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MEDICARE SUBVENTION DEMONSTRATION

DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues

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This report conveys our findings on the early implementation of the Department of Defense (DOD) Medicare Subvention Demonstration.[1] The demonstration is designed to test whether DOD, by forming Medicare Health Maintenance Organizations (HMO) at six sites, can provide accessible and quality health care to military retirees and their survivors and dependents, while not increasing federal costs for either Medicare or DOD.[2]

Military health care and Medicare share a sizable service population. There are 1.3 million military retirees (including their dependents and survivors) who are 65 and older. Most of them are eligible for Medicare as well as for military health benefits—dual eligibles—and many of these dual eligibles are enrolled in traditional fee-for-service Medicare or a Medicare HMO. Some of these Medicare enrollees obtain Medicare-covered health services at military treatment facilities (MTF) as well as from their private physician or HMO. However, legislation prior to this demonstration prohibited Medicare from reimbursing DOD, which had paid for these services from appropriated funds. DOD's 1999 appropriation for military health care was almost $16 billion, of which about $1.2 billion was spent on those 65 and older.

Although retirees 65 and older have historically received some care at MTFs, prior to this demonstration DOD could not offer them comprehensive care.[3] DOD had a managed care program (TRICARE Prime), but only for service members on active duty, retirees under 65, and their respective dependents and survivors. However, once they reached 65, retirees were no longer eligible for TRICARE Prime. The demonstration program, called TRICARE Senior Prime, extends DOD-provided managed care at the six sites to these older retirees.

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[1] "Subvention" means a transfer of money from one federal department to another.

[2] For the names of the six sites and summary information about them, see table 1. More detailed information about the sites is included in appendixes I through VI.

[3] We will use the term "retirees" in this report when referring to retirees and their dependents and survivors.

Senior Prime differs from TRICARE Prime in three important ways. First, Senior Prime covers Medicare benefits, such as care at a skilled nursing facility, in addition to TRICARE Prime benefits. Second, Senior Prime serves two masters. It must comply with Medicare as well as DOD requirements and answer to the Health Care Financing Administration (HCFA), which administers the Medicare Program, as well as to Defense health care officials. Third, Senior Prime involves Medicare subvention payments to DOD, provided that certain conditions are met.

In principle, the subvention demonstration offers several advantages. It enables older military retirees to obtain Medicare managed care benefits within the military health care system, which is an option that military retiree groups have supported. It also enables DOD to receive Medicare funds for services to Medicare-eligible retirees, beyond what DOD was already providing at its own expense. Medicare might gain from the subvention demonstration if its payments to DOD are lower than what Medicare would otherwise have paid on behalf of these beneficiaries.

However, key features of the demonstration are new and there were many questions as to how the program would work out. Accordingly, the Balanced Budget Act of 1997 (BBA),[4] which established this demonstration, directs us to evaluate the demonstration's results. The BBA poses 15 evaluation questions covering 3 key areas: feasibility of and difficulties in program implementation; costs to Medicare and DOD; and effects on beneficiaries (in terms of access to and quality of care). The questions also ask about possible side effects—for example, whether the demonstration affects other users of DOD health care, military readiness and training, and private providers. We have already issued an initial report on cost information and related payment issues.[5] Other interim reports on cost, access, and quality issues will follow this report. The BBA calls for us to issue a final report several months after the demonstration ends in December 2000.

This report focuses on program implementation during the start-up phase of the demonstration. Our objectives were (1) to report on progress in establishing the ground rules for program operation, receiving HCFA approval, attracting enrollment, and starting to deliver health services; (2) to present information on useful practices and operational difficulties that emerged during program start-up; and (3) drawing on experience to date,

[4] P.L. 105-33.

[5] Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns (GAO/HEHS-99-39, May 28, 1999).

to identify issues for the future. Side effects, to the extent that they can be identified at this early stage of program operation, are included in the discussion.

Results in Brief

The start-up period of the Medicare Subvention demonstration was successful. Despite unanticipated delays, the six demonstration sites met the requirements for Medicare managed care plans, enrolled substantial numbers of beneficiaries, and began delivery of health care services by January 1, 1999. The sites' experience in dealing with the difficulties that arose along the way has yielded valuable lessons and has also pinpointed issues that remain to be resolved. While the successful start-up of the demonstration is encouraging, it will be some time before the results of its mature operation can be assessed.

Establishing the ground rules for the demonstration took longer and the HCFA approval process was more demanding than anticipated. As a result, the demonstration will cover 24 to 28 months of service rather than 3 years. The initial demand for enrollment overall was not as great as expected, in part because retirees were wary of a temporary program and feared that they might be unable to obtain affordable supplementary (Medigap) insurance at the demonstration's end. Enrollment also reflected site-specific factors, such as prospects for getting space-available care at an MTF without joining Senior Prime, the breadth of services available at the MTF, and options for care elsewhere in the community.

Preparing for the start-up of the demonstration brought some useful new senior health care and management practices to the MTFs, but also revealed operational difficulties. Such new practices included enrollee orientations and the early identification of health care needs that affected patients' transition into Senior Prime. Some of the operational difficulties that arose—such as bulges in demand for primary care—were solved at individual sites. Others were linked to HCFA and DOD central direction, such as difficult-to-combine data systems or inconsistent policy guidance.

The fact that this demonstration program operates within two bureaucracies—DOD and HCFA—caused some points of strain. Being new to Medicare, demonstration sites had to devote substantial DOD staff and consultant time learning HCFA requirements. The dual organizational structures within DOD—the governance structure of the Senior Prime Medicare plan and the military chain of command—carry with them the potential for conflict. Additionally, dual DOD and HCFA procedures, although perhaps necessary, may result in duplication of effort.

Finally, experience in the start-up phase of this demonstration raises issues for the future of this or other similar demonstrations. Current enrollees will need to know several months in advance of the end of this demonstration whether service will continue so that they can plan for their continued health care. Questions continue to arise concerning which aspects of Senior Prime operation DOD will handle centrally for the program as a whole and which aspects will be left to the sites. The demonstration also raises questions about arrangements for seniors' care during periods of deployment of military medical staff. It is uncertain how program expansion, if enacted at the end of the demonstration, would take place—for example, how sites distant from the DOD regional office that directs a Senior Prime plan might be added. Also, the viability of expanding the program to isolated sites that offer limited services deserves careful review. We make recommendations in this report concerning issues that affect the current demonstration.

Background

The DOD Medicare Subvention Demonstration combines a national health care delivery system operated by DOD with a health insurance system—Medicare—operated by HCFA within the Department of Health and Human Services (HHS). The demonstration includes six sites in different regions of the country.

The DOD Health Care System

The DOD health care system covers a service population that includes 1.6 million active-duty military personnel, 2.2 million dependents of active-duty personnel, and 4.4 million military retirees and their dependents, including the 1.3 million who are 65 and older. DOD delivers health care through its system of almost 500 MTFs worldwide. These facilities include 15 medical centers that offer extensive specialty care and provide graduate medical education (GME), such as residency training. In addition, DOD operates 76 smaller community hospitals with less extensive service options and 374 clinics offering outpatient services only.[6] Pharmacy services are available at most MTFs and are free-of-charge.

The direct care provided at MTFs is supplemented with care provided by a network of contracted civilian providers through DOD's TRICARE program. TRICARE offers beneficiaries three options for health care delivery, including an HMO option called TRICARE Prime. There are 12 TRICARE regions within the U.S., each headed by a lead agent, who is usually the commander of the largest medical center in the region. Each region also has a managed care support contractor who manages the private provider network and performs various beneficiary assistance and

[6] Approximately 10 community hospitals also offer GME.

management support services. The Office of the Lead Agent (OLA) oversees the TRICARE management support contractor for the region and coordinates TRICARE activities.

Priority for military medical care is given to active-duty personnel and their dependents and retirees under 65 who are enrolled in TRICARE Prime, thus enabling them to receive comprehensive health care coverage. TRICARE Prime coverage ends when a retiree reaches 65. Older retirees are eligible to receive medical care at an MTF, but only when space is available. Some MTFs have considerable space available after high-priority beneficiaries have been served, and others have very little space.

Medicare

Medicare is a federally financed health insurance program for the elderly, some disabled people, and people with end-stage kidney disease. Medicare covers 39 million beneficiaries and spends about $212 billion a year. Its benefits include hospital, physician, and other services, such as home health care and limited skilled nursing facility care. Medicare Part A covers inpatient hospital care, skilled nursing facility care, and hospice care; Medicare Part B covers physician and other outpatient services for beneficiaries who choose to pay a monthly premium.

Traditional Medicare reimburses private providers on a fee-for-service basis and allows Medicare beneficiaries to choose their own providers without restriction. Beneficiaries who receive care are responsible for part of the charges. Medicare beneficiaries can also join a Medicare HMO, and Medicare+Choice provisions that took effect in January 1999 permit them to choose other private health plans as well. Currently, 17 percent of these beneficiaries use Medicare managed care. Most Medicare managed care plans have only modest beneficiary cost-sharing and some offer extra benefits, such as eyeglasses and prescription drugs. Military retirees are eligible for Medicare on the same basis as anyone else.

HCFA administers Medicare and regulates participating providers and health plans. Both headquarters and regional office HCFA staff have oversight responsibilities regarding Medicare+Choice organizations. Headquarters staff handle legal and financial matters, while the regions are responsible for operational matters.

HCFA's oversight of Medicare+Choice plans begins with the certification process. To receive certification and begin health care delivery, an organization must complete the following tasks, among others:

- submit a comprehensive application to HCFA and respond to HCFA's requests for clarification and additional information;
- develop an organizational structure, bylaws, and policies and procedures, which are subject to approval by HCFA;
- conduct training for all staff and providers, including making provisions for training of new staff as they come onboard;
- prepare for and participate in a HCFA site visit, during which a team of HCFA personnel examine policies and procedures to determine if the site has the potential to deliver health care according to HCFA regulations;
- upon HCFA approval, begin marketing activities to inform beneficiaries about the program;
- enroll beneficiaries and provide for coordination of their health care, by assigning each to a primary care manager or by other means; and
- begin delivery of health care.

HCFA requires a variety of performance information from the plans once they are in operation and conducts both technical assistance and monitoring visits.

The Demonstration

To test a program granting Medicare-eligible military beneficiaries guaranteed access to health care provided through DOD but paid for by Medicare, Congress established the Medicare Subvention Demonstration Project. This demonstration authorized DOD to establish HCFA-certified Medicare plans and provide care to Medicare-eligible military beneficiaries at six sites for a 3-year period—January 1, 1998, to December 31, 2000. The DOD Medicare demonstration program is known as Senior Prime.

The goal of this demonstration is to provide a cost-effective alternative for accessible and quality health care while not increasing the federal cost for Medicare or DOD. HHS is to reimburse DOD from the Medicare Trust Funds for Medicare-covered health care services provided to Medicare-eligible military beneficiaries at an MTF or through contracts. However, to receive payment, DOD must at least match DOD's baseline cost for serving this dual-eligible population in the recent past.[7]

To be eligible for Senior Prime, dual-eligibles must be enrolled in both Medicare Part A and Part B, reside in one of the six geographic areas covered by the demonstration, and have used an MTF before July 1, 1997, or become Medicare-eligible after that date. Beneficiaries enrolled in the program will not have to pay a premium during this demonstration, but

[7] For more information on the payment mechanism for the Medicare Subvention Demonstration, see GAO/HEHS-99-39.

must pay any applicable cost-sharing amounts and must agree to receive all of their health care exclusively through Senior Prime. They will be subject to all of the Medicare+Choice requirements. Enrollees must have a primary care manager within the MTF. The benefit package for Senior Prime is the full Medicare benefits package supplemented by other benefits that DOD provides for its TRICARE Prime enrollees, such as prescription drugs. Senior Prime enrollees are to be given priority for treatment at MTFs over other dual-eligibles who are not enrolled in Senior Prime.

The Sites and Their Health Care Environments

Each of the six demonstration sites is located in a different DOD TRICARE health care region. The lead agent of the region is the chief executive officer (CEO) of the Senior Prime plan located in that region. Table 1 lists the demonstration sites, their locations, and their Senior Prime enrollment capacities. (Note that sites may have more than one MTF and more than one geographic service area.) For more specific information about each site, consult appendixes I through VI at the end of this report.

Table 1: Medicare Subvention Demonstration Sites

Demonstration site name	Facility type	Other HMO choices in area at start of services	TRICARE Senior Prime enrollment capacity	
			For MTF	For Site
Colorado Springs				
Evans Army Community Hospital, Fort Carson	Community hospital	Limited	2,000	
Air Force Academy Hospital	Community hospital	Limited	1,200	
Total (Colorado Springs)				3,200
Dover				
Dover Clinic, Dover Air Force Base, Dover, DE	Clinic	None	1,500	1,500
Keesler				
Keesler Medical Center, Keesler Air Force Base, Biloxi, MS	Medical center	None	3,100	3,100
Madigan				
Madigan Army Medical Center, Fort Lewis, Tacoma, WA	Medical center	Plentiful	3,300	3,300
San Antonio				
San Antonio Sites:				
Brooke Army Medical Center, Fort Sam Houston	Medical center	Plentiful	5,000	
Wilford Hall Medical Center, Lackland Air Force Base	Medical center	Plentiful	5,000	
Texoma Sites:				
Sheppard Community Hospital, Sheppard Air Force Base, Wichita Falls, TX	Community hospital	None	1,300	
Reynolds Army Community Hospital, Fort Sill, Lawton, OK	Community hospital	None	1,400	
Total (San Antonio)				12,700
San Diego				
Naval Medical Center, San Diego, CA	Medical center	Plentiful	4,000	4,000
Total	**N/A**	**N/A**	**27,800**	**27,800**

Sources: Facility information is from documents received from each site. Information on HMO choices is from interviews, the HCFA plan comparison World Wide Web site, and HCFA quarterly enrollment tables. Enrollment capacity figures are from DOD TRICARE Senior Prime Plan Operations Report tables.

The MTFs in the demonstration sites vary in size and types of services offered. The medical centers (Madigan, Brooke, Wilford Hall, San Diego, and Keesler) offer a wide range of inpatient services and specialty care, as well as primary care. These centers also have GME training programs. The Sheppard, Reynolds, Evans, and Air Force Academy MTFs are smaller community hospitals with more limited capabilities. Much of the specialty care at these hospitals is contracted out to the civilian network. One site, Dover, is a clinic, offering only outpatient services at the MTF and thus

requiring all inpatient and specialty care to be purchased from the civilian network.

The six demonstration sites serve Senior Prime populations within the 40-mile radius, or catchment area,[8] around each facility. All sites had served seniors to some extent before the demonstration. At the medical centers, seniors had been a substantial part of the workload to support GME in both primary and specialty care. Centers with GME in internal medicine had formed panels of seniors who regularly received primary care at the MTF. At most of the smaller sites, and in specialty areas in which a particular medical center did not have a GME program, care for seniors was more limited and likely to be episodic.

Some demonstration sites are located in areas such as the Seattle-Tacoma area, San Diego, and San Antonio where seniors can choose among a number of private Medicare HMOs. Other sites are located in areas where there are no other Medicare HMOs, such as Mississippi and rural Delaware.

Scope and Methodology

We began the evaluation of Senior Prime implementation with a review of the BBA and DOD and HCFA documents relating to the demonstration as well as interviews with headquarters staff from both agencies. We then visited each of the six sites 8 to 12 weeks after the start of program operation at that location. At the sites, we conducted group interviews with administrators and staff, including the lead agent, medical director, health delivery staff, financial managers, and contractor officials as well as beneficiaries and representatives of retiree groups. We collected interview and documentary data on

- site features pertinent to this demonstration;
- processes used to set up the program and enroll and serve beneficiaries;
- issues that arose and how they were addressed;
- initial results, such as enrollees' use of health care and Senior Prime's impact on other patient populations and on MTF operations generally; and
- lessons learned.

Follow-up teleconferences were conducted with the sites toward the end of the study period when the sites had from 4 to 8 months' experience with program operation. We analyzed documentary and interview data to

[8] The demonstration service areas are defined by ZIP codes and differ slightly from the catchment areas.

identify crosscutting and site-specific issues as well as effective problemsolving strategies.

The six sites we studied can support operational findings about the demonstration as a whole. However, the study has several limitations. Although they illustrate a variety of conditions, the six demonstration sites—four of which are major medical centers—are not representative of the universe of DOD health care facilities. A site's capacity to support the demonstration and its evaluation was a factor in site selection, so our findings will not necessarily apply to sites that do not meet this capacity threshold. We did not conduct interviews with network providers or providers outside of the demonstration plan, nor did we independently verify study data. These findings pertain to the start-up period but not to mature operation of the program. It is also too early to measure midterm or long-term results of the program. We have no comparable information about approval and early implementation for multisite, private Medicare+Choice organizations.

We conducted our review from October 1998 through June 1999 in accordance with generally accepted government auditing standards. We requested comments on a draft of this report from the Department of Defense, but none were provided. We also requested comments from the Health Care Financing Administration, and their written responses are presented and evaluated in the final section of this report and reprinted in appendix VII.

The Application Process Encountered Difficulties, But All Sites Earned HCFA Approval

The process of securing HFCA certification for demonstration sites to receive Medicare contracts proved difficult in two respects. First, the process got off to a late start, and there was considerable pressure to complete it quickly. The demonstration could not get started until HHS and DOD had negotiated a Memorandum of Agreement (MOA) that set forth the basic conditions of the demonstration. Several complex issues had to be resolved along the way. The MOA spelled out the benefit package, rules for Medicare's payments to DOD, and the HCFA requirements DOD would have to meet, along with some exceptions, such as waivers of HCFA regulations concerning physician licensing and fiscal soundness.[9] In general, DOD would be operating a Medicare+Choice plan following all of the HCFA requirements.

[9] The licensing waiver reflects the fact that each military physician, although licensed in some state, is not necessarily licensed in the state where he or she is currently stationed. Also, as a federal agency, DOD is deemed fiscally sound.

Although the MOA certified that DOD had the resources and expertise to operate the demonstration program, the MOA still required that each demonstration site submit an application to be certified through the HCFA approval process. (In requiring each site to complete an application, HCFA was following the same procedure that it would use with any multisite, private Medicare+Choice organization, such as Kaiser Permanente.)

The six sites were not officially announced until the MOA was signed on February 13, 1998, by which time 6 weeks of the demonstration period (which started Jan. 1, 1998) had already passed. DOD immediately directed sites to prepare application materials and submit them within a few weeks. Site officials commented that 3 months would have been a more reasonable length of time.

Second, having had no prior experience with HCFA reviews, DOD initially underestimated the detailed and Medicare-specific nature of the information required. Given that the MOA had recognized that existing DOD and TRICARE procedures meet many of HCFA's requirements, DOD officials had thought that the applications could be based largely on central- and site-level documents that were already on hand. The applications initially submitted consisted largely of such documents, and thus described procedures and service provider networks that predated Senior Prime. These applications did not include signed contracts with network providers of Medicare services as HCFA requires, nor did they describe the site-level policies and procedures through which Medicare requirements would be met. From HCFA's viewpoint, these applications were incomplete and, if not part of a demonstration, would have been sent back for further development.

In view of the pressure of time and considering that demonstration programs are often given extra assistance, HCFA officials agreed to proceed with the application review and scheduling of site visits despite the deficiencies in the applications. However, these officials emphasized that signed contracts would have to be available for inspection during the site visit and that standard review criteria and procedures would be applied. To further speed the reviews, HCFA

- scheduled site visits sooner than usual after the application review,
- gave the demonstration sites priority over other applicants and contributed extra central staff to the site reviews where a particular regional office did not have sufficient staff available, and
- permitted two sites to proceed with marketing on the basis of verbal approval so as to enable services to start by selected target dates.

DOD, in turn, provided funding for sites to retain consultants experienced in Medicare to help the sites prepare for the reviews. The demonstration sites varied in their initial knowledge of HCFA requirements and in the amount of work (especially network development) that remained to be done. Each site team mounted an all-out effort to prepare for the site visits. The first sites were visited in June 1998. DOD staff from the earlier sites gave later sites the benefit of their experience, and the last two site visits were completed by the end of September 1998.

The sites' efforts were ultimately successful. All of the sites received certification. However, because of the time required to develop the MOA and complete the application and review process, the demonstration will cover 24 to 28 months of service rather than 3 years.

The first site certified, Madigan, began service September 1, 1998, and all of the sites had begun delivering services by January 1, 1999. HCFA reviewers found the site visit presentations and staff commitment to the program impressive. But two lessons from the experience stood out in our review. First, the application process was more demanding and time-consuming—and required more reworking of existing procedures—than DOD had envisioned. Officials at nearly every site told us that completing all of the work required in the short time available was a major difficulty they faced in implementing the program. Second, HCFA facilitation of the process was critical. HCFA officials indicated that under normal circumstances, the process would have taken considerably longer.

Enrollment Levels Reflected Both General and Local Factors

Initial enrollment in the demonstration was lower than DOD officials and other observers expected, and enrollment rates varied considerably from site to site. The demand for enrollment appeared to reflect both the temporary nature of the demonstration and site-specific factors.

The Temporary Nature of the Demonstration Affected Enrollment

At every demonstration site, we heard either directly from beneficiaries or from Senior Prime staff that many retirees were reluctant to enroll in Senior Prime because of the temporary nature of the demonstration. Some took a "wait and see approach," wanting some time to observe the demonstration before committing themselves. Other beneficiaries were concerned about how they would receive medical care after the demonstration was over and whether they would be able to affordably re-enroll in their previous Medigap (supplementary insurance) plans or other Medicare HMOs when the demonstration ended. The fact that the temporary nature of this demonstration reduced enrollment numbers to an unknown degree argues that the demonstration may not be an accurate

indicator of the number of people who would enroll in a permanent program.

The Medigap issue was a major concern to retirees who were enrolled in fee-for-service Medicare. Medigap policies are private health insurance policies that require a monthly premium and cover certain expenses not covered by fee-for-service Medicare. The BBA provided that participants in demonstration programs would be guaranteed issuance of a Medigap policy and protected against price discrimination if they applied for Medigap insurance after leaving the demonstration. However, implementation of this "guaranteed issue" provision required action by state insurance commissioners. The timing of such actions was uncertain at the beginning of the demonstration. Accordingly, DOD's marketing materials warned potential enrollees that it may be difficult for them to obtain Medigap coverage under previous terms and conditions when they disenrolled from the demonstration. Beneficiaries told us that a couple pays as much as $190 per month for Medigap coverage.[10] Some beneficiaries did not drop their Medigap policies when enrolling in Senior Prime because of their concern that Medigap re-enrollment would be at a higher rate. However, this problem is being worked out as the demonstration continues. As of the end of July 1999, guaranteed issue protections were in place in each state that includes a demonstration site.

Various Site Factors Also Made a Difference

Our interviews indicated that there were also variables at each site that affected enrollment, such as the

- breadth of services available at the MTF,
- amount of space-available care at the MTF,
- health care environment in the area, and
- maturity of the TRICARE program.

The demonstration sites varied in the number of eligible beneficiaries within each catchment area, the enrollment capacity, and the number enrolled, as shown in table 2 below.

[10] The monthly cost of an individual Medigap policy in the demonstration states ranges from about $50 for basic benefits to about $200 per month for the most comprehensive coverage.

Table 2: Medicare Subvention Demonstration Program Enrollment as of June 28, 1999, by site

Demonstration site	Start of health care	Eligible beneficiaries	TRICARE Senior Prime enrollment capacity	Capacity as percentage of eligible	Enrolled beneficiaries			Number open enrolled as percentage of capacity
					Open	Age-in[a]	Total	
Colorado Springs[b]	1/1/99	13,689	3,200	23.4%	2,878	243	3,121	89.9%
Dover	1/1/99	3,905	1,500	38.4	706	30	736	47.1
Keesler	12/1/98	7,361	3,100	42.1	2,661	186	2,847	85.8
Madigan	9/1/98	21,709	3,300	15.2	3,303	427	3,730	100.0
San Antonio:								
San Antonio Sites[c]	10/1/98	34,148	10,000	29.3	9,929	827	10,756	99.3
Texoma Sites[d]	12/1/98	7,067	2,700	38.2	1,819	114	1,933	67.4
San Diego	11/1/98	35,619	4,000	11.2	3,101	180	3,281	77.5
Total	**N/A**	**123,498**	**27,800**	**22.5%**	**24,397**	**2,007**	**26,404**	**87.8%**

[a] Age-ins are persons enrolled in TRICARE Prime before their 65th year, and assigned to a primary care manager at an MTF, who were eligible for and applied to Senior Prime upon turning 65. Age-ins are guaranteed acceptance, and the number of age-ins does not count toward capacity.

[b] MTFs include Evans Army Community Hospital, which had reached 84.55 percent of capacity, and the Air Force Academy Hospital, at 98.92 percent of capacity.

[c] MTFs include Brooke Army Medical Center and Wilford Hall Medical Center, both of which had reached 99 percent of capacity.

[d] MTFs include Sheppard Community Hospital, which had reached 57 percent of capacity, and Reynolds Army Community Hospital, at 77 percent of capacity.

Source: DOD's TRICARE Senior Prime Plan Operations Report, June 28, 1999.

Site officials told us that they arrived at their Senior Prime capacity figure by estimating the workload capability of physicians in the primary care clinics. Financial considerations played a role at some sites, as discussed in a later section of this report. As shown in table 2, the percentage of the eligible population that a site could accommodate if filled to capacity varied from 11 percent to 42 percent. The lowest capacity percentages were at Madigan and San Diego. The highest were at Keesler, Dover, and the Texoma sites, where Senior Prime is the only Medicare HMO in the market area.

Although most sites anticipated that there would be a high initial demand for enrollment, only two MTFs filled up within the first few months—Madigan reached capacity the 3rd month of operation, and Wilford Hall Medical Center in San Antonio reached capacity the 4th month. The Air Force Academy Hospital reached capacity after 6 months, and Brooke Army Medical Center reached capacity at 8 months. By the end of June, Keesler and Evans Army Community Hospital were over 80-percent full, San Diego was over 75-percent full, the Texoma sites were over 65-percent full, and Dover was just under 50 percent full.

One site factor that apparently affected enrollment was the breadth of services available at an MTF, where Senior Prime beneficiaries receive care at no charge. (See apps. I through VI for services available at each site.) For example, at the large medical centers with many specialties, most medical services needed by seniors could be within the MTF. Thus, very little specialty care would need to be referred to the civilian network, where beneficiaries would be required to make co-payments for their care. Smaller hospitals, such as those in Colorado Springs (Air Force Academy and Evans) and Texoma (Fort Sill and Sheppard), needed to refer seniors to the civilian network for most specialty care, and the Dover clinic needed to refer all inpatient care to the network. Co-payments, ranging from $12 to $40 for outpatient services, could be a disincentive to enrollment for some retirees.

Also influencing enrollment was the likely availability or shortage of space-available care at an MTF. We found that some MTFs with GME programs had substantial space-available care in specialty areas. For example, the Naval Medical Center in San Diego had ample space-available care in some specialties (such as cardiology) at the MTF, and we were told that some seniors felt they could get the specialty care they needed without joining Senior Prime. Other sites, such as Madigan, Sheppard, and the Air Force Academy Hospital, were nearly full before Senior Prime and warned beneficiaries that there would be little space-available care left after Senior Prime reached its enrollment capacity. In this case, retirees realized that if they did not enroll in Senior Prime, they would probably not be able to receive care at the MTF.

The health care environment for seniors at each site was also a factor. In some areas, seniors could choose from several Medicare HMOs as well as fee-for-service Medicare. For example, in San Diego, private HMOs have a 48-percent market share of eligible Medicare beneficiaries. This high penetration rate brings with it much competition for beneficiaries. To attract customers, San Diego area HMOs offered enhanced benefits, compared to which the Senior Prime plan was perhaps less attractive. In other demonstration areas (Keesler, the Texoma sites, and Dover), Senior Prime was the only Medicare HMO option for most potential beneficiaries. In these areas, being an HMO was not necessarily an advantage for Senior Prime: some retirees at these sites expressed reluctance to enroll because of their discomfort and unfamiliarity with managed care plans in general. These retirees would be returning to fee-for-service care if the demonstration were not continued, and concerns about the future availability of Medigap insurance added to their reluctance. However, MTF officials told us that some seniors had difficulty finding fee-for-service care

in these areas (and sometimes at the MTF) and welcomed the ready access to care that Senior Prime offered.

The maturity of DOD's managed care program, TRICARE Prime, in an area also apparently affected enrollment in Senior Prime. In sites where TRICARE Prime had been in operation for 3 or 4 years, such as Madigan, initial problems had been resolved and seniors could see how the program was working. TRICARE Prime was new in the area where Dover is located, having begun in June 1998. This new program brought new and unfamiliar procedures and encountered some start-up difficulties, and TRICARE Prime enrollment was low. Thus, Dover staff predicted that Senior Prime enrollment would be well below capacity, and that most enrollees would be those who had already been regularly receiving care at Dover.

Aging-in May Stretch Capacity

When TRICARE Prime enrollees at demonstration sites turn 65, those who are Medicare-eligible and assigned to a primary care manager in the MTF are guaranteed enrollment in Senior Prime—a process called "aging in." Age-ins do not count toward capacity levels at demonstration sites. DOD expected age-ins to come from the already enrolled population and to increase at a modest rate. However, some sites are finding that eligible beneficiaries are enrolling in TRICARE Prime in their 64th year, so that they can join Senior Prime when they turn 65. At sites where MTFs are nearing their planned enrollment limit, an increasing number of age-ins might strain current resources.

Preparing for Health Care Delivery Brought Useful New Practices

The delivery of medical services under Senior Prime largely followed the managed care framework and procedures established for TRICARE Prime. The principal difference was that Senior Prime enrollees now received the full range of TRICARE Prime care, plus added Medicare benefits such as home health care. But in other respects, preparing for the implementation of the Senior Prime demonstration brought useful new practices to the MTFs. (For practices specific to each site, see apps. I through VI.)

Patient Care Enhanced Through Demonstration Activities

Sites adopted several new practices to meet the needs of their senior patients. One such practice was to conduct orientation sessions for new enrollees to educate them on the program and identify their individual health care needs. Each site conducted some form of orientation for the enrollees to explain the program benefits, health service delivery, the role of the primary care manager, and how to schedule appointments with their health service providers. Many sites combined this educational orientation with identifying the health care needs of enrollees through administering a health assessment survey and/or holding individual health screenings in one-on-one meetings between enrollees and medical staff. As part of the

intake of enrollees, sites identified patients who had neglected medical conditions and arranged for the immediate care they needed. For example, at one site a patient with a life-threatening heart condition was identified and scheduled for surgery the following day.

Other useful changes that Senior Prime brought to the MTFs included the following:

- Identifying enrollees' continuing health care needs before the start of health care delivery, such as patients who needed durable medical equipment or needed to complete previously scheduled care outside of the MTF.

- Changing or augmenting case management, already practiced under TRICARE Prime, to meet the special needs of older patients. (Case managers are assigned to monitor certain patients' care over time, including patients with multiple diseases or complex health problems and patients taking multiple medications.)

- Monitoring and assisting older patients who did not qualify for case management but were likely to have difficulty following through on their own care, for example, following up with certain patients to ensure that they scheduled their needed appointments.

Management Improvements From Meeting HCFA Requirements

Certain HCFA data collection and reporting requirements prompted or accelerated management improvements at the demonstration sites. For example:

- Acceleration of the MTFs' efforts to improve and refine their information systems and generate better data while meeting HCFA reporting requirements. To illustrate, one site trained MTF providers and staff on how to enter outpatient and inpatient data accurately and in accordance with HCFA coding guidelines.

- Consolidation and simplification of MTF quality improvement efforts to respond to HCFA program rules, including developing quality indicators and monitoring health care process and outcome metrics. The quality management and utilization management work plans required by HCFA were seen as a useful tracking device that could also be applied to TRICARE Prime.

- Improved coordination and collaboration between the lead agent offices, MTFs, and managed care support contractors. In San Antonio, this coordination extended across service lines.

Officials at one site commented that reviewing HCFA requirements had prompted re-examination of traditional practices, and that preparing for the demonstration had "invigorated" the DOD health care system in that region.

Comprehensive Treatment of Seniors Seen as Supporting GME and Readiness

Demonstration site officials see the comprehensive treatment of older patients under Senior Prime as being useful in supporting the MTFs' training of providers and readiness missions. According to MTF officials, treating relatively healthy patients is not enough to keep doctors challenged; however, treating older patients with complex cases gives doctors the chance to practice a broader range of clinical skills.[11] Before Senior Prime, MTFs relied on space-available care to provide older patients, and therefore could not be guaranteed a consistent population for training residents. Under Senior Prime, MTF residents provide the full spectrum of care for these patients and are more likely to have the mix of medical cases they need to develop their skills.

MTF officials said that treating seniors helps indirectly with the readiness mission. According to MTF officials, treating the more complex cases indirectly aids retention and recruitment of doctors. In addition, they indicated that having an enrolled population provides a firm basis for planning for such contingencies as the deployment of MTF medical staff.

Preparing for Service Delivery Also Revealed Operational Difficulties

Sites' experiences during marketing, enrollment, and the first weeks of service delivery revealed several operational difficulties. Some of these difficulties were solvable (and solved) at the site level, but others were linked to central DOD or HCFA direction, policy, or information systems.

Some Difficulties Were Solved at the Site Level

The first sites to begin service encountered operational problems as a result of not identifying patients' transition needs in advance. Some incoming enrollees' supplies of durable medical equipment, such as home oxygen, were disrupted in the transition to Senior Prime. Other enrollees kept previously scheduled appointments with out-of-network providers after Senior Prime coverage began, which required retroactive approval.

[11] See Medical Readiness: Efforts are Underway for DOD Training in Civilian Trauma Centers (GAO/NSIAD-98-75, Apr. 1, 1998).

Later sites found ways to ensure that vital equipment was available on the first day of service and to arrange permission for out-of-network care in advance. For example, one site sent a letter to new enrollees before the start of service urging those with transitional needs to call Senior Prime program managers about them right away. Another obtained this information through telephone calls to all new enrollees.

Madigan's experience also illustrated the difficulties of starting services for large numbers of new enrollees on a single start date. Serving 3,000 new enrollees led to bulges in demand that strained the capacity of primary care clinics and made it difficult for them to meet access standards. It was also difficult to process large numbers of enrollments in the time available, as sites typically received HCFA's list of approved applicants around the 25th of the month, for services starting on the 1st day of the following month.

Sites dealt with the first of these difficulties by phasing in enrollment over 2 or 3 months. This helped spread out enrollment processing and cut down on bulges in demand, although they still occurred in some primary care clinics and in certain specialties such as eye care. (Senior Prime beneficiaries were entitled to a health evaluation within 90 days and an eye examination during the course of the demonstration, for which space-available care had previously been scarce.) However, phased-in enrollment was disadvantageous for applicants who needed a firm start date. For example, applicants in Colorado whose former HMOs withdrew from Medicare December 31, 1998, needed to know in advance whether, if accepted into Senior Prime, their services would start January 1, 1999. Start dates were phased in on a first-come, first-served basis, and program officials were unable to tell which applicants were in the January group until late December, when the list of approved applicants arrived from HCFA.

Sites employed several strategies to deal with the tight timelines for processing enrollments, including

- preparing enrollment materials for every applicant in advance and then removing the packets for the few who were not approved,
- immediately sending approved enrollees a letter of acceptance that also served as a temporary ID until their full enrollment packet arrived, and
- seeking access to a HCFA data system (the MCCOY system) that would allow site officials to track approvals as they were made rather than waiting for a batched report.

Other Difficulties Were Linked to Central Direction, Policy, or Information Systems

Other operational difficulties were linked to central direction, policy, or information systems. While sites devised strategies for handling some of these difficulties in the short term, longer-term solutions would require central action.

Limited Access to Medicare Expertise

DOD authorized sites to purchase up to 1,000 hours of consulting time from experts on Medicare HMO application and site visit requirements and procedures to assist them in preparing for site visits, and all of the sites found this assistance to be very helpful. (San Antonio, with four MTFs, was allowed 2,000 hours.) The HCFA Web site on the Internet was also helpful, and design teams from some sites visited nearby Medicare HMOs. But DOD barred officials at the demonstration sites from consulting another important source—HCFA regional office staff. Instead, they were to direct questions about HCFA requirements to officials at DOD headquarters, who would refer the questions to central HCFA headquarters officials as needed. (Apparently, this restriction was intended to ensure that the information provided was consistent across sites and to minimize the demands on busy HCFA regional offices.)[12] Some sites ignored the ban and worked actively with HCFA regional staff. Others honored the ban, but felt that doing so put them at a considerable disadvantage. Site officials generally agreed that the ban was an impediment, and HCFA regional officials shared this view.

Unclear or Inconsistent Guidance

We found several instances of unclear or inconsistent central guidance to sites. Site officials reported that central program documents described the Senior Prime benefits package in such general terms that they had difficulty determining exactly what was covered. For example, the documents listed diabetic supplies but did not specify which particular diabetic supplies (such as glucose strips and syringes) were included. The sites called for clearer central guidance in the interest of uniformity. Direction was also inconsistent with respect to allowable marketing activities. One site, San Antonio, used direct mail as a part of its marketing strategy with HCFA approval. Other sites asked DOD whether they could use direct mail, and were told that direct mailing was not permitted. (Staff at these sites believed this response to be based on HCFA guidance.) Some sites received DOD approval to arrange for Medicare consultant assistance

[12] The issue of inconsistency across HCFA regional offices has been discussed in previous GAO reports and testimonies. See, for example, Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999).

beyond the site visit, but another site requested such assistance and was turned down.

The clarity of HCFA guidance was also an issue for the sites. While some HCFA regional offices sent detailed letters outlining material to be covered in the site visit, others provided only general guidance or no guidance in advance. Lacking detailed guidance, DOD staff at two sites had not prepared contract materials that the HCFA regional staff person expected to review. During the HCFA approval process, consistency was an issue as well. At one site, HCFA regional staff asked to see the entire provider contract, while at other sites the Senior Prime addendum to the contract was sufficient for review. Similarly, staff at one HCFA regional office objected to marketing materials that had been approved centrally for the demonstration as a whole. DOD site staff we spoke with understood that the regional offices operate somewhat differently from one another. Each site ultimately developed a good working relationship with HCFA regional office staff.

Policy Changes in Mid-process

Changes in policy during the start-up process complicated program planning and management. For example, some sites did not know until the last minute that they would be included in the demonstration, and some began their planning with the understanding that program management would be lodged at the MTF level only to learn later that the lead agent would be in charge. Several critical changes in or clarifications of benefits were made after program operation had begun, which required adjustments in MTF and managed care support contractor operations. Finally, sites had to rewrite their Senior Prime policies and procedures to conform to the BBA-required Medicare+Choice regulations that went into effect on January 1, 1999.

Outdated Marketing Materials

Key changes in eligibility and benefits were made after DOD marketing materials had already been printed. For example, DOD greatly increased the number of days of skilled nursing facility care without a co-payment, and under Medicare+Choice, eligibility was expanded to include persons who spent up to 12 consecutive months outside of the service area. However, DOD continued to use the already printed material, supplemented by lengthy errata sheets. Sites reported that seniors were confused by information presented in this fashion, and that outdated provisions continued to be quoted long after they had been changed.

Design Flaw in the Age-in Process

The program permits eligible retirees and their dependents who were enrolled in TRICARE Prime and assigned to a primary care manager at a demonstration MTF to age in to Senior Prime upon reaching 65, even if

Senior Prime enrollment has reached capacity at a given site. The age-in process calls for such individuals to be identified 150 days in advance and notified of this option 120 days in advance of their 65th birthday. However, this procedure was not in place for each site 150 or even 120 days before the start of service. Sites had to develop their own procedures for identifying and notifying individuals whose 65th birthdays fell within that period. A further complication was that HCFA considers a person to have turned 65 on the first day of his birth month, whereas DOD data systems use the actual date of birth.

Divergence in Data Systems and Measures

The Senior Prime program draws from various DOD, contractor, and HCFA data systems that must be consistent with one another. Experience during the start-up period showed that constant monitoring is needed to ensure alignment between the data in these different systems, and that even apparently minor differences in data entry practice can make programwide reporting difficult. For example:

- Senior Prime enrollment data must be entered separately into a DOD data system, a data system specifically designed to transmit DOD data to HCFA, and sometimes into a support contractor data set as well. Multiple entry creates the potential for error at initial entry and also as information is updated. Also, the data sets use different conventions. DOD lists a dependent under the sponsor's (retiree's) Social Security number with a prefix, whereas HCFA lists each individual under his or her own Social Security number. Sites found that discrepancies in information across these various systems did occur, and that checking for them (as HCFA required) and determining which of two discrepant entries was correct was extremely labor-intensive.

- Differences in coding practices complicated the task of aggregating clinical data for Senior Prime from different clinics or MTFs. For example, in Colorado Springs, the Army hospital used only the base or generic code for mammograms, while the Air Force hospital used the base code with extensions to differentiate various types of mammograms. The DOD data system that generates management reports reads the generic and extended codes differently, such that equal numbers of mammograms from the two sites as recorded in the original data system did not necessarily produce equal totals in the management reporting system.

Unclear Payment Arrangements Did Not Affect Early Care

Funding arrangements for the demonstration presented site officials with many uncertainties during the start-up period. Medicare payments are due to DOD under the demonstration only if DOD's cost of caring for Medicare eligibles (using the level of effort calculation) during the period exceeds

the costs incurred to serve this population in the recent past. Funding arrangements provide for DOD to receive interim reimbursement monthly when a site's enrollment in Senior Prime meets a specified threshold. However, the demonstration as a whole must also meet an annual threshold. Failure to reach this threshold can result in DOD's returning a portion of the interim payments.[13]

Managers at each site could tell, on the basis of enrollment, whether that site was likely to earn interim payments for DOD. However, when services started they did not know, because DOD had not indicated, whether and how interim payments might flow to participating MTFs. They also did not know whether sites that received interim payments would be responsible for turning back these funds if the demonstration as a whole did not meet the annual threshold. Thus, the only funds the sites could be sure of were those already provided from DOD appropriations. Site officials worried that these DOD funds might not be sufficient to cover the cost of services added under Medicare, such as home health care. The officials were also concerned that sites might be asked to bear the cost of very expensive procedures or equipment, such as liver transplants, if medically necessary for a Senior Prime beneficiary. Existing MTF budgets were not designed to cover such extraordinary expenses for the senior population. These expenses would previously have been borne largely by Medicare.

Although frustrated by the uncertainty in the funding formula, site officials told us that this uncertainty had relatively little impact on site operations during the start-up period. Two sites (San Antonio and Keesler) adjusted their enrollment target upward on the basis of funding considerations. Funding considerations also influenced Madigan's decision to begin services for all enrollees on a single start date, which would help generate interim payments. However, other sites elected to phase in enrollment in the interest of avoiding overload, despite the potential financial disadvantage to DOD. With respect to health care delivery, officials told us that during this period of uncertainty, they were putting financial considerations on the back burner and concentrating on providing care to seniors. Utilization management procedures were in place to guard against unnecessary or unnecessarily expensive care.

By late spring of 1999, interim payments had been made to DOD and were being used to pay claims for Senior Prime services received through network providers. DOD had informed the demonstration sites that the funds that remained would be released to the various services. However, it

[13] For a more detailed explanation of the payment mechanisms, see GAO/HEHS-99-39.

takes some time for claims to come in, and DOD was reluctant to release funds until it was clear that reserves for claims payment were adequate. Sites expected that some funds would be released to them shortly, but details and amounts were still not known. Substantial uncertainty will remain until the first annual reconciliation takes place.[14]

Dual Systems Create Points of Strain

This demonstration, involving both DOD and HCFA and their separate requirements, contains some inherent duplication. Operating in a dual-systems environment has created some points of strain for the test sites.

Substantial DOD Investment in Learning HCFA Requirements

DOD officials told us that contrary to what they first thought, Senior Prime is not a DOD program with some extra Medicare benefits, it is a Medicare+Choice plan. Staff at each site had to learn and comply with Medicare rules and regulations to receive certification and operate the demonstration program. Complicating the learning process, the subvention demonstration start-up got caught in a major transition in Medicare. In addition to becoming familiar with prior regulations, personnel at all sites also had to learn the new HCFA regulations for Medicare+Choice, which under the BBA became effective January 1, 1999. Thus, Senior Prime managers at each site have made a substantial investment in learning.

This substantial investment in learning the HCFA regulations has the potential for being lost because of DOD's policy of staff rotation. Under this policy, about one-third of military staff rotate to a new assignment each year. Already some lead agent military personnel, recently knowledgeable about Medicare, are being transferred to locations where there is no test site or where their new job responsibilities will not require them to use their Medicare knowledge. Their replacements will have to go through the same learning process. As a result, some test sites have considered placing civilian employees in charge of administering the demonstration so that their investment in having staff learn HCFA requirements and procedures will not be lost to transfer. The OLA for Madigan currently has a civilian in charge of running the day-to-day aspects of the program, and there is a civilian chief operating officer at the Colorado Springs OLA.

Dual Organization Carries Potential for Conflict and Duplication

To meet HCFA's accountability requirements, the Senior Prime program has its own organizational structure, which differs from the structure for TRICARE Prime. At each demonstration site, the lead agent serves as CEO of the Senior Prime plan and is accountable to HCFA for the plan's

[14] The first annual reconciliation was expected to take place in late summer of 1999. The results were not available during our work for this report.

performance. However, the lead agent position, established to oversee the managed care support contractor and foster communication among MTFs for TRICARE, is not a part of the military chain of command. MTF commanders report to, and receive appropriated funds from, the Surgeon General of their respective service (Army, Navy, or Air Force). The position of lead agent does not carry direct authority over the commanders of the MTFs in the region, nor do staff in the OLA have authority over staff with similar functional responsibilities in the MTFs.

Typically, the commanding officer of the largest MTF in the region is appointed to serve as lead agent/Senior Prime CEO; as MTF commander, he or she has direct authority over that MTF's staff. In three of the demonstration sites (Madigan, San Diego, and Keesler) the lead agent is the commander of the only MTF offering Senior Prime. In other sites, the situation is more complex. The lead agent/Senior Prime CEO for the San Antonio demonstration site commands one of the four participating MTFs, two of which are within a different service than his. None of the MTFs participating in the Dover and Colorado Springs sites were under the lead agent's command. (See apps. I through VI for details.)

Staff in the demonstration sites recognized the potential for tension in these arrangements. Having the same person fill three positions (lead agent, Senior Prime CEO, and MTF commander) could be awkward if the interests of the three positions do not coincide. Where no formal reporting relationship between lead agent and MTF staff exists, smooth operation of Senior Prime depends on cooperation.

As of our review, the sites had worked out command and control issues to operate the Senior Prime program. Often, program operation rested on informal lines of authority and cooperation among the individuals involved. However, staff turnover and expansion of the program could strain such relationships, bringing the potential for conflict.

Overlap and potential duplication are also an issue in some aspects of this demonstration program. For example, HCFA and DOD operate parallel quality assurance systems, both with the goal of ensuring that beneficiaries receive quality medical care. Although the activities are similar, each has its own measurement and reporting requirements. Such requirements may be necessary to support the purposes of their respective agencies. However, overlapping requirements do not necessarily improve the quality of care at the MTFs, and these requirements do add cost and administrative work for Senior Prime staff.

Appeals and grievance procedures provide a second example of overlap. HCFA's requirements, which strongly emphasize patients' rights, are sufficiently different from DOD's requirements that sites ended up operating two sets of procedures—one for TRICARE Prime and another for Senior Prime. The two sets of procedures raised the prospect of unequal treatment for different groups of patients.

Finally, some HCFA requirements do not apply to the military context. Demonstration sites have to submit a report of physician incentive payments, even though there are no such payments in DOD. Additionally, some items need adaptation for DOD enrollees, such as the Notice of Discharge and Medicare Appeal Rights, which is given to hospitalized patients when they are informed of their discharge date. HCFA's model language for this document states that the patient would be liable for the cost of hospital care beyond the discharge date. Patients in DOD hospitals are not liable for such costs, and this inapplicable language has caused much confusion for beneficiaries.

Administrative Workload Similar for Larger and Smaller Populations

DOD site officials reported that operating a Medicare HMO required a similar administrative workload, regardless of the size of the enrolled population, both during the application process and as the new Medicare+Choice program was being launched. Firm measures of administrative workload are not yet available. Most sites told us they had devoted about four full-time equivalents (FTE) from their lead agent staff (more at San Antonio, where there are four MTFs, and fewer at Dover, where the start-up of TRICARE absorbed the attention of lead agent staff). In addition, many MTF staff hours were also devoted to this demonstration. Madigan, for example, estimated that about three FTEs from the MTF were dedicated to Senior Prime. However, administrative workload was not initially counted as program cost for the level of effort calculation and was not measured. HCFA and DOD are now discussing whether administrative cost could be included in the level of effort. DOD has hired a contractor to determine the actual administrative costs of this demonstration, including staff time devoted to the project.

Managed care support contractors are responsible for many aspects of the demonstration, including network development, enrollment, marketing, appointments, and claims processing, and the FTEs devoted to these activities were substantial. Cost information from contractors was just becoming available when we concluded this study and bears watching in the future.

Experience in the Start-up Phase Raises Issues for the Future

Experience in the start-up phase raises issues for the later years of this demonstration program, as well as for any future subvention program. For the current program, the issue for beneficiaries is what will happen to them when the demonstration ends. A second issue, both for the demonstration period and for any future program, concerns uniformity versus local variation in program benefits and operation. Other issues are concerned with possible expansion of the program. Finally, military readiness activities raise issues for Senior Prime.

Planning for Transition at the End of the Demonstration

Beneficiaries and site officials alike expressed concern that enrollees had not been informed what arrangements would be made for their transition back to other forms of Medicare if the demonstration were to end as scheduled. Nor was anything said initially about when the decision regarding the demonstration's future would be made. DOD has since stated, in the 1999 Annual Notice of Change for Senior Prime, that the program must give enrollees 90 days notice if the program is to be terminated at the end of the demonstration period (Dec. 31, 2000). Such notice would give them time to apply to other Medicare plans during the November 2000 open enrollment period. However, such advance notice would also mean that Congress would have to make a decision regarding continuation—at least with respect to the current sites—before the evaluation of the demonstration had been completed.

Our conversations with beneficiaries after the Notice of Change was issued indicate that the notice did not fully resolve their concerns. Questions about access to Medigap insurance remained, and seniors also wanted information regarding whether they would be able to get space-available care at MTFs if the demonstration were terminated.

Central v. Local Decision

Another major question is whether Senior Prime will be operated as one DOD program, as six local programs, or as a combination. Although HCFA central officials coordinated regional offices' efforts across the demonstration, HCFA generally treats each site as an independent HMO, allowing each the latitude given by the Medicare statute to structure its own product and operations. Thus, HCFA called upon sites to make operational decisions concerning such matters as details of the benefits package, patient notification procedures, and Year 2000 data compliance plans. DOD guidance also permits variation from site to site on many operational matters, and, as each new HFCA directive arrived, the question of central versus local response had to be resolved. In the case of the patient notification-of-discharge requirement, for example, each site framed its own initial response. Responses varied widely, in part because the requirement incorporates assumptions that do not apply to DOD. Sites

inquired whether a central DOD response to the issue might not be more appropriate—as it was for the Year 2000 issue, which was handled centrally within DOD. The central versus local question is likely to come up within DOD again.

It Is Unclear How Potential Expansion, If Enacted, Would Take Place

The current demonstration raises several questions regarding how expansion of the program, if enacted at the end of the demonstration, would take place. Specifically, it is unclear how plans would incorporate MTFs that are administratively independent of the lead agent and geographically distant from the lead agent's office. The demonstration offers only two sites as examples—San Antonio and Dover. Each of these sites raises questions that have not yet been addressed.

The San Antonio site includes (1) an initial service area containing the medical center commanded by the lead agent and an independent medical center in the same city and (2) an expansion area containing two geographically distant and independently commanded community hospitals, one of them in another state. This arrangement represents a possible prototype for adding additional MTFs to a plan. However, HCFA officials emphasized that they make decisions about expansion on a site-by-site basis. Because distance can lead to insufficient oversight, HCFA approves such arrangements only when there is evidence of close communication, as there was in San Antonio. HCFA officials told us that they are generally wary of very large service areas. Thus, adding more (and more distant) sites to the San Antonio plan would likely raise questions for HCFA. But adding new plans within the region, each with the lead agent as CEO, might raise issues as well.

The Dover site consists of a single clinic that is administratively independent of and about a 2-hour drive from the OLA in Washington, D.C., and not under the lead agent's command. Before the demonstration, the Dover MTF had little contact with the OLA itself. While HCFA approved the Senior Prime plan for Dover, this is no guarantee that similar arrangements with more distant MTFs in the region would also be approved.

It is unclear to what extent Senior Prime procedures and organizational structures developed for each current site could be transferred to or extended to cover other sites in the region. Sites in the demonstration found that although materials from other, already-approved sites were a useful starting point, they generally needed adaptation to local circumstances. Finally, the regional structure of the two agencies is a complicating factor. Some DOD regions overlap with several HCFA

regional offices. For example, the DOD Northeast Region, with the lead agent in Washington, D.C., includes states that fall under HCFA's Philadelphia, New York, and Boston Regional Offices.

Expectations of Rapid Expansion May Not Be Realistic

As previously indicated in this report, the six sites in this demonstration completed the application and approval process in a little less than 1 year, but only because of HCFA's willingness to augment regional office staff and expedite the process for the sake of the demonstration. HCFA's capacity to process applications with current staffing is limited, and HCFA officials made clear to us that if the program were no longer a demonstration, applications from DOD would be treated the same as applications from any other source. Staff capacity limits at the OLAs may be a factor as well.

The experience that DOD gained through the demonstration would likely ease the task of preparing applications at new sites, but even so, substantial time and effort would likely be required. Existing policies and procedures would likely be helpful, but may need to be adapted to local circumstances. Even if materials prepared elsewhere were applicable, staff at new sites would need time to absorb their content thoroughly. On the basis of what we heard of the visits to demonstration sites, HCFA reviewers would likely probe site officials' understanding of the program's operational procedures, as off-the-shelf procedures that are insufficiently understood may invite problems in program operation.

Finally, Medicare+Choice requirements concerning the effective date of enrollment could limit initial enrollment at new DOD sites. Starting with 1999, the Medicare+Choice regulation provides for an annual election period in November with enrollments effective January 1 of the following year. At other times, enrollment is to be effective 1st day of the month following the application. These provisions appear to preclude phasing in initial enrollment over several months. As we have seen, DOD sites found phased enrollment essential for handling large numbers of new beneficiaries. Without phasing in, new DOD sites would have to limit initial enrollment or face overloading their primary care clinics.

The Viability of the Program at Isolated MTFs That Offer Limited Services Merits Careful Review

Judging from experience thus far, MTFs that offer limited services (community hospitals and especially clinics) and are located in isolated or rural areas would likely have special difficulty building a Senior Prime program. The demonstration sites with these characteristics operated in a fee-for-service environment in which private physicians (1) were in relatively short supply and (2) had little incentive to contract with a Medicare managed care plan. Building and maintaining a Senior Prime

network or providers under such circumstances took extra effort. Building Senior Prime enrollment offered additional challenges as well. At most of the community hospitals and clinic we studied, relatively little space-available care had been available in recent years, so that the initial customer base among seniors was fairly small. The Senior Prime networks for these MTFs offered a limited choice of private specialists, and some seniors chose not to join to stay with a favorite physician who was not included. The use of network specialists also involves co-payments, which decrease the financial advantage of joining the program. Finally, Senior Prime program management at these sites may consume a disproportionate share of administrative resources to serve a small percentage of the patient population.

Procedures and Data Systems That Work at a Small Scale May Not Be Adequate at Larger Volume

In discussing the interim "fixes" they had made to compensate for the limitations in the data sets essential for program administration, site officials commented that although workable at a small scale, these labor-intensive procedures would not be adequate to handle a substantially larger volume of enrollees.

Readiness Raises Senior Prime Issues

Finally, military readiness raises important issues for Senior Prime. Most importantly, if medical staff from the MTF were deployed to support a military action, would each site still have sufficient resources to meet its commitments for seniors' care?[15] This issue arose in concrete form in Colorado Springs, where both the Air Force Academy Hospital and Evans Army Community Hospital had medical staff (including primary care physicians) deployed overseas at the time of our visit. In the temporary absence of one colleague, each of the three remaining Air Force primary care physicians in internal medicine carried a substantial extra number of Senior Prime beneficiaries. Having just gotten to know one new doctor, these beneficiaries were not eager to be reassigned to another when the deployed physician returned. Evans also had some trouble fitting in all of the requested Senior Prime appointments, in light of deployment. Losses of staff due to deployment are particularly important for Senior Prime because DOD requires that Senior Prime beneficiaries (unlike those in TRICARE Prime) be assigned to primary care managers within the MTF—they cannot be assigned to network physicians.

MTFs in the demonstration vary in the extent to which staff are subject to absence for readiness training or short-term deployment under normal circumstances. All lead agents are expected to engage in readiness

[15] This question is part of the broader question of how DOD can best balance the need for wartime medical training with the needs of its peacetime health care system. See GAO/NSIAD-98-75.

planning and provide for backup coverage of deployed staff. Readiness contingency plans in demonstration sites include shifting Senior Prime beneficiaries to network specialty care and, if primary care capacity at the MTF is greatly reduced, shifting TRICARE Prime beneficiaries to primary care managers in the network. Site officials might ask DOD to permit Senior Prime beneficiaries to be shifted to network primary care managers as well. If the existing network were not able to take on this extra load, support contractors would seek to expand the network, paying higher than normal rates if necessary. If physicians who were willing to take on added patients were available, coverage would be provided, although perhaps at an added cost. However, availability may be a problem in areas where private physicians are in short supply.

The effects of a major deployment on the order of Desert Storm are much harder to predict. For example, San Diego is the deploying platform for a hospital ship and Keesler for an Air Transportable Hospital, but under deployment, staff for these mobile units may be drawn from other locations as well as the home base. MTFs that contribute staff to back-fill for deployments at other MTFs do not themselves receive backfill. However, such a major deployment could potentially lead to gaps in coverage or inability to maintain access standards, especially in sites that were operating close to capacity before the deployment.

Conclusions

A demonstration is intended to produce useful evidence of the feasibility or effectiveness of a new approach, and the start-up period of the Medicare Subvention Demonstration has done so.[16] This demonstration provides evidence that it is feasible for DOD-designed plans to meet HCFA requirements for Medicare managed care plans and begin delivering health care to seniors, building on the TRICARE Prime framework but adapting it to the needs of this older population. But as demonstration site officials expressed it, Senior Prime is not a DOD program with Medicare benefits added on—it is a Medicare+Choice plan accountable to HCFA. The dual nature of the program affected its implementation in many ways.

Several feasibility issues connected with the design of the program affected the start-up period and would likely pertain to any similar demonstration program in the future. For example:

- The lead time needed to develop interagency agreements and secure HCFA certification before service delivery was substantial and shortened the period of service delivery to 24 to 28 months.

[16] Evidence concerning cost, access, and quality of care will be assessed in future reports.

- This shortened demonstration period apparently discouraged enrollment.
- A key feasibility issue from the enrollees' standpoint—how they will make the transition to other forms of Medicare at the end of the demonstration—was not adequately addressed.
- It was not feasible to start services at all sites on the same date. However, phased-in start dates turned out to be advantageous. The phased dates spread out the HCFA workload over several months and allowed difficulties to be discovered (and solved) early, when their effects were small-scale.

The start-up period also offered lessons regarding coordination within and between DOD and HCFA. Coordination between staffs of the two agencies at the central level was clearly necessary. However, coordination at the central level was not sufficient to enable sites to prepare adequately for certification (i.e., direct contact between site officials and HCFA regional office staff was essential as well). As Medicare+Choice provisions are put into effect, the question of which matters to handle locally and which might more appropriately be handled centrally for this demonstration continues to arise.

Finally, experience to date has revealed both useful practices and certain practical difficulties in operating Medicare+Choice plans within the DOD framework. Some of the difficulties—such as the lack of alternative designs for adding sites and bringing large numbers of beneficiaries into the program at once—do not affect current operations. However, these difficulties would affect expansion of the program, if authorized at the close of the demonstration. Other difficulties affect the demonstration itself. These difficulties include (1) possible overlaps in procedures, (2) the lack of clear provisions for beneficiaries' transition to other forms of health care at the end of the demonstration, (3) uncertainty regarding which aspects of Senior Prime operation DOD will handle centrally for the program as a whole and which will be left to the sites, and (4) insufficient information regarding the adequacy of arrangements for seniors' care during periods of deployment of military medical staff.

Recommendations to the Secretary of Defense

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

- work with HCFA to examine Medicare and DOD procedures, measurement, and reporting systems with an eye toward seeking

waivers (where warranted) and eliminating duplication to the extent possible;

- work with HCFA to determine conditions for transitioning out of the demonstration into other coverage (including Medicare options, access to Medigap insurance, and care at the MTF) and to notify enrollees of these conditions as soon as possible;

- determine (in advance, whenever possible) which HCFA directives and operational matters will be handled centrally and will be uniform across the Senior Prime program and which matters will be handled at the site level; and

- review plans for the provision of health care to seniors during times of military deployment and either (1) ensure that staffing at participating MTFs is sufficient to provide seniors with primary care or (2) provide for primary care to be delivered through some other means.

Recommendations to the Administrator of HCFA

We recommend that the Administrator of the Health Care Financing Administration work with the Assistant Secretary of Defense (Health Affairs) to (1) examine Medicare and DOD procedures, measurement, and reporting systems with an eye toward granting waivers where warranted and eliminating duplication as previously discussed, and (2) determine or clarify the conditions for transitioning out of the demonstration into other Medicare coverage and notify enrollees of these conditions as soon as possible.

Agency Comments and Our Evaluation

HCFA concurred with our recommendations and provided information about current and planned activities to address them, including activities to determine conditions for Senior Prime beneficiaries' transition to other Medicare coverage at the end of the demonstration.

Our work documented that military retirees enrolled in the Medicare Subvention Demonstration need clearer information about their options for care through the military health system as well as their Medicare options once the demonstration has ended. This observation points to the need to identify the options open to Senior Prime enrollees more broadly and for DOD and HCFA to communicate information about these options more clearly. For example, Senior Prime beneficiaries will need to know whether they will be permitted to complete a course of care at the MTF after returning to other Medicare coverage at the end of the demonstration and what chance they will likely have of getting care on a space-available basis. In addition, Senior Prime enrollees will need an explanation of the

guaranteed issue rights that apply to Medigap supplemental insurance policies, expressed in terms they can understand. Those who dropped Medigap coverage because they had enrolled in Senior Prime may also want information on Medigap options, availability, and rates. These examples illustrate the need for the recommendations we are making in this report.

We are sending copies of this report to the Honorable William S. Cohen, Secretary of Defense, and the Honorable Nancy-Ann Min DeParle, Administrator of HCFA, and will make copies available to others upon request.

If you have any questions regarding this report, please contact Ms. Westin or Gail MacColl at (202) 512-5108, or Mr. Backhus at (202) 512-7111. Other key contributors to this assignment were Cheryl Brand, Linda Lootens, and Ruth McKay.

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List of Committees

The Honorable John W. Warner
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The Honorable Carl Levin
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Committee on Armed Services
United States Senate

The Honorable William V. Roth, Jr.
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Committee on Commerce
House of Representatives

The Honorable Bill Archer
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

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Abbreviations

BAMC	Brooke Army Medical Center
BBA	Balanced Budget Act of 1997
CEO	chief executive officer
DOD	Department of Defense
FTE	full-time equivalent
GME	graduate medical education
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMHS	Humana Military Health Services
HMO	health maintenance organization
MAMC	Madigan Army Medical Center
MOA	memorandum of agreement
MTF	military treatment facility
NMCSD	Naval Medical Center of San Diego
OLA	Office of the Lead Agent
SMHS	Sierra Military Health Services

Colorado Springs (Central Region)

The TRICARE Region and the Demonstration Site

The Central Region, which combines Regions 7 and 8, encompasses 16 states and 1 million eligible beneficiaries, of whom about 183,000 are 65 or older. There is no Medical Center in the region, and the lead agent does not command a military treatment facility (MTF). Rather, he is assigned full-time to the Office of the Lead Agent (OLA), in Colorado Springs.

The demonstration site includes 2 Colorado Springs MTFs with overlapping 40-mile catchment areas: the 140-bed Evans Army Community Hospital at Fort Carson and the 40-bed U.S. Air Force Academy Hospital. (The clinic at Peterson Air Force Base is also included in the demonstration, but only for "age-ins.") These community hospitals provide primary care, some specialty care, and ancillary services, relying on the network to fill specialty gaps. The combined catchment areas include a service population of 134,341, including about 13,500 retirees who are 65 or older. The two hospitals had collaborated on programs and shared resources before Senior Prime. Each had lost medical staff, including primary care staff, to deployment at the time of our visit.

TRICARE began in this region in 1997. The Managed Care Support Contractor, TriWest Healthcare Alliance, is an organization owned by 14 local health care entities (including Blue Cross and Blue Shield plans and university hospitals) that was formed in 1995 to bid on the TRICARE contract. TriWest's main office is in Phoenix, AZ, with satellite staffs at various MTF locations. The firm has no experience in operating Medicare managed care plans, although many of its providers have Medicare experience.

Local retiree organizations strongly supported the demonstration and this site's inclusion in it. Thus, site officials were involved well before site selection was announced.

The Senior Health Care Environment

With reductions in staff and the advent of TRICARE, space available to Medicare eligibles at these hospitals has been very limited since 1997, especially for primary care. There were four commercial Medicare Health Maintenance Organizations (HMO) operating in the area, but two of them discontinued service as of January 1, 1999. The supply of private physicians is also limited and military retirees who no longer found space at the MTFs reportedly had difficulty finding private physicians who would accept new patients. Evidence from Senior Prime intake screening suggests that some of these retirees simply went without care.

Preparing for HCFA Approval

This site's primary source of information on Medicare requirements was a local independent consultant who had worked with Health Care Financing Administration's (HCFA) regional office staff in Denver. She was hired by TriWest as a full-time employee to assist in preparing for the site visit and continued to provide assistance through the start-up period. Site staff also contacted Denver HCFA staff directly and sent them documents to review before the site visit. Information from other Department of Defense (DOD) demonstration sites about their experiences was also useful. However, policy and procedures documents from earlier sites were of limited use because they were designed for larger medical centers and reflected earlier Medicare requirements rather than the later Medicare+Choice rules.

Program Features

- The enrollment target for the site is 3,200 (1,200 for the Air Force hospital and 2,000 for Evans). Initial enrollment was less than expected, but by the end of June, the Air Force hospital was at 99-percent capacity and Evans at 85 percent.
- Service delivery was phased in over 3 months to avoid overload.
- Retiree organization representatives were hired to assist with marketing and orientation meetings to help put attendees at ease.
- Beneficiaries' transition needs, such as ongoing use of oxygen or other medical equipment and completion of previously scheduled care outside the MTF, were identified before the start of services.
- The two hospitals' approaches to enrollee orientation and health screening reflected differences in their staffing for primary care. Evans included health screenings in the orientation meetings, which were used to identify patients with immediate needs for medical care or coordination of care. The Air Force Academy held briefer orientation meetings, with health assessment covered in the initial visit to the primary care physician.

Operational Difficulties and Issues

- To ensure coverage during the phase-in of Senior Prime, some retirees applied to a commercial HMO as well, which led HCFA to reject both applications.
- Deployments of medical staff during the start-up period created a substantial extra workload for the primary care managers that remained. Reassigning Senior Prime patients to even-out workloads once the deployed staff returned posed something of a problem.
- Retirees nearing 65 joined TRICARE Prime in order to age in to Senior Prime. As enrollment continues, adding these age-ins may strain capacity.
- Differences between the two MTFs in coding medical procedures on the ambulatory care data form make it difficult to compile data for the demonstration site as a whole.
- The base year for judging level of effort for funding purposes precedes TRICARE and reflects conditions very different from the present.

Dover (Northeast Region)

The TRICARE Region and the Demonstration Site

The Northeast Region, Region 1, extends from Maine to Virginia, encompassing 12 states and the District of Columbia. Its service population is 957,000, of whom 194,000 are 65 or older. The region includes three medical centers and two additional military inpatient facilities. All other MTFs in the region deliver only outpatient care. The position of lead agent rotates annually among the commanders of the three medical centers located in the national capital area—Andrews Air Force Base Hospital, Bethesda Naval Hospital, and Walter Reed Army Medical Center. The OLA staff of 33 is located at Walter Reed.

Dover is the smallest Senior Prime MTF, with the most limited services beyond primary care. It was added to the demonstration to illustrate outpatient-only services and rural conditions. Staffing at Dover has declined sharply since 1996, and inpatient service was discontinued in 1998. MTF facilities are being renovated, and most patient care is currently in temporary buildings. Sixty percent of the care delivered to Dover's patients was outside of the MTF even when Dover offered inpatient services. Located about a 2-hour drive from Washington, D.C., Dover has a service population of 26,000, of whom 4,100 are eligible for Senior Prime. A unique feature of the site is its proximity to the medical centers of the national capital area. A government van transports Dover patients to and from these centers several days a week. Another unique feature of the site is its inclusion in a demonstration that allows military retirees to join the Federal Employees Health Benefits Program.

TRICARE began in this region in June 1998, bringing with it practices that were unfamiliar to beneficiaries in the region, such as a contractor-operated centralized appointment system. Start-up problems in TRICARE were being resolved while Senior Prime was being implemented. The Managed Care Support Contractor is Sierra Military Health Services (SMHS) whose parent company in Nevada has Medicare HMO experience. Local military retiree organizations helped publicize Senior Prime.

The Senior Health Care Environment

About 800 seniors, concentrated in a few locations, have traditionally used the Dover MTF. Space-available care has been shrinking with the advent of TRICARE Prime. The geographically isolated Delmarva Peninsula, where Dover is located, has several hospitals but relatively few private sector physicians in each specialty area. The military medical centers of the national capital area have been an important additional source of care for military retirees. Medicare in the Dover area has been primarily fee-for-service. There were commercial Medicare HMOs, but they withdrew at the end of 1998. Their departure may have exacerbated seniors' concerns about the temporary nature of Senior Prime.

Preparing for HCFA Approval

Although Dover was named as a possible demonstration site beginning in August 1997, its participation was uncertain until sites were announced in February 1988. Pressed to produce an application quickly, Dover sent in a thin binder that contained placeholders for sections still to be developed at the site. Concerted program development started in June, when staff met in San Diego with staff from other sites and learned what was really needed. The design teams relied heavily on the HCFA site visit guide, documents and advice from Madigan and San Antonio, and consultant assistance. Because the OLA viewed the consultant as critical for implementing the program, it persuaded DOD to continue funding the consultant (through the SMHS contract) beyond the HCFA site visit.

HCFA regional office staff in Philadelphia first saw the Dover plan in early July and notified the OLA of additional materials that would be needed. Site officials were not permitted to contact the regional office until shortly before the site visit, which took place September 28 through 30. To meet a January 1 service start date, marketing had to start November 1. HCFA gave verbal approval for the marketing to go forward in advance of the formal plan approval document, which was issued November 18.

Program Features

- The capacity for the site was set at 1,500, but open enrollment had reached only 706 by the end of June. Enrollment consists largely of individuals who had traditionally used the MTF and is not likely to exceed about 800.
- With a small staff and TRICARE start-up duties, the OLA delegated considerable responsibility for Senior Prime to the MTF level. At the MTF, staffing and administrative workload for Senior Prime were about the same as at larger sites.
- Flu shots were given at new member orientation sessions.
- Case management for seniors is located at Dover rather than at SMHS' central site and will be supplemented by MTF nurses.

Operational Difficulties and Issues

- Network development has been a struggle and network maintenance requires ongoing attention. The few specialists in the area have been reluctant to undergo credentialing and to adopt referral procedures for the sake of a small number of Senior Prime patients.
- The new DOD data module used as an enrollment vehicle in this region has encountered technical problems and has had difficulty handling age-ins and multiyear enrollment.
- Distance between the MTF and the OLA was an impediment. Materials and information important to the program were not always sent to both locations.
- Availability of nearby specialty care through the Senior Prime network might reduce seniors' use of the more-distant capital area medical centers.

Keesler (GulfSouth Region)

The TRICARE Region and the Demonstration Site

The GulfSouth Region, Region 4, encompasses Alabama, Mississippi, parts of Florida and Louisiana, and Tennessee. Its service population of 605,000 includes 112,748 who are 65 or older. The region includes 13 military hospitals and clinics (Departments of the Air Force, Navy, and Army and the U.S. Coast Guard) plus Keesler Air Force Medical Center, whose commanding officer serves as lead agent. The OLA has a staff of 32, of whom 4 are assigned part-time to Senior Prime. Keesler's status as a site was uncertain, but a strong presentation to DOD helped to win its place in the demonstration.

Keesler is a tertiary care teaching facility providing primary care, 44 medical and surgical specialties, and graduate medical education (GME) programs in internal medicine and several specialty areas. It serves a close-knit, local retiree population and attracts space-available patients from a wide area for specialized services, such as sleep studies. Vacationers also use Keesler services, particularly its pharmacy. Humana Military Health Services (HMHS), the Managed Care Support contractor, is a new subsidiary of Humana and had no previous experience with Medicare or with government military contracting. The site's experience with managed care began with TRICARE Prime in 1996. Volunteers from military retiree and veterans' groups and the Red Cross helped with marketing Senior Prime. One retiree organization did a direct mailing of national material on Senior Prime to 3,500 members.

The Senior Health Care Environment

Keesler has traditionally emphasized primary care and continuity of care. Historically, most of the internal medicine care at the center has been given to seniors, and 1,500 seniors were considered "continuity empaneled" with an internal medicine provider. Space-available care was provided to support GME. However, space-available care outside of GME was episodic and has been decreasing in recent years. Seniors who were not empaneled reported difficulty in getting appointments.

Mississippi had no HMOs for any age group before TRICARE Prime, and Keesler Senior Prime is the only Medicare HMO. Managed care is a relatively new concept in the Keesler area, and providers and beneficiaries are reluctant to accept it. Keesler's Senior Prime service area includes a few ZIP codes in Mobile, AL, where Medicare managed care is an option.

Preparing for HCFA Approval

Planning teams at Keesler had little understanding of Medicare requirements when Keesler prepared its initial application in late February 1998. To meet DOD's March deadline, the OLA took boilerplate information from San Antonio's application and made changes later.

The Keesler team received useful information from other demonstration sites, but otherwise lacked access to Medicare expertise. There were no nearby Medicare HMOs to visit. HMHS delayed hiring a consultant until the contract modification to authorize this action was in place. (Once hired, the consultant was very helpful.) Keesler waited for DOD approval before contacting the regional HCFA office in Atlanta. Central rather than regional HCFA staff had reviewed the Health Services Delivery portion of the application, and when Keesler staff first visited the regional office on July 31, the HCFA staff had apparently just received the Memorandum of Agreement and had not yet been briefed about the demonstration.

Because of a misunderstanding of HCFA requirements, Keesler lacked signed contracts with the network providers at the time of the HCFA site visit in late August. HCFA gave verbal approval to start marketing the program even though the contracts were not complete. Keesler asked DOD to support additional consultant help in preparing for the first HCFA monitoring visit, but this request was turned down.

Program Features

- Keesler had enrolled 2,661 beneficiaries toward its capacity of 3,100 by the end of June. About 600 had been in primary care at the MTF before the demonstration.
- The program includes a board-certified geriatrician who has sensitized staff to the needs of patients 65 and over, including the need for louder telephone messages and larger print on signs.
- 99 percent of Senior Prime enrollees chose an Internal Medicine over a Primary Care (Family Practice) clinic team. Some younger patients were shifted from Internal Medicine to accommodate the seniors.
- Internal Medicine nurse-managers and other staff called all 2,200 people who were enrolled for December 1 and January 1 start dates to screen for special needs and make appointments for the orientation seminars.
- Primary care appointments for Senior Prime were lengthened by 5 minutes to allow providers to complete administrative work for each encounter.
- Keesler had given previous attention to data quality and data use in program management, which was helpful for Senior Prime.

Operational Difficulties and Issues

- Limited access to Medicare expertise has been a major difficulty.
- Keesler must market the concept of managed care, not simply the Senior Prime program, to both customers and providers in the community. Network development has been difficult.
- The administrative demands of Senior Prime have drawn effort from the health care delivery system for active duty personnel and their families.
- Loss of program knowledge through administrative staff turnover is a major concern.

Madigan (Northwest Region)

The TRICARE Region and the Demonstration Site

The Northwest Region, Region 11, covers Washington, Oregon, and part of Idaho, and a service population of about 370,250, including about 62,290 who are 65 and older. There are eight MTFs in this region—one major medical center, two community hospitals, and five ambulatory clinics.

The demonstration site consists of Madigan Army Medical Center (MAMC), a major medical center, colocated with the OLA at Fort Lewis in Tacoma, WA. MAMC is a 227-bed tertiary care teaching hospital that provides the full range of care, including primary, specialty, and ancillary care, relying on the network to fill gaps in specialty care. The service area for the demonstration covers most of the catchment area around MAMC as well as a few areas outside of the catchment area. There are about 137,791 total beneficiaries in the catchment area with about 19,323 beneficiaries who are 65 and older.

This region was the first to implement TRICARE in early 1995. The managed care support contract was awarded to Foundation Health Federal Services, an experienced TRICARE contractor, which also operates TRICARE in Regions 6, 9, 10, and 12. Foundation's main office is in Rancho Cordova, CA, with satellite staff at various MTF locations. Foundation has experience running Medicare managed care plans in its commercial operation. Since 1994, the Madigan staff had been exploring ways for the MTF to be reimbursed for care provided to Medicare patients, and MAMC had been on the list of potential demonstration sites for the DOD program.

The Senior Health Care Environment

MAMC has had a commitment to managed care and has been providing care to seniors before the demonstration, helping to meet the training needs of the MTF physicians. Before Senior Prime, the MTF provided ongoing care to certain seniors who were empanelled to the MTF. Space-available care at the MTF has declined for all beneficiaries, but many factors in addition to Senior Prime (e.g., resource reductions) have contributed to this decline. Managed care has long been established in the Pacific Northwest, and seniors in the Madigan area can choose from four commercial HMOs.

Preparing for HCFA Approval

The site staff worked with Medicare consultants, who were hired by the managed care support contractor, to prepare for the HCFA site visit and learn about Medicare requirements. The consultants' most significant contribution was the mock site visit conducted with site staff to educate them on HCFA's expectations before the actual site visit. The site staff worked closely with the HCFA regional staff in writing the application and preparing for the site visit, in spite of a lack of authority from DOD

headquarters to contact the regional staff. Madigan was the first site to implement Senior Prime, so there were no other DOD examples to follow.

Program Features

- The site was successful in meeting the enrollment target of 3,300 within 3 months, but there were some surprises. Enrollment among formerly empanelled beneficiaries who had been served by the MTF was lower than expected, and among "new" beneficiaries was greater than expected.
- Service delivery was not phased in over time. DOD headquarters encouraged taking in all enrollees at once, and MAMC wanted to begin a large volume of service so that HCFA interim payments would begin.
- In implementing the demonstration, there was no change in medical care delivery, other than adding HCFA-required services, such as skilled nursing facility care. Ninety-five percent of the specialty care under Senior Prime will be provided at the MTF.
- In marketing the program, the MTF worked with local retiree groups, such as The Retired Officers' Association and the Fort Lewis Retiree's Association, for example, using retiree newsletters to publish program information.
- The site conducted beneficiary orientations to provide information on program benefits, how to access care, and the role of primary care managers as well as to obtain information from beneficiaries on current medications and health care needs.

Operational Difficulties and Issues

- Deployment of MTF specialists has caused gaps in providing care, which may also be an issue for Senior Prime.
- The level of effort provision and uncertainty concerning funding have not affected health care delivery, but have caused frustration and concern. Health care delivery and costs are different than they were in 1996—the base year for level of effort.
- More time was needed for preparing marketing materials, clarifying the benefit before presenting to enrollees, preparing enrollee documents once HCFA had provided the approved list of enrollees, beneficiary orientation, and provider and staff education.
- Enrolling a large number of patients on a single start date strained primary care capacity and the site's ability to meet the appointment standards.
- Two full-time staff in the OLA are needed for start-up and continuation of Senior Prime. One key position is held by a civilian.

San Antonio (Southwest Region)

The TRICARE Region and the Demonstration Site

The Southwest Region, Region 6, consists of 4 states—Texas (except the far western portion), Oklahoma, Arkansas, and most of Louisiana—and about 1 million beneficiaries, of whom about 162,000 are 65 and older. There are 18 MTFs in this region—2 major medical centers, both located in San Antonio, 7 community hospitals, and 9 ambulatory care clinics.

The demonstration site is the most complex, consisting of two service areas—San Antonio (urban) and Texoma (rural), four MTFs, two states (Texas and Oklahoma), and two branches of the armed services—the Army and Air Force. The San Antonio service area MTFs include Wilford Hall, which is a 350-bed medical center located at Lackland Air Force Base and Brooke Army Medical Center (BAMC), a 238-bed medical center located at Fort Sam Houston. Both of these medical centers provide primary care, most specialty care, and tertiary care. The Texoma service area includes Sheppard Air Force Base Hospital, which is a 60-bed community hospital located in Wichita Falls, TX, and Reynolds Army Community Hospital, an 150-bed community hospital located at Fort Sill in Lawton, OK. Both of the Texoma hospitals provide primary care and some specialty care, but rely on the network to fill in specialty care unavailable in the MTFs. The San Antonio service area has a beneficiary population of about 192,000, including almost 33,000 retirees 65 and older. The Texoma service area includes a beneficiary population of about 70,000, of whom 6,643 are 65 and older.

The TRICARE managed care support contract was awarded for this region in late 1995 to Foundation Health Federal Services, an experienced TRICARE contractor that was discussed in appendix IV. Foundation also supports TRICARE in Regions 9, 10, 11, and 12.

The Senior Health Care Environment

Enrollees in the San Antonio area formerly had limited access to space-available care for primary care, but some of those with complex problems were seen for GME purposes. In Texoma, the Ft. Sill senior population had accessed primary care at the MTF as part of its Silver Care Program. The San Antonio area has many Medicare providers and seniors have a choice of enrolling in four commercial HMOs. The Texoma area has more limited availability of civilian physicians and the Senior Prime demonstration in the Texoma area is the first Medicare HMO in this rural market.

Preparing for HCFA Approval

With the coordination required among four MTFs, the OLA became central in leading the effort for the site to obtain HCFA approval. Staff from the four MTFs worked together with OLA staff to prepare policies and procedures and prepare for the site visit. Foundation provided the same consultants used by the Madigan site to teach the San Antonio site about

Medicare. In addition, OLA staff took the initiative to inform themselves about HCFA requirements from other sources, such as the HCFA Web page and commercial Medicare HMOs.

Program Features

- Enrollment capacity was set at 12,700 (5,000 each for BAMC and Wilford Hall, 1,300 for Sheppard, and 1,400 for Ft. Sill.) Although initial enrollment was slower than expected, the San Antonio area had reached 99-percent capacity and the Texoma area 67 percent by the end of June 1999.
- Service delivery was phased in to avoid overload.
- The MTFs had always served substantial numbers of patients who were 65 and older as part of Ft. Sill's Silver Care Program, and largely to support GME at BAMC and Wilford Hall. Senior Prime changed the scope of seniors' care at BAMC and Wilford Hall from providing specialty care services to meeting patients' overall medical needs.
- This demonstration site accounts for almost half of all enrollees across the six demonstration sites.
- HCFA approved the Texoma service area as an "expansion area." This has the potential to be a model if the program goes nationwide.
- New member orientation and health screening procedures resulted in innovative changes for the Senior Prime population, such as telephone calls to all new enrollees at Sheppard for health care screening and orientation meetings that also screened enrollees for health care needs at Wilford Hall.

Operational Difficulties and Issues

- A phased-in enrollment process, which also allowed enrollees to designate a preferred MTF and primary care manager, proved to be a challenge for data systems not equipped to handle these refinements, requiring manual corrections.
- Continuous shifts in the ground rules with respect to what benefits were actually being offered to enrollees required many adjustments as preparations moved forward.
- Combining policies and procedures from the four MTFs and rewriting them into a single plan that meets HCFA requirements and worked for all the MTFs was a daunting task managed by the OLA. This was a new role for the OLA—that of being directly involved with MTFs rather than primarily focusing on contract oversight.

San Diego (Southern California Region)

The TRICARE Region and the Demonstration Site

The Southern California Region, Region 9, encompasses southern California and Yuma, AZ. Its service population totals approximately 643,848, of whom 107,197 are 65 or older. The region includes the Naval Medical Center of San Diego (NMCSD), a 320-bed tertiary care facility with the largest GME in the Navy, as well as 6 other MTFs not included in the demonstration. NMCSD's service area contains about 35,000 Medicare eligible beneficiaries in an overall service population of 257,658. NMCSD covers every area of medical treatment except burns and transplants.

Retired officers in the San Diego area were among the first to propose subvention, and San Diego volunteered to be a subvention demonstration site in 1995. It was dropped from consideration for a time, but reinstated in November 1997. NMCSD is the only Navy facility in the demonstration. The OLA has a staff of 48; the 7 OLA staff assigned to Senior Prime include 1 full-time and 6 part-time positions, for a total of 4 full-time equivalents. The OLA expects to convert one key administrative position to civilian status.

The site's experience with managed care began with TRICARE in 1995. The support contractor is Foundation Health Federal Services, whose parent company has previous Medicare HMO experience. Foundation also supports Madigan and San Antonio and drew on lessons learned in setting up Senior Prime at those earlier sites. Local retiree groups supported San Diego's inclusion in the demonstration, and some 20 retiree organizations in the area sent out newsletters about the program.

The Senior Health Care Environment

The extensive range of services and space available for seniors' care have led, historically, to high use of the Naval Hospital by seniors and have attracted military retirees to this area. About 18,000 seniors are current users of services. Seniors constitute about half of the patients seen overall and as high as 80 percent in some specialties. However, space has been limited in primary care. About 20 percent of those who joined Senior Prime had been seen regularly in primary care clinics.

The Medicare HMO market is highly saturated and enrolls about 49 percent of eligible beneficiaries (military and civilian combined). Some of the commercial HMOs offer richer benefits than Senior Prime. Many dual eligibles who used NMCSD were in private HMOs; some had used the MTF for backup while others used the MTF as primary provider and the HMO as backup. Local HMOs, aware of potential competition, ran newspaper advertisements at the start of the demonstration; one even held a ball for military retirees. Of the 165,000 Medicare eligibles (both military and civilian), site officials estimated that only 10,000 do not have Part B.

Preparing for HCFA Approval

San Diego had 6 weeks to develop its initial application and turned in a supplemental application 2 months after the first. Materials from DOD, Madigan, and San Antonio were useful for the general sections, but San Diego had to develop site-specific materials from scratch. Foundation brought their previous HMO experience to developing the application, and their Arizona Medicare HMO provided a copy of its operating manual.

The San Francisco HCFA regional office has a perspective that reflects the highly competitive Medicare HMO market in southern California. By respecting the ban on communication with that office, DOD regional and MTF officials had no opportunity to learn what HCFA regional staff considered important. Nor could HCFA regional staff develop a clear picture of the demonstration program or offer guidance in advance of their visit. San Diego officials found that experience at Madigan and San Antonio did not help them anticipate the HCFA regional office's special concerns and information requests. Having to respond to newly expressed concerns on the spot added tension to the visit.

Program Features

- As of the end of June, the site had enrolled 3,101 beneficiaries toward its capacity of 4,000; early enrollment was phased in.
- "Welcome Aboard" orientation sessions for enrollees included the use of a health assessment form tailored for senior populations.
- Cardiology clinic staff took over some duties of the Internal Medicine staff early in the demonstration to ensure that each Senior Prime beneficiary received a first appointment within 90 days of enrolling.
- Program officials identify frequent users of emergency room services and alert their primary care manager so that any problems in accessing primary care can be remedied or patients educated on how to obtain care.
- Appeals and grievances requirements have led to new mechanisms, such as a 24-hour 800 number to better serve the Senior Prime expedited 72-hour appeal process, and a new role for the lead agent serving as central point of contact for all appeal or grievance actions.

Operational Difficulties and Issues

- The regional HCFA office considered DOD's marketing material insufficiently detailed to allow retirees in commercial HMOs to compare their current benefits to Senior Prime.
- Developing a table that HCFA and site officials could agree was a fair presentation proved challenging.
- On the basis of outdated information, some retiree organizations erroneously informed their members that Senior Prime did not provide skilled nursing facility care.
- The clinical encounter form had been in use for only a year. Coding issues were not yet resolved and completion rates at some clinics were low.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: SEP - 2 1999

TO: Susan S. Westin, Associate Director
Advanced Studies and Evaluation Methodology, GAO

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare Subvention Demonstration: DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues"

We appreciate the opportunity to review your draft report to Congress on the implementation of the Medicare subvention demonstration, and we agree with your findings and recommendations.

The GAO report aptly identifies the difficulties HCFA, and the various provider entities we contract with, face when developing and implementing a demonstration. Demonstrations, innovative in nature, often pose operational challenges. Such experiments, however, provide opportunities to make improvements in the administration of the Medicare program and the outcomes for our beneficiaries.

The Health Care Financing Administration recently initiated a comprehensive review of the Medicare+Choice (M+C) regulations with the objective of determining which requirements should routinely be waived for the Department of Defense (DoD) in future years and/or, potentially, with future sites. While some of the waivers have already been implemented, others are in the process of being reviewed with regional office staff responsible for monitoring the demonstration sites.

We believe that military retirees who enroll in the demonstration have the same protections afforded to Medicare-eligible civilian enrollees in other M+C organizations. We will continue to work with DoD and the states in order to ensure that these options are available, and will also seek other options for enrollees.

Included for your review are our comments to your draft recommendations. We will continue to monitor this subject matter carefully, and we look forward to working with GAO on this and other issues.

Attachment

Comments of the Health Care Financing Administration
on the General Accounting Office (GAO) Draft Report, "Medicare Subvention Demonstration: DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues"

We reviewed GAO's draft report on implementation of the Medicare subvention demonstration and concur with its observations and conclusions. GAO highlights several start-up issues and problems that the demonstration sites faced. However, the willingness of both the Department of Defense (DoD) and the Health Care Financing Administration (HCFA) enabled us to surmount the variety of obstacles and challenges inherent in such a demonstration.

GAO Recommendation

"We recommend that the Administrator of the HCFA work with the Assistant Secretary of Defense (Health Affairs) in order to examine Medicare and DoD procedures, and measurement and reporting systems, with an eye to granting waivers warranted and eliminating duplication."

HCFA Comment
We concur. We have recently initiated a comprehensive review of the Medicare+Choice (M+C) regulations with the objective of determining which requirements should routinely be waived for DoD in future years and/or, potentially, with future sites. While some of the waivers have already been implemented, others are in the process of being reviewed with regional office staff responsible for monitoring the demonstration sites.

GAO Recommendation
"The Administrator of the HCFA has been directed to work with the Assistant Secretary of Defense (Health Affairs) to determine conditions for transitioning out of the demonstration into other Medicare coverage, and to notify enrollees of these conditions as soon as possible."

HCFA Comment
Throughout the development and implementation of the demonstration, we have operated under the assumption that military retirees who enroll in the demonstration have the same protections afforded to Medicare-eligible civilian enrollees in other M+C organizations. That is, demonstration enrollees would be entitled to enroll in a Medigap policy under a "guaranteed issue" provision and/or enroll in another M+C organization in the service area under a special election period. We will continue to work with DoD and the states to ensure that these options are available, and will also seek other options for enrollees.

Related GAO Products

Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999).

Medicare Subvention: Challenges and Opportunities Facing a Possible VA Demonstration (GAO/T-HEHS/GGD-99-159, July 1, 1999).

Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns (GAO/HEHS-99-39, May 28, 1999).

Medicare Subvention Demonstration: DOD Experience and Lessons for a Possible VA Demonstration (GAO/T-HEHS/GGD-99-119, May 4, 1999).

Medicare+Choice: HCFA Actions Could Improve Plan Benefit and Appeal Information (GAO/T-HEHS-99-108, Apr. 13, 1999).

Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS-99-92, Apr. 12, 1999).

Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights (GAO/HEHS-99-68, Apr. 12, 1999).

Medicare: Progress to Date in Implementing Certain Major Balanced Budget Act Reforms (GAO/T-HEHS-99-87, Mar. 17, 1999).

Medicare HMO Institutional Payments: Improved HCFA Oversight, More Recent Cost Data Could Reduce Overpayments (GAO/HEHS-98-153, Sept. 9, 1998).

Medical Readiness: Efforts Are Underway for DOD Training in Civilian Trauma Centers (GAO/NSIAD-98-75, Apr. 1, 1998).

Military Retirees' Health Care: Costs and Other Implications of Options to Enhance Older Retirees' Benefits (GAO/HEHS-97-134, June 20, 1997).

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