TRICARE Plus: A Cost, Capacity and Enrollment Analysis

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Naval Hospital Pensacola, Florida
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**Abstract**

This study looks at the TRICARE Plus (TP) impact on the cost of primary care (PC) within the Naval Hospital Pensacola (NHP) catchment area by determining current costs and NHP's TRICARE Prime enrollment capacity. Recommended TRICARE Plus options are provided based on NHP's and the Military Health System (MHS) costs and capacity. NHP's fiscal year 2001 (FY01) PC capacity was nearly 50 percent, which equated to over 45,000 unfilled visits. NHP's and the MHS PC costs in FY01 for the Pensacola catchment area were $17,357,609 and $23,753,608 respectively. Increasing enrollment will reduce these costs. Over 28,000 eligible beneficiaries in the Pensacola catchment area are not enrolled in TRICARE Prime at NHP. Recapturing a portion of these beneficiaries could result in $2.25 million savings for the MHS and decrease the cost of a NHP PC visit to $44. Specific enrollment strategies will determine actual savings. It is recommended that NHP recapture all Active Duty Dependents (ADD) currently enrolled in the Civilian Provider Network (CPN) while actively enrolling TRICARE Plus eligibles. By FY06, ADD Civilian Prime Network recaptures should increase NHP's TRICARE Prime enrollment nearly 4500. Additionally, TRICARE Plus enrollment could increase by over 3000. Estimated annual cost savings for NHP and the MHS would be $90 thousand and $2.25 million respectively.
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# Table of Contents

*Introduction* .................................................................................................................................... 1  
  Conditions which prompted the study ................................................................. 1  
*Statement of Problem* ............................................................................................................. 4  
  Literature Review ..................................................................................................................... 4  
    Cost of Care .......................................................................................................................... 4  
    Determining Capacity ......................................................................................................... 7  
    Increasing Enrollment ......................................................................................................... 9  
*Purpose* ..................................................................................................................................... 10  
*Methods and Procedures* ......................................................................................................... 11  
  Assumptions............................................................................................................................. 11  
  Clinic Capacity ....................................................................................................................... 12  
  Enrollment Capacity ............................................................................................................. 13  
  Cost Analysis ........................................................................................................................... 14  
*The Results* ................................................................................................................................ 15  
  Capacity ................................................................................................................................... 16  
  Cost of Delivering Care ......................................................................................................... 16  
  Current Visit Availability ...................................................................................................... 18  
*Discussion* .................................................................................................................................... 23  
*Conclusions and Recommendations* .......................................................................................... 24  
*Appendices* .................................................................................................................................. 27  
*References* .................................................................................................................................... 30
List of Tables and Figures

Tables:

Table 1 – PCM Enrollment by Clinic ................................................................. 8
Table 2 – Appointments Per Hour for Relative Value by Beneficiary Category, Adjusted ..... 13
Table 3 – Maximum Enrollment based on Visit Availability ........................................ 14
Table 4 – Direct Costs Allocation per Cost Center .................................................. 15
Table 5 – Available Visit Capacity ........................................................................ 16
Table 6 – Cost per Bed Day or Visit ...................................................................... 17
Table 7 – Estimated Current TFL Costs ................................................................. 17
Table 8 – Available Visits ..................................................................................... 18
Table 9 – TRICARE Plus Capacity Scenario One ..................................................... 19
Table 10 – TRICARE Plus Capacity Scenario Two ................................................... 19
Table 11 – Total Cost based on projected enrollment maximizing total CPN Recapture ..... 20
Table 12 – Total Cost based on projected enrollment, ADD CPN Recapture Only ........ 21
Table 13 – Total Cost based on increased MTF Visits ............................................. 21

Figures:

Figure 1. MHS and NHP total cost savings based on enrollment capacity and scenario, ..... 22
Figure A1. Estimated NHP Catchment Area Healthcare Costs with 100% CPN Recapture .. 27
Figure B1. Estimated NHP Catchment Area Healthcare Costs with ADD CPN Recapture Only ................................................................. 28
TRICARE PLUS: A Cost, Capacity and Enrollment Analysis

Introduction

Conditions which prompted the study

TRICARE is the U.S. military’s health benefit plan that provides three options of care to its eligible beneficiaries. The first option, TRICARE Prime, is the military’s equivalent to a hybrid staff model Health Maintenance Organization (HMO). Qualified beneficiaries must enroll in TRICARE Prime and are assigned a Primary Care Manager (PCM) at their local Military Treatment Facility (MTF) or with a local civilian network provider. TRICARE Prime provides the least out-of-pocket expense for the beneficiary. The other two options, TRICARE Extra and TRICARE Standard (traditional CHAMPUS) are similar, except TRICARE Extra is much like a Preferred Provider Organization (PPO), whereby the outpatient cost share for the beneficiary is reduced when services are rendered by a network provider. Beneficiaries using either of these options have more flexibility in receiving care but bear a higher cost in the form of annual deductibles and cost sharing. Currently, the annual deductible is $150 per beneficiary/$300 per family ($50/$100 for junior enlisted E-5 and below). The outpatient cost share is 20 and 25 percent after the annual deductible has been met for active duty dependents and retirees under the age of 65 respectively. Services provided by a TRICARE Extra provider receive a 5 percent discount off these cost shares. Out-of-pocket expenses are limited to $1000 per family for active duty and $3000 for a retiree family. Thereafter, TRICARE pays 100 percent of appropriate medical care (TRICARE, 2001).

Before October 2001, TRICARE provided healthcare coverage for active duty (AD) personnel and their dependents (ADD), retired personnel under the age of 65 and their dependents (NADD), and other qualifying individuals. Once a retired beneficiary reached the
age of 65, they were no longer eligible for TRICARE benefits with limited exceptions. They could be seen space available in MTFs and their medications could be filled at MTF pharmacies if the medication was part of the MTFs formulary. However, much “space available” care at MTFs vanished during the 1990s due to downsizing. Many military retirees over the age of 65 and their eligible dependents (NADD>65) were enraged at losing their healthcare benefit at a MTF. They felt that “free healthcare” was a right based on documented promises made by the government when they entered military service. One of their arguments was that Medicare differed from military health care in that it did not have a pharmacy benefit (Harris, 2000).

Through strong legislative lobbying by retiree organizations, TRICARE Senior Prime, a Medicare subvention demonstration project, was piloted at six select locations during the late 1990s. It ended December 31, 2001. These demonstration projects allowed a specified number of NADD>65 beneficiaries to enroll in the military’s HMO program and receive the same care and access standards afforded TRICARE Prime patients. Each demonstration project was geographically dispersed and only affected a small portion of the NADD>65 population. These demonstration projects did not address the healthcare needs for the majority of military retirees over the age of 65. Additional lobbying to Congress by military affiliated organizations was performed on behalf of these beneficiaries. These efforts paid off in 2000 with the passing of the National Defense Appropriations Act of 2001 (NDAA). The NDAA made sweeping changes in military healthcare reform.

The NDAA introduced a few, yet significant, healthcare benefits for the NADD>65 population starting in fiscal year 2002 (FY02). Title VII Subtitle B of the DAA (Senior Health Care) updated the pharmacy benefits to include access to retail pharmacies and the National Mail Order Pharmacy (NMOP). This benefit began April 1, 2001. Sections 712 and 713 under the
aforementioned Subtitle established a new benefit that has been tabbed “TRICARE for Life” (TFL). This benefit started in October 2001 and essentially made TRICARE a secondary payer to MEDICARE for approved services. NADD>65 beneficiaries must be enrolled in both MEDICARE A and B in order to be eligible for TFL. However, a portion of the NADD>65 population do not have Medicare Part B and/or would still prefer to receive their care at the local MTF. Prior to October 2001, no TRICARE MTF care option existed for this population other than space available care. However, a small portion of the NADD>65 population has been empanelled in certain Family Practice teaching hospitals for Graduate Medical Education (GME) residency programs. This population currently accounts for approximately 2000 empanels at Naval Hospital Pensacola (NHP). Since no TRICARE option existed for the care of the NADD>65 population at a MTF, a new option, TRICARE Plus (TP), was developed to fill this void.

TRICARE Plus allows any beneficiary, including NADD>65, not currently enrolled in TRICARE Prime or other Health Maintenance Organizations (HMOs) to enroll in TRICARE Plus (Assistant Secretary of Defense, 2001). It potentially affects over 12,000 NADD>65 beneficiaries that reside in the Pensacola catchment area. TRICARE Plus works much like TRICARE Prime in that enrollees are assigned a PCM with the local MTF and have similar access standards for primary care. However, there are no guaranteed access standards for specialty care. Specialty care is provided on a space available basis. The main advantages to TRICARE Plus are that enrollees do not have an enrollment fee and NADD>65 beneficiaries are not required to have Medicare Part B coverage to qualify. However, any NADD>65 beneficiary with only Medicare Part A would subject themselves to 100 percent of the cost of any civilian care because TRICARE only becomes secondary payer when the NADD>65 beneficiary has
Medicare Part B coverage. There are some disadvantages to TRICARE Plus. First, TRICARE Plus enrollees must reside in the MTFs catchment area (50 miles) as the program is only utilized by MTFs. Additionally, TRICARE Plus is MTF specific and not portable. Guaranteed access standards are only specific to the enrolled facility. If a TRICARE Plus enrollee leaves an area that has a participating MTF, there is no guarantee that another MTF will be able to enroll them in TRICARE Plus or whether that MTF even participates in TRICARE Plus. Lastly, MTF commanders can elect not to participate in TRICARE Plus (TMA, 2001). Currently, no additional funding is afforded commanders that participate in TRICARE Plus. Therefore, TRICARE Plus will have a significant impact on any MTF that elects to participate, both in cost of care and capacity management (quality of care and access to care), in treating this new beneficiary category. Validating capacity and cost of providing TRICARE Plus at an MTF is crucial.

Statement of Problem

Capacity management and cost efficiency are concerns to any MTF commander, but a unique twist presents itself with regards to TRICARE Plus particularly the NADD>65 population. Since the NADD>65 population is traditionally seen more often and their care more costly than most current Military Treatment Facilities (MTFs) beneficiaries, the impact of treating this population is not fully understood. This particular study will determine the capacity at NHP and the most cost efficient measures to treat the NADD>65 population enrolled in TRICARE Plus that reside in the Pensacola catchment area.

Literature Review

Cost of Care. Cost of care is derived in a number of ways. Costs can be associated directly with the care received or spread across an organization through a step-down process.
There are three traditional methods used for cost accounting in medical services: historical method, margin, and weighted-average method. Historical method looks at what an organization has traditionally charged and what a payor has paid. Generally, margin looks at cost plus profit margin. Lastly, weighted-average accounting looks at the total costs divided by the number of procedures (i.e. visits) in order to arrive at an average cost per event (Zelman, McCue, and Millikan, 1998). In the DOD healthcare system, the Military Expense Performance Reporting System (MEPRS) is used for cost accounting purposes and most closely resembles a weighted-average costing system. In 1999, the DoD average MTF cost per outpatient visit was $105 (TRICARE, 2001). Per visit cost for Civilian Prime Network, TRICARE Extra, and TRICARE Standard was $116, $99, and $117 respectively in FY 2000 for services provided in the NHP catchment area (Lead Agent Region 4, 2001). The current cost impact of TRICARE Plus is unknown.

TRICARE Plus is a new aspect of the overall TRICARE Health Plan. Very little research is available on its impact on MTFs. However, TRICARE Plus closely matches a three-year demonstration project, MACDILL 65, which ended in September 2001. It provided medical care for 2000 NADD>65 beneficiaries at the MacDill AFB MTF. While MTF size and capabilities may cause variations among facilities, the MACDILL 65 project noted that per member per month (PMPM) cost for treating the NADD>65 population was $80.90, over half which was attributable to pharmaceuticals (BUMED, 2001). Center for Medicare (CMS) data for calendar year 2000 (CY00) indicated $6937 was the average amount spent on healthcare for each Medicare enrollee (CMS, 2001). This figure increases to nearly $700 PMPM for Medicare enrollees in the state of Florida. The average amount of an outpatient visit for a Medicare recipient is $157 (HHS, 2001). The low PMPM cost of the MACDILL 65 project compared to
the PMPM rate for Florida Medicare enrollees suggest cost efficiencies could be met through NADD>65 care being received at a MTF.

NHP spent in excess of $11 million providing over age 65 care in FY01. The majority of this care was spent on the Medicare population empanelled in the GME residency program. However, some of this care was spent on the non-eligible, age 65 and older population (i.e. civilian humanitarian care). The amount spent PMPM at NHP for the Medicare population was $423. This amount does not include ancillary services. Comparatively, this amount is 26 percent less than the average amount spent on each Medicare eligible recipient in the state of Florida.

Health Metrix Research Inc., a leading research organization in the cost of Medicare HMOs, reports plans in three phases based on health status. These three phases are: good, fair and poor. Health status is determined by the amount of usage by the enrollee. NHP’s NADD>65 empanelment average nearly 10 provider visits and 1 ER visit annually which closely matches the utilization rates of Florida’s Medicare enrollees with fair health status. A participant with fair health status on average includes 12 provider visits, 1 ER visit, 1 inpatient stay of 3 days, and 24 prescriptions per year. HMO participants with fair health status average over $1800 per year in out-of-pocket expenses, which does not include their Medicare part B premiums (Health Metrix Inc, 2002). Overall, Florida’s Medicare HMO enrollees average annual out-of-pocket expenses range from $1000-$3500.

Under TFL, eligible Medicare enrollees’ out-of-pocket expenses are absorbed by the MHS for approved services. Therefore if the MHS can treat the NADD>65 population through unused capacity for less than the out-of-pocket expenses that would normally be absorbed by the
MHS, it makes financial sense to recapture this care in local MTFs. Capacity is a driving force in how much NADD>65 care can be accomplished within the MTFs.

**Determining Capacity.** Historically, enrollment has been set using a ratio of patients to provider. There are many sources available to estimate an average empanelment per provider based on the provider’s specialty. Since TRICARE Plus operates much like a staff model HMO, enrollment should mirror that of a civilian staff HMO with expected variations for military primary care managers (PCM). Generically, capacity is defined as the number of available providers multiplied by the maximum number of enrollees per primary care manager. For example, a MTF with 20 primary care managers with a maximum enrollment of 1200 patients per provider would have a capacity of 24,000 enrollees. Available capacity, represented as a percentage, is derived by subtracting current enrollment from total available enrollment and dividing the results by total available enrollment. Using the above example of 24,000 enrollees, a MTF with 12,000 actual enrollees would have an available capacity of 50 percent (24000-12000 = 12000, 12000/24000 = .50). A recent study sponsored by Aventis Pharmaceuticals found an average of 205 HMO members per PCM when all HMOs were taken into account. This figure is lower than actual PCM enrollment because many PCMs spread their enrollment over multiple HMO plans and other payors. However, enrollment figures more than tripled to 753 members per PCM when only staff model HMOs were considered (Adventis, 2000). In staff-model HMOs, PCM patient enrollment is more closely associated with member per PCM size because enrollment is usually limited to the specific plan enrollees. This is especially true in a closed staff-model HMO like TRICARE Prime. Another large-scale report, done in 1997, found an average of 779 members per PCM in staff model HMOs. The enrollment population in staff model Medicare HMOs was reduced to 661 enrollees per PCM (Kongstvedt, 2001).
latter figure is better for comparison with TRICARE Plus, assuming that the majority of enrollees will be NADD>65. Determining if any of these figures are representative of MTF PCM enrollment is difficult to gauge, but it does give a measure to use for comparison.

MTFs generally have a smaller enrolled population than the private sector because of unique military requirements. A few examples include; increased military leadership duties, physical readiness requirements, annual leave, and military medicine specific education. In some military capacity models, military physicians have been considered .75 of a standard full-time equivalent (FTE) for enrollment purposes. Utilizing this assessment, a contracted civilian provider in a MTF may have an enrollment of 1000 patients and a military provider would have an enrollment of 750 (.75 x 1000). Reviews of enrollments throughout MTFs show great variation. NHP enrollment figures (October 2001) per primary care manager (PCM) vary from 0-1046 patients per provider (Table 1) and depend on the role and availability of the PCM. Enrollment figures presented are a snapshot and PCMs with an enrollment of zero were new arrivals to the Pensacola area at the beginning of FY02.

Table 1

<table>
<thead>
<tr>
<th>Clinic</th>
<th>FP</th>
<th>IM</th>
<th>PEDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Providers</td>
<td>49</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Total Enrollment</td>
<td>10,977</td>
<td>4,800</td>
<td>3,891</td>
</tr>
<tr>
<td>Low Enrollment</td>
<td>0</td>
<td>0</td>
<td>419</td>
</tr>
<tr>
<td>High Enrollment</td>
<td>379</td>
<td>1046</td>
<td>746</td>
</tr>
<tr>
<td>Avg Enrollment</td>
<td>201</td>
<td>435</td>
<td>648</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>90.957</td>
<td>361.545</td>
<td>135.559</td>
</tr>
</tbody>
</table>

Source: Director Healthcare Management and Plans, NHP (October 2001)

Accurate capacity modeling results in better access for enrolled patients and allows both the local MTF and the overall MHS to function more cost efficiently. At MTFs lacking accurate
validation procedures, including number of enrollees and type of patients, capacity can easily get
out of control either through over-enrollment or under-enrollment.

Over-enrollment traditionally leads to patient dissatisfaction. Enrollees would have
difficulty in acquiring timely appointments within the MTF and/or with their PCM as a result of
over-enrollment. Thus, care would have to be received “outside the network” resulting in higher
costs for the patient and the MHS. If access standards can’t be met, MTFs may be forced to
disenroll patients at the MTF. In this scenario, the TRICARE Plus enrolled population would be
disenrolled first. The failure to meet access standards, the higher costs associated with failure of
delivery, and the possibility of disenrollment would ultimately lead to increased beneficiary
dissatisfaction, a quality indicator.

On the other hand, under-enrollment has a greater cost impact on the overall Military
Healthcare System (MHS). Under-enrollment leads to an increase in the number of available
visits going unfilled. Any visit going unfilled may have a financial impact on the MHS as
unfilled visits can result in a higher bid price adjustment process with the managed care support
contractor (MCSC). The bid price adjustment process requires MTFs to have a minimum
number of visits (Philpott, 2001). Therefore, if an MTF is not being fully utilized and falls short
of the required number of visits, it increases the workload provided “in the network” resulting in
higher overall costs to the MHS through an increase in TRICARE contractor costs. Therefore,
under enrollment has a direct impact on higher costs per enrollee. Increasing enrollment in an
under-enrolled environment will help reduce the bid price adjustment and result in overall MHS
savings.

**Increasing Enrollment.** NHP plans to increase MTF enrollment of TRICARE Prime by
5000 beneficiaries over the next 2 years through new marketing efforts and realignment of
enrollment policies. It is estimated sixty percent of that increase will come from newly reporting personnel enrolling in TRICARE Prime at NHP. The other forty percent will be recaptured through marketing efforts of those currently in the Civilian Prime Network or those choosing the TRICARE Standard/Extra option.

There are over 30,000 beneficiaries, including Medicare eligibles, in the NHP catchment area that are not enrolled in TRICARE Prime at NHP. Of those, 11,000 are enrolled in the Civilian Prime Network and 10,000 are potential Medicare eligible TRICARE Plus enrollees (Naval Hospital Pensacola, 2002). While recapturing TRICARE Standard patients into TRICARE Prime is the most cost-effective approach, the assumption is that most of those beneficiaries who have elected TRICARE Standard over TRICARE Prime will continue to do so. Recapturing Medicare eligible beneficiaries through unused MTF capacity is cost efficient for the MHS and NHP up to the point of full capacity since TRICARE only pays 20 percent of an outpatient visit for an NADD>65 beneficiary. In other words, the marginal cost of an outpatient visit at the MTF is less than the average Medicare co-pay of treating any NADD>65 beneficiaries up to the point of full capacity. Additionally, future funding for NADD>65 care to MTFs will be based on level of effort. This level of effort will be base lined to FY2000 (TRICARE Management Activity, 2001). Any MTF that recaptures more NADD>65 care than they received credit for in FY2000 may receive additional funding for providing that care. Reimbursement determinations are being discussed at TMA and service specific agencies.

Purpose

The purpose of this study is to best determine the capacity (patient/provider) for enrolling beneficiaries into TRICARE Plus at NHP and thus assist in controlling the cost of care within the MTF and the MHS. The hypothesis of this study is that capacity and cost are functionally related
within a local MTF in regards to TRICARE Plus. Fully utilizing unused capacity in treating
TRICARE Plus enrollees should reduce the overall cost of the MHS. A secondary hypothesis is
that utilizing MTFs for cost savings is only achievable up to the point of current MTF capacity in
regards to the NADD>65 population. After capacity is reached within a MTF, cost of providing
care to the NADD>65 population is prohibitively more expensive to the MHS when the care is
performed within the MTF because the MHS, as secondary payor to Medicare, is only
responsible for the deductibles and cost shares of civilian care. In both instances, the null
hypothesis is that no significant cost differences exist in regards to where the care is received
regardless of available capacity.

Methods and Procedures

Assumptions

To answer the basic questions of capacity and costs of TRICARE Plus at NHP, a few
assumptions must be made. First, while TRICARE Plus is open to all TRICARE beneficiaries
not currently enrolled in TRICARE Prime or another HMO, it is expected that the majority
desiring to enroll in TRICARE Plus will be age 65 and older. Other beneficiary categories
already have the ability to enroll in TRICARE Prime and for whatever reason have elected not to
do so. Additionally, those currently enrolled in TRICARE Prime, including NADD, are
discouraged from changing enrollment from TRICARE Prime to TRICARE Plus because the
guarantee to all levels of care and portability of the healthcare plan doesn’t exist in TRICARE
Plus. TRICARE Plus is a local MTF specific option, and not all MTFs are required to
participate. Therefore, this study will focus primarily on NADD>65 beneficiaries and their
impact on TRICARE Plus in relation to capacity management and cost efficiencies. Secondly,
the study will not include the NADD>65 population already empanelled in Family Practice at
NHP for GME purposes except for historical usage comparison since these beneficiaries are already enrolled in TRICARE Plus. Third, since TRICARE Plus only guarantees access to primary care through a PCM, only outpatient, non-specialty care will be considered in this analysis. Lastly, any computations in this paper will assume MTFs are reimbursed at 50 percent of the average Medicare outpatient visit cost share. Based on the current average Medicare cost share of $31, this model will use $15.50 reimbursement per visit for any visit over the FY2000 level of effort baseline.

**Clinic Capacity**

Determining PCM availability for further enrollment was done using a comprehensive capacity model of the hospital’s primary care clinics developed by NHP’s Healthcare Plans directorate. A limit to this model is that current provider appointment availability is self-reported by the clinics, which may differ from actual capacity. The primary care clinics in the model include Family Practice (including the residency program), Internal Medicine, and Pediatrics. Data from fiscal year 2001 was used in this study. A formula was developed that takes into account the current mix of enrolled beneficiaries and their average primary care usage by provider type (staff physician, resident, etc.) by taking the number of beneficiary category (bencat) visits divided by the total visits and then multiplied by the number of bencat appointments per hour based on provider input. The formula gives a weighted average per beneficiary category. For example, a physician assistant (PA) in the Internal Medicine Clinic saw 2631 total patients of which 698 were active duty family members (ADFM). The PA reported that he/she could see 3 ADFMs per hour. Therefore, \((698/2631)*3.0\) yields the adjusted appointments per hour based on relative volume for an ADFM as .80 (rounded). See Table 2. This weighted average was used with current enrollment to determine current usage levels. This
model gives a very accurate assessment of current usage levels (Naval Hospital Pensacola, 2001). Model data can be adjusted on a periodic basis to demonstrate any change in enrollment mix.

Table 2

Appointments Per Hour for Relative Value by Beneficiary Category, Adjusted

<table>
<thead>
<tr>
<th>Family Practice</th>
<th>Appts Per Hour Adjusted for Relative Volume by Bencat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AD</td>
</tr>
<tr>
<td>Staff FP’s, FNP’s &amp; PA’s</td>
<td>0.55</td>
</tr>
<tr>
<td>Residents (3rd Yr)</td>
<td>0.24</td>
</tr>
<tr>
<td>Residents (2nd Yr)</td>
<td>0.24</td>
</tr>
<tr>
<td>Residents (1st Yr)</td>
<td>0.12</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>Internists</td>
<td>0.32</td>
</tr>
<tr>
<td>PA</td>
<td>0.80</td>
</tr>
<tr>
<td>Resource Sharing</td>
<td>1.34</td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
</tr>
<tr>
<td>Pediatricians</td>
<td>2.62</td>
</tr>
<tr>
<td>PNP</td>
<td>2.09</td>
</tr>
</tbody>
</table>

The adjusted appointments per hour multiplied by the number of hours in clinic (hours available per week multiplied by number of available week per year) yield maximum clinic appointment output. This output divided by average number of visits per enrollee will determine maximum visit capacity.

Enrollment Capacity

Research indicates that potential enrollees’ outpatient visit patterns differ from current enrollees. Based on FY01 visit patterns, the average number of visits per enrollee for family practice, pediatrics, and internal medicine are 3.40, 3.34, and 2.95 respectively. Comparatively, Civilian Prime Network enrollees’ average 3.2 visits per year (TRICARE Region 4, 2001) and Florida Medicare recipients average 6.8 visits per year (Adventis, 2000). The current usage
patterns of non-enrollees must be used to determine the potential number of enrollees to prevent over enrollment. As new enrollees’ care is better managed in a primary care setting, annual visits should decrease. This decrease in usage will open the system for additional enrollees. Table 3 depicts the maximum number of potential enrollees by beneficiary category based on available visit capacity.

Table 3

<table>
<thead>
<tr>
<th>Beneficiary Type</th>
<th>Visits per Year</th>
<th>Avail Visits</th>
<th>Maximum Recapture</th>
<th>Potential Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPN Enrollees</td>
<td>3.2</td>
<td>45849</td>
<td>14161</td>
<td>11081</td>
</tr>
<tr>
<td>TS/E Beneficiaries</td>
<td>4.8</td>
<td>45849</td>
<td>9494</td>
<td>18120</td>
</tr>
<tr>
<td>Medicare Eligibles</td>
<td>6.8</td>
<td>38901</td>
<td>5721</td>
<td>10464</td>
</tr>
</tbody>
</table>

*Available pediatric visits not included in Medicare Eligibles’ visits

Cost Analysis

Current costs were calculated using a step-down process. MEPRS generically uses the weighted-average cost accounting method within the MHS. It steps down total costs to specific codes (i.e. outpatient). Once the step-down process occurs, MEPRS then averages the cost of a visit by taking the total cost of care divided by the number of visits. However, this methodology may be misleading in some instances. Since each visit consumes a different amount of resources, it could be argued some visits cost more than other visits (Zelman et al. 1998). In MEPRS, costs are equally dispersed among all visits; therefore the true costs of a particular visit can’t be ascertained. In general, the formula for determining the cost of care is basically the number of visits divided by the total costs. In this study a similar step-down process was done. In this step-down process, all costs were allocated to a “cost center” to find the cost of services. Utility costs were stepped-down based on square footage. All other costs were based on full-time equivalent (FTE) fair share computations. Traditionally in healthcare, a “cost center” is a
patient interaction, revenue generating work center (i.e. clinic). Three cost centers were used in this study; outpatient services, inpatient services, and specialty services. Costs were allocated to the primary care clinics (FP, IM, and PEDS) as illustrated in Table 4. Ancillary services were not included because they are a separate cost under most healthcare plans. Additionally, the major ancillary service, pharmacy, should not be greatly impacted by this study because most beneficiaries that would considered joining TRICARE Plus most likely already have their prescriptions filled by NHP. Therefore, all ancillary related costs were removed prior to any calculations.

Table 4

<table>
<thead>
<tr>
<th>Workcenter</th>
<th>Direct Costs</th>
<th>Utilities</th>
<th>General Admin</th>
<th>Total Direct Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilities</td>
<td>$4,899,495</td>
<td>($4,899,495)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>$16,158,242</td>
<td>$1,758,611</td>
<td>($17,916,853)</td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$11,108,397</td>
<td>$1,335,721</td>
<td>$4,411,200</td>
<td>$16,855,317</td>
</tr>
<tr>
<td>Primary Care Clinics</td>
<td>$11,344,571</td>
<td>$1,164,070</td>
<td>$3,845,662</td>
<td>$16,354,303</td>
</tr>
<tr>
<td>Specialty Clinics</td>
<td>$10,156,742</td>
<td>$1,567,736</td>
<td>$5,170,637</td>
<td>$16,895,115</td>
</tr>
</tbody>
</table>

\[a\] Utilities include repair and custodial services
\[b\] Administration includes all administrative services not directly associated with particular service (i.e. Command Suite)

Note: Computations do not equal 100% because some operations are not allocated to clinical services (i.e. POMI)

Financial Source: Director Resource Management, Naval Hospital Pensacola
Square Foot Allocation Source: Facilities Department, Naval Hospital Pensacola

The Results

The results of this study are divided into four categories. First, the capacity of the MTFs outpatient clinics is presented. Second, NHP’s current total cost of services is provided. Third, the estimated number of visits that can be recaptured is provided. Lastly, the effects of increased enrollment on NHP’s total costs are presented. These four sections indicate that capacity and
cost are functionally related and that cost efficiencies can be ascertained by enrolling Medicare eligibles into TRICARE PLUS until maximum capacity is achieved.

Capacity

Unused capacity in the primary clinics was determined by subtracting the current enrollment level from total capacity. This model determined total availability (100 percent) by taking the total number of clinic provider hours per week multiplied by number of available weeks per year that they are available and further multiplied by average number of appointments per hour. This result was then divided by average annual enrollee visits to arrive at a maximum capacity in visits. FY01 visit data was derived from Composite Healthcare System (CHCS).

Aggregate results of primary care clinics are provided in Table 5. 80 percent capacity is also shown because in any service related industry, which healthcare is a part, running capacity above 80 percent begins to impact access to services. For NHP primary care, impeding access will have a direct impact on higher network costs.

Table 5

<table>
<thead>
<tr>
<th>Clinic/PCM</th>
<th>Hrs. Avail/Week</th>
<th>Weeks Worked/Year</th>
<th>Appts/Hr</th>
<th>Enrollment Capacity (Visits)</th>
<th>80% Capacity FY01 Visits</th>
<th>Available Capacity (Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>601</td>
<td>44.00</td>
<td>2.67</td>
<td>70,478</td>
<td>56,382</td>
<td>37,818</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>273</td>
<td>39.33</td>
<td>2.3</td>
<td>25,035</td>
<td>20,028</td>
<td>18,794</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>204</td>
<td>44.00</td>
<td>2.40</td>
<td>21,542</td>
<td>17,234</td>
<td>14,594</td>
</tr>
</tbody>
</table>

Cost of Delivering Care

Four factors determine the total MHS costs of delivering healthcare. They are MTF costs (includes resource sharing), Civilian Prime Network (CPN) costs, TRICARE Standard (traditional CHAMPUS) costs, and TFL costs. Table 6 illustrates total MTF costs.
Table 6

Cost per Bed Day or Visit

<table>
<thead>
<tr>
<th>Workcenter</th>
<th>Total Direct Costs</th>
<th>Visits/Bed Days</th>
<th>Costs per Bed Day or Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
<td>$16,855,317</td>
<td>7977</td>
<td>$2,112.99</td>
</tr>
<tr>
<td>Primary Care Clinics</td>
<td>$16,354,303</td>
<td>180224</td>
<td>$90.74</td>
</tr>
<tr>
<td>Specialty Clinics</td>
<td>$16,895,115</td>
<td>56140</td>
<td>$300.95</td>
</tr>
</tbody>
</table>

Visit/Bed Day Data Source: Director Healthcare Management and Plans, Naval Hospital Pensacola

The primary care visit costs outlined above in Table 6 do not include any ancillary services (i.e. pharmaceuticals). Further drill down of the data reflects of the $90.74 spent in FY01 on a primary care visit, only slightly more than $6 dollars is associated with variable costs (VC) of the visit. Similar results were noted in inpatient and specialty services too. The high fixed cost (FC) is primarily due to the low number of visits being spread across a high amount of labor costs.

Civilian Prime Network costs in support of over 11,000 beneficiaries totaled $4,162,394 in FY00. Other NHP area TRICARE costs (Extra and Standard) totaled $15,035,929 (Region 4 Lead Agent, 2001). Figures for TFL are not available. However, Table 7 is an estimated illustration of TFL costs. The cost of eligibles enrolled in the GME program is not included in the TFL cost calculation because these beneficiaries are already captured in total MTF costs. The estimated TFL cost per visit is 20 percent of the average Medicare outpatient visit.

Table 7

Estimated Current TFL Costs

<table>
<thead>
<tr>
<th>NHP Area Medicare Eligibles</th>
<th>Estimated TFL Outpatient Visits</th>
<th>TFL Cost per visit</th>
<th>Total Estimated TFL Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10464</td>
<td>71155</td>
<td>$31.40</td>
<td>$2,234,273</td>
</tr>
</tbody>
</table>
Current Visit Availability

Table 8 depicts the approximate number of available visits that went unfilled during FY01 based on capacity. With current staffing, NHP can recapture enough additional enrollees that will satisfy 37,000 to 46,000 annual visits.

Table 8
Available Visits

<table>
<thead>
<tr>
<th>Clinic/PCM</th>
<th>Total Visits Avail</th>
<th>80% Avail Visits</th>
<th>FY01 Visits</th>
<th>Avail Visits Filled Pct</th>
<th>Current Avail Visits Unfilled</th>
<th>80% Avail Visits Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>70478</td>
<td>56382</td>
<td>37818</td>
<td>54%</td>
<td>32660</td>
<td>26128</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>25035</td>
<td>20028</td>
<td>18794</td>
<td>75%</td>
<td>6241</td>
<td>4993</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>21542</td>
<td>17234</td>
<td>14594</td>
<td>68%</td>
<td>6948</td>
<td>5559</td>
</tr>
<tr>
<td>NHP Total</td>
<td>117,055</td>
<td>93,644</td>
<td>71,206</td>
<td>65%</td>
<td>45,849</td>
<td>36,679</td>
</tr>
</tbody>
</table>

Capacity exists at NHP’s three primary care clinics. There are two primary ways to gain efficiencies in capacity: reduce staff or increase enrollment. Since NHP catchment area has a demonstrated need for services, increasing enrollment seems to be the most logical, cost effective measure. Increasing enrollment will come from three areas; beneficiaries enrolled in the Civilian Prime Network (both ADD and NADD<65), TRICARE Standard/Extra beneficiaries, and the NADD>65 population through enrollment in the TRICARE Plus program. It should be pointed out again in this study that it is assumed most beneficiaries electing TRICARE Standard/Extra, for whatever reason, will continue to do so. They are not considered in any recapturing calculations. The next two tables depict recapturing capacity. Table 9 calculates recapturing all Civilian Prime Network beneficiaries into NHP TRICARE Prime before enrolling TRICARE Plus. Table 10 calculates recapturing ADD Civilian Prime Network
and TRICARE Plus beneficiaries. It assumes NADD<65 beneficiaries will remain in the Civilian Prime Network since they are not required to enroll at the MTF.

Table 9
TRICARE Plus Capacity Scenario One

<table>
<thead>
<tr>
<th>Clinic/PCM</th>
<th>Current Avail Visits Unfilled</th>
<th>Civ Prime Visits for Recapture</th>
<th>Civ Prime Visits for Recapture (adjusted)</th>
<th>Avail Appts for TP</th>
<th>80% Avail Appts for TP</th>
<th>Avail TP Visits for Recapture</th>
<th>Avail TP Visits for Recapture (adjusted)</th>
<th>Avail TP Visits over 80% capacity</th>
<th>Clinic Capacity after Recapture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Appts</td>
<td>35,877</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>71155</td>
<td>68963</td>
<td>6532</td>
<td>100%</td>
</tr>
<tr>
<td>FP</td>
<td>32,660</td>
<td>28,535</td>
<td>26,128</td>
<td>6532</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM</td>
<td>6241</td>
<td>2,801</td>
<td>3440</td>
<td>2192</td>
<td>2192</td>
<td>1248</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peds</td>
<td>6948</td>
<td>7342</td>
<td>6948</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHP Total</td>
<td>45,849</td>
<td>35,877</td>
<td>35,877</td>
<td>9,972</td>
<td>2,192</td>
<td>2,192</td>
<td>7,780</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Note: TP Visits = 10464 Medicare Eligibles multiplied by 6.8 (average number of annual visits by Medicare recipient in the state of Florida)

Table 10
TRICARE Plus Capacity Scenario Two

<table>
<thead>
<tr>
<th>Clinic/PCM</th>
<th>Current Avail Visits Unfilled</th>
<th>80% Avail Visits Unfilled</th>
<th>Civ Prime Visits for Recapture</th>
<th>80% Avail Appts for TP</th>
<th>Avail TP Visits for Recapture</th>
<th>Avail TP Visits over 80% capacity</th>
<th>Clinic Capacity after Recapture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Appts</td>
<td>36,679</td>
<td>30,369</td>
<td>15,480</td>
<td>21,199</td>
<td>20,655</td>
<td>7,780</td>
<td>96%</td>
</tr>
<tr>
<td>FP</td>
<td>32,660</td>
<td>26,128</td>
<td>15,480</td>
<td>22194</td>
<td>15662</td>
<td>6532</td>
<td>100%</td>
</tr>
<tr>
<td>IM</td>
<td>6241</td>
<td>0</td>
<td>6241</td>
<td>4993</td>
<td>4993</td>
<td>1248</td>
<td>100%</td>
</tr>
<tr>
<td>Peds a</td>
<td>6948</td>
<td>5015</td>
<td>1933</td>
<td>544</td>
<td></td>
<td></td>
<td>72%</td>
</tr>
<tr>
<td>NHP Total</td>
<td>45,849</td>
<td>36,679</td>
<td>15,480</td>
<td>30,369</td>
<td>20,655</td>
<td>7,780</td>
<td></td>
</tr>
<tr>
<td>TP Enrollment Capacity</td>
<td>80 pct</td>
<td>3,038</td>
<td>100 pct</td>
<td>4182</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Civilian Prime Visits = 4553 enrollees multiplied by 3.4 (average number of annual visits per enrollee)
Note: TP Visits = 10464 Medicare Eligibles multiplied by 6.8 (average number of annual visits by Medicare recipient in the state of Florida

a Estimated figure as a percentage of total enrolled population based on current NHP enrollment figures
The ability for NHP to open enrollment in TRICARE Plus for NADD>65 exist. Tables 9 and 10 suggest TRICARE Plus additional enrollment could range between 300 and 4200 depending on NHP’s strategy on recapturing enrollees. Table 11 and 12 are cost benefit analyses of increasing enrollment. Graphical presentation of tables 11 and 12 showing estimated MTF Costs, Network Costs, and TFL costs are presented in Appendix A and B. Annual cost avoidance for the MHS would be over $2.25 million. Cost savings, based on reimbursement for recapturing TRICARE PLUS visits, for NHP could be as high as $100 thousand annually. Figure 1 illustrates total cost savings of increasing enrollment based on scenarios one and two. In Table 12, there is a surplus of pediatric visits after recapturing all ADD Civilian Prime Network beneficiaries because it is assumed that TRICARE Plus will enroll mainly NADD>65. Therefore, no available pediatric visits were associated with TRICARE Plus enrollees.

Table 11
Total Cost based on projected enrollment maximizing total CPN Recapture

<table>
<thead>
<tr>
<th>Primary Care Visits</th>
<th>Increased MTF Visits</th>
<th>CPN Visits</th>
<th>TP Visits</th>
<th>TFL Visits</th>
<th>Total Visits</th>
<th>Total Care Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current (FY01)</td>
<td>N/A</td>
<td>35877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$23,753,608</td>
</tr>
<tr>
<td></td>
<td>10000</td>
<td>25,877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$22,653,608</td>
</tr>
<tr>
<td></td>
<td>15000</td>
<td>20,877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$22,103,608</td>
</tr>
<tr>
<td></td>
<td>20000</td>
<td>15,877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$21,553,608</td>
</tr>
<tr>
<td></td>
<td>25000</td>
<td>10,877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$21,003,608</td>
</tr>
<tr>
<td></td>
<td>30000</td>
<td>5,877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$20,453,608</td>
</tr>
<tr>
<td></td>
<td>35000</td>
<td>877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$19,903,608</td>
</tr>
<tr>
<td>80% Capacity</td>
<td>38069</td>
<td>0</td>
<td>2,192</td>
<td>68963</td>
<td>107032</td>
<td>$19,751,461</td>
</tr>
<tr>
<td></td>
<td>40000</td>
<td>0</td>
<td>4,123</td>
<td>67032</td>
<td>107032</td>
<td>$19,702,414</td>
</tr>
<tr>
<td></td>
<td>45000</td>
<td>0</td>
<td>9,123</td>
<td>62032</td>
<td>107032</td>
<td>$19,575,414</td>
</tr>
<tr>
<td>100% Capacity</td>
<td>45849</td>
<td>0</td>
<td>9,972</td>
<td>61183</td>
<td>107032</td>
<td>$19,553,849</td>
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<tr>
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<td>50000</td>
<td>0</td>
<td>14,123</td>
<td>57032</td>
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<td>$19,823,414</td>
</tr>
<tr>
<td></td>
<td>107032</td>
<td>0</td>
<td>71,155</td>
<td>0</td>
<td>107032</td>
<td>$22,499,801</td>
</tr>
</tbody>
</table>

*a Non-referral visits only
*b Does not include the NADD>65 beneficiaries currently enrolled
<table>
<thead>
<tr>
<th>Primary Care Visits</th>
<th>Increased MTF Visits</th>
<th>CPN Visits (^{a})</th>
<th>TP Visits (^{b})</th>
<th>TFL Visits (^{b})</th>
<th>Total Visits</th>
<th>Total Care Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current (FY01)</td>
<td>N/A</td>
<td>35877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$23,753,608</td>
</tr>
<tr>
<td>10000</td>
<td>25,877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$22,653,608</td>
<td></td>
</tr>
<tr>
<td>15000</td>
<td>20,877</td>
<td>0</td>
<td>71155</td>
<td>107032</td>
<td>$22,103,608</td>
<td></td>
</tr>
<tr>
<td>20000</td>
<td>20,397</td>
<td>4,520</td>
<td>66635</td>
<td>107032</td>
<td>$21,936,000</td>
<td></td>
</tr>
<tr>
<td>25000</td>
<td>20,397</td>
<td>9,520</td>
<td>61635</td>
<td>107032</td>
<td>$21,809,001</td>
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</tr>
<tr>
<td>30000</td>
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<td>14,520</td>
<td>56635</td>
<td>107032</td>
<td>$21,682,000</td>
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<td>20,397</td>
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<td>51635</td>
<td>107032</td>
<td>$21,555,000</td>
<td></td>
</tr>
<tr>
<td>40000</td>
<td>20,397</td>
<td>24,520</td>
<td>46635</td>
<td>107032</td>
<td>$21,428,000</td>
<td></td>
</tr>
<tr>
<td>45000</td>
<td>20,397</td>
<td>29,520</td>
<td>41635</td>
<td>107032</td>
<td>$21,376,000</td>
<td></td>
</tr>
<tr>
<td>50000</td>
<td>20,397</td>
<td>34,520</td>
<td>36635</td>
<td>107032</td>
<td>$21,624,000</td>
<td></td>
</tr>
<tr>
<td>86635</td>
<td>20,397</td>
<td>71,155</td>
<td>0</td>
<td>107032</td>
<td>$23,443,471</td>
<td></td>
</tr>
</tbody>
</table>

\(^{a}\) Non-referral visits only

\(^{b}\) Does not include the NADD >65 beneficiaries currently enrolled
Figure 1. MHS and NHP total cost savings based on enrollment capacity and scenario.
Discussion

As demonstrated in the results, secondary questions had to be answered prior to determining whether capacity for TRICARE Plus existed at NHP and at what cost impact TRICARE Plus would have. These questions included; finding out total capacity, where capacity existed, and the total current cost.

Total capacity was achieved through self-reported provider availability input compared to actual FY01 primary care visits. This calculation verified that unused capacity existed. Next, the number of visits available in each primary clinic was calculated. Calculating capacity based on visits instead of percentage of enrollment is vital because potential enrollees have a significant different usage pattern than those currently enrolled. For example, NADD>65 currently enrolled to the Family Practice clinic have an average of 4.11 visits per year whereas the Medicare recipients in Florida average 6.8 visits per year. Knowing the capacity levels in each clinic is a key ingredient in the strategy to increase enrollment. Another key ingredient is the cost of delivering healthcare.

The average, current cost of a NHP primary care visit is slightly less than $91. The average government cost of a TRICARE approved visit to a civilian provider is $111. The estimated cost share for a TFL visit is $31.40. Table 13 depicts projected costs based on increasing visits at the NHP. Network costs are eliminated after 35,877 visits are recaptured. TFL costs are eliminated after 107,032 visits are recaptured.
Table 13

Total Cost based on projected enrollment

<table>
<thead>
<tr>
<th>PC Visits</th>
<th>Increased MTF Visits</th>
<th>MTF Fixed Costs</th>
<th>MTF Variable Costs</th>
<th>MTF Total Costs</th>
<th>Network Costs</th>
<th>TFL Costs</th>
<th>Total Care Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY01</td>
<td>N/A</td>
<td>$16,224,000</td>
<td>$1,133,609</td>
<td>$17,357,609.00</td>
<td>$4,161,732</td>
<td>$2,234,273</td>
<td>$23,753,614</td>
</tr>
<tr>
<td>20000</td>
<td>$16,224,000</td>
<td>$1,253,609</td>
<td>$17,477,609.00</td>
<td>$1,841,732</td>
<td>$2,234,267</td>
<td>$21,553,608</td>
<td></td>
</tr>
<tr>
<td>30000</td>
<td>$16,224,000</td>
<td>$1,313,609</td>
<td>$17,537,609.00</td>
<td>$681,732</td>
<td>$2,234,267</td>
<td>$20,453,608</td>
<td></td>
</tr>
<tr>
<td>40000</td>
<td>$16,224,000</td>
<td>$1,373,609</td>
<td>$17,597,609.00</td>
<td>$0</td>
<td>$2,104,805</td>
<td>$19,702,414</td>
<td></td>
</tr>
<tr>
<td>100% Cap</td>
<td>45849</td>
<td>$16,224,000</td>
<td>$1,408,703</td>
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Conclusions and Recommendations

Capacity management can become more efficient by increasing enrollment at NHP and can result in cost savings for NHP and the MHS. Maximizing capacity would drive the average cost of a primary care visit down to $43.50 at NHP. While current cost per visit is 22 percent less than the average cost of a civilian provider visit, maximizing capacity results in a 155 percent savings. However, current unused capacity (45,849 visits) limits the number of potential enrollees that can be recaptured. Three sources exist for increased enrollment: ADD and NADD<65 Prime enrollees in the Civilian Prime Network, TRICARE Standard/Extra beneficiaries, and the Medicare eligible population through enrollment in TRICARE Plus.

The most cost effective approach for the MHS is to recapture all Civilian Prime Network enrollees. However, current NHP policy does not require any network enrollee to abandon their current patient/provider relationship in favor of enrolling in NHP TRICARE Prime. New Tricare Prime enrollees have been required to enroll at NHP since February 2002. In a three to four-year period, this should attrite most ADD beneficiaries from the Civilian Prime Network. Under
current policy, NADD<65 enrolled in the Civilian Prime Network will continue to do so until they relocate outside NHP catchment area, disenroll from TRICARE Prime, or elect to abandon their current provider relationship in favor of NHP’s TRICARE Prime option. Although it is possible to recapture over 11,000 beneficiaries from the Civilian Prime Network, it is the conclusion of this author that only the ADD will be recaptured. Heavy marketing efforts may attract some NADD<65 enrollees, but without requiring formal conversion, few will abandon their current healthcare relationships.

TRICARE Standard/Extra beneficiaries are the second most cost effective approach to increase enrollment. However, this population has already chosen not to enroll in TRICARE Prime, including the Civilian Prime Network, for whatever reason. It is the conclusion of the author that few, if any of these beneficiaries will enroll in TRICARE Prime unless drastic changes in benefits (perceived care, copays, etc.) occur, which are not expected in the near term.

Medicare eligibles may not be the most cost effective approach, but they are cost effective up until capacity is achieved. Also, they are probably the most attractive population to market. In many cases, they are eager to receive their care at a MTF where they already get their medications. In essence, “a one-stop shop.” Arguably, they could be considered the MTF’s most loyal customer. Additionally, MTFs that attract NADD>65 care to their facility may gain increased funding from the “accrual fund”, a fund set up to pay for NADD>65 care beginning in fiscal year 2003 (FY03). The dilemma in attracting Medicare eligibles back into the MTF is that now their care with a civilian provider is essentially free so long as they pay Medicare Part B premiums. Also, this population was forced out of the MTFs when they turned age 65. Recruiting them back may prove difficult. However, this population may still be the second best source for increasing enrollment outside the ADD population.
Two courses of action are depicted in Tables 11 and 12 in the results section of this paper. Although there are two other courses of action, they are without merit. The first would be maintaining the status quo, which is not efficient or effective as it pertains to capacity or cost. The second, eliminating staff to meet efficiencies, is not viable in a market that has a demonstrated need for services and an operational commitment for the active duty staff.

Of the two viable options, the first scenario would recapture all Prime beneficiaries currently enrolled in the Civilian Prime Network before increasing any TRICARE Plus enrollment. The second scenario looks at increasing TRICARE Plus enrollment based on projected numbers of ADD beneficiaries being recaptured from the Civilian Prime Network. The second scenario does not forecast any NADD<65 enrollees coming back into NHP’s TRICARE Prime. Neither scenario directs efforts to recapture TRICARE Standard/Extra beneficiaries because it is concluded that they are the hardest population to attract and the least likely to enroll.

The second option is the recommended approach for NHP for two primary reasons. First, it attracts the most marketable populations, ADD and NADD>65. Secondly, as both scenarios produce significant savings for the MHS, only the second scenario has the potential to produce actual cost savings for NHP through estimated reimbursements from the NADD>65 accrual fund. At 80 percent capacity, the second scenario will increase TRICARE Prime enrollment by over 4500 and TRICARE Plus enrollment by at least 3000 from December 2001 levels. TRICARE Plus enrollment could increase an additionally 1100 if maximum capacity was considered. At 80 percent capacity, the increased enrollment will result in annual savings of $90 thousand and $2.25 million for NHP and the MHS respectively.
Appendix A

Figure A1. Estimated NHP Catchment Area Healthcare Costs with 100% CPN Recapture.
Appendix B

Figure B1. Estimated NHP Catchment Area Healthcare Costs with ADD CPN Recapture Only.

![Cost of NHP Area Healthcare](image-url)
Appendix C

Alphabetical List of Key Acronyms Included in this Paper

AD      Active Duty Service Member
ADD     Active Duty Dependent
Bencat  Beneficiary Category
ADFM    Active Duty Family Member
CDR     Commander, United States Navy
CHAMPUS Civilian Health and Medical Plan of the Uniformed Services
CHCS    Composite Healthcare System
CPN     Civilian TRICARE Prime Network
CY      Calendar Year (Jan – Dec)
DAA     Defense Authorization Act
DoD     Department of Defense
FY      Fiscal Year (Oct – Sep)
GME     Graduate Medical Education
HMO     Health Maintenance Organization
LCM     Lieutenent Commander, United States Navy
MAJ     Major, United States Army
MEPRS   Military Expense Performance Reporting System
MHS     Military Health System
MTF     Military Treatment Facility (Hospital)
NADD<65 Non-Active Duty Beneficiary under the age of 65
NADD>65 Non-Active Duty Beneficiary over the age of 65 (Medicare Eligibles)
NHP     Naval Hospital Pensacola
NMOP    National Mail Order Pharmacy
NP      Nurse Practitioner
PA      Physician Assistant
PC      Primary Care
PCM     Primary Care Manager
PPO     Preferred Provider Organization
TP      TRICARE Plus
TFL     TRICARE for Life
References


