presented on Appendix A. Tab C provides provides this information.

Department of the Navy Response

to

Department of Defense Inspector General Report of 05 July 1989

on

Audit of Primary Care for the Uniformed Services
and
Navy Cares Program

FINDING D: Internal Management Control Program

SUMMARY: The PRIMUS and NAVCARE programs were not evaluated in the Military Department's Internal Management Control Program. This condition occurred because the Military Departments were not aware of the program's annual review requirement. As a result, internal controls were inadequate to protect the PRIMUS and NAVCARE programs from waste, fraud, and mismanagement.

RECOMMENDATION: "We recommend that the Commander, U. S. Army Health Services Command; the Commander, U. S. Naval Medical Command; and the Air Force Surgeon General:

1. Include the PRIMUS and NAVCARE programs in the Internal Control Management Review program.

2. Provide guidance and training to senior- and mid-level management officials involved in the PRIMUS and NAVCARE programs."

DON POSITION: To each recommendation in turn,

1. The NAVCARE program is planned for inclusion in the Bureau of Medicine and Surgery management control inventory as an assessable unit under the functional category "Support Services" by 31 October 1989 in preparation for the FY90 Management Control Review cycle.

On 8 December 1988, contract administration was directed for review by Naval Medical Command (now Bureau of Medicine and Surgery) activities. This included: 1) Contract renewal procedures; 2) Quality assurance review procedures; 3) Personal services contracting; and 4) Health services contracting.

2. Management Control training was provided to echelon II and subordinate program coordinators between 17 October 1988 and 23 March 1989. Subsequent training to senior- and mid-level management personnel is provided by activity coordinators on an ongoing basis.

PREPARED TO RESPOND TO DODIG
NAVY COMPTROLLER LTR NCB-532 DTD 10 APR 1989

01 AUG 1989

FY 1988 NAVCARE STATISTICS

ACTUAL DATA

		TOTAL VISITS SEEN *	AVG COST PER VISIT **	TOTAL VISIT COST	START-UP COST
NAVCARE I					
	CAMP LEJUENE	63,991	$43.01	$2,752,466	$53,302
	MAYPORT	43,821	$48.72	$2,134,804	$42,401
	NORFOLK	75,021	$37.54	$2,816,328	$254,318
	SAN DIEGO	89,165	$39.90	$3,557,655	$308,702
	SUB TOTAL	271,998	$41.40	$11,261,253	$658,723
		PRORATED START-UP COST PER VISIT (12 MONTHS) >	$0.94	START-UP COST PER MONTH OVER LIFE OF CONTRACT - DEC 86 (31 MONTHS) >	$21,249.13
	TOTAL COST PER VISIT	>	$42.34		
NAVCARE II					
	CAMP PENDLETON	9,464	$85.14	$805,772	$530,111
	CHARLESTON	16,005	$59.83	$957,570	$607,971
	LONG BEACH	8,034	$89.04	$715,339	$652,474
	NORFOLK	14,359	$62.48	$897,122	$668,074
	OAKLAND	4,795	$92.98	$445,846	$650,814
	SAN DIEGO	11,127	$80.14	$891,760	$502,270
	SUB TOTAL	63,784	$73.90	$4,713,409	$3,611,714
		PRORATED START-UP COST PER VISIT (3 MONTHS) >	$3.33	START-UP COST PER MONTH OVER LIFE OF CONTRACT - JUL 88 (51 MONTHS) >	$70,817.92
	TOTAL COST PER VISIT	>	$77.23		
FY88 NAVCARE TOTALS		335,782	$48.97	$15,974,662	$4,270,437

*
NAVCARE II VISITS ARE FOR A THREE MONTH PERIOD
**
SUB TOTAL COLUMN EXCLUDES START-UP COSTS

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OPNAV 5216/175 (3-81) SN 0107-LF-052-2475
FORMERLY NAVSO 5216/16

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CR5	CR6	REMARKS/DISTRIBUTION
PROGRAM	BEH-5014	SECNAVINST 5740.25B APPLIES.

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DEPARTMENT OF THE AIR FORCE
WASHINGTON DC 20330-1000

OFFICE OF THE ASSISTANT SECRETARY

18 August 1989

MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL FOR AUDITING
OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF DEFENSE

SUBJECT: Draft Report on the Audit of Primary Care for the Uniformed Services and Navy Cares Program (Project No. 8FH-5014) - INFORMATION MEMORANDUM

This is in reply to your MEMORANDUM FOR COMPTROLLER OF THE AIR FORCE requesting comments on the findings and recommendations made in the subject demonstration project report. Our detailed comments are attached.

Thank you for the opportunity to comment. Point of contact in the Surgeon General's office is Colonel Schindel, HQ USAF/SGHA, telephone 767-5066.

KAREN R. KEESLING
Assistant Secretary of the Air Force
(Manpower and Reserve Affairs)

1 Atch
Air Force Comments

AIR FORCE RESPONSE TO DOD(IG) FINDINGS AND RECOMMENDATIONS:

Program Objectives and Goals - Tab A

Site Selection and Services - Tab B

Quality Assurance Program - Tab C

Internal Management Control Program - Tab D

RESPONSE TO FINDINGS AND RECOMMENDATIONS
ON
PROGRAM OBJECTIVES AND GOALS

AIR FORCE RESPONSE TO FINDINGS AND RECOMMENDATIONS

A. Program Objectives and Goals

FINDING

The Primary Care for the Uniformed Services (PRIMUS) and Navy Cares (NAVCARE) program objectives and goals were not formalized to comply with congressional mandate and therefore not consistent or monitored within the Military Departments. These conditions existed because the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) had not established a policy for this DoD-wide program or monitored its results. As a result, DoD could not determine whether the programs were achieving the desired results in a cost-effective and efficient manner.

RESPONSE

Partially Concur. It is true that no DoD-wide goals and objectives have been established by the ASD(HA) for the PRIMUS/NAVCARE Clinics. However, none of the Services PRIMUS/NAVCARE Clinics were established as part of a DoD-wide program, nor as a response to any specific congressional mandate. The Omnibus Defense Authorization Act of 1984 discusses DoD studies and demonstrations, but the PRIMUS Clinic initiative was never sponsored by DoD as a demonstration project. The Air Force Clinics were established as a result of the favorable impact the Army's initial clinics had with respect to improved access and patient satisfaction. Our primary purpose for this initiative was to improve beneficiary access to high quality primary medical care consistent with that in Air Force Medical Treatment Facilities (MTFs) and to increase patient satisfaction and convenience. Each Statement of Work (SOW) is tailored to meet the local needs of the location involved. All contractor operations are in accordance with Joint Commission on Accreditation of Hospitals and Ambulatory Health Care Standards.

It should be noted that at the time of the DoD(IG) PRIMUS/NAVCARE site visits, the only operational Air Force clinic was at Omaha. It had been operational only three weeks. An effective assessment of the Air Force management and quality assurance mechanisms could not possibly have been made at that time.

The DoD(IG) states the avearage cost per PRIMUS clinic visit was based on start-up costs and payments issued to the vendor for FY 1988. Start-up costs should not be included in the computation of a PRIMUS cost per visit. For example, the capital costs for military treatment facililty MCPs are never included in the MEPRS (standard DoD medical cost and workload reporting system) outpatient unit costs. The initial PRIMUS start-up costs should be viewed as a cost to improve accessibility, the stated primary objective of the PRIMUS clinics. Following the initial investment to improve accessibility, it is appropriate to compare recurring PRIMUS clinic costs to similar outpatient visit costs under the CHAMPUS program to

fiscally justify the establishment of PRIMUS clinics. In conducting a comparison of PRIMUS and CHAMPUS outpatient unit costs, the use of CPT-4 codes is probably appropriate and we can use this methodology when establishing new contracts or renewing existing contracts.

The report further suggests quantifiable goals need to be established, such as reducing CHAMPUS cost by 5 percent or providing the service cheaper than can be done in the MTFs. We would not recommend such "goals". First, the primary objective of the PRIMUS clinics is to improve accessibility, which the report suggests is being achieved. Emphasis on cost savings must ensure cost comparisons are accurate and based on similar services. Second, goals to reduce CHAMPUS costs by any percentage would be almost impossible to achieve, especially since PRIMUS clinics offer primary care or family practice type clinic appointments and not the more costly outpatient specialty visits. At best, PRIMUS clinics might help reduce the rate of increase in CHAMPUS overall costs; in affect that would be almost impossible to measure. Third, we should never establish a goal that states the service should be provided cheaper in the PRIMUS environment than that of the MTF. We would hope the service can be provided more economically in the MTF setting almost every time; if not, we should then stop providing that service in our MTFs and pursue PRIMUS contracts for that service.

The issue is not one of is it cheaper in the MTF or PRIMUS. We would like to provide the service in the MTF. Unfortunately, the MTF doesn't always have the manpower, space, or other resources to accommodate the additional workload. We should consider MTF unit costs only as a gauge to compare the reasonableness of the PRIMUS unit costs.

RECOMMENDATIONS FOR CORRECTIVE ACTION

DoD(IG) Recommends that the Assistant Secretary of Defense (Health Affairs) (ASD[HA]):

1. Establish DoD-wide objectives and goals for the Primary Care for Uniformed Services and Navy Cares programs that are consistent with the original congressional intent.

RESPONSE

Nonconcur. The Air Force recommends that the ASD(HA) not establish DoD-wide objectives and goals for the PRIMUS and NAVCARE projects. The Services established their own goals with respect to the desired outcomes of these clinics. For the Air Force, these include improved access to convenient, high quality primary care services for our patients and resultant improvement in their satisfaction with health care services. Further, the PRIMUS/NAVCARE projects are not congressional demonstration projects. They are independent, Service sponsored efforts for improving patient access to primary care services.

2. Develop a DoD-wide tracking system to monitor the programs achievements and results.

Nonconcur. The Air Force recommends that the ASD(HA) not develop a DoD-wide tracking system to monitor achievements and results of these clinics. The Services do this now. For the Air Force, budget, workload, quality assurance and patient satisfaction information is collected and monitored at each local clinic site to insure that clinic operations are consistent with Air Force PRIMUS goals. Additional, redundant tracking systems will increase the cost and manpower requirements associated with these clinics.

The Air Force Surgeon General is already working with the Air Force Inspection and Safety Center/Inspector General (AFISC/SG) to consider inspecting the PRIMUS clinics as a logical extension of their current health services management inspection (HSMI) process.

RESPONSE TO FINDINGS AND RECOMMENDATIONS
ON
SITE SELECTION AND SERVICES

AIR FORCE RESPONSE TO FINDINGS AND RECOMMENDATIONS

B. Site Selection and Services

FINDING

The Department of Defense did not perform sufficient analyses to determine the best alternatives for servicing their outpatients' needs. This condition existed because methods were not developed for determining how to best serve outpatients' needs in terms of quality, efficiency, convenience and cost. As a result, the Military Departments selected locations and opened Primary Care for Uniformed Services (PRIMUS) or Navy Cares (NAVCARE) clinics that did not provide the most cost-effective alternatives to the Government for outpatient medical care.

RESPONSE

Nonconcur. As recognized by the DoD(IG), the Air Force Surgeon General requested input from its MTFs and MAJCOMS to determine where to place our initial PRIMUS clinics. The stated site selection criteria (by priority) were as follows:

- support a large active duty population;
- show evidence of excess demand, such as appointment backlogs, clinic overcrowding, and history of access complaints;
- have an existing or projected shortfall of primary care providers;
- exhibit high CHAMPUS costs and volume;
- be within an Air Force hospital catchment area;
- have Major Command and Surgeon General concurrence and local Air Force base support;
- avoid competition with planned Army and Navy clinics;
- have local civilian resources available to support operation of PRIMUS clinics such as having the facilities to lease and the available providers;

The Air Force approach to identifying potential sites for PRIMUS clinics is fully consistent with our policy that health care needs are best identified and managed locally. While the DoD(IG) report focuses on selected criteria (e.g., active duty population) in criticizing the site selection methodology, the Air Force took all of the above criteria into consideration in making its final selections. Certainly, focusing on one or another of the criteria could lead to alternative site(s) considerations.

The report further implies that all PRIMUS and NAVCARE clinics are the same in terms of service offering. However, this is erroneous. The local MTF at each Air Force PRIMUS location is afforded the opportunity to identify the hours of operation and range of services most appropriate to its local patient population.

The cost comparisons performed by the DoD(IG) evaluation team led them to the conclusion that the PRIMUS and NAVCARE clinics are more costly alternatives for providing primary outpatient health care. The Air Force

PRIMUS-Omaha initial year contract cost is higher than option years, yet the DoD(IG) report still shows Air Force PRIMUS-Omaha more economical (reference DoD(IG) report, Appendix D, pg 1). The PRIMUS clinic offers medical care ranging from Primary Care and Pediatrics to Internal Medicine. The chart at Appendix D, pg 1 of the report indicates the average cost per PRIMUS visit at Omaha is less than both the MTF or CHAMPUS. However, comparing costs among the direct care system (MTFs), CHAMPUS and PRIMUS can be misleading. Hence, to make an overall statement that the cost of providing PRIMUS care is higher, compared to the MTF, during this audit period is erroneous.

When comparing cost data between CHAMPUS and PRIMUS programs, it must be remembered the cost per CHAMPUS outpatient visit does not contain such ancillary services as pharmacy prescriptions, x-rays, or lab procedures. The PRIMUS cost per outpatient visit does include such support services. One cannot assume that CHAMPUS beneficiaries will seek ancillary support from the nearest MTF. Also, the comparison of costs is more valid if actual costs for the same time period are used for both programs. Using FY 1987 CHAMPUS costs and inflating those costs by an estimated inflation factor to compare FY 88 PRIMUS and estimated CHAMPUS data can prove to be inaccurate, depending on the actual inflation experienced. When conducting a comparison of unit costs for a given service in one system with the costs of the same service in another system, the evaluator must ensure he is really comparing apples to apples. Otherwise, the comparison is not valid.

Another important factor this report fails to consider when comparing costs among the three systems is the "gatekeeper" role played by the PRIMUS and NAVCARE clinics. Patients requiring more intensive specialty care or hospitalization are referred to the MTF, by the PRIMUS/NAVCARE clinics for evaluation and disposition. These patients, under CHAMPUS, might otherwise end up being referred to more costly CHAMPUS providers.

The report erroneously states that the Air Force plans to establish 13 additional clinics by the end of FY 1994. This is not true. In addition to the three PRIMUS clinics that are already open, two more clinics are planned for FY 1990. While a PDP was prepared in the last POM cycle to establish additional clinics, it was never submitted through the Air Force board structure. Consideration of future sites is pending an objective evaluation of those Air Force PRIMUS clinics already operational.

In terms of workload, the report cites PRIMUS demand at the Air Force clinic in Omaha as 33 percent more visits than allotted in the contract. This generalization after only three weeks of operation was unfounded. Typically these new clinic sites experience early heavy demand as beneficiaries seek to evaluate the new service.

RECOMMEDATION FOR CORRECTIVE ACTION

DoD(IG) recommends that the Commander, U.S. Army Health Services Command, the Commander, U.S. Naval Medical Command, and the Air Force Surgeon General develop methods and perform the analyses to determine how their

outpatient needs can best be served in terms of quality, efficiency, convenience, and cost.

Concur. A model for such analyses is being developed as part of the Air Force Catchment Area Management (CAM) demonstrations to be implemented at Phoenix, AZ and Austin, TX. Such analyses will incorporate consideration of capacity and configuration of the MTF, availability of professional and support staff, other federal and civilian services available locally, catchment area demand, competitiveness of the civilian health care sector, and readiness/operational mission demands. We expect the results of these demonstrations to provide valuable insights into effective methodologies and management practices when considering/selecting alternative delivery systems for meeting local patient health care needs. These demonstrations are scheduled for FY90-FY92 with independent evaluation being performed by the RAND Corporation. No additional Air Force PRIMUS sites have been budgeted prior to that completed demonstration. (ECD: Jan 92)

RESPONSE TO FINDINGS AND RECOMMENDATIONS
ON
QUALITY ASSURANCE PROGRAM

C. Quality Assurance Program

FINDING

The Primary Care for Uniformed Services (PRIMUS) Quality Assurance (QA)Program did not ensure the identification and timely correction of unacceptable health care service. The weaknesses in the program were due to inadequate staffing and training, inadequate guidance and contract provisions, and a lack of oversight by the contracting officers and DoD management. As a result, the Government could be held liable for harm to the patients who receive unacceptable health care. In addition, the Government did not receive the level of service for which it contracted.

RESPONSE

Nonconcur. At the time of this audit, the only Air Force PRIMUS Clinic surveyed had been in operation less than three (3) weeks. The QA Program was being finalized but was evident and there was documentation to this effect. Staffing assignments were being developed and training ongoing. The QA Program at the PRIMUS Clinic is a mirror image of the MTFs program. The standards in the Ambulatory Health Care Standards Manual published by the Joint Commission on Accreditation of Health Care Organizations are followed. Monitoring and Evaluation (M&E) procedures are in effect and equivalent to the MTF procedures. The credentials file of every provider in the PRIMUS-Omaha is complete and assuredly appropriate. PRIMUS-Omaha uses the same forms as the MTF and follows guidelines from AFR 168-13. Credential files were made available to the COR prior to opening the clinic. There is a memo from the COR stating that on 24 Aug 88, credential files were reviewed. On 25 Aug 88, the clinic saw its first patient. Each credential folder at that time had:

1. AMA profile
2. Bond certification/eligibility
3. Licensure
4. Delineation of provider privileges
5. ECFM6 certification, where appropriate
6. Medical Director privileges approved by PHP (the PRIMUS contractor)

The credentials were again reviewed on 31 Aug 88. These documents were made available to the auditor. The PRIMUS-Omaha pharmacy is licensed by the Nebraska State Health Department and follows all the same drug dispenssing guidelines the MTF does. To state the Air Force did not provide adequate guidance to their QAE Surveillance Plan, is a gross misstatement. As stated throughout this report, the PRIMUS-Omaha was open less than three (3) weeks at the time of the audit. Weekly, monthly, quarterly, and annual inspections, using a comprehensive checklist, are completed by competent military personnel inspecting areas within their area of expertise. All inspections are documented. A daily audit of all patient visits is accom-

plished. Approximately 10% of medical records are audited for compliance and appropriateness of the patient visit with a determination made as to the level of visit to be billed. Patient records are reviewed if seen at PRIMUS-Omaha within the previous 7 days. A daily patient visit log is generated and audited of every patient visit. PRIMUS-Omaha has a professional and administrative screening methodology which statistically reviews physicians' records and 100% of physician assistant records. A thorough review and verification of the DD Form 250, Contractors Reimbursement Request, are made using detailed tracking documents maintained by the QAE and the contractor before authorizing payment. In surveying those areas beyond the scope and expertise of the QAE, qualified clinical personnel are selected to review those appropriate functions thereby assuring quality care and appropriate contractor performance.

At page 40 of the Draft Audit Report, to quote, "The JCAHO standards require quarterly inspections by government health care professionals as a team to monitor contractor QA efforts to ensure that quality care is provided." The fact is, JCAHO standards do not have such a requirement. The JCAHO does not require the government, or any other professional organization, to monitor contracts quarterly or at any other frequency.

The Air Force does in fact offer a detailed three (3) day training course, which QAE's are required to attend, on responsibilities of administering a contract.

RECOMMENDATIONS FOR CORRECTIVE ACTION

DoD(IG) recommends that the Commander, U.S. Army Health Services Command and the Office of the Surgeon General, Air Force:

1. Develop appropriate guidelines for staffing, monitoring, and inspecting the Primary Care for Uniformed Services clinics.

RESPONSE

Partially Concur. There are appropriate guidelines developed for monitoring and inspecting the PRIMUS-Omaha. The Surveillance Activity Checklists are audited weekly, monthly, quarterly, and annually in detail. Audits of the DD Form 250 are complete and extensive. The government receives the services for which it contracts. Again, it must be re-emphasized that the PRIMUS-Omaha was in its infancy, having opened less that three weeks, prior to the DoD Audit/Survey. We are evaluating the guidelines for all our PRIMUS clinics to insure consistency and appropriateness. We expect to have this guidelines review completed by Nov 89, and standardized by Jan 90.

2. Develop uniform and enforceable Performance Requirement Summaries to evaluate a contractor's performance to ensure that the Government receives the services for which it contracts.

RESPONSE

Concur With Exception. The Quality Assurance Division, Office of the Surgeon General prepared a set of QA standards with measurable criteria and a weighted scale for use with the Performance Requirement Summary (Atch 1). This was designed to be used by the Contracting Office Representative (COR) and the support MTF to evaluate the QA program in PRIMUS clinics. These standards parallel the services required by Section C, Statement of Work, of the contract.

The present Air Force PRIMUS contracts do not include a Performance Requirements Summary (PRS) with a method to deduct for unacceptable services. However, these contracts do contain a clause in which the Government can take deductions under the provisions of the Inspections of Services Clause (by negotiating the value of unacceptable services, if necessary).

Inclusion of a PRS in current contracts may be impractical. There are at least 25 different performance requirements contained in six line items which would need to be agreed upon between the Government and the PRIMUS clinic contractors. As prescribed in AFR 400-28, Base Level Service Contracts, "in order to make a deduction from payment for unacceptable services, the amount deducted must correlate to the price of the service not performed, it may not be an arbitrary figure." This would be the case since there was no payment analysis conducted prior to initiation of the acquisition process. A payment analysis must be conducted to properly allocate percentages for each performance requirement. There is no agreement as to PRSs and their values in current contracts. It would be very difficult to negotiate performance requirements and their values into an already definitized contract. To include the PRSs will probably increase the cost of the contract inasmuch as the contractor will claim that additional effort will be required to comply. If a decision is made to renegotiate, this can be accomplished by the local base contracting offices since contract administration was decentralized after contract award.

In future acquisitions of PRIMUS Clinics a Fixed Priced Award Fee (FPAF) type contract will be used. This type of contract motivates the contractor to perform above the minimum standards of the contract to earn a monetary reward. The FPAF requires continual and committed high local command involvement to include the wing and medical treatment facility (MTF) commanders, MTF executive committees, functional and contracting personnel. It also encourages corporate management participation in order to earn the maximum award fee amounts.

This method dissuades the contractor from cutting costs at the expense of quality services to increase profits because as the quality of performance increases the amounts of the award fee increases. The use of performance incentives has a positive inpact on improving the quality of work. They motivate the contractor to interpret the spirit of the contract versus the letter of the contract. Therefore, the contractor is more customer oriented and strives to provide superior services.

A PRS will be included in the contracts but without the deduct methodology. If it is necessary to deduct for unacceptable services, the provisions of the Inspection of Services Clause can be invoked. However, it is unlikely that deductions will be necessary because the contractor is motivated to consistently perform above the satisfactory level.

The Quality Assurance Surveillance Plan (QASP) and the Award Fee Plan (AFP) will be used for surveillance of contractor performance. Evaluation results will be used to support payment or nonpayment of the award fee. The amounts will be based on both objective and subjective evaluations.

3. Develop and implement a Contracting Officer's Representative training course.

RESPONSE

Concur. A joint Air Force and Army COR training course will be held in San Antonio, Texas either in October or November 1989. Additional courses will be scheduled as needed.

1 Atch
QA Standards for PRS in
PRIMUS Clinics Contracts

QUALITY ASSURANCE STANDARDS

FOR

AIR FORCE PRIMUS CLINICS

1. Required Service: Quality Assurance

Contract Paragraph: 1.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: There exists a system for timely identification and notification of those patients who require additional follow-up for significant problems or illnesses including results of laboratory and radiology studies. (JCAHO AHC QC 1.1.13)

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2. Required Service: Patient Complaints

Contract Paragraph: 1.2.2.1

Minimum Level of Compliance: 90%

Weighted Scale (x% of 100%): 3%

Standard: All legitimate patient complaints shall be resolved within 48 hours.

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3. Required Service: Credential Review Process

Contract Paragraph: 1.2.3

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 5%

Standard: There exists a separate credentials file for each health care provider awarded privileges to practice in the PRIMUS clinic. (AFR 168-13, Atch 2-7)

---

4. Required Service: Credential Review Process

Contract Paragraph: 1.2.3

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 5%

Standard: Each provider with the authority and responsibility to individually begin, alter or end a plan of treatment has been awarded privileges prior to seeing patients. [For list of applicable personnel, see AFR 168-13, Atch 2-1b]. (AFR 168-13, Atch 2-2a)

---

5. Required Service: Credentials Review Process

Contract Paragraph: 1.2.3

Minimum Level of Compliance: 85%

Weighted Scale (x% of 100%): 2%

Standard: Each provider's credentials file is organized IAW AFR 168-13, Atch 2-7a prior to the provider seeing patients. (AFR 168-13, Atch 2-7a)

---

6. Required Service: Credentials Review Process

Contract Paragraph: 1.2.3.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: Each provider's privileges are based only on those treatments and procedures for which he/she is qualified to perform. (AFR 168-13, Atch 2-2c)

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7. Required Service: Quality Assurance Program

Contract Paragraph: 1.3.5

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 2%

Standard: The QA Committee convenes every month to ensure effective monitoring and evaluation mechanisms for the PRIMUS clinic. (AFR 168-13, Atch 2-1)

---

8. Required Service: Quality Assurance

Contract Paragraph: 1.3.5

Minimum Level of Compliance: 90%

Weighted Scale (x% of 100%): 3%

Standard: All monitored indicators reflect significant high risk, high volume, and/or problem prone areas for staff or patients. (AFR 168-13, Para 2-2c)

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9. Required Service: Quality Assurance Program

Contract Paragraph: 1.3.5 and 5.1.4.1.3.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: Each clinical and administrative activity within the PRIMUS clinic monitors and evaluates its activities as they affect patient care. (AFR 168-13, Para 2-3)

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10. Required Service: Contractor's QA Program

Contract Paragraph: 1.5.2

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: The contractor submits to an evaluation team of health care professionals from the AF MTF on a quarterly basis for inspection of all facets of the contractor's QA/RM program.

---

11. Required Service: Emergency Services

Contract Paragraph: 5.1.1.2

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: All emergency carts are kept in adequate and proper supply. (JCAHO AHC QC.1.1.16)

---

12. Required Service: Emergency Services

Contract Paragraph: 5.1.1.2

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 2%

Standard: Written policies exist which address the timely review and inspection of each emergency cart. (JCAHO AHC QC.1.1.16.1)

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13. Required Service: Emergency Services

Contract Paragraph: 5.1.1.2.1

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 2%

Standard: All contractor personnel hold current certification in cardiopulmonary resuscitation (CPR).

---

14. Required Service: Triaging of Patients

Contract Paragraph: 5.1.1.5

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 3%

Standard: All patients shall be triaged and registered within 10 minutes after arrival at the PRIMUS clinic.

---

15. Required Service: Credentials Review Process

Contract Paragraph: 5.1.4.1.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: Each physician credentialed in the PRIMUS clinic is either board eligible or board certified and is licensed to practice as a physician in the state of the PRIMUS clinic.

---

16. Required Service: Staffing Requirements

Contract Paragraph: 5.1.4.1.1

Minimum Level of Compliance: 90%

Weighted Scale (x% of 100%): 3%

Standard: There exists a maximum of three physician extenders for each physician onsite.

---

17. Required Service: Staffing requirements

Contract Paragraph: 5.1.4.1.1.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%):

Standard: At least one physician is onsite during all hours of operation.

---

18. Required Service: Physician Extenders

Contract Paragraph: 5.1.4.1.2

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: All physician extenders have a state license (where applicable).

---

19. Required Service: Nursing Services

Contract Paragraph: 5.1.4.1.3

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 3%

Standard: There exists, at all times, nursing personnel onsite to meet patient care requirements as established by the State's professional standards of practice.

---

20. Required Service: Radiology Services

Contract Paragraph: 5.1.4.1.4.1

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 3%

Standard: Within 24 hours after examination, the results of interpretations of all radiographics are reported on Standard Form 519A, Radiographic Report, signed by the examining radiologist and made a part of the patient medical record.

---

21. Required Service: Pharmaceutical Services

Contract Paragraph: 5.1.4.1.5.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: If a pharmacy is provided in-house, all drugs and biologicals are stored, secured, prepared, dispensed, transported, administered, and discarded in compliance with applicable federal, state and local laws. (JCAHO AHC PS.1.1)

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22. Required Service: Pharmaceutical Services

Contract Paragraph: 5.1.4.1.5.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: The PRIMUS clinic pharmacy is supervised by a licensed pharmacist. (JCAHO AHC PS.1.4)

---

23. Required Service: Pharmaceutical Services

Contract Paragraph: 5.1.4.1.5.2

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 2%

Standard: A current formulary is available to all providers in the PRIMUS clinic.

---

24. Required Service: Pharmaceutical Services

Contract Paragraph: 5.1.4.1.5.5.1.1

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 2%

Standard: All patients receiving medication on a long term basis receive a minimum of a thirty day supply.

---

25. Required Service: Pharmaceutical Services

Contract Paragraph: 5.1.4.1.5.5.1.2; 5.1.4.1.5.5.2.1 and 5.1.4.1.5.3

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 2%

Standard: All original prescriptions include the number of refills required and medically advisable, to avoid unnecessary renewal visits and/or physician contact visits by the patient.

---

26. Required Service: Laboratory Services

Contract Paragraph: 5.1.4.1.6

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%):3%

Standard: All test results performed by the PRIMUS clinic laboratory are distributed within 24 hours after completion of a test. [Note: JCAHO states "timely" but that is not measurable. I stated 24 hours because that is the requirement in the contract for radiology studies and they should both be the same. Twenty-four hours for posting lab results is not directly stated in the contract but certainly is a reasonable standard]. (JCAHO AHC LP.1.2.3)

---

27. Required Service: Laboratory Services

Contract Paragraph: 5.1.4.1.6.1

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: All laboratory personnel are registered or eligible for registration with an accrediting agency appropriate to the skill level needed in the clinical laboratory as defined by the College of American Pathologists.

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28. Required Service: Laboratory Services

Contract Paragraph: 5.1.4.1.6.2

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: All laboratory procedures required for proper diagnosis that are beyond the capability of the onsite laboratory, but are within the standards of practice for Family Practice/Primary Care, are obtained from an accredited medical laboratory.

---

29. Required Service: Chaperones

Contract Paragraph: 5.1.5

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: All care is chaperoned whenever the provider is of a different sex than the patient and when the patient must partially or completely disrobe.

---

30. Required Service: Medical Records

Contract Paragraph: 5.1.5

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 2%

Standard: There is an individual in charge of maintaining the confidentiality, security and physical safety of the patient's medical records. (JCAHO AHC MR.1.4.1.1)

---

31. Required Service: Medical Records

Contract Paragraph: 5.1.6

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 2%

Standard: All reports of histories and physical examinations, progress notes, and other materials--such as laboratory reports, x-ray readings, and consultations--are incorporated into each patient's record at the PRIMUS clinic within 24 hours. [Note: Again, JCAHO standard only states "timely." See my note in standard Number 26]. (JCAHO AHC MR.1.7)

---

32. Required Service: Medical Records

Contract Paragraph: 5.1.6

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 3%

Standard: A summary list of significant past surgical procedures and past and current diagnoses or problems is conspicuously documented in <u>each</u> patient's medical record to facilitate the ongoing provision of effective medical care. (JCAHO AHC MR.1.9)

---

33. Required Service: Medical Records

Contract Paragraph: 5.1.6

Minimum Level of Compliance: 95%

Weighted Scale (x% of 100%): 3%

Standard: <u>All</u> medical record entries are legible to clinical personnel. (JCAHO AHC MR.1.11)

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34. Required Service: Mammograms

Contract Paragraph: 5.1.11

Minimum Level of Compliance: 100%

Weighted Scale (x% of 100%): 3%

Standard: <u>All</u> female patients are scheduled for a mammogram based on protocol established by the PRIMUS clinic and within AF guidelines.

RESPONSE TO FINDINGS AND RECOMMENDATIONS
ON
INTERNAL MANAGEMENT CONTROL PROGRAM

AIR FORCE RESPONSE TO FINDINGS AND RECOMMENDATIONS

D. Internal Management Control Program

FINDING

The Primary Care for Uniformed Services (PRIMUS) and Navy Cares (NAVCARE) programs were not evaluated in the Military Departments' Internal Management Control Programs (IMCP). This condition occurred because the Military Departments were not aware of the program's annual review requirement. As a result, internal controls were inadequate to protect the PRIMUS and NAVCARE programs from waste, fraud, and mismanagement.

RESPONSE

Partially Concur. It is true that the Air Force PRIMUS program was not evaluated within the Departments' IMCP and that managers were not aware of the annual review requirement for these clinics. However, we disagree that internal controls of Air Force PRIMUS clinics are inadequate to protect against waste, fraud and mismanagement. Our PRIMUS clinics have been contracted according to existing federal acquisition regulations. Necessary internal controls of contractor performance are incorporated as required by those regulations. Further, administration of the contract at the Air Force site is designed to insure satisfactory contractor performance and satisfactory receipt of all services billed.

RECOMMENDATIONS FOR CORRECTIVE ACTION

DoD(IG) recommends that the Commander, U.S. Army Health Services Command; the Commander, U.S. Naval Medical Command; and the Air Force Surgeon General;

1. Include the Primary Care for Uniformed Services and Navy Care programs in the Internal Control Management Review Program (IMCP).

Concur with Reservation. If inclusion in IMCP is a requirement that is mandated, we will have no alternative but to comply. However, it is our position that internal controls already in place are sufficient to protect against waste, fraud and mismanagement by the contractor. Weekly, monthly, quarterly, and annual inspections, using a comprehensive checklist, are completed by competent military personnel inspecting areas within their area of expertise. All inspections are documented. A daily audit of all patient visits is accomplished. Approximately 10% of medical records are audited for compliance and appropriateness of a patient visit, with a determination made as to the level of visit to be billed. Patient records are reviewed if that patient was seen at PRIMUS-Omaha within the previous seven days. A daily patient visit log is generated, audited and maintained daily of every patient visit. PRIMUS-Omaha has a professional and administrative screening methodology which statistically reviews physicians records and 100% of physician assistant records. A thorough review and

verification of the DoD Form 250, Contractors Reimbursement Request, is made using detailed tracking documents maintained by the Quality Assurance Evaluator (QAE) and the contractor.

The audit made inaccurate reference to the Air Force's mismanagement of the DoD Form 250 due to bills being forwarded to another site for payment. The PRIMUS-Omaha first month's billing was paid at Bolling AFB because funds had not yet been transferred to Offutt. In October 1988, funds were transferred to Offutt and the auditor was informed of this at that time.

It is erroneous, in the draft at pg 41, stating, "the Air Force PRIMUS location COR did not validate the contractors DoD Form 250." Prior to submitting the DoD Form 250 to base contracting for payment a thorough verification is made by the QAE, prior to signature authorizing payment. Granted, the QAE's functions are assigned as collateral duty with other duties within the MTF but, sufficient time is taken to effectively perform the QAE surveillance. Furthermore, in surveying those areas beyond the scope and expertise of the QAE, qualified clinical personnel are selected to review those appropriate functions thereby assuring quality care and appropriate contractor performance. 41

Effective communication between MTF and clinic management is key to effective management and oversight of the PRIMUS clinics. For example, at the Omaha PRIMUS site, policy and procedure memoranda are regularly updated at the clinic and include such subjects as professional, adminstrative, Air Force requirements and organizational matters which pertain to the internal management of the clinic. Each is coordinated with the MTF. The Administrator of the PRIMUS clinic sits on the MTF's Executive Board and the clinic's Medical Director is a member of the MTF's Quality Assurance/ Risk Management Committee. Both these key clinic staff members also sit on the MTF's Consumer Health Advisory Council Committee which is chaired by the Director/Base Medical Services.

Further, and as referenced in our response to the "Program objectives and Goals" recommendation number two; we are working with the AFISC/SG to evaluate the appropriateness of their oversight of the PRIMUS clinics as part of their normal HSMI role.

2. Provide guidance and training to senior- and mid-level management officials involved in the Primary Care for Uniformed Services and Navy Cares programs.

RESPONSE

Concur. We will take action to insure guidance and training is provided to appropriate management officials involved in the PRIMUS programs. (ECD: Jan 90)

ACTIVITIES VISITED OR CONTACTED

Office of the Secretary of Defense

Comptroller of the Department of Defense, Washington, DC
Office of the Assistant Secretary of Defense (Health Affairs), Washington, DC
Office of the Civilian Health and Medical Program of the Uniformed Services, Aurora, CO

Department of the Army

Assistant Secretary of the Army (Financial Management), Washington, DC
Office of the Surgeon General, Falls Church, VA
Health Services Command, Fort Sam Houston, TX
Military Treatment Facilities:
- DeWitt Army Community Hospital, Fort Belvoir, VA
- Womack Army Community Hospital, Fort Bragg, NC
- Winn Army Community Hospital, Fort Stewart, GA
- Silas B. Hayes Community Hospital, Fort Ord, CA

Department of the Navy

Comptroller of the Navy, Washington, DC
Director of Naval Medicine/Surgeon General, Washington, DC
Naval Medical Command, Washington, DC
Naval Medical Command, Mid-Atlantic Region, Norfolk, VA
Naval Medical Command, Southwest Region, San Diego, CA
Naval Medical Materiel Support Command, Fort Detrick, MD
Naval Regional Contracting Center, Philadelphia, PA
Military Treatment Facilities:
- Portsmouth Naval Hospital, Portsmouth, VA
- San Diego Naval Hospital, San Diego, CA
- Naval Hospital, Oakland, CA

Department of the Air Force

Office of the Administrative Assistant, Information Management Division, Washington, DC
Office of the Surgeon General, Washington, DC
Medical Logistics Division, Directorate of Health Care Support, Brooks Air Force Base, San Antonio, TX
Military Treatment Facility:
- USAF Hospital Ehrling Bergquist, Offutt Air Force Base, Omaha, NE

ACTIVITIES VISITED OR CONTACTED (Continued)

Defense Agencies

Defense Supply Service - Washington, Washington, DC
Defense Enrollment Eligibility Reporting System,
  Program Office, Baileys Crossroads, VA

Non-DoD Activities

General Accounting Office - DoD Health Audit Division,
  Washington, DC
Committee on Appropriations, U.S. House of Representatives,
  Washington, DC

Non-Government Activities

PHP Healthcare Corporation, Alexandria, VA
  PRIMUS Clinic, Woodbridge, VA
  PRIMUS Clinic, Fairfax, VA
  PRIMUS Clinic, Fayetteville, NC
  PRIMUS Clinic, Savannah, GA
  PRIMUS Clinic, Omaha, NE
  NAVCARE Clinic, San Diego, CA
  NAVCARE Clinic, Oakland, CA

John Short & Associates, Inc., Columbia, MD
  NAVCARE Clinic, Virginia Beach, VA
  NAVCARE Clinic, San Diego, CA

Sisters of Charity of the Incarnate Word Health Care System,
  Houston, TX
   PRIMUS Clinic, Presidio of Monterey, CA
   PRIMUS Clinic, Salinas, CA

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Danny Hatten	Auditor
Billy Joe McCain	Auditor
Barbara Wright	Auditor

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Commander, Health Services Command

Department of the Navy
Secretary of the Navy
Assistant Secretary of the Navy (Financial Management)
Office of the Director of Naval Medicine/Surgeon General
Commander, Naval Medical Command, Washington, DC

Department of the Air Force
Secretary of the Air Force
Comptroller of the Air Force
Office of the Surgeon General, Air Force

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Senate Committee on Armed Services
Senate Committee on Governmental Affairs
Senate Ranking Minority Member, Committee on Armed Services
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House Committee on Armed Services
House Committee on Government Operations
House Subcommittee on Legislation and National Security, Committee on Government Operations
House Committee on the Budget