

MILITARY GROWTH TASK FORCE



HEALTH AND SOCIAL
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Introduction

The Military Growth Task Force (MGTF) of North Carolina's Eastern Region completed a Regional Growth Management Plan (RGMP) in October 2009, which included a thorough assessment of the health care and social services needs in the seven county MGTF region. Some of the greatest issues raised in the RGMP included physician and other clinical professional shortages, insufficient behavioral health services and low TRICARE reimbursement levels. Members of the Health Planning Source, Inc. (HPS) and MGTF teams met with local health care stakeholders in March, 2010 to discuss many of these issues. As a result, the following eleven priority issues were established for study by HPS:

- I. TRICARE Management Authority's TRICARE Prime Service Areas
- II. Lack of TRICARE Reimbursement for Mental Health Services
- III. Limited Coordination between Community and Military Providers
- IV. The Impact of the Downgrade of Naval Hospital Cherry Point on Obstetrics and Emergency Services at Local Hospitals
- V. The Impact of Potential Medicare Payment Reductions on Regional Health Care Providers
- VI. The Impact of Health Reform on Regional Health Care Providers
- VII. Regional Reliance on Government Payors
- VIII. Reimbursement Differences for Mid-Level Providers
- IX. Recession's Impact on TRICARE Participation
- X. Health Care Provider Demand
- XI. The Impact of Aging Physicians in the MGTF Region

Each of these issues and the resulting needs are discussed in turn below.

I. TRICARE Management Activity's TRICARE Prime Service Areas

Earlier this year, the Military Growth Task Force learned that Health Net Federal Services (Health Net) determines the need for the number of TRICARE network providers for North Carolina's Eastern Region based on the number of providers available in a given TRICARE Prime Service Area. TRICARE Prime Service Areas (PSAs) are geographic markets near Military Treatment Facilities (MTFs) where regional contractors have established TRICARE Prime networks. In general, a PSA is defined as a 40 mile radius around a designated point of reference, such as an MTF. There are three designated PSAs in North Carolina's Eastern Region: one around each of the two military bases (MCB Camp Lejeune and MCAS Cherry Point) and one centered in Wilmington. These PSAs were developed by Health Net and approved by the TRICARE Management Activity¹ (TMA) in 2004.

¹ The TRICARE Management Activity (TMA) is a field activity of the Undersecretary of Defense for Personnel and Readiness. TMA partners with regional contractors, such as Health Net, to provide health care services and support to TRICARE beneficiaries.

Based on information received regarding the relationship between physician recruitment and these regions, there was concern that the PSAs in North Carolina's Eastern Region were too large to identify physician needs in many of the region's major population centers. As a result, Health Net was apparently not placing sufficient focus on physician recruitment in those population centers. In particular, it seemed that even if there were enough TRICARE physicians to meet the needs for all military families living within a PSA, there may not be enough physicians in particular population centers to ensure that Health Net could meet TRICARE Prime access standards for many military families in North Carolina's Eastern Region. Access standards state that under normal circumstances TRICARE Prime beneficiaries should have no more than a 30-minute drive to a primary care manager for routine care, and no more than an hour's drive for specialty care. In portions of the MGTf region, one cannot travel between one and 40 miles in 30 minutes. As such, the MGTf felt there was a need to develop/define more reasonable PSAs based on the population centers in the region. However, as outlined below, it has been determined that the relationship between recruitment and the PSAs was overstated, and that there is no need to convert the PSAs into service areas surrounding the population centers in the region.

Health Net's contract with the Department of Defense requires that a network of civilian providers exists to complement the capabilities and capacity of the local MTFs. Health Net also works to ensure that the civilian network is large enough to handle contingency plans, such as MTF staff deployments. For example, Health Net ensured adequate civilian resources when Cherry Point lost its inpatient capabilities during the 2005 BRAC cycle by adding Carteret General Hospital to the TRICARE network. Further, although the PSAs provide a geographic template for the recruitment of physicians into the TRICARE network, Health Net has stated that the PSAs are not the sole determinative factor regarding recruitment. Primarily, Health Net is focused on developing a network of physicians and mid-level providers to adequately support the local MTFs. As such, if an MTF notifies Health Net that it currently has, or expects to have, a shortage of a particular specialty, Health Net begins the process of recruiting community physicians into the TRICARE Network. Although the PSA provides a guide for recruitment, Health Net is not limited to recruiting physicians in the PSA. Ultimately, it is Health Net's goal to build a stable network of civilian providers that complement MTF capabilities in each PSA thereby providing TRICARE beneficiaries with a cost-effective, quality health care plan.

Health Net's contract with the government does not require recruitment of physicians and mid-level providers to locate their practices in a particular region. However, Health Net has encouraged providers to relocate to areas when unmet needs are identified. For example, Health Net worked diligently over several years to bring The May Institute, a nationally recognized provider of Applied Behavioral Analysis Services, to the Camp Lejeune community to ensure service availability to autistic dependents. However, the primary responsibility for recruiting physicians and mid-level providers to the community ostensibly remains in the hands of community hospitals and physician practices. Once physicians locate to the region, Health Net then attempts to recruit these physicians to participate in the TRICARE network.

Need 1: Review physician density to population density ratios

There does not appear to be a need to convert the TRICARE PSAs into service areas surrounding major population centers in the region as Health Net recruitment in the region is not solely determined by the PSAs. However, the MGTf expects to have population estimates by zip code

in the near future. At that time HPS will monitor the physician density in high military population areas to determine if local physician needs are being met for military families. Upon identification of any shortage areas, HPS will work with Health Net to determine the best course of action to address those needs.

Benefits if Need is Satisfied

It is important that military families have access to in-network TRICARE services in a timely manner and within close proximity to their homes. Deployment readiness includes the good health of active duty service members and their families. As such, the availability of physician services is essential to the missions of MCB Camp Lejeune and MCAS Cherry Point.

Effects if Need Not Satisfied

Health Net officials currently believe that there is a sufficient supply of TRICARE network providers in the MGTf region to support the needs of the local MTFs. However, without a more thorough review of the locations of these providers relative to the military population, some military families may be experiencing geographic barriers to accessing physician services. Although these families will still be able to access services regionally, there may be more convenient options. Additional study of physician to population density is expected to inform Health Net of any shortage areas.

Next Steps

HPS will work with the MGTf to obtain population data by zip code and continue to refine existing physician supply data. Please see Section X for a complete discussion of existing physician needs by county.

II. Lack of TRICARE Reimbursement for Mental Health Services

The behavioral health needs of military families continue to increase as deployments continue. In 2007, a survey of soldiers and Marines confirmed what many suspected: the mental health of service members worsens as deployments lengthen and increase in frequency. In May 2010, the Pentagon announced that mental health disorders caused more hospitalizations among U.S. troops in 2009 than any other condition. In North Carolina's Eastern Region, regional providers report that Marines are experiencing higher rates of mental health and substance abuse disorders as deployments increase. Mental health providers also indicate that families at home are under greater stress as deployments increase; as a result, spouses and dependents are seeking services at higher rates.

The Department of Defense has recognized that Operations Enduring and Iraqi Freedom have and will continue to result in increasing behavioral health needs for service members and their families. However, DoD resources cannot fully meet the needs of military families for several reasons. First, the current needs of active duty service members and their families are simply greater than the capacity of most DoD facilities, such as Naval Hospital Camp Lejeune and Naval Health Clinic Cherry Point. In August 2010, the Associated Press featured MCB Camp Lejeune in an article titled *Marines pour resources into mental health care*, which highlighted the tremendous growth in the demand for mental health care and the need to increase the

resources available for mental health services. (See Appendix 1) As a result of growth in demand, some Marines and many family members must be referred to community providers, particularly for longer term care. In addition to demand for existing services outpacing capacity at local MTFs, neither Naval Hospital Camp Lejeune nor Naval Health Clinic Cherry Point currently provides child and adolescent behavioral health services.² Therefore, clients must be referred to the community. Further, some Marines and family members continue to prefer seeking services off base. For many, off base services ensure greater privacy; for others it is simply a matter of convenience. Regardless, community behavioral health providers remain an essential component of the behavioral health system for military families.

Unfortunately, TRICARE does not currently pay for a range of behavioral health services provided in the community. TRICARE will cover a set number of psychotherapy sessions, six hours of psychological testing a year, medication management, 60 days in a psychiatric partial hospitalization program, 150 days in a residential treatment center for patients under 21 years of age and a limited number of substance abuse services. (Please see the flyer in Appendix 2 for the specific behavioral health services covered by TRICARE.) Each of these services is reimbursed based on specific procedure codes. Although these services are part of a successful continuum of behavioral health services, they do not cover the full spectrum of behavioral health services available in North Carolina.

In North Carolina Local Management Entities (LMEs) are responsible for managing, coordinating, facilitating and monitoring the provision of mental health, developmental disabilities and substance abuse services (MH/DD/SA) in their catchment areas. This includes ensuring clients' access to services 24/7/365, development and oversight of providers, and management of consumer complaints and grievances. The MGTf region is primarily served by Onslow-Carteret Behavioral Healthcare Services (Onslow and Carteret Counties) and East Carolina Behavioral Health (Craven, Pamlico, Jones).³ LMEs can help connect consumers, including military families, to medication management and psychotherapy resources. However, LMEs also receive funding from the state to provide enhanced benefit services to local beneficiaries. These services are not reimbursed by procedure, but rather through a bundled payment system for a continuum of services or a set of procedures. Services are designed to be preventive, diagnostic, therapeutic and rehabilitative. Many of these services are evidence based practices. In the mental health field, evidence-based practices are specific clinical interventions or services that produce benefits to consumers and their quality of life (e.g., employment, reduced hospitalization, etc.), as established by several clinical studies. Unfortunately, TRICARE does not pay for many of these enhanced benefit services.⁴ Due to the lack of TRICARE coverage, the LMEs provide those services to military families using state funds. Given that state funding is rapidly declining for mental health services, there is a need for TRICARE to cover a larger portion of the costs for its beneficiaries.

The lack of reimbursement for Mobile Crisis Management is particularly concerning. If a military service member or family member reaches out to the LME in crisis, TRICARE will only reimburse providers for an initial assessment by a licensed provider. TRICARE will not cover the costs of an

² Please note some counseling services are available through Marine and Family Services.

³ Eastpointe LME covers Duplin County and Southeastern Center for MH/DD/SAS covers Pender County.

⁴ Please see Table 1 for a complete listing of services not covered by TRICARE as indicated by Onslow Carteret Behavioral Healthcare Services.

evaluation by an evaluator, stabilizing the client or connecting them with a provider for longer term treatment. Many crisis clients are willing to pay out of pocket to receive critical services; however, the LMEs are obligated to report any active duty service member accessing crisis services to their commanding officer and cannot immediately provide services for active duty service members if they are not suicidal or homicidal. As such, a portion of the service members accessing services are not actually utilizing them for fear of repercussions. Further, many crisis clients do not comply with their prescribed follow up care because of the absence of TRICARE payment for those services. As such, those clients are more likely to relapse and need crisis services in the future.

The lack of reimbursement for child and adolescents also is of great concern. Given the limited child and adolescent behavioral health resources on base, and the convenience of receiving care in the community for many families, there is a need for TRICARE funding. Most military families must receive extensive financial counseling to ensure that their services are covered. For example, for residential and intensive in home care, families must have both TRICARE and Medicaid to receive full financial coverage for treatment. This places an additional burden on families who are already experiencing difficulty with children in crisis. There is a need for DoD funding to support their ability to receive these beneficial and needed services.

Finally, Onslow County providers report recent growth in referrals from Naval Hospital Camp Lejeune to complete neurological testing for Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD). However, TRICARE will not authorize active duty service members to return to the community provider for result reporting and follow up care. Instead, Naval Hospital clinicians prefer to interpret tests completed by community providers. This arrangement is troubling for community providers who prefer to interpret their own studies and follow up with patients appropriately.

Table 1
Behavioral Health Services Not Covered by TRICARE

<i>Service</i>	<i>Definition</i>
Mobile Crisis Management	Involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities.
Intensive In-Home Services	A time-limited, intensive child and family intervention based on the clinical needs of the youth (defined as less than 20) intended to: <ul style="list-style-type: none"> • Reduce presenting psychiatric or substance abuse symptoms, • Provide first responder intervention to diffuse current crisis, • Ensure linkage to community services and resources, and • Prevent out of home placement for the child/adolescent.
Multisystemic Therapy	Services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community.
Community Support Team	An intensive community-based rehabilitation team service for adults (defined as over 18) that provides direct treatment and restorative interventions as well as case management designed to: <ul style="list-style-type: none"> • Reduce presenting psychiatric or substance abuse symptoms and promote symptom stability, • Restore the recipient’s community living and interpersonal skills, • Provide first responder intervention to deescalate the current crisis, and • Ensure linkage to community services and resources.
Assertive Community Treatment Team	Service targeted to the 10% of MH/DD/SA service recipients who have serious and persistent mental illness or co-occurring disorders, dual and triply diagnosed and the most complex and expensive treatment needs. ACTT is provided by an interdisciplinary team that ensured service availability 24/7 and is prepared to carry out a full range of treatment functions wherever and whenever needed.

Psychosocial Rehabilitation	Focuses on skill and resource development related to life in the community and to increasing the participant's ability to live as independently as possible, to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational and vocational goals.
Child and Adolescent Day Treatment	Day Treatment is a structured treatment service in a licensed facility for children or adolescents and their families that builds on strengths and addresses identified needs. Interventions are designed to reduce symptoms, improve behavioral functioning, increase the individual's ability to cope with and relate to others, promote recovery, and enhance the child's capacity to function in an educational setting, or to be maintained in community based services.
Partial Hospitalization	Partial Hospitalization is a short-term service for acutely mentally ill children or adults, which provides a broad range of intensive therapeutic approaches which may include: group activities/therapy, individual therapy, recreational therapy, community living skills/training, increases the individual's ability to relate to others and to function appropriately, coping skills, medical services. This service is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility.
Professional Treatment Services in Facility-Based Crisis Program	A 24-hour residential facility with 16 beds or less that provides support and crisis services in a community setting.
Substance Abuse Intensive Outpatient Program	A structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent consumers to begin recovery and learn skills for recovery maintenance.
Substance Abuse Comprehensive Outpatient Treatment Program	A periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery.
Substance Abuse Non-Medical Community Residential Treatment	A 24-hour residential recovery program professionally supervised residential facility that provides trained staff who work intensively with adults with substance abuse disorders who provide or have the potential to provide primary care for their minor children.

Substance Abuse Medically Monitored Community Residential Treatment	A non-hospital twenty-four hour rehabilitation facility for adults, with twenty-four hour a day medical/nursing monitoring, where a planned program of professional directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems and/or addiction occurs.
Substance Abuse Halfway House	Clinically managed low intensity residential services are provided in a 24 hour facility where the primary purpose of these services is the rehabilitation of individuals who have a substance abuse disorder and who require supervision when in the residence.
Ambulatory Detoxification	An organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule.
Social Setting Detoxification	An organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for patients who are intoxicated or experiencing withdrawal symptoms sufficiently severe to require 240hour structure and support.
Non-Hospital Medical Detoxification	An organized service delivered by medical and nursing professionals, that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less.
Medically Supervised or ADATC Detoxification/Crisis Stabilization	An organized service delivered by medical and nursing professionals that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds.
Outpatient Opioid Treatment	A service designed to offer the individual an opportunity to effect constructive changes in his lifestyle by using methadone or other drug approved by the FDA for the treatment of opiate addiction in conjunction with the provision of rehabilitation and medical services.

There are a plethora of comprehensive behavioral health services available to North Carolina residents, including those serving in the military and their dependents. However, the lack of TRICARE reimbursement for these services places a strain on the State's already limited behavioral health budget. In general, the current payment system reinforces the beliefs of many active duty military service members and their families: Marines, soldiers and airmen report that they often feel like their needs are not addressed when seeking behavioral health services given the paucity of providers in the market. TRICARE funding of comprehensive behavioral health benefits offered in the region (via LMEs or other mechanisms) would greatly improve the care provided to military families.

Need 2: Seek TRICARE funding for comprehensive behavioral health services

The comprehensive behavioral health services provided in North Carolina have been proven to be effective interventions for persons facing behavioral health issues, particularly those with the most severe and persistent diagnoses. However, these services are currently not covered by TRICARE. There is a critical need to provide funding for these services in order to better serve active duty military, active duty military families, retirees and TRICARE eligible retiree families.

TRICARE allows individuals and organizations to propose changes to the current reimbursement schedule. With the assistance of the regional LMEs, the MGTf should pursue an appeal process to ensure coverage of needed services, beginning with crisis management services. Additional services should be appealed following the success of an initial appeal.

Benefits if Need is Satisfied

The improvement of mental health services in any given region offers great benefits for the community. When a community's mental health improves, it often results in greater workforce productivity and a reduction in the burden on social services and acute care systems. As service members return from abroad, providing the appropriate mental health services will allow them to return to work faster and at higher levels of productivity. In addition, creating a system with multiple, client-friendly access points allows persons to seek psychiatric treatment without significant disruptions in their work and personal lives. Growth in the number of providers, coupled with improved crisis services will reduce the number of psychiatric patients being treated in local emergency departments. This is a more appropriate model of care for these clients, and will relieve the pressure on local hospitals which function as providers of last resort. Given the nature of military jobs and communities, increasing access to mental health services will have a significant beneficial impact on the members of the military and their families located in the MGTf region.

Effects if Need Not Satisfied

The lack of coverage for TRICARE beneficiaries ultimately results in reduced access to mental health services with proven benefits. Each of the enhanced benefit services funded by the state of North Carolina is designed to be preventive, diagnostic, therapeutic and rehabilitative. In addition, these services are intended to reduce long term psychiatric hospitalizations and promote care options in the community. The use of comprehensive community interventions

represents a more cost effective model for all health care providers in the region, in addition to offering clients more efficacious and effective care. Perpetuating a system of last resort drives costs of services up and is the least optimal care model. Further, members of the military and their families are under increasing stress as deployments continue. It is essential that support for these persons be in place, as the need for behavioral health services will continue to increase. Moreover, given the availability of these much-needed services in the community to civilians, military families should not face barriers to accessing these services due to lack of TRICARE coverage. Not only is it the right thing to do for those serving our country and our communities, it is the most cost-effective and clinically appropriate option for meeting the behavioral health needs of the community.

Next Steps

HPS will work with the MGTf and regional providers to determine interest in initiating an appeal process with TRICARE and establish a timeline for completion of that appeal.

III. Limited Coordination between Community and Military Providers

Coordination and communication between military and community providers continues to be a major concern in the region, particularly in Onslow, Craven and Carteret counties which are closest to the region's MTFs. MTFs are the cornerstone of the military health system and are essential to maintaining a deployment ready military. However, neither Naval Hospital Camp Lejeune nor Naval Health Clinic Cherry Point have the capacity to serve the entire beneficiary population, including active duty service members, active duty family members, retirees and eligible retiree family members. As such, the MTFs depend on the community to complement, if not support, their needs. Naval Hospital Camp Lejeune officials estimate that approximately 70 percent of the non-active duty beneficiary needs are met by community providers. In addition, providers in the region have reported that up to 35 percent⁵ of total patient volume is vulnerable to fluctuation based on the number of referrals received from Health Net.⁶ Despite this significant relationship between military and civilian providers, both groups report that communication and coordination is not sufficient at this time, resulting in less than optimal service for regional military families.

The majority of community providers in the region consider it an honor and a patriotic duty to serve military families. However, both the hospitals and physicians in the region report that the military often places an undue burden on practices simply due to lack of communication and the inability to appropriately plan for the military's needs. Regional physicians understand that there are many reasons that the MTFs send referrals to the community, some of which are unplanned. However, MTFs can improve the referral process to community providers if better

⁵ Source: HPS Physician and Practice Manager Survey. Survey respondents were asked: "During a given year, what percentage of your total volume (rough estimate) is vulnerable to fluctuations in the levels of military personnel (i.e. patient volumes decrease 15% during time of significant deployment)?" Responses ranged from zero to 35 percent.

⁶ If a physician appointment is not available for a specialty service at an MTF, a referral is forwarded to the regional TRICARE Managed Care Support Contractor, Health Net. Upon receiving a referral, Health Net provides the beneficiary with the name, number, and authorization for care with a PRIME network provider in the civilian community.

planned in advance. In particular, planned physician deployments and transfers, planned increases in the base population and planned changes in MTF service offerings often have a significant impact on the number of referrals to community physicians and hospitals. However, the majority of physicians in the region report receiving no communication from the bases regarding expected changes in the services at MTFs and resulting referrals. One regional practice reported that the only advance notice it receives is when patients share knowledge of changes at the MTFs. This lack of communication is embedded in the military health system culture and breeds unnecessary ill-will within the community. Without advance knowledge as to when referral patterns might change, providers often spend resources to hire new staff or increase capacity. When that volume is pulled back to the MTF, providers are left with increased capacity and not enough patients to justify expenditures.

In addition, physicians report an inability to follow-up with many of their TRICARE patients. In particular, referrals from primary care physicians (internal medicine, family medicine, OB/GYN, pediatrics) to specialty care physicians must go through Health Net. In some cases, these referrals are made to specialty providers at the MTF, rather than community providers. Community providers report that they rarely receive follow-up reports for care rendered unless patients schedule another appointment at their offices. Sending follow up reports is common practice among community providers and, as such, this represents a significant change in practice patterns for community physicians. Further, the lack of physician follow-up results in concerns that patients will be less compliant with recommended treatments.

Working with the MTFs also presents compliance and quality challenges for community providers. For example, the Centers for Medicare and Medicaid Services (CMS) incentivizes community physicians to use electronic prescribing. However, the MTFs, specifically the pharmacy at MCB Camp Lejeune, require paper prescriptions. This represents a significant change in practice patterns for community physicians and results in quality control issues. Further, given that DoD and CMS are both government agencies, there appears to be a need to better align federal policies. Another challenge relates to the method of physician referrals. Historically, physicians were able to make referrals for TRICARE patients online, which improved the efficiency of making referrals. After ongoing technical problems with the electronic referral system that caused a loss of data, physicians abandoned the system. Although physicians continue to make referrals by conventional means, which are not as prone to technological difficulties, most would prefer an electronic system, particularly given the increased efficiency it offers. The current administration has indicated that developing better health records is a priority as it will ultimately result in improved quality of care. In the near future, military and civilian systems must work together to develop effective and coordinated health information technology.

The MTFs also represent significant competition to community providers regarding staff recruitment. MTFs are able to pay nurses and other providers significantly higher salaries than the civilian providers. In addition, providers at the base generally work more reasonable hours. As such, it is difficult for the community providers to compete. These practices create ill-will among community providers.

Concerns regarding coordination and collaboration are not only from community providers. Health Net and the MTFs often feel that there is a lack of effort on the part of community providers to develop more collaborative and open relationships. For example, Health Net

officials report that community providers were invited to a reception at Naval Hospital Camp Lejeune intended to foster better relationships between community and military providers early in 2010. No community providers attended the event. In addition, Health Net officials indicated that they have suggested the formation of a collaborative health organization, similar to the Ft. Drum Regional Health Planning Organization⁷, which would build a stronger relationship between civilian and community providers. However, community providers have consistently told Health Net that they are not interested.

Collaboration and communication between community and military health care providers are constant concerns in the MGTf region. Both parties have expressed a willingness to improve relationships, but neither has taken meaningful action to improve the situation. In the future, both parties must humbly demonstrate a willingness to work together to better serve the entire region.

Need 3: Ensure regular participation from military physicians in local medical society meetings

Both civilian and military providers agree that there is a need to improve coordination and collaboration relative to the treatment of military families in the MGTf region. Providers from both health care communities indicated that local medical society meetings provide the ideal opportunity to connect within an established framework. Community providers should take the initiative to invite military providers to participate as soon as possible. In addition, the MTFs must commit to ensuring participation at meetings. Given the turnover in military physician population, it is easy to abandon these types of relationships when providers leave the MTF. The military must find ways to ensure long term, consistent participation, either through a rolling delegation of representatives or the appointment of a civilian physician who is expected to remain at the MTF for a longer period of time.

Benefits if Need is Satisfied

The regular participation of military physicians in local medical society meetings will have a significant positive impact on the provision of care to the local military community and required minimal efforts from the medical community. Currently, the lack of coordination between military and civilian providers leads to the development of ill-will in both communities. Much of this can be avoided through open communication.

Effects if Need Not Satisfied

Failure to ensure participation of military physicians at local medical society meetings will simply result in the maintenance of the status quo. As outlined above, the majority of regional providers believe that there is a need to improve upon the status quo.

Next Steps

The MGTf should work as an intermediary to ensure that military physicians begin attending medical society meetings.

⁷ See Appendix 3 for more information on the Fort Drum Health Planning Organization.

Need 4: Improve use of information technology

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized incentive payments for providers who use electronic prescription systems for their Medicare patients. These incentives have encouraged many physicians to adopt electronic prescription systems (eRx) for all their patients, to provide consistency, maximize efficiency and reduce the potential for errors. Moreover, beginning in 2012, physicians will be penalized for failing to use eRx for their Medicare patients. Physicians are not permitted, however, to use eRx for TRICARE patients who have prescriptions filled at the base pharmacy (MCB Camp Lejeune). Some physicians report that the pharmacy on base insists that the use of eRx is a violation of HIPAA and indicate that physicians who attempt to use eRx for TRICARE patients may be reported for HIPAA violations. Due to this situation, prescriptions to be filled on base for TRICARE patients must be completed by hand, which, for those practices that have migrated completely to eRx, represents a departure from normal practices with all other patients. In addition, community physicians are not permitted to call-in prescriptions to the base pharmacy and, since eRx is not permitted, patients must travel to physicians' offices and pick up hand-written prescriptions to take to the pharmacy. Policy measures should be enacted to align the incentives of CMS, DoD and civilian providers toward quality care.

In the long term, there is a need to share access to electronic health records (EHR) between the DoD facilities and community facilities. Currently, the VA has a record sharing system in place, which substantially improves the quality of patient care. The use of this system by the MTFs will significantly improve the care provided to military families.

Benefits if Need is Satisfied

Implementation of an eRx system to be used with the MCB Camp Lejeune pharmacy, improving the electronic referral system and expanding access to EHR for community physicians will likely result in the delivery of service to TRICARE patients at the same levels of care they can currently provide to patients with other payors. Quality, patient compliance and satisfaction, and communication among providers will be enhanced, which will result in more optimal health outcomes for TRICARE patients.

Effects if Need Not Satisfied

Without the improvements in the use of information technology, military families and retirees will not benefit from the measures to improve quality of care and outcomes. In addition, physicians will be disincentivized to care for TRICARE patients, particularly since these patients will represent higher costs (through less efficient, paper-based systems). These higher costs, combined with the lower TRICARE reimbursement, may limit the number of providers available to care for TRICARE patients.

Next Steps

The MGTG should facilitate a dialogue with the MTFs concerning these issues, perhaps to include representatives from the Medical Society or other physician representatives. The discussion should include an inquiry into any unknown factors that prevent the use of eRx for TRICARE patients, the presentation of the needs of both community physicians and MTFs to enhance

understanding and mitigate hostility, and the possibility of expanding access to EHR for physicians in the community.

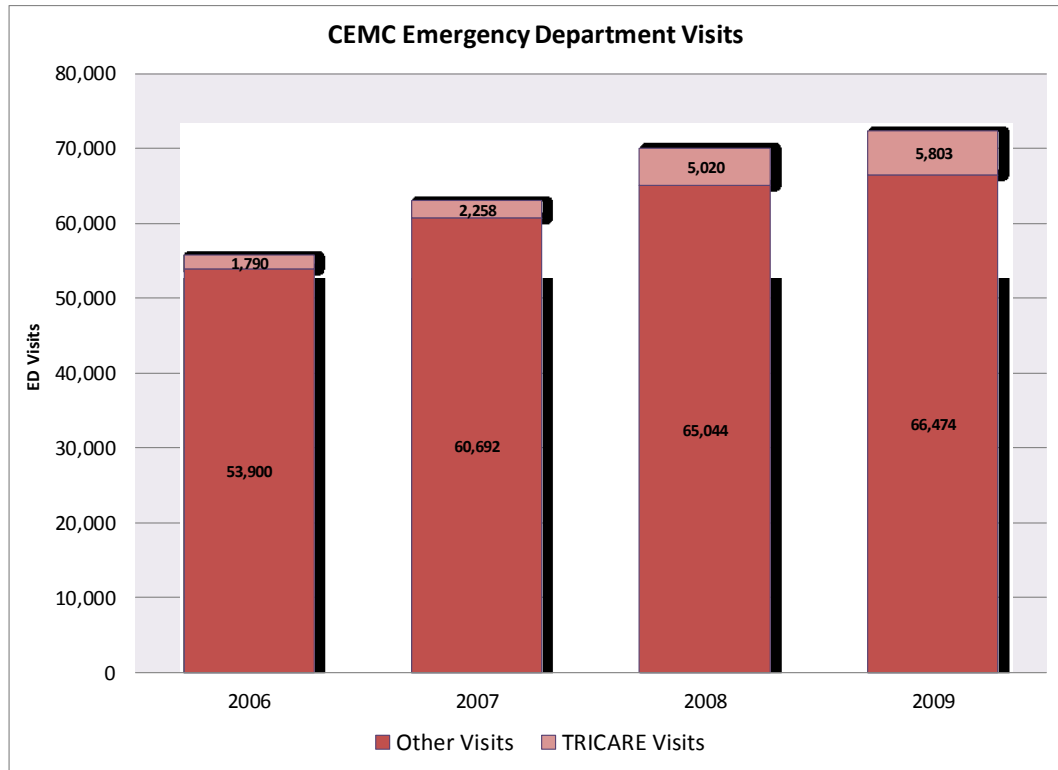
IV. Impact of the Downgrade of Naval Hospital Cherry Point on Obstetrics and Emergency Services at Local Hospitals

As part of the 2005 Base Realignment and Closure, the inpatient mission at Naval Hospital Cherry Point was disestablished and the hospital was converted into an outpatient clinic with an ambulatory surgery center. The official conversion from a hospital to a clinic took place on October 1, 2007. During this transition, all emergency department (ED) and obstetric volume was shifted to community providers, particularly CarolinaEast Medical Center (CEMC) and Carteret General Hospital (CGH). This shift occurred during a period of growth in the military population in the area. As a result of these simultaneous events, these providers have experienced noticeable growth in TRICARE volumes. In addition, since some primary care physicians in the area do not accept TRICARE, emergency departments are further burdened by serving as the only source for primary care for many enlisted men and women and their dependents.

Please note that CEMC and CGH provided their obstetrics utilization data in slightly different ways. CEMC has provided its Labor and Delivery visits, which include outpatient visits prior to delivery, and days of care provided in the nursery. CGH has provided its obstetrics deliveries. Each metric is a reasonable avenue to determine the impact of the downgrade of Naval Hospital Cherry Point.

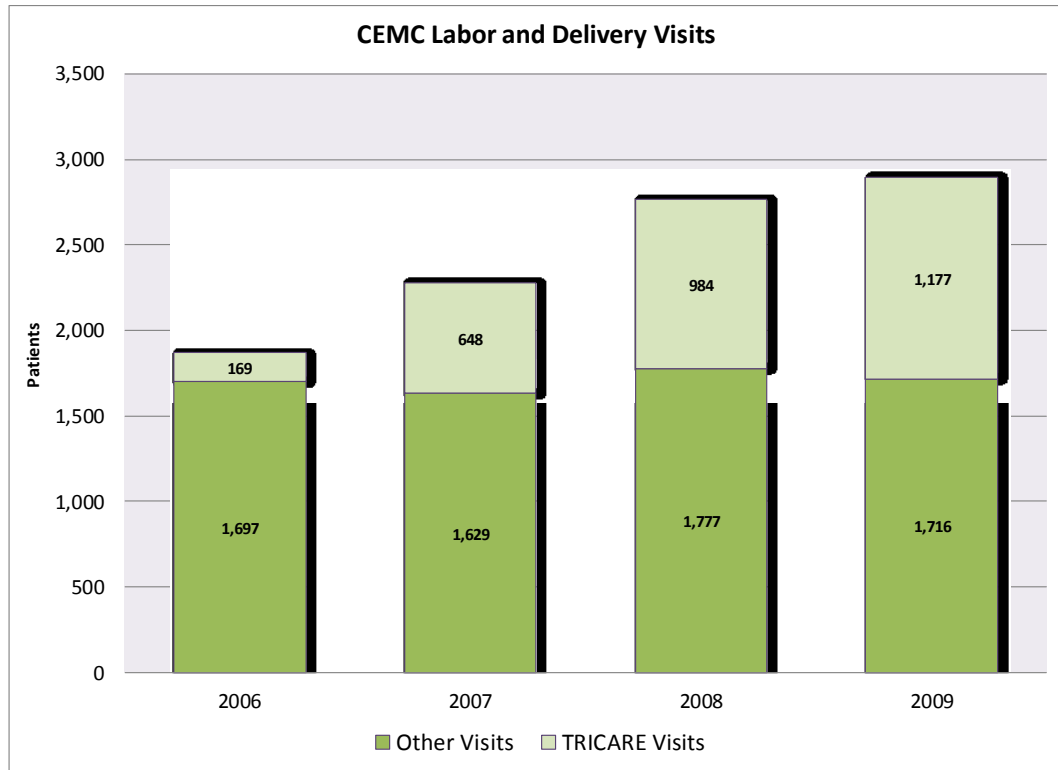
Impact on CarolinaEast Medical Center

From 2006 to 2009, CEMC experienced a 224 percent increase in the number of TRICARE visits in its ED; over that time period TRICARE ED utilization grew from nearly 1,800 to more than 5,800 visits.



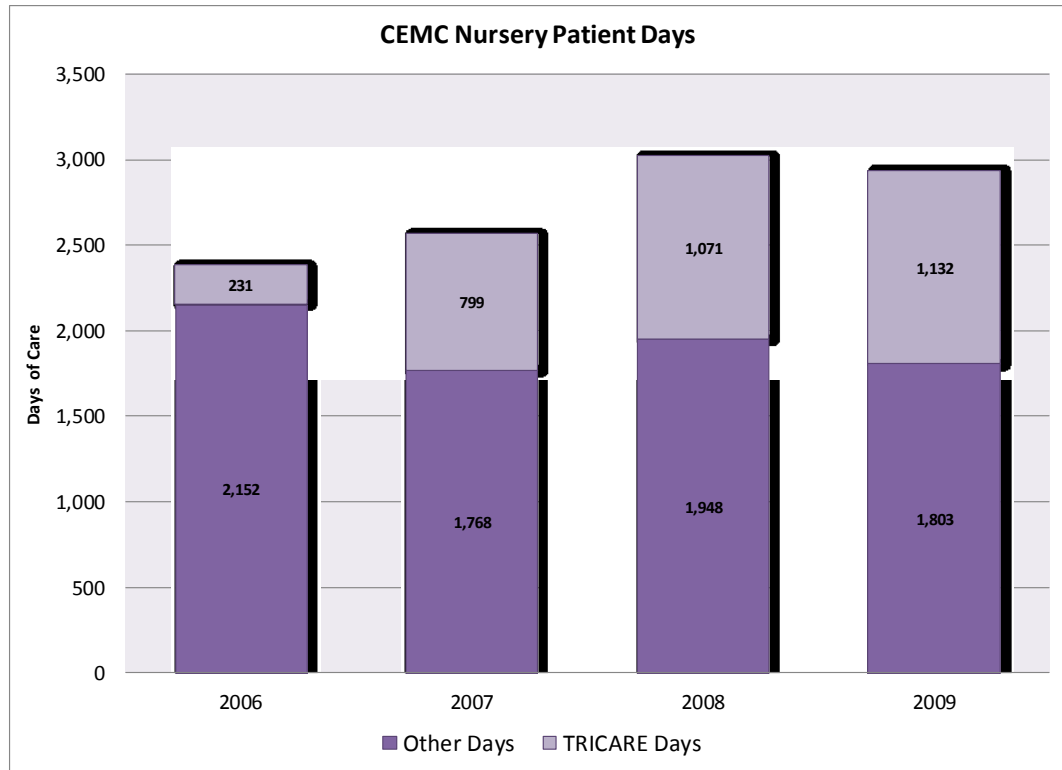
While TRICARE utilization has grown significantly, it should be viewed in the context of the growth in total CEMC ED visits, which have also grown substantially since 2006. In 2009, CEMC experienced nearly 16,600 more ED visits than it had in 2006. Of that, TRICARE growth represented about 4,000 visits, or almost 24 percent of incremental volume growth. In addition, TRICARE volume grew from three to eight percent of total ED visits from 2006 to 2009.

While CEMC's emergency department has been affected modestly by the downgrade of Naval Hospital Cherry Point, the utilization of its obstetrics service has been much more significant. CEMC provided Labor and Delivery inpatient services to only 169 TRICARE beneficiaries in 2006; by 2009 that number had jumped to 1,177, an increase of nearly 600 percent. As a result, TRICARE beneficiaries now comprise over 40 percent of all CEMC Labor and Delivery cases (versus only nine percent in 2006).



The growth in TRICARE utilization in CEMC’s ED was only a quarter of the overall growth for the service. By contrast, the growth in TRICARE utilization in CEMC’s labor and delivery unit is responsible for almost all of the growth for the service overall: CEMC’s total Labor and Delivery utilization has grown by 1,027 visits since 2006 of which more than 98 percent are attributable to the growth in TRICARE beneficiaries. As stated in the RGMP, much of this growth is due to an increase in pre-delivery visits which have stressed the capacity of the women’s services departments. On average, most civilian mothers-to-be have two visits to the hospital prior to delivery for minor health concerns. Military women on average have four visits. This is likely because they are located away from their support networks. Moreover, TRICARE patients do not pay co-pays for outpatient visits; therefore, they have no financial disincentives for additional visits.

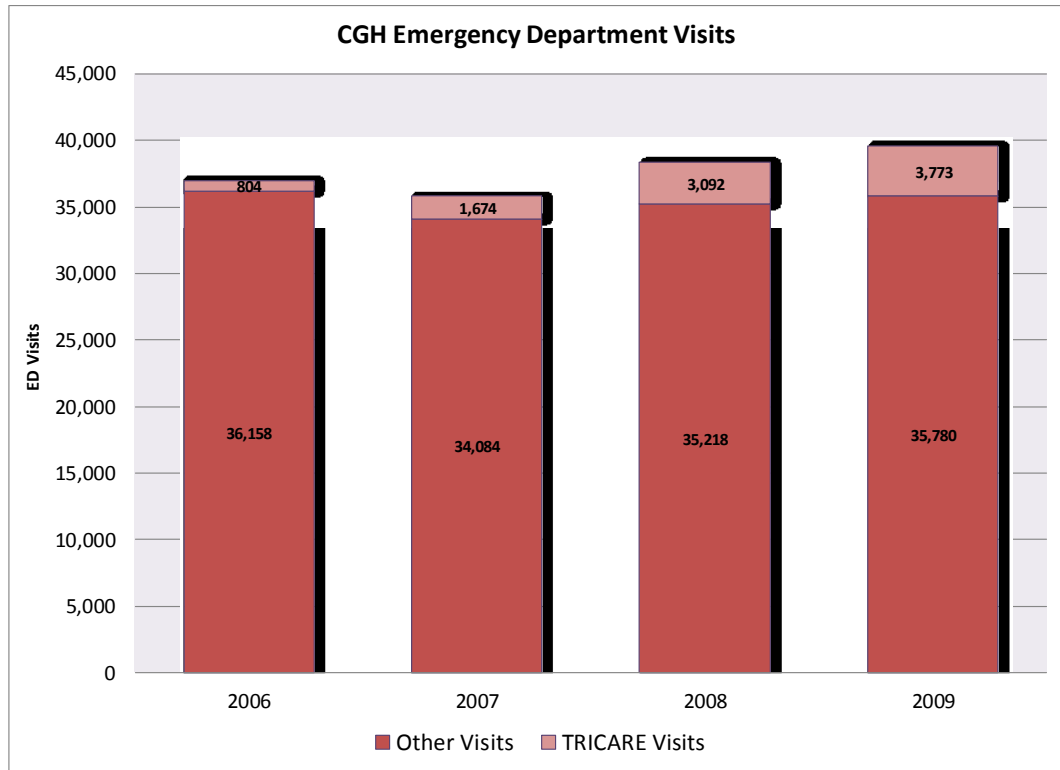
From 2006 to 2009, CEMC experienced a 390 percent increase in the number of TRICARE days of care in its nursery; over that time period TRICARE nursery utilization grew from 231 to 1,132 days of care. As a result, TRICARE days now comprise nearly 40 percent of CEMC’s total nursery volume.



The growth of TRICARE utilization within CEMC’s ED and Labor and Delivery services has been a subset of total growth in each of those services. By contrast, the growth in TRICARE utilization in CEMC’s nursery has exceeded growth for the service overall: total nursery volume has grown by 552 days since 2006, or approximately 23 percent, whereas TRICARE volume alone has grown by 901 days. As such, CEMC is presently providing fewer nursery days to non-TRICARE infants than in 2006.

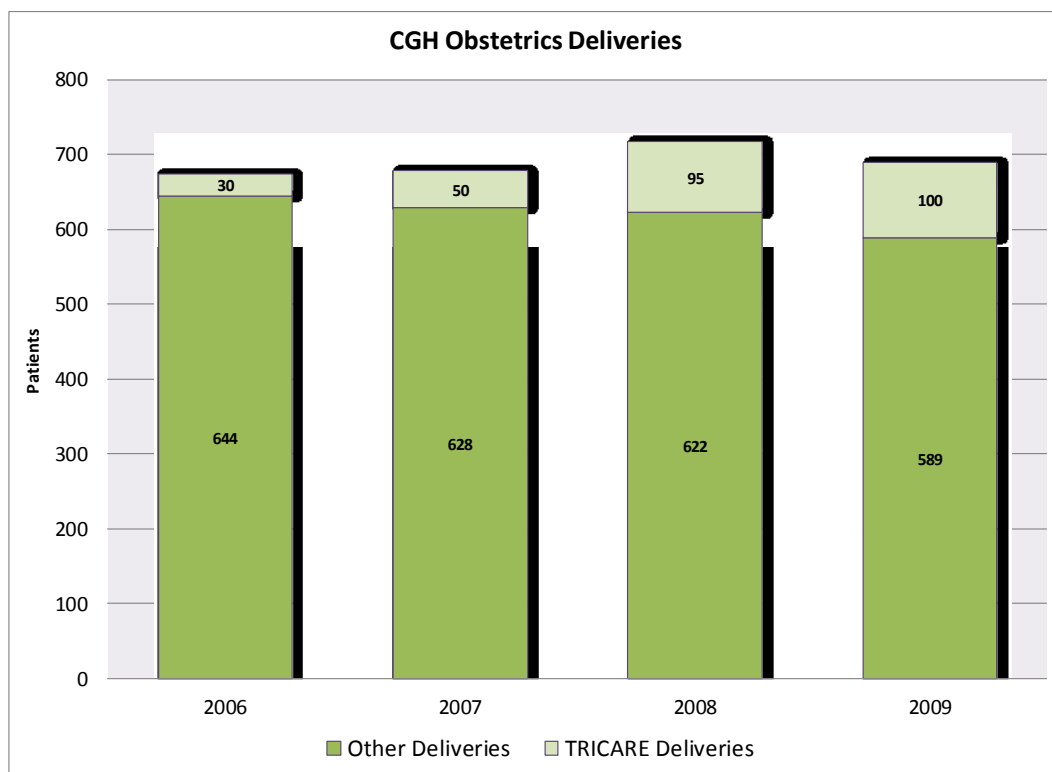
Impact on Carteret General Hospital

The impact of the downgrade of Naval Hospital Cherry Point has not been as significant to CGH as CEMC. From 2006 to 2009, CGH experienced a 115 percent increase in the number of TRICARE visits in its ED, from over 800 to nearly 3,800 visits.



The growth in TRICARE volume has been a primary driver of the growth for the service overall: total ED volume has grown by nearly 2,600 visits since 2006 whereas TRICARE volume alone has grown by nearly 3,000 visits. TRICARE grew from two to ten percent of total ED visits from 2006 to 2009.

CGH's women's services have also been affected by the downgrade of Naval Hospital Cherry Point, though again not as significantly as CEMC. In 2006, CGH provided 30 deliveries to TRICARE beneficiaries. In 2009, TRICARE deliveries climbed to 100, an increase of 233 percent.



Similar to its ED, the growth in TRICARE deliveries at CGH has exceeded overall growth in total deliveries: total deliveries increased by 15 since 2006 or two percent whereas TRICARE deliveries alone grew by 70. TRICARE deliveries grew from four to 15 percent of total deliveries from 2006 to 2009.

Need 5: Locate Financial Support for Community Providers

In order to respond to utilization pressures, CEMC has invested in several new construction projects, including expansion of women's and emergency services. However, CEMC leadership is concerned these expansions will not be sufficient to meet the growing demand for these services as well as the potential increase in demand due to health reform. Further, CGH leadership indicates that the hospital is in need of renovations and expansions for both its emergency department and labor and delivery unit. To the extent possible, there is a need to determine how to provide financial support for these endeavors.

Primary care physician reimbursement by TRICARE discourages current non-network providers from participation and causes current network providers to limit their panels. By granting a locality waiver and reimbursing physicians at a higher rate, a greater number of TRICARE patients could obtain routine care in physician offices and not be forced to rely as heavily on community emergency services.

Benefits if Need is Satisfied

Financial assistance for expansion and renovation projects will allow CEMC and CGH to ensure that the organizations can meet the needs of current and future patients, many of which are

military or their dependents. Further, the ability to serve an increasing number of patients at each facility will allow a greater number of TRICARE patients to receive care close to home.

A TRICARE locality waiver would positively impact overall health care access for TRICARE beneficiaries beyond women's and emergency services. Increased reimbursement would encourage greater numbers of physicians to accept TRICARE patients and potentially to ease the recruitment of physicians to the area.

Effects if Need Not Satisfied

Without additional financial support, CEMC and CGH will be required to self-fund expansion projects. As a result, the facilities may be unable to complete expansion projects. Further, if completed, these projects will likely significantly deplete each organization's capital reserves and leave it financially vulnerable. This vulnerability will no doubt be exacerbated by the impact of health care reform.

If TRICARE reimbursement for physicians is not increased, current network providers may withdraw from the network in the future leaving patients with more limited access to services. Moreover, low TRICARE reimbursement is a disincentive to the successful recruitment and retention of physicians in the region.

Next Steps

HPS will continue to analyze the utilization trends at CEMC and CGH as future data becomes available.

V. The Impact of Potential Medicare Payment Reductions on Regional Health Care Providers

To adjust the current fee schedule formula for physician payment, a 21.1 percent cut in Medicare reimbursement to physicians was slated to be enacted in the spring of 2010. Recognizing the negative effects for physicians and patients throughout the country the House approved a plan to defer cuts for another six months (until November 2010).

The 21 percent cut was determined using a formula for physician payment and the Medicare Sustainable Growth Rate (SGR)⁸ which is used to determine the reduction of physician payments in order to sustain the solvency of Medicare. Instead of a permanent solution, the cuts continue to be proposed, then pushed back, which only exacerbates the problem. CNN Money reports that Congress has blocked physician payment cuts ten times in the last eight years, including four times since January 2010. By simply deferring the cuts and not resolving an apparent economic problem, even larger cuts are likely needed in subsequent proposals in order to meet the goal of Medicare solvency. If changes are not made to Medicare's SGR formula, a 23.6 percent cut will take effect December 1, 2010, followed by an additional cut of 6.5 percent in January 2011.

⁸ The SGR is the maximum rate of growth that Medicare can sustain before it is insolvent.

If and when these cuts occur, it will likely have a deleterious effect on health care access for Medicare and TRICARE patients throughout the country. The American Medical Association (AMA) and the Medical Group Management Association (MGMA) both conducted physician surveys^{9 10} in 2010 regarding physicians' reactions to the proposed cuts. The AMA found that about one in five physicians (17 percent) and nearly one third (31 percent) of primary care physicians are currently restricting the number of Medicare patients in their practices due to low reimbursement and the threat of future payment cuts. If the 21 percent Medicare cut had taken effect in July 2010, the AMA reports that 60 percent of physicians surveyed would consider opting out of Medicare completely. MGMA found that if no action was taken to stop future Medicare cuts nearly one-half of medical groups would likely no longer accept new Medicare patients, while more than one-quarter stated that they would discontinue Medicare panels all together. In addition, HPS asked health care providers in the MGTF region if a 10 percent or greater reduction in Medicare would impact their acceptance of TRICARE patients. A small percentage of providers, all but one of whom have participated in the TRICARE network for more than five years, indicated that if Medicare rates decreased by 10 percent or more, they would decrease or discontinue their treatment of TRICARE patients.

Need 6: Pursue a longer term solution to Medicare solvency

Congress continues to delay permanent decisions with regard to proposed Medicare cuts for physicians. In November 2010, Congress will again face this issue, with the threat of a 23.6 percent cut in December 2010, or a 30.1 percent cut in January 2011. The Military Growth Task Force should oppose Medicare cuts to physicians and encourage legislators to seek alternative solutions to preserve Medicare solvency. Because TRICARE reimbursement is tied to Medicare reimbursement, physicians will not only see these reimbursement reductions for Medicare patients, but for TRICARE patients as well. Many physicians may limit or eliminate their TRICARE and Medicare practices, which would significantly reduce the already limited access for seniors and military families in the region.

Benefits if Need is Satisfied

At the least, a longer term solution to Medicare solvency will maintain the current level of access for Medicare and TRICARE beneficiaries. However, ideally the solution will result in expanded access for Medicare and TRICARE beneficiaries. If physicians are able to increase the number of Medicare patients they accept, patients should be able to make appointments faster and in more convenient locations. Ultimately, this will result in healthier military families.

Effects if Need Not Satisfied

As stated previously, if Medicare cuts occur, it will have a devastating effect on health care access for Medicare and TRICARE patients all over the country, including the MGTF region. As studies by the AMA and MGMA show, extreme cuts will likely result in many physicians restricting or cutting Medicare patients from their practices. Physicians in the MGTF region

⁹ American Medical Association physician survey, Available at <http://www.ama-assn.org/ama1/pub/upload/mm/399/medicare-survey-results.pdf>

¹⁰ Medical Group Management Association physician survey, Available at <http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=39774>

have also indicated that Medicare cuts will impact the provision of services to TRICARE beneficiaries.

Next Steps

The Military Growth Task Force should continue to communicate the impacts of potential Medicare cuts with local representatives. In addition, HPS will continue to monitor legislation as it may impact the region.

VI. The Impact of Health Reform on Regional Health Care Providers

In March 2010, the President signed the Patient Protection and Affordable Care Act (Affordable Care Act) into law. The new legislation is expected to have far-reaching effects on the United States health care system. Although all implications of the law will not be known for many years, it is necessary to begin planning for known repercussions in the near term. The following section highlights key portions of the health reform law that are likely to have an impact on the ability of military personnel and their families to access health care.

TRICARE

The Affordable Care Act will have no direct implications on the TRICARE program, which will remain under the authority of the Department of Defense. Many of the new regulations within the Affordable Care Act apply to insurance coverage and consumer protection, and it is important to note that TRICARE coverage already meets most of the new provisions, including annual limits, lifetime maximums, and denial of coverage due to preexisting conditions. However, TRICARE reimbursement is strongly linked to Medicare reimbursement.¹¹ As such, Medicare cuts within the Affordable Care Act should be monitored. As discussed below, most of the changes and cuts to Medicare are not system wide; hence, as currently outlined, these changes should have little impact on TRICARE reimbursement.

Medicare

The Affordable Care Act includes several changes for the Medicare program. Many are limited to Medicare Part B¹² and Medicare Advantage¹³ plans and do not have overarching effects on the Medicare program as a whole. The new law will however cut Medicare reimbursement on readmissions as soon as 2012, and reimbursement for hospital acquired conditions in 2015. It also establishes an Independent Payment Advisory Board that will monitor the ever-increasing Medicare spending rate of growth per capita and make recommendations to reduce per capita Medicare spending if these rates exceed a target growth rate. These provisions will immediately

¹¹ Please see page 153 of the Regional Growth Management Plan for more discussion regarding the linkages between TRICARE and Medicare.

¹² Medicare has four parts; Part A is hospital insurance which covers inpatient hospital stays, Part B is medical insurance which covers procedures and services generally performed on an outpatient basis, Part D covers prescription drugs, and Medicare Advantage plans (part C).

¹³ Medicare Advantage plans allow beneficiaries to receive their Medicare benefits through private health insurance plans, instead of the original Medicare plan.

impact military retirees covered under Medicare and also demonstrate potential future changes to the TRICARE payment system.

Physician Shortage

As detailed in Section X, there is a shortage of physicians in the MGTf region. Among programs in the Affordable Care Act are potential opportunities for additional funding to support recruitment and retention of physicians in the MGTf region. The majority of funding and grants that will be available are geared toward expansion of, and improved access to, primary care. In addition, some funding has been proposed for scholarships, loans, and grants for health professional training, especially for primary care providers in Medically Underserved Areas (MUAs)¹⁴, as designated by the Health Resources and Services Administration (HRSA). Carteret, Craven, Duplin, Jones, Onslow, Pamlico, and Pender counties have been designated as MUAs so funding may be available. In addition, there will likely be growth in the number of Graduate Medical Education training positions with priority given to primary care and general surgery. There are also funds for physicians who practice in rural areas. More details around the availability and value of these funds and grants will be disclosed as the Affordable Care Act is implemented.

The Newly Insured

The Congressional Budget Office estimates that an additional 32 million individuals will have insurance coverage when the new law is fully implemented in 2019.¹⁵ In federal fiscal year 2009, approximately six to ten percent of the discharges originating in the MGTf region were self pay/indigent patients, and it is expected that these individuals will have coverage. With a larger percentage of the population insured, there will likely be growth in the number of physician visits in the area. Although access to care will likely be enhanced for those that are currently uninsured, the current physician shortage and capacity issues that exist in the community may be strained further by larger patient pools. This will further exacerbate the existing shortages discussed in Section X. Consequently, access to health services would be compromised as existing physicians' practices become overcrowded and new appointments become more difficult, or even impossible to schedule.

Behavioral Health

Growth of insured individuals (see previous section) will likely result in increased demand for behavioral health providers in the region. As such, the existing shortage of providers will be further strained, which may limit access to behavioral health services for military families. Please see Section X and XI for a complete discussion regarding health care provider needs in the region.

The Affordable Care Act provides additional support for the development of interdisciplinary mental and behavioral health training programs. Details for how funding will be distributed will be available as the Act is implemented. HPS will continue to monitor the developing legislation and notify the MGTf when more information is available.

¹⁴ A Medically Underserved Area is a geographic area such as a county, group of contiguous counties, civil divisions, or group of urban census tracts, in which residents have a shortage of personal health services.

¹⁵ Congressional Budget Office: <http://www.cbo.gov/publications/collections/health.cfm>

Need 7: Continue to stress the importance of health care access for military families and monitor the development of the Affordable Care Act

The MGTf should continue to stress to legislators the need for appropriate access to care for military families in the region. The Affordable Care Act will likely offer additional funding and insurance coverage, but some of the new regulations may reduce health care access in the MGTf region.

Although the Affordable Care Act will enable changes within the Medicare program, these changes do not directly affect TRICARE reimbursement at this time. It is important, however, to note the tone and direction that the new law is taking. There is an increased awareness of wasteful Medicare spending. Because TRICARE reimbursement is linked to Medicare reimbursement¹⁶ at this time, any cuts to Medicare will impact TRICARE reimbursement as well. TRICARE reimbursement is already disproportionately low in comparison to other payors, making physicians less likely to accept TRICARE patients. If reductions to Medicare reimbursements continue, the regional providers will not be relieved from already insufficient TRICARE payments. The Military Growth Task Force should continue to present their concerns regarding low TRICARE reimbursement to legislators.

Additional funding for programs that will support physician recruitment, especially in primary care and behavioral health may be available as a consequence of the Affordable Care Act, but specific details around how to apply for these funds have not yet been released. The Military Growth Task Force must monitor and be proactive about any opportunities for additional funding. (New grant opportunities are posted at www.grants.gov as they are available.)

There is also a need to monitor the impact of newly insured persons on health care provider demand in the region. As more persons become insured, the need for physicians is likely to continue increasing. This will intensify the existing needs presented in Section X, and will negatively impact regional access to physician services.

Benefits if Need is Satisfied

Aligning with legislators and providers around these issues will ideally result in positive legislative action, resulting in increased health care access for TRICARE beneficiaries in the region. In addition, monitoring any of the funding opportunities may result in much needed funding for area providers.

Effects if Need Not Satisfied

If the Military Growth Task Force fails to remain knowledgeable of changes due to the Affordable Care Act, funding opportunities may be overlooked.

¹⁶ Please see page 153 of the Regional Growth Management Plan for more discussion regarding the linkages between TRICARE and Medicare.

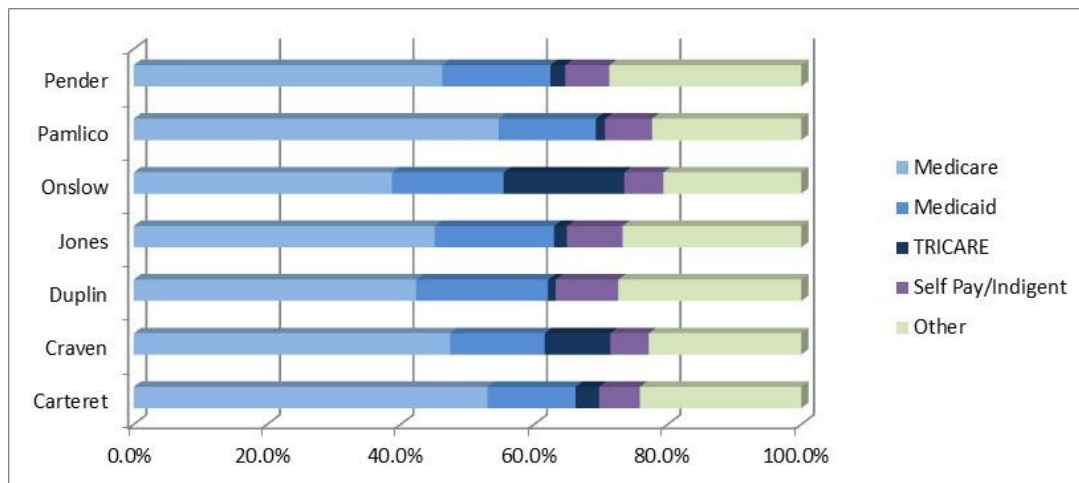
Next Steps

HPS will continue to monitor the impact of the Affordable Care Act on the MGTf region and determine required actions. In addition, the MGTf should follow and apply for any funding opportunities that may soon be available due to the passage of the Affordable Care Act, especially those that offer support for physician recruitment, primary care, and behavioral health.

VII. Regional Reliance on Government Payors

Between 63 and 74 percent of discharges originating from the MGTf region counties are covered by Medicare, Medicaid and TRICARE, as shown in the chart below.

Chart 1
MGTf Federal Fiscal Year 2009 Payor Mix by County



In comparison, approximately 57 to 65 percent of patients originating in similarly sized communities in North Carolina (not located near military installations) are covered by the three major government payors.

Government payors have historically provided lower reimbursement than commercial or managed care insurers for health care services. As such, it is more difficult for providers to become and remain profitable with a high percentage of government payors. In the MGTf region, Onslow Memorial Hospital, CarolinaEast Medical Center and Carteret General Hospital all retain sole-community provider status with Medicare. Sole Community Providers are hospitals or home health agencies that are the only provider of their kind within a 35 mile radius. This designation makes the hospitals eligible for higher payments from Medicare and TRICARE. However, this designation does not extend to the physicians in these regions. As such, payment from Medicare and TRICARE remain lower for physician and non-physician providers. Further, Medicaid, which is the nation’s public health insurance program for low-income Americans, is generally recognized as the lowest payor for health care services.

Approximately 13 to 20 percent of patients originating in the MGTf counties are covered by Medicaid. Again, this has a significant impact on the financial viability of providers in the region.

Although the majority of health care providers entered their professions to serve all patients, as expenses associated with running practices continue to increase, providers are opting to be more selective about the payor mix of their patient panels. In-person and phone interviews with regional physicians were completed in association with this assessment. In addition, several physicians in the region completed an online survey regarding their practice patterns. Through these interviews and surveys, regional physicians and practice managers were asked if the high presence of patients covered by government payors had an impact access to services. The majority of respondents felt that the high presence of government payors negatively affected patients' access to services in the region.

Next Steps

At this time, the MGTf needs to continue monitoring legislative activities regarding Medicare payment rates (see Needs VI and VII). Because the MGTf region depends so heavily on government payors, including Medicare and TRICARE, any reduction in payment will likely have a substantial impact on the region. Further, it is beneficial for Onslow Memorial Hospital, CarolinaEast Medical Center and Carteret General Hospital to maintain Sole Community Provider status which can contribute to their profitability despite the high government payor mix.

VIII. Reimbursement Differences for Mid-Level Providers

It is common for mid-level providers to be reimbursed at lower rates than physicians. Under TRICARE, this is no exception. The TRICARE Management Activity (TMA) sets TRICARE Maximum Allowable Charges by procedure¹⁷ for physicians and non-physicians¹⁸ in facilities and non-facilities. In general, the Maximum Allowable Charge for non-physician providers is 85 percent of the physician rate for medical services¹⁹ and 75 percent for psychiatric services. However, as stated in the Regional Growth Management Plan, TRICARE regional contractors have the purview to negotiate lower rates than the maximum allowable charges with providers. Although the non-physician rates generally remain at the same percentage of physician rates, this generally means that non-physician rates are even lower than the stated maximum allowable charges.

Most physicians and practice managers who responded to the on-line survey indicated that the lower reimbursement for mid-level providers has no impact on their use of extenders.

¹⁷ Physician and non-physician (mid-level providers/physician extenders) services are reimbursed by private and public health insurers on a per-procedure basis. The most widely accepted medical nomenclature to report medical procedures and services is Current Procedural Terminology, or CPT Codes. For example, CPT code 74181 denotes a MRI scan of the abdomen without contrast material.

¹⁸ Mid-level providers or physician extenders include physician's assistants, nurse practitioners, clinical social workers and psychologists.

¹⁹ For some medical procedures, the maximum allowable charge for non-physician providers is 100 percent of the physician rate and for other medical procedures; non-physicians are not reimbursed at all.

However, as mid-level providers become more important to the provision of health and medical services, it is important that the payment for services is attractive.

The maximum allowable charges for mid-level psychiatric providers are particularly low. There is a need for a policy change to increase reimbursement for these services. As outlined in Section X of this report, there is a shortage of psychiatric providers in the region despite growing demand for services. As such, there is a need to take advantage of mid-level providers to support the system. However, these providers must be compensated adequately for services rendered. The MGTf should work with state and federal representatives to push for an increase in the maximum allowable charge for non-physician psychiatric services.

Need 8: Pursue increased reimbursement for mid-level providers of psychiatric services

Non-physician services are reimbursed at lower rates than physician services across most insurers. However, the reimbursement rate for behavioral health services is particularly low under TRICARE. These services will continue to be in demand and mid-level providers are an important part of the behavioral health system. As such, there is a need to pursue increased reimbursement for these services. In the future, there may be a need to pursue increased reimbursement for additional physical health services.

Benefits if Need is Satisfied

An increase in reimbursement for behavioral health services provided by mid-level providers is likely to result in increased recruitment and retention of mid-level psychiatric providers to the region. As demand for behavioral health services continues to increase, this represents a significant benefit for the region by increasing access to timely, local services.

Effects if Need Not Satisfied

Maintaining the status quo will result in a continued shortage of behavioral health providers in the region. Mid-level providers are increasingly important to the health care system as a whole, and the behavioral health sector is no different. The military and community providers have an obligation to take all steps possible to ensure that the behavioral health needs of our military community.

Next Steps

The MGTf and TMA (with the assistance of HPS) need to work together to determine the best approach to ensuring higher reimbursement for psychiatric mid-level provider services.

IX. The Recession's Impact on TRICARE Participation

In a meeting of health care stakeholders in early 2010, it was suggested that many physicians who have historically not participated in TRICARE have recently enrolled during the economic downturn in order to sustain their volumes. As such, there was concern that the recently enrolled providers would choose not to participate in TRICARE once economic conditions improve thereby having a significantly negative impact on the availability of TRICARE providers.

Health Net has not been able to provide the number of providers that joined the TRICARE network in the MGTF region over the past year. However, the survey of physicians and practice managers in the region provided significant insight into this issue. Specifically, the majority of respondents indicated that the economic conditions have had no impact on their levels of TRICARE acceptance, many due to the fact that they simply have never participated in the network. The primary reason given for not participating is lower levels of physician reimbursement associated with TRICARE. In addition, some providers noted that TRICARE paperwork was too time consuming and referrals were problematic. Of those that responded they had increased acceptance of TRICARE patients, all were already participating prior to the economic downturn.

Providers were also asked the following questions:

- If/When the economy improves, how do you anticipate your level of acceptance for TRICARE patients will change?
- If significant (10%+) reductions in Medicare payments to physicians occur, how do you anticipate your level of acceptance for TRICARE patients will change?

Again, the majority of physicians and practice managers indicated that the economic conditions and Medicare reimbursement changes would have no impact on their TRICARE acceptance/participation. A small percentage of respondents indicated that they would increase their acceptance of TRICARE patients if/when the economy improves; however, each of these respondents have been participating in TRICARE for more than five years. In addition, a small percentage of providers, all but one of whom have participated in TRICARE for more than five years, indicated that if Medicare rates decreased by 10 percent or more, they would decrease or discontinue their care of TRICARE patients.

Many physicians and hospital leaders interviewed by HPS indicated that the greater driver of physician behavior at this time is the uncertainty surrounding health care reform. Given that there is little mention of TRICARE in the Patient Affordability and Accountability Act, it is generally not in the forefront of physicians' minds. Physicians are concerned about creating stronger alliances with hospitals and health systems. In addition, most physicians are concerned that there will simply not be enough providers to meet the needs of the newly insured in the region. As described in Section VII above, between six and nine percent of residents in the MGTF counties are currently uninsured. When these individuals become insured, there is likely to be a surge in demand for physician services, particularly primary care. (Please see Sections V and VI above for further discussion regarding health care reform efforts.)

Next Steps

The economy seems to have little impact on health care providers' willingness to participate in TRICARE. Rather, uncertainty regarding health reform is apparently having a greater effect on physician behavior. As such, health reform should continue to be monitored. (Please see Sections V and VII for additional discussion.)

X. Health Care Provider Demand

HPS has updated its health care provider demand models, by county, to assess any changes in the projected need for physicians in the region. At the time of the RGMP, HPS did not have the ability to ensure the accuracy of health care provider full time equivalent (FTE) supply data. The data used in the analyses below have updated FTE values based on available information, which captures any time physicians may spend in different counties (e.g. a physician may spend half of his/her time in Craven County and half in Jones County. Thus, each county would have 0.5 FTE for that physician). In addition, the analyses below use physician age, which allows for projected retirements based on an assumed retirement age of 65. HPS will continue to monitor and update supply/FTE statistics in subsequent reports.

In the MGTF region Onslow County has the greatest current and projected health care provider needs. Onslow County has the largest population in the MGTF region and is also home to MCB Camp Lejeune. Carteret, Duplin and Pender counties also have significant provider needs. However, the needs in Duplin and Pender counties are mitigated by the presence of an acute care hospital in each county, which is part of a larger regional health care system (Duplin General Hospital is a member of University Health Systems and Pender Memorial Hospital is an affiliate of New Hanover Regional Medical Center).

A summary of physician needs by county has been provided in the subsequent pages. Summaries are provided in alphabetical order, based on county name, and include detail related to estimated FTE supply as compared to the estimated number of providers needed to serve the unique demographics associated with each county's current and projected 2015 population.

Please note the provider need by specialty group²⁰ is not cumulative. Specialties with a surplus of physicians are not counted against deficits in other specialties. For example, in 2015 Craven County is projected to have a supply of 64.9 FTE primary care providers and a need for 62.0 FTEs. This includes a projected surplus of 5.0 FTE internists and 4.1 FTE pediatricians. By contrast, the county is projected to have a deficit of 1.0 FTE family practice provider and 5.3 FTE obstetricians/gynecologists. The surplus for internal medicine and pediatrics is not counted against the deficit for family practice and obstetrics/gynecology. Thus, the projected need for primary care providers is representative of the deficit only, 6.3 FTEs, and not the difference between the need and supply shown in the bar chart, which would indicate that the county's supply exceeds its need. Thus, the difference between provider need and provider supply for a specialty group, as shown in the exhibits below, is not necessarily representative of the deficit for that specialty group. Specific specialty needs are noted in each County.

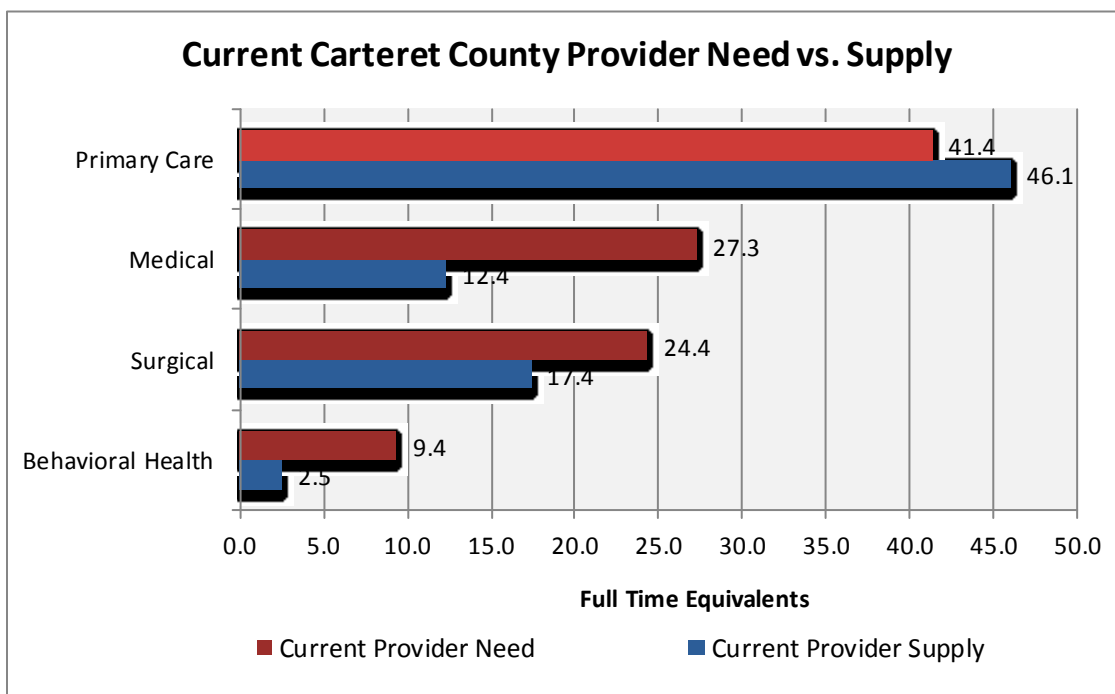
²⁰

Please see Appendix 4 for a detailed listing of specialties within each specialty group (primary care, medical specialists, surgical specialists and behavioral health).

Carteret County Physician Needs

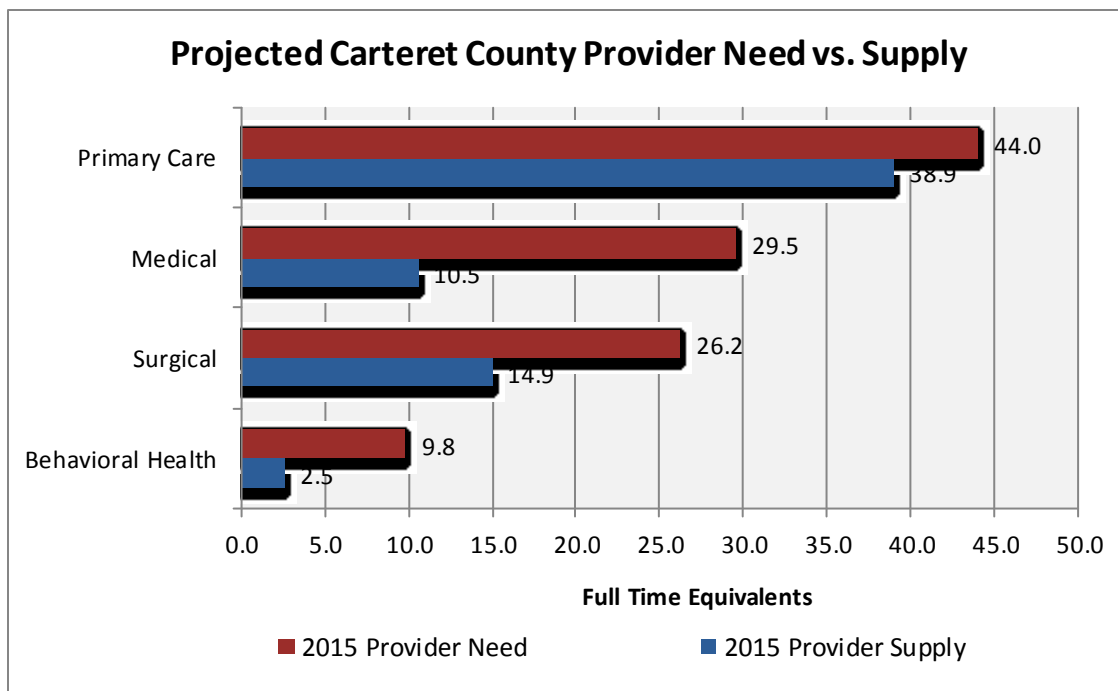
Carteret County is estimated to have sufficient primary care providers relative to its population’s needs; however, it is estimated that the county has a need for an additional 16.0 FTE medical specialists, 10.8 FTE surgical specialists, and 6.9 behavioral health providers. Existing supply in the county is comprised of the following:

- Primary Care: 46.1 FTEs (32.1 physicians and 14.0 physician extenders)
- Medical Specialties: 12.4 FTEs (10.9 physicians and 1.5 physician extenders)
- Surgical Specialties: 17.4 FTEs (14.4 physicians and 3.0 physician extenders)
- Behavioral Health: 2.5 FTEs (0.0 physicians and 2.5 physician extenders)



By 2015, after accounting for expected population growth and physician retirements, Carteret County will have a need for an additional 10.6 FTE primary care providers, 19.9 FTE medical specialists, 13.7 FTE surgical specialists, and 7.3 FTE behavioral health providers. Need estimates are driven by an expected total Carteret County population of 68,700 in 2015. Please note that there are surpluses in specific specialties which cause the supply to appear to exceed the need for the primary care, medical, and surgical specialty groups. The estimated need for additional providers in each specialty group is the sum of all specialties in which there are projected deficits, and any surpluses are not counted against this total deficit (please see page 29 for a more detailed explanation).

Relative to specific specialties included within the broader categories provided in the above chart, it is estimated that Carteret County will have additional needs for at least the following specialties: gastroenterologists, nephrologists, neurologists, podiatrists, ophthalmologists, orthopedic surgeons, internists, and psychiatrists.



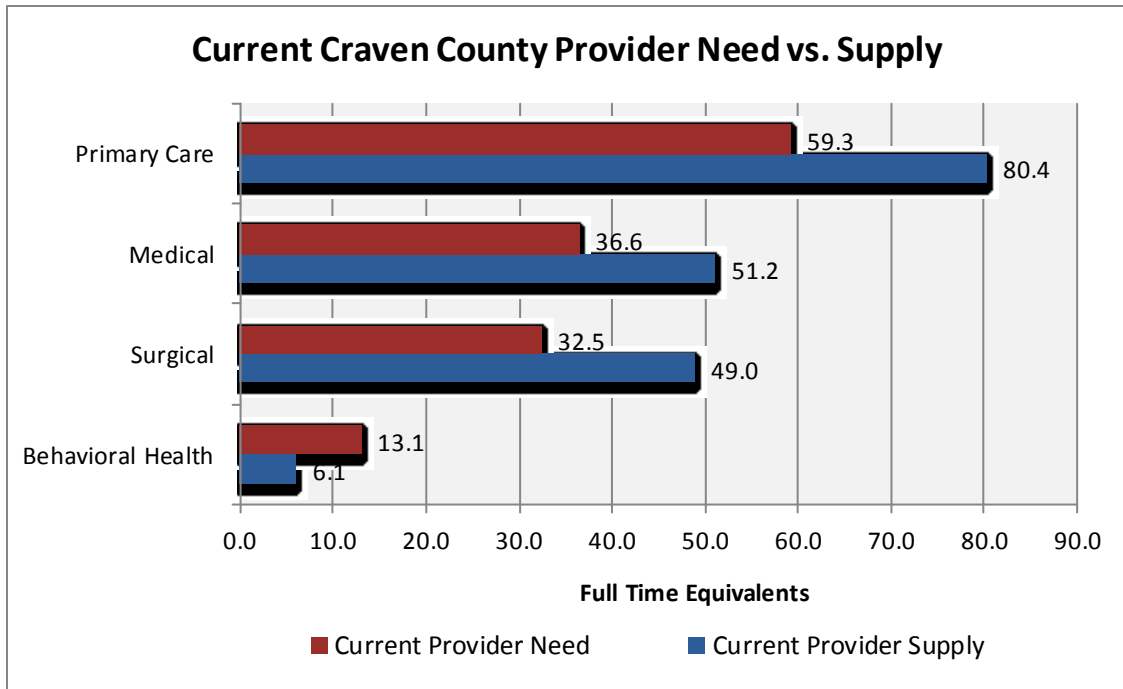
Craven County Physician Needs

Craven County has modest physician needs in order to serve its residents based on civilian and military physician supply data²¹. This need assumes that all uniformed providers retain 50 percent capacity relative to their civilian counterparts, due primarily to their additional duties beyond patient care. Existing supply in the county is comprised of the following:

- Primary Care: 80.4 FTEs (69.6 physicians and 10.8 physician extenders)
- Medical Specialties: 51.2 FTEs (44.2 physicians and 7.0 physician extenders)
- Surgical Specialties: 49.0 FTEs (46.0 physicians and 3.0 physician extenders)
- Behavioral Health: 6.1 FTEs (4.2 physicians and 1.9 physician extenders)

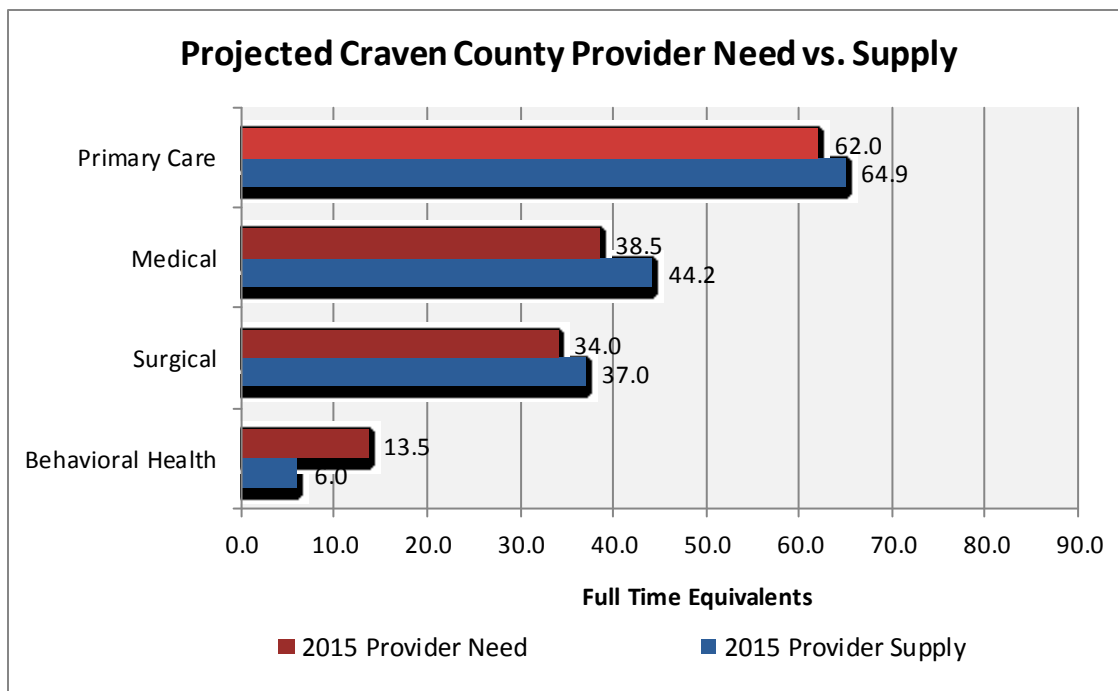
²¹

HPS has updated the civilian physician supply data for Onslow and Craven counties; however, the military physician supply data is currently unavailable. As such, the section below reflects the physician supply data Naval Clinic Cherry Point and Naval Hospital Camp Lejeune provided for the development of the RGMP. However, it is expected to be updated prior to HPS' January 2011 quarterly report and will be provided as an addendum to this report as soon as it is available.



By 2015, after accounting for expected population growth and physician retirements, Craven County will have an estimated need for an additional 6.3 FTE primary care providers, 6.3 FTE medical specialists, 5.8 FTE surgical specialists, and 7.5 FTE behavioral health providers. Need estimates are driven by an expected total Craven County population of 105,000 in 2015. Please note that there are surpluses in specific specialties which cause the supply to appear to exceed the need for the primary care, medical, and surgical specialty groups. The estimated need for additional providers in each specialty group is the sum of all specialties in which there are projected deficits, and any surpluses are not counted against this total deficit (please see page 29 for a more detailed explanation).

Relative to specific specialties included within the broader categories provided in the chart below, it is estimated that Craven County will have additional needs for at least the following specialties: allergists, endocrinologists, general surgeons, obstetricians/gynecologists, pathologists, and psychiatrists.

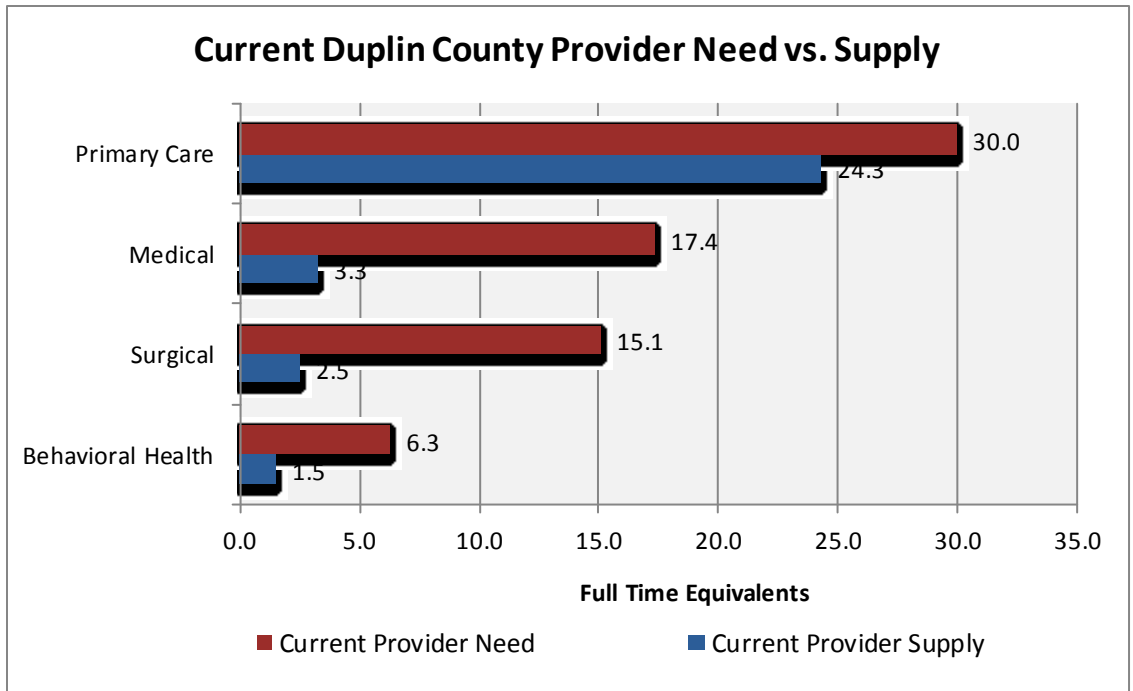


Although physician needs in Craven County appear modest relative to other counties in the region, it is important to recognize that CERMC functions as a regional referral center. As such, many of the physicians located in Craven County also treat patients from other communities in the region. In particular, residents of Jones and Pamlico Counties often travel to New Bern for medical and health services. Thus, it is important to contrast the apparent “surplus” of health care providers in Craven County with the estimated needs in Jones and Pamlico Counties.

Duplin County Physician Needs

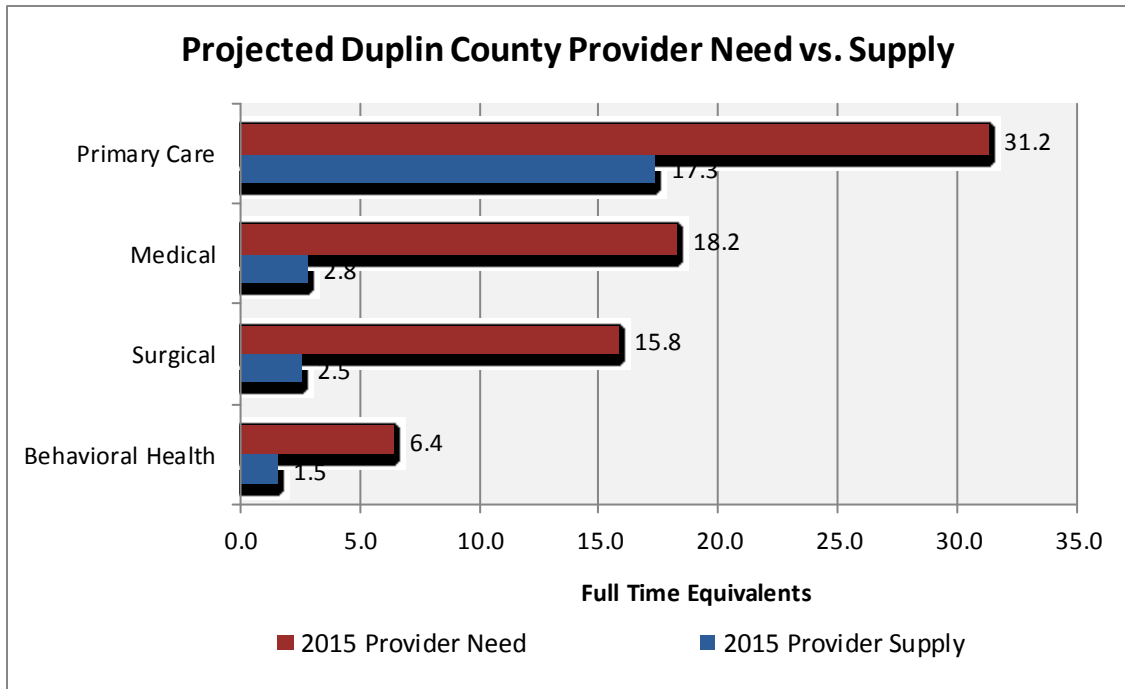
Duplin General Hospital’s affiliation with University Health Systems based in Greenville and the presence of Goshen Medical Center mitigate the challenges associated with physician recruitment and retention in the county. Many providers split their time between Duplin General Hospital and Goshen Medical Center as these two institutions often jointly recruit new providers to the area. Currently, the county has a need for an additional 9.5 primary care providers, 14.1 medical specialists, 12.6 surgical specialists, and 4.8 behavioral health providers. Existing supply in the county is comprised of the following:

- Primary Care: 24.3 FTEs (18.8 physicians and 5.5 physician extenders)
- Medical Specialties: 3.3 FTEs (3.3 physicians and 0.0 physician extenders)
- Surgical Specialties: 2.5 FTEs (2.5 physicians and 0.0 physician extenders)
- Behavioral Health: 1.5 FTEs (1.0 physicians and 0.5 physician extenders)



By 2015, after accounting for expected population growth and physician retirements, Duplin County will have a need for 13.9 primary care providers, 15.5 medical specialists, 13.3 surgical specialists, and 4.9 behavioral health providers. Need estimates are driven by an expected total Duplin County population of 56,300 in 2015.

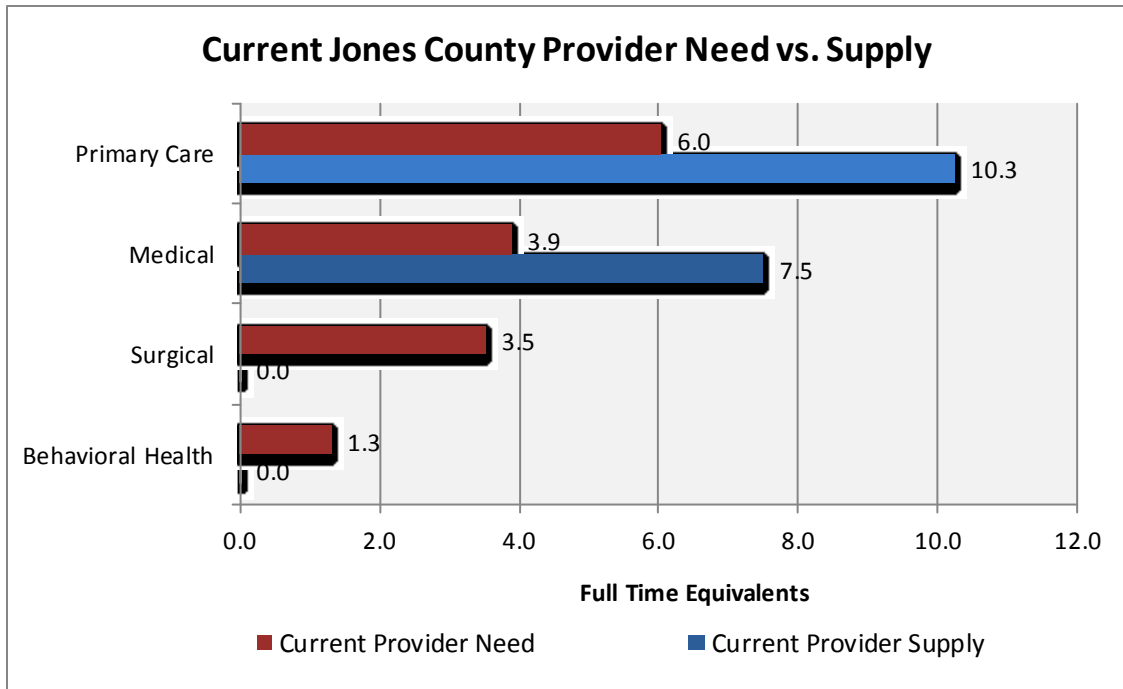
Relative to specific specialties included within the broader categories provided in the above chart, it is estimated that Duplin County will have needs for at least the following specialties: cardiologists, oncologists, general surgeons, ophthalmologists, orthopedic surgeons, internists, pediatricians, and psychiatrists.



Jones County Physician Needs

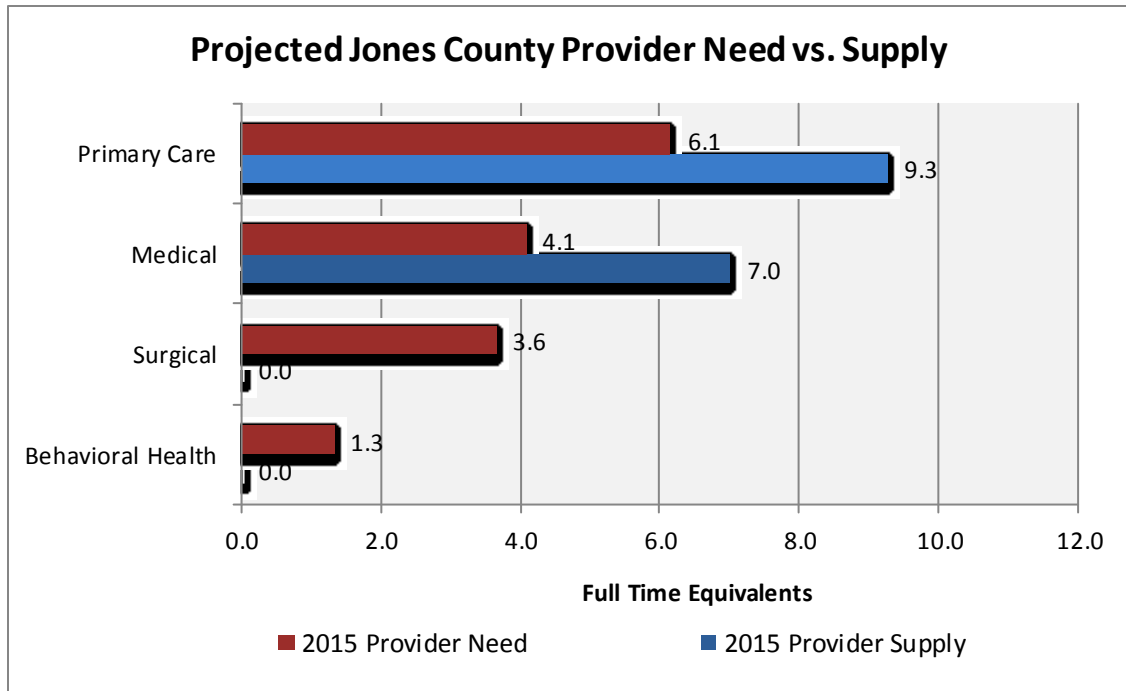
Jones County has modest physician needs in order to service its residents, who often travel outside the county for care. Currently, the county has a need for an additional 0.9 primary care providers, 2.3 medical specialists, 3.5 surgical specialists, and 1.3 behavioral health providers. Existing supply in the county is comprised of the following:

- Primary Care: 10.25 FTEs (10.0 physicians and 0.25 physician extenders)
- Medical Specialties: 7.5 FTEs (7.5 physicians and 0.0 physician extenders)
- Surgical Specialties: 0.0 FTEs
- Behavioral Health: 0.0 FTEs



By 2015, after accounting for expected population growth and physician retirements, Jones County will have a need for 2.9 primary care providers, 2.4 medical specialists, 3.6 surgical specialists, and 1.3 behavioral health providers. Need estimates are driven by an expected total Jones County population of 10,100 in 2015. Please note that there are surpluses in specific specialties which cause the supply to appear to exceed the need for the primary care and medical specialty groups. The estimated need for additional providers in each specialty group is the sum of all specialties in which there are projected deficits, and any surpluses are not counted against this total deficit (please see page 29 for a more detailed explanation).

Relative to specific specialties included within the broader categories provided in the above chart, it is estimated that Jones County will have additional needs for at least the following specialties: cardiologists, general surgeons, orthopedic surgeons, obstetricians/gynecologists, and psychiatrists.



Physicians at larger medical centers in Carteret, Craven and Pitt counties provide care to Jones County residents that migrate out to those locations. As such, a portion of the need in Jones County are already being met by providers located outside of the county. Apparent “needs” shown for Jones County should be considered relative to apparent “oversupply” in surrounding counties.

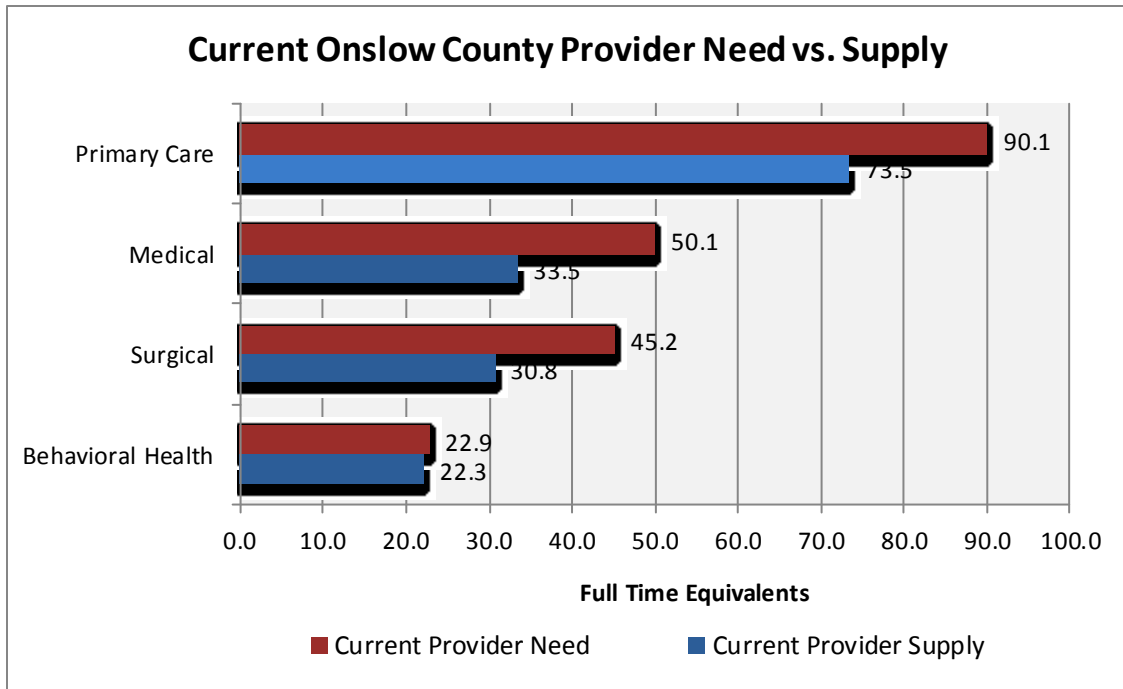
Onslow County Physician Needs

Onslow County has the greatest physician need in the MGTf region based on the civilian and military physician supply data²². It is estimated that the county has a need for an additional 25.3 primary care providers, 23.4 medical specialists, 14.9 surgical specialists, and 0.6 behavioral health providers. This need assumes that all uniformed providers have 50 percent capacity relative to their civilian counterparts, because of their additional duties beyond patient care. Existing supply in the county is comprised of the following:

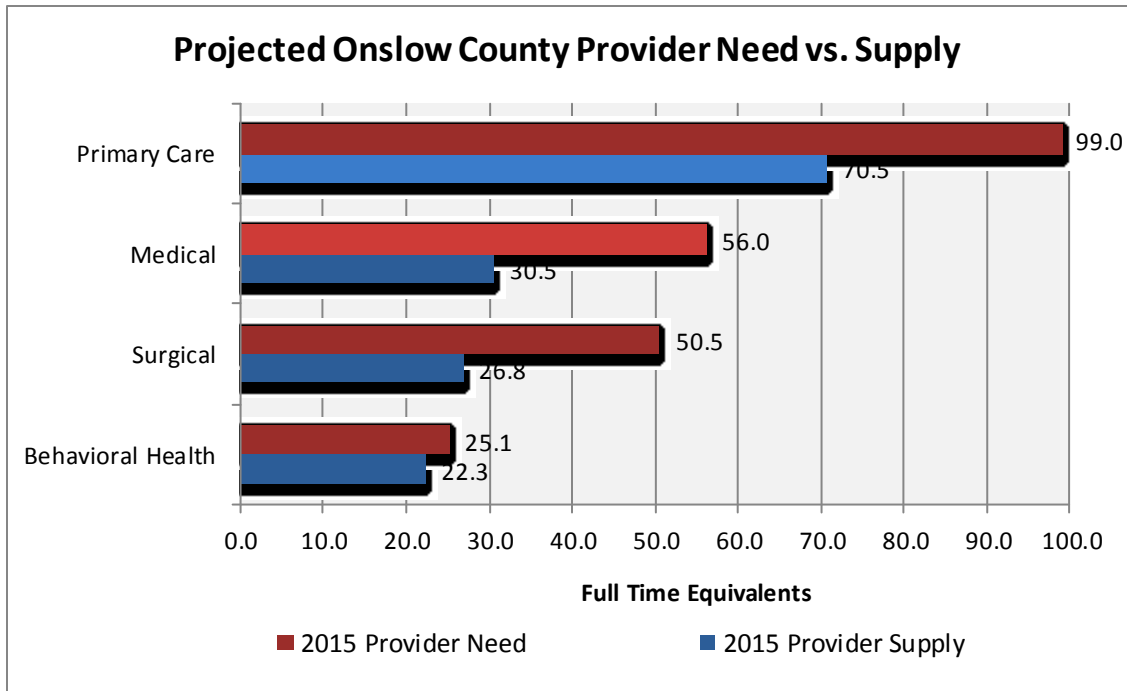
- Primary Care: 73.5 FTEs (54.0 physicians and 19.5 physician extenders)
- Medical Specialties: 33.5 FTEs (32.5 physicians and 1.0 physician extenders)
- Surgical Specialties: 30.8 FTEs (29.0 physicians and 1.8 physician extenders)
- Behavioral Health: 22.3 FTEs (8.0 physicians and 14.3 physician extenders)

²²

ibid.



By 2015, after accounting for expected population growth and physician retirements, Onslow County will have a need for 32.4 primary care providers, 31.9 medical specialists, 23.7 surgical specialists, and 2.8 behavioral health providers. Need estimates are driven by an expected total Onslow County population of 198,000 in 2015. Please note that there are surpluses in specific specialties which cause the supply to appear to exceed the need for the primary care and medical specialty groups. The estimated need for additional providers in each specialty group is the sum of all specialties in which there are projected deficits, and any surpluses are not counted against this total deficit (please see page 29 for a more detailed explanation).

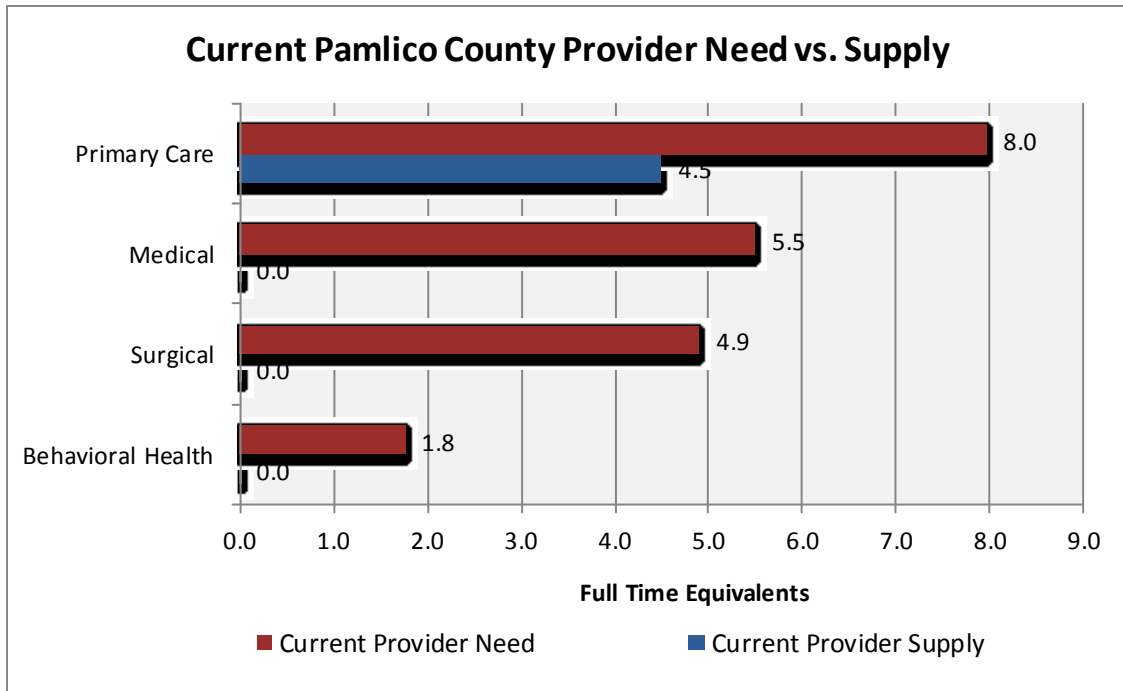


Relative to specific specialties included within the broader categories provided in the above chart, it is estimated that Onslow County will have additional needs for at least the following specialties: allergists, cardiologists, dermatologists, gastroenterologists, otolaryngologists, thoracic surgeons, urologists, internists and pathologists.

Pamlico County Physician Needs

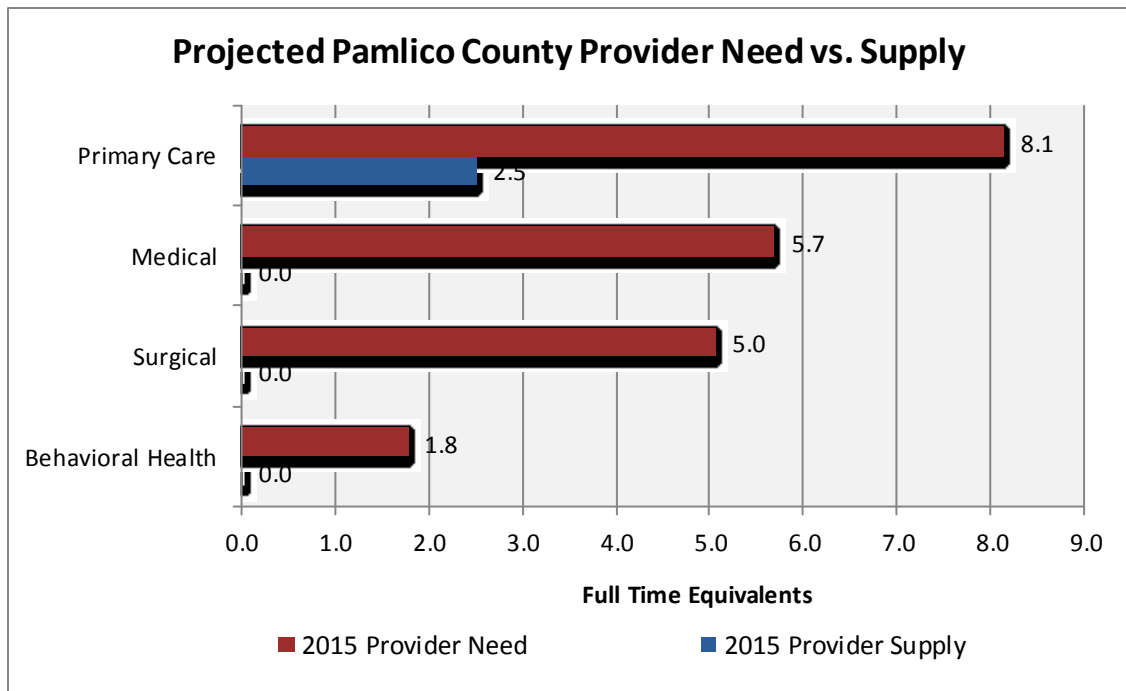
Pamlico County has small physician needs in order to service its residents, who often travel to outside the county for care. Currently, the county has a need for an additional 4.7 primary care providers, 5.5 medical specialists, 4.9 surgical specialists, and 1.8 behavioral health providers. Existing supply in the county is comprised of the following:

- Primary Care: 4.5 FTEs (3.5 physicians and 1.0 physician extenders)
- Medical Specialties: 0.0 FTEs
- Surgical Specialties: 0.0 FTEs
- Behavioral Health: 0.0 FTEs



By 2015, after accounting for expected population growth and physician retirements, Pamlico County will have a need for 5.8 primary care providers, 5.7 medical specialists, 5.0 surgical specialists, and 1.8 behavioral health providers. Need estimates are driven by an expected total Pamlico County population of 12,000 in 2015. Please note that there are surpluses in specific specialties which cause the supply to appear to exceed the need for the primary care specialty group. The estimated need for additional providers in each specialty group is the sum of all specialties in which there are projected deficits, and any surpluses are not counted against this total deficit (please see page 29 for a more detailed explanation).

Relative to specific specialties included within the broader categories provided in the above chart, it is estimated that Pamlico County will have additional needs for at least the following specialties: cardiologists, gastroenterologists, oncologists, general surgeons, ophthalmologists, orthopedic surgeons, internists, obstetricians/gynecologists, and psychiatrists.



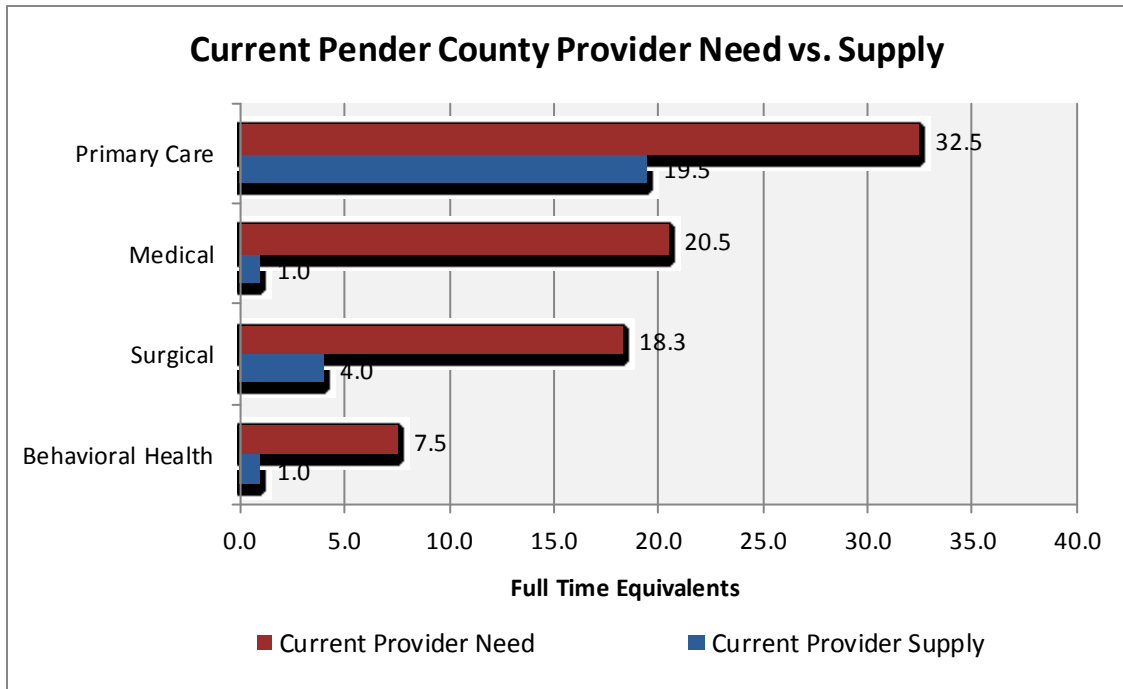
Physicians at larger medical centers in Craven and Pitt counties provide care to Pamlico County residents. As such, a portion of the physician needs of the Pamlico County population are already being met by providers located outside of the county. Apparent “needs” shown for Pamlico County should be considered relative to access to providers in surrounding counties.

Pender County Physician Needs

Pender County is designated as a HPSA by HRSA for primary care and mental health. Being designated as a geographic HPSA for primary care allows all physicians in the county to receive a reimbursement bonus on services provided to Medicare patients. However, that status is currently proposed to be withdrawn and would have potential negative implications of provider financial viability in the county.

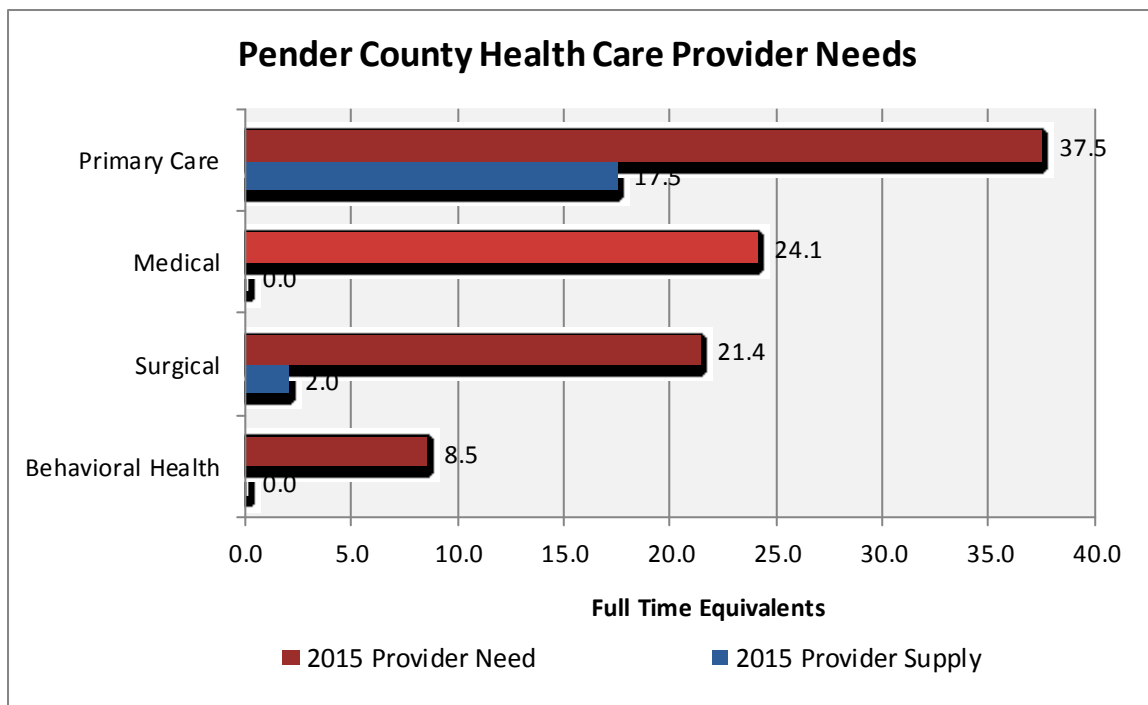
It is important to note that Pender County benefits from Pender Memorial Hospital’s affiliation with New Hanover Health Network based in Wilmington. This relationship helps to mitigate the challenges associated with physician recruitment and retention in the county. However, it is estimated that the county has a need for an additional 15.3 primary care providers, 19.5 medical specialists, 14.3 surgical specialists, and 6.5 behavioral health providers. Existing supply in the county is comprised of the following:

- Primary Care: 19.5 FTEs (19.5 physicians and 0.0 physician extenders)
- Medical Specialties: 1.0 FTEs (1.0 physicians and 0.0 physician extenders)
- Surgical Specialties: 4.0 FTEs (4.0 physicians and 0.0 physician extenders)
- Behavioral Health: 1.0 FTEs (1.0 physicians and 0.0 physician extenders)



By 2015, Pender County will have a need for 20.0 primary care providers, 24.1 medical specialists, 19.4 surgical specialists, and 8.5 behavioral health providers. Need estimates are driven by an expected total Pender County population of 62,000 in 2015.

Relative to specific specialties included within the broader categories provided in the above chart, it is estimated that Pender County will have additional needs for at least the following specialties: cardiologists, dermatologists, gastroenterologists, nephrologists, neurologists, oncologists, general surgeons, orthopedic surgeons, urologists, internists, obstetricians/gynecologists, pediatricians, and psychiatrists.



Please note all of Pender County’s medical specialists and behavioral health providers are expected to retire by 2015.

Physicians at larger medical centers in New Hanover County provide care to Pender County residents that migrate out to those locations. As such, a portion of the physician needs of the Pender County population are already being met by providers located outside of the county. Apparent “needs” shown for Pender County should be considered relative to existing capacity in surrounding counties.

Needs and Next Steps

Please see the discussion in Section XI regarding needs regarding physician recruitment and retention in the region.

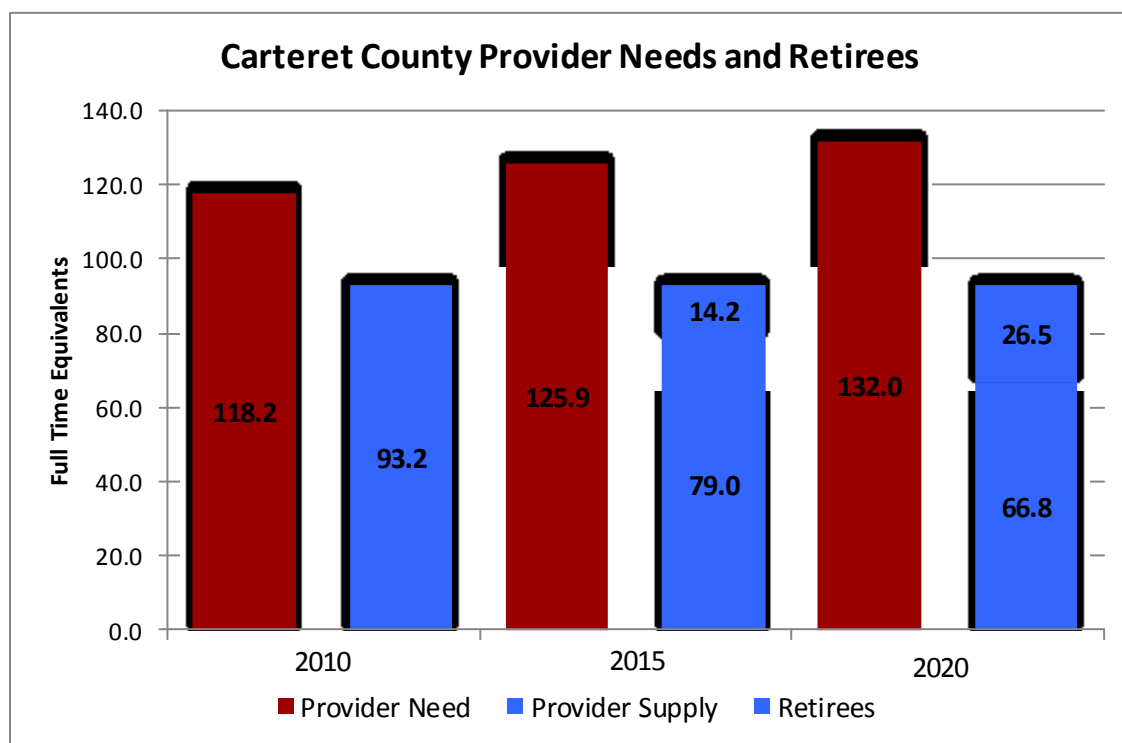
XI. Impact of Aging Physicians in the MGTf Region

The physician population in the MGTf region is rapidly aging relative to the additions of new/younger providers. Providers in the region expect a substantial number of retirements over the next several years. As a result, even without considering future population growth in the market there will be a significant need to recruit new providers simply to replace retirees. Physician supply models have been updated to include the ages of physicians and the impact of retirements by 2015 as well as by 2020. Retirements have been estimated based on the aging of the civilian physician population. Because the military physician supply is fairly unpredictable, due to deployments and station changes, no assumptions were made relative to retirements within that portion of the physician population.

As with the analysis of provider needs discussed earlier, county-specific summaries of retiree impact are provided below.

Retiree Impact in Carteret County

Based on existing physician supply data, predicted retirements, as well as updated population projections, it is estimated that Carteret County’s current health care provider deficit of 49.2 FTEs will increase to 62.5 by 2015 and to 76.0 by 2020.²³ Of the 93.2 FTE physicians and physician extenders in the county, 14.2 are expected to retire by 2015 and 26.5 by 2020.²⁴ Said another way, while Carteret County’s population is growing by an estimated 12 percent over the next 10 years, retirements are expected to reduce physician supply by nearly 30 percent.

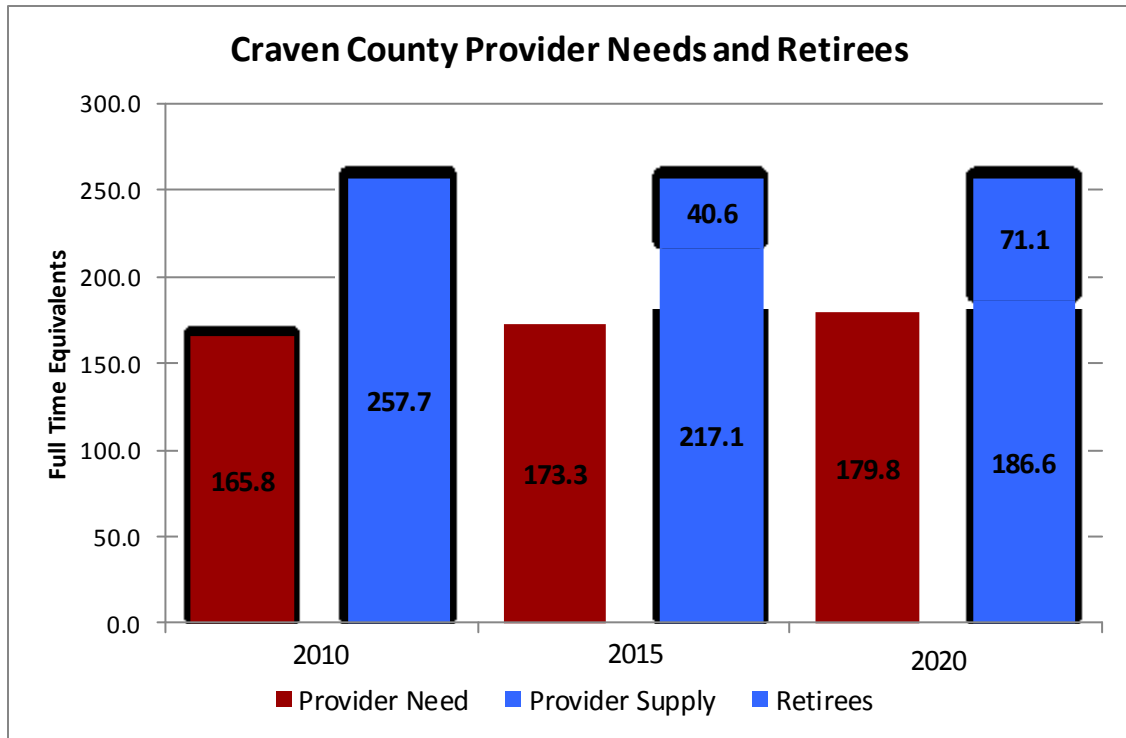


Retiree Impact in Craven County

Based on existing physician supply data, predicted retirements, as well as updated population projections, it is estimated that Craven County’s current health care provider deficit of 16.1 FTEs will increase to 28.6 by 2015 and to 46.8 by 2020. Of the 257.7 FTE physicians and physician extenders in the county, 40.6 are expected to retire by 2015 and 71.1 by 2020. While Craven County’s population is growing by an estimated eight percent over the next 10 years, retirements are expected to reduce physician supply by nearly 30 percent. Craven County’s expected reduction in physician supply is the largest, in absolute terms, in the MGTf region.

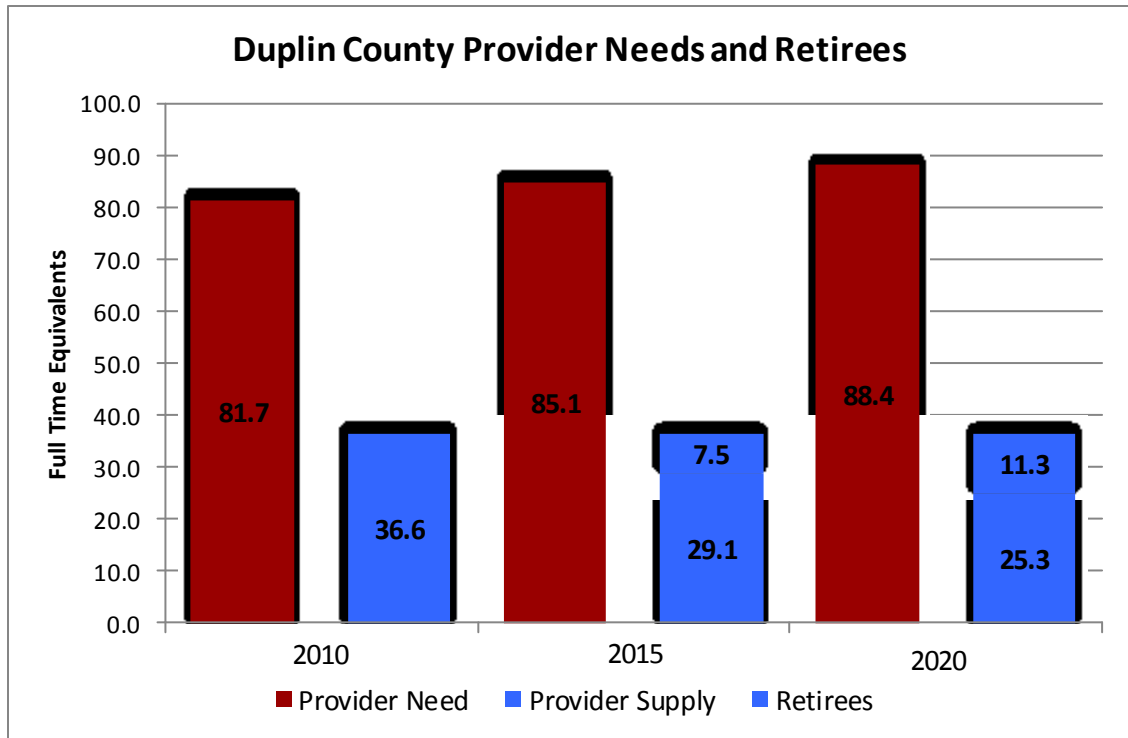
²³ Total provider need is not cumulative. Specialties with a surplus of physicians are not counted against deficits in other specialties. Thus, the difference between total provider need and total provider supply is not representative of the total deficit.

²⁴ HPS assumed a retirement age of 65 years old.



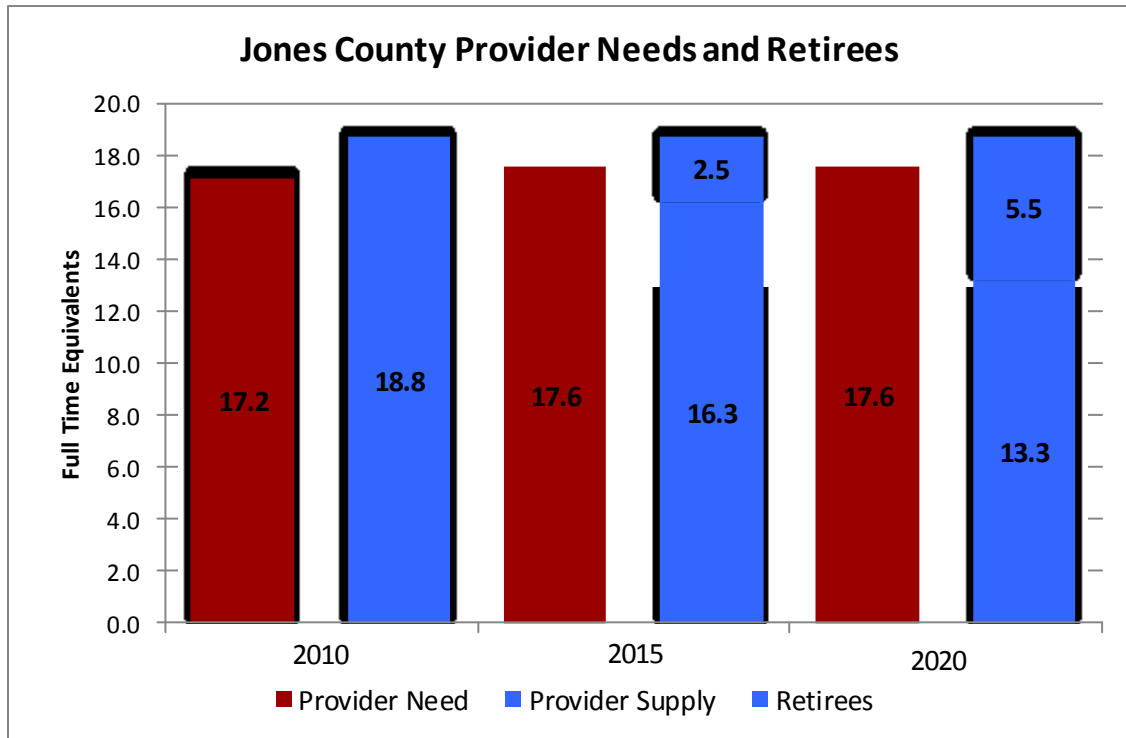
Retiree Impact in Duplin County

Based on existing physician supply data, predicted retirements, as well as updated population projections, it is estimated that Duplin County’s current health care provider deficit of 53.0 FTEs will increase to 60.1 by 2015 and to 67.1 by 2020. Of the 36.6 FTE physicians and physician extenders in the county, 7.5 are expected to retire by 2015 and 11.3 by 2020. While Duplin County’s population is growing by an estimated eight percent over the next 10 years, retirements are expected to reduce physician supply by over 30 percent.



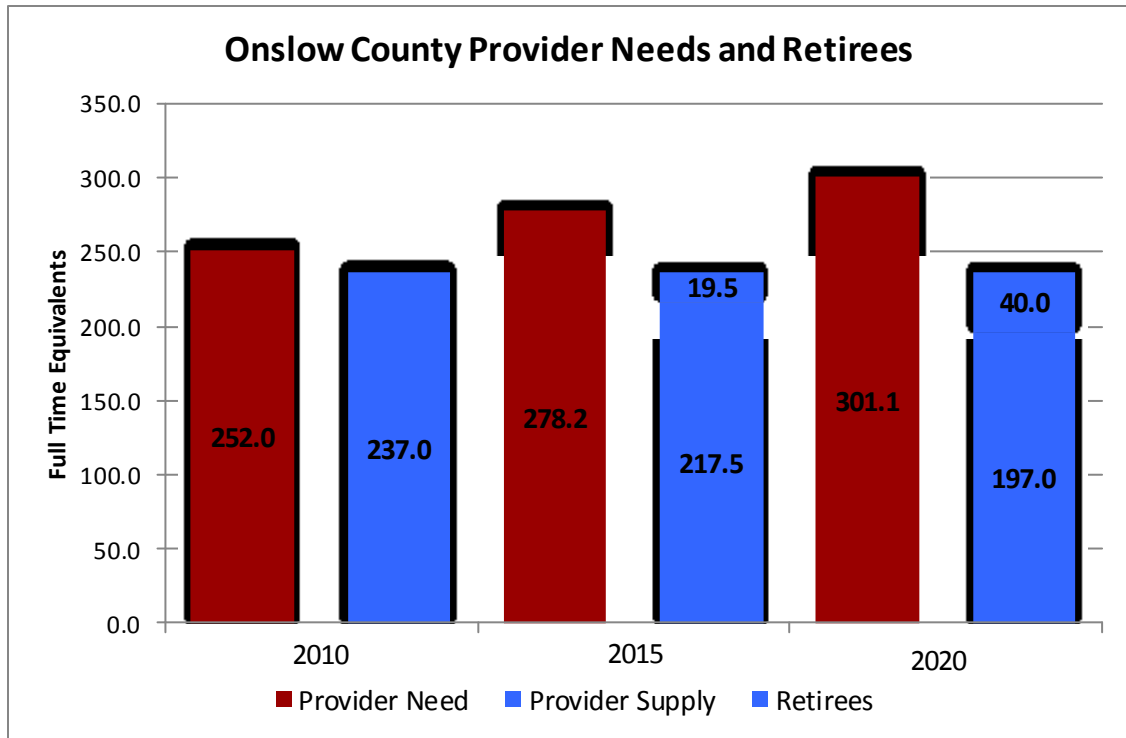
Retiree Impact in Jones County

Based on existing physician supply data, predicted retirements, as well as updated population projections, it is estimated that Jones County's current health care provider deficit of 11.7 FTEs will increase to 12.7 by 2015 and to 13.2 by 2020. Of the 18.8 FTE physicians and physician extenders in the county, 2.5 are expected to retire by 2015 and 5.5 by 2020. While Jones County's population is growing by an estimated three percent over the next 10 years, retirements are expected to reduce physician supply by nearly 30 percent.



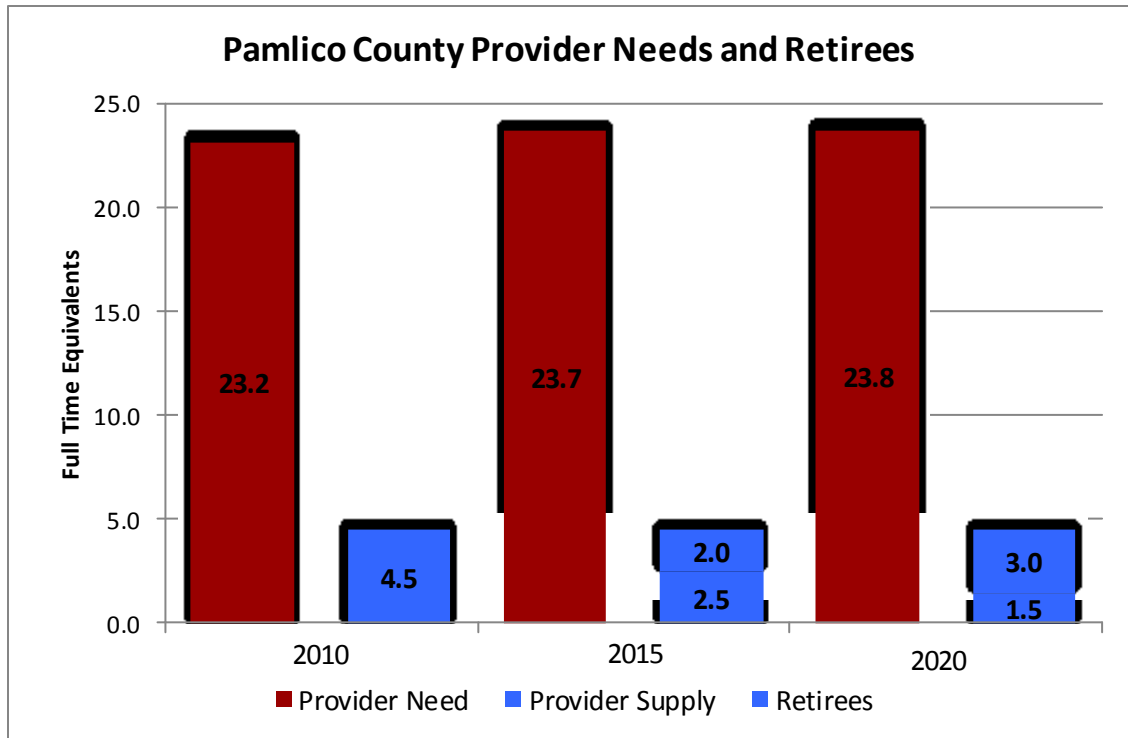
Retiree Impact in Onslow County

Based on existing physician supply data, predicted retirements, as well as updated population projections, it is estimated that Onslow County’s current health care provider deficit of 67.8 FTEs, the largest in the MGTF region, will increase to 96.2 by 2015 and to 129.6 by 2020. Of the 237.0 FTE physicians and physician extenders in the county, 19.5 are expected to retire by 2015 and 40.0 by 2020. Said another way, while Onslow County’s population is growing by an estimated 20 percent over the next 10 years, which represents the largest growth in absolute numbers in the MGTF region, retirements are expected to reduce physician supply by nearly 20 percent.



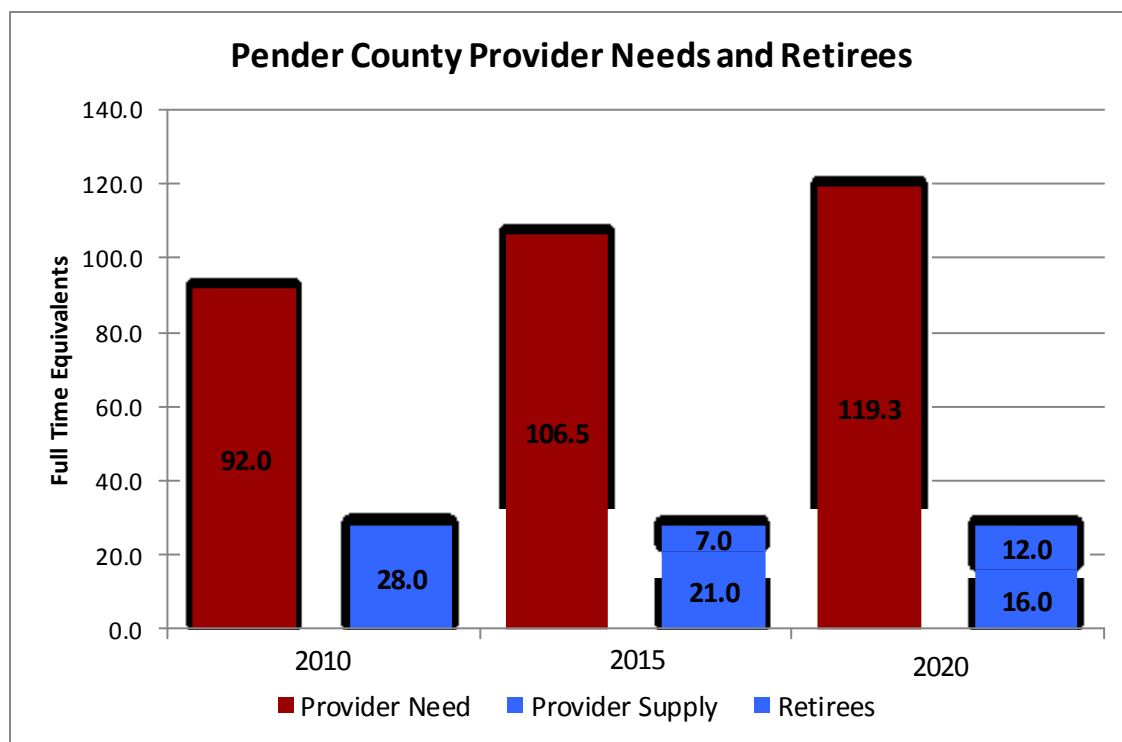
Retiree Impacts in Pamlico County

Based on existing physician supply data, predicted retirements, as well as updated population projections, it is estimated that Pamlico County’s current health care provider deficit of 19.9 FTEs will increase to 21.4 by 2015 and to 22.5 by 2020. Of the 4.5 FTE physicians and physician extenders in the county, almost half (2.0) are expected to retire by 2015 and almost all (3.0) are expected to retire by 2020. While Pamlico County’s population is growing by an estimated three percent over the next 10 years, retirements are expected to reduce physician supply by nearly 70 percent, the highest percent reduction in physician supply in the region.



Retiree Impacts in Pender County

Based on updated physician supply data, predicted retirements, as well as updated population projections, it is estimated Pender County's current health care provider deficit of 67.2 FTEs will increase to 86.5 by 2015 and to 103.3 by 2020. Of the 28.0 FTE physicians and physician extenders in the county, 7.0 are expected to retire by 2015 and 12.0 by 2020. Said another way, while Pender County's population is growing by an estimated 30 percent over the next 10 years, retirements are expected to reduce physician supply by over 40 percent. Pender County's percent population growth is the highest in the MGTf region.



Need 9: Support Provider Recruitment and Retention

In order to respond to the severe and growing health care provider needs across the seven counties, it is recommended that the MGTf undertake several actions that were identified in the Regional Growth Management Plan.

Need 9.a: Continue to pursue TRICARE locality waiver.

Local health care providers are currently working toward obtaining a Locality Waiver from the DoD which will effectively increase TRICARE reimbursement for physician and non-physician providers serving TRICARE beneficiaries. Low TRICARE reimbursement is already a key concern for providers in the region and the growth of the TRICARE eligible population in the region will only intensify this concern going forward. Failure to increase TRICARE reimbursement will likely discourage current non-network providers from participation and cause current network providers to limit their panels or withdraw from the network in the future.

Need 9.b: Pursue private grant funding targeted at covering professional school debt in exchange for service in a region with a high TRICARE population.

Recent medical school graduates have virtually no financial incentive to practice in an area with a significant TRICARE population. The physicians in the NC MGTf region overall are aging, raising concerns about future provider supply in the region. As such, it is imperative that incentives are put in place to attract younger physicians to the region. The region faces similar concerns related to dentists.

Federal and State loan repayment programs exist to incentivize physicians and dentists to practice in rural and health professional shortage areas for a stated period of time (two to four

years). However, only portions of some NC MGTF counties are eligible for these types of grants. In particular, Onslow County, which has the highest physician shortage, is not eligible for this type of funding. The addition of requirements to State and Federal loan repayment programs for heavily populated TRICARE areas is not a likely funding resource because of existing commitments to rural communities. Private foundations (such as The Duke Endowment and the Robert Wood Johnson Foundation) provide grants targeted at improving the health of communities. In addition, many foundations seek to develop programs which can be replicated in other locations. TRICARE physician recruitment grants could be replicated in other large TRICARE populations in North Carolina, as well as other states.

The proposed grants should mirror North Carolina loan repayment programs which offer \$70,000 to a physician in exchange for four years of service. In addition, these programs include tax stipends to help offset the provider's increased tax liability.

Need 9.c: Pursue the use of telemedicine services to supplement specialty physician needs, including behavioral health needs.

Although specialty physician resources are not available locally, they are available in surrounding regions. Both the VA and East Carolina Behavioral Health have had recent success using telemedicine to provide physician services to the local community.

The Distance Learning, Telemedicine, and Broadband provision of the American Recovery Reinvestment Act (ARRA "Stimulus Bill") provides \$2.5 billion to the USDA for grants, loan and loan guarantees to increase broadband infrastructure (thereby allowing telemedicine to be a possibility in rural areas). The grants are available to areas in which 75 percent of the area does not have sufficient access to high speed broadband service. In addition, ARRA included a \$19 billion provision for Health Information Technology (HIT) which primarily focused on the development of EMR, but could include telemedicine. In addition, several grants have been developed primarily for the purpose of encouraging the development of these services.

Need 9.d: Pursue regional partnerships for health care provider recruitment.

Several counties in the region require substantial numbers of additional health care providers that are unlikely to be met in a short timeframe. Local providers will need to employ creative recruitment techniques to begin to slowly address the needs. One such technique is the joint recruitment providers. Where appropriate, local providers, particularly acute care hospitals, should partner with other regional providers to recruit needed physicians to practice part time in each county. By sharing recruitment expenses, needs could be met in multiple counties.

Need 9.e: Revise health care provider licensure and certification laws regarding reciprocity between states.

The shortage of health care provider is the most pressing need facing the region. Often, the spouses of military members are health care providers, but have difficulty obtaining licensure and certification in North Carolina. As such, many choose to change fields or not work at all. By reducing the challenges to obtaining licensure and certification, more of these professionals may choose to practice in the region.

Benefits if Needs are Satisfied

Any alleviation of the provider shortage in the seven county region will allow military and their dependents as well as civilians to receive comprehensive high quality health care within their communities. An increase in the health care provider supply would also likely positively impact the financial situation of the acute care hospitals in the region as outmigration for specialty services would decline. These hospitals are cornerstones of the region's health care system which must maintain their financial health in order to provide needed community services.

Effects if Needs are Not Satisfied

Current physician shortages in the region force patients to forgo needed care or seek care in another community. In addition, due to the shortage in primary care providers, many have little to rely on other than hospital emergency rooms for care, even for less severe problems which could be more cost-effectively treated in other settings.

Next Steps

HPS will provide additional updates to the military physician supply data in an addendum to this report at a later date. Future reports will continue to update the changing civilian and military supply to identify any emerging gaps in supply.

Summary and Suggested Future Analyses

In summary, the issues outlined above have resulted in nine primary needs for the MGTF:

- Need 1:** Review physician density to population density ratios
- Need 2:** Seek TRICARE funding for comprehensive behavioral health services
- Need 3:** Ensure regular participation from military physicians in local medical society meetings
- Need 4:** Improve use of information technology
- Need 5:** Locate Financial Support for Community Providers
- Need 6:** Pursue a longer term solution to Medicare solvency
- Need 7:** Continue to stress the importance of health care access for military families and monitor the development of the Affordable Care Act
- Need 8:** Pursue increased reimbursement for mid-level providers of psychiatric services
- Need 9:** Support Provider Recruitment and Retention

In addition, as interviews are completed with regional hospitals, LMEs and physicians, items for future study arose. Many providers stated that there would be value in speaking directly with TRICARE consumers regarding their physical and behavioral health needs, as well as their ability to access services in a timely and convenient manner. HPS proposes that these interviews would take place for reporting in the January 31 and April 30, 2011 quarterly reports. In addition, for future reports HPS will follow up on any relevant issues in the above report, as well as inpatient acute care, rehabilitation and psychiatric needs, and social services needs.