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MEDICARE SUBVENTION DEMONSTRATION

DOD Experience and Lessons for Possible VA Demonstration

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Medicare Subvention Demonstration: DOD Experience and Lessons for Possible VA Demonstration

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you review the Medicare subvention demonstration for the Department of Defense (DOD), as well as subvention demonstration proposals for the Department of Veterans Affairs (VA). The stated goal of subvention is to implement an alternative for delivering accessible and quality care to Medicare-eligible military retirees and certain Medicare-eligible veterans, without increasing the cost to DOD or VA, or to Medicare. In principle, Medicare-eligible military retirees who enrolled in the subvention program would get higher priority at military facilities than before, permitting them to get Medicare-covered care from DOD—a new alternative to retirees' current Medicare options. Similarly, proposals have surfaced to allow certain Medicare-eligible veterans to use their Medicare benefits at VA facilities. Subvention could allow DOD and VA to augment appropriated funds with Medicare payments and to use excess capacity where it exists. Medicare might gain because under subvention it would pay DOD and VA less than the rate paid to private Medicare providers and managed care plans.

The 3-year DOD demonstration involves about 30,000 enrolled retirees and limits Medicare payments to DOD to at most $65 million a year. A nationwide DOD subvention program with all eligibles participating could potentially provide military health care to at least 600,000 retirees and might generate, by one estimate, as much as $2 billion a year in Medicare payments to DOD. (Experience to estimate the percentage of eligibles who would enroll does not exist.) In VA, the potential may be even greater.

These outcomes are not, however, guaranteed, so the Balanced Budget Act of 1997 (BBA) authorized a large-scale, 3-year demonstration of DOD subvention and directed GAO to evaluate the demonstration's results. The BBA posed 15 evaluation questions about the demonstration, including its effects on cost to DOD and Medicare as well as on access to and quality of care. We are currently surveying approximately 20,000 military retirees, dependents, and survivors so we can profile the characteristics of those who enrolled and did not enroll, their access to health care, and their satisfaction with it. We are also analyzing the costs to DOD and to Medicare—compared with what the costs would have been without the demonstration—for the 125,000 people eligible for the demonstration. A team visited all the demonstration sites to evaluate implementation and progress. We will be providing you with interim reports on aspects of the demonstration. Our final results will not, however, be available until several months after the demonstration ends in December 2000.

Our testimony today focuses on the lessons from the experience to date of the DOD demonstration and its implications for a possible VA demonstration. Specifically, we report on the early phases of implementing the DOD demonstration, issues raised by that experience for DOD subvention, and lessons from the DOD demonstration for a possible VA demonstration.

In summary, subvention holds the potential to benefit military retirees and veterans, DOD and VA, and Medicare. Although it got off to a slow start, DOD has initiated its subvention demonstration and is now serving Medicare-eligible military retirees at six sites. Several key operational issues remain. These include development of more understandable payment rules, viable for the longer term, and development of data to manage the demonstration and support its evaluation. Most important, the demonstration's final results, in terms of access to health care, quality of patient care, and costs to DOD, Medicare, and retirees, will not be known until the evaluation is completed, several months after the end of the demonstration in December 2000.

DOD's early experience with subvention does offer insights if proposals are acted on to permit Medicare subvention for VA. In particular, it would need to consider, in collaboration with the Health Care Financing Administration (HCFA), how to determine its baseline costs and payment rules, as well as the need for good data for implementation, management, and controlling costs. Moreover, VA would need to make its regular enrollment of veterans who wish to use VA health care services interface smoothly with subvention demonstration enrollment. VA would also need to be concerned about potential crowding-out of other, currently higher-priority veterans by subvention enrollees. Our early work on DOD subvention suggests that VA would have a greater chance of success if it has sufficient time to plan and establish the demonstration, and if the value and feasibility of implementing fee-for-service and managed care subvention models simultaneously were reconsidered.

Background

Medicare

Most military retirees age 65 and over are eligible for Medicare, a federally financed health insurance program for the elderly, some disabled people, and people with end-stage kidney disease. Medicare covers about

39 million beneficiaries and spends about $212 billion a year. Its benefits include hospital, physician, and other services such as home health and limited skilled nursing facility care. HCFA administers Medicare and regulates participating providers and health plans.

Original, or traditional, Medicare reimburses private providers on a fee-for-service basis and allows Medicare beneficiaries to choose their own providers without restriction. A newer option within Medicare[1] allows beneficiaries to choose among private, managed care health plans. Currently, 17 percent of beneficiaries use Medicare managed care. In original Medicare, beneficiaries must pay a share of the costs for various services. Most Medicare managed care plans have only modest beneficiary cost-sharing and many offer extra benefits, such as prescription drugs.

DOD Health Care

DOD received an appropriation for military health care of almost $16 billion in fiscal year 1999. Of that, an estimated $1.2 billion is spent on the 1.3 million Medicare-eligible military retirees. Under its TRICARE program, DOD provides health benefits to active duty military, retirees, and their dependents, but most retirees 65 and over lose their eligibility for comprehensive, DOD-sponsored health coverage. DOD delivers most of the health care needed by active duty personnel and military retirees[2] through its military hospitals and clinics. DOD gives priority for care to active duty personnel and their dependents, and to certain retirees under 65. Retirees who turn 65 and become eligible for Medicare can get military care if space is available (called space-available care)—that is, after other DOD beneficiaries are treated.[3] Some military facilities have little or no space-available care.

Since the early 1990s, DOD health care has shifted toward managed care. DOD established its own managed care plan, TRICARE Prime, which uses military providers, supplemented by a network of civilian providers. However, it is not available to retirees aged 65 and over.[4] TRICARE Prime

[1]The BBA expanded this option to include plans in addition to health maintenance organizations and labeled it "Medicare+Choice."

[2]We use "retirees" to refer to military retirees, their dependents, and their survivors.

[3]A partial, unofficial exception to this rule occurs at teaching hospitals, where aged retirees with serious, persisting conditions are treated on an ongoing basis, in large measure so that medical residents can be given the clinical experience required.

[4]Active duty members of the armed forces receive their health care through TRICARE Prime. Dependents of active duty military can choose among three DOD-run health plans that include TRICARE Prime. Retirees under 65 can pay a premium and "buy in" to TRICARE Prime.

covers services of military physicians as well as civilian network providers by drawing on DOD's appropriated funds and premiums and copayments charged to some enrollees. In TRICARE Prime, DOD generally organizes the delivery of care on managed care principles—for example, an emphasis on a primary care manager for each enrollee. DOD has gained considerable experience with managed care, but it relies heavily on contractors to conduct marketing, build a network of providers, and perform other critical functions.

The DOD Subvention Demonstration

The BBA established a 3-year demonstration of Medicare subvention, to start on January 1, 1998, and end on December 31, 2000. Within the BBA's guidelines, DOD and HCFA negotiated a Memorandum of Agreement (MOA). The MOA stated the ways in which HCFA would treat DOD like any other Medicare health plan and the ways in which HCFA would treat it differently. The MOA also spelled out the benefit package and the rules for Medicare's payments to DOD. After DOD and HCFA signed the MOA, they selected six demonstration sites. They would be able to serve about 30,000 of the 125,000 people eligible for both Medicare and military health benefits in these areas.

The subvention demonstration made DOD responsible for creating a DOD-run Medicare managed care organization for elderly retirees. This pilot health plan, which DOD named Senior Prime, is built on DOD's existing managed care model. By enrolling in Senior Prime, Medicare-eligible military retirees obtain priority for services at military facilities—an advantage, compared to nonenrollees. Senior Prime's benefit package is "Medicare-plus"—the full Medicare benefits package supplemented by some other benefits, notably prescription drugs.

The BBA provides the basic rules by which, under the demonstration, Medicare pays DOD. First, Medicare is to pay DOD for each enrollee the Medicare managed care rate, less several adjustments and a 5-percent discount. Second, in order to receive Medicare payments, DOD must at least match its baseline costs, or "level of effort" (LOE)—that is, devote at least the same resources as it did in the recent past to providing care to 65-and-over retirees. The MOA translated these guidelines into a complex payment system. For example, it allows any demonstration site to earn monthly interim payments if its Senior Prime enrollment exceeds a threshold derived from baseline LOE. But at the end of the year, DOD can

only retain a portion of these payments if that year's costs for the six sites together exceed baseline LOE.[5]

VA Health Care

VA provides a comprehensive array of health services to veterans with service-connected disabilities or low incomes. Since 1986, VA has also offered health care to higher-income veterans, who must however make copayments for services. Overall, VA serves over 13 percent of the total veteran population of 25 million, with the remaining veterans receiving their health care through private or employer health plans or other public programs. Many of the veterans whom VA serves also get part of their care from other sources, such as DOD, Medicaid, and private insurance. The administration has requested $17.3 billion for VA medical care in fiscal year 2000. To make up the differences between appropriated funds and projected costs, VA estimates that, by fiscal year 2002, it can derive almost 8 percent of the medical care budget from nonappropriated sources, including Medicare reimbursement.

Since the early 1990s, VA has shifted its focus from inpatient to outpatient care. At the same time, it implemented managed care principles, emphasizing primary care. In 1995, VA accelerated this transformation by realigning its medical centers and outpatient clinics into 22 service delivery networks and empowering these networks to restructure the delivery of health services.

In 1996, the Congress passed the Veterans' Health Care Eligibility Reform Act that established, for the first time, a system to enroll or register veterans. Enrollment is in effect a registration system for veterans who want to receive care. The law establishes seven priority groups, with Priority Group 1 the highest and Priority Group 7 the lowest. Priority Group 7 includes veterans whose incomes and assets exceed a specified level and (a) do not have a service-connected disability or (b) do not qualify for VA payments for those disabilities. Priority Group 7 veterans must agree to make copayments for health services.

Each year, VA determines, on the basis of available resources, which priority groups of enrolled veterans will be eligible for VA care in the coming year. Currently, VA serves all seven priority categories, but in the future that will not necessarily be true. Enrolled veterans in any of the priority groups are eligible for the VA Uniform Benefits Package. This is a

[5]These issues are discussed in greater detail in a forthcoming report on the DOD demonstration of Medicare subvention.

broad package that covers inpatient and outpatient care; rehabilitative care and services; preventive services; respite and hospice care; and pharmaceuticals, durable medical equipment, and prosthetics.

Enrolled veterans remain free to get some or all of their care from other private or public sources, including Medicare. VA, on the other hand, is committed to serving all enrolled veterans.

Possible VA Subvention Demonstration

The structure of any VA subvention demonstration would depend upon the principles and directions that the Congress incorporates in authorizing legislation. We have found certain common elements in all demonstration proposals we reviewed. A VA subvention demonstration would serve certain higher-income[6], Medicare-eligible veterans (effectively, Priority Group 7 veterans):

- for a limited time period, such as 3 years;
- in a limited number of locations; and
- in compliance with Medicare rules that HCFA applies to the private sector, although HCFA could waive rules that were inappropriate or irrelevant to VA.

Regarding Medicare payments to VA,

- HCFA would pay VA at a lower rate than it currently pays to private Medicare providers or health plans;
- HCFA would pay VA for care of veterans in the demonstration only after VA exceeds its historic spending, or level of effort, for higher-income veterans; and
- HCFA payments to VA would be limited to a predetermined annual amount, such as $50 million.

Several current proposals also

- direct VA to establish at least one demonstration site near a closed military base;
- direct VA to establish at least one demonstration site that serves a predominantly rural area; and

[6]Those who exceed VA's income thresholds. For example, the current threshold for a single veteran without dependents is $22,350.

- direct VA to maintain reserves against the risk that appropriated funds would be needed to pay for the care of veterans enrolled in the subvention demonstration.

Some proposals authorize VA to establish both fee-for-service and managed care subvention sites, while at least one only authorizes managed care.

DOD Demonstration Launched After Delay, but Key Issues Remain

In implementing the subvention demonstration, DOD and HCFA completed numerous and substantial tasks. DOD sites had to gain familiarity with HCFA regulations and processes, prepare HCFA applications, prepare for and host a HCFA site visit to assess compliance with managed care plan requirements, develop and implement an enrollment process, market the program to potential enrollees, establish a provider network (for care that cannot be provided at the military treatment facilities), assign Primary Care Managers to all enrollees, conduct orientation sessions for new enrollees, and begin service. The national HCFA and DOD offices developed a Memorandum of Agreement, spelling out program guidelines in broad terms. They also developed payment mechanisms, and translated the BBA requirement that DOD maintain its historical LOE in serving dual eligibles into a reimbursement formula. HCFA accelerated review procedures and assigned additional staff so that timelines could be met. But these accomplishments were not without difficulties, and several issues remain that are likely to impact the demonstration's results. These include the extent to which payment rules can be made more understandable and workable, and the extent to which DOD can operate successfully and efficiently as a Medicare managed care organization.

Implementation Delayed by Several Factors

In view of the steep learning curve that DOD faced—it started without any Medicare experience—it is not surprising that the demonstration did not start on time. The BBA was enacted in August 1997 and authorized a demonstration beginning in January 1998. The first site started providing service in September 1998, and all sites were providing service by January 1999. Officials at all DOD sites emphasized to us that the process of establishing a Medicare managed care organization at their facility was far more complex than they had expected. They noted several issues that caused difficulty during this accelerated startup phase, including the following:

- Delayed notification to sites of their selection for the demonstration.

- Difficulties in learning and adapting to HCFA rules, procedures, and terms for managed care organizations. For example, DOD had to significantly rework grievance and appeals procedures to comply with HCFA requirements.
- Difficulties due to shifts in Medicare requirements. All sites started planning as HCFA was developing the new Medicare managed care regulations to replace the rules for the former risk contract managed care program. Consequently, the sites had to adapt to changed rules when they were published.

Capacity and Enrollment

Sites vary significantly in their capacity for caring for Medicare-eligible retirees, how close enrollment is to capacity, and what fraction of eligibles has enrolled. This variation suggests that potential demand for a subvention program is uncertain. Retirees' enrollment decisions reflect several factors, some that DOD may be able to influence but others—such as the extent of managed care presence in an area—outside its control.

In establishing their enrollment capacity—which effectively became an enrollment target—some sites were more conservative than others. Sites' assessment of their resources focused on the availability of primary care managers—physicians and other clinicians who both provide primary care and serve as gatekeepers to specialist care. Additionally, the national TRICARE office developed a model to show how many enrollees a site would need to meet its LOE threshold and start receiving increased resources from subvention, and these results were made available to sites. Capacity varied from San Antonio, the largest site with four hospitals and a capacity of 12,700, to Dover, which provides only outpatient care in its military health facility and set its capacity at 1,500.

Many DOD officials and other observers expected that sites would be deluged with applications and would rapidly reach capacity, but this did not happen. One site is currently at capacity, but only after several months. Other sites have enrolled between 44 percent and 91 percent of capacity as of the end of April 1999.

As table 1 shows, there is a four-fold difference in sites' enrollment as a percentage of eligibles in their catchment areas—from 8 percent (San Diego) to 35 percent (Keesler). Several factors may explain this variation:

- Enrollment in other Medicare managed care plans varies widely, from one site with a low percentage of eligible enrollees (San Diego)—where nearly

50 percent of dual eligibles are in private Medicare managed care plans—to two sites with higher percentages of enrollees (Keesler and Dover)—where no one is in managed care because no plans are available.

- The availability of military care varies. Several sites emphasized in their marketing that retirees who did not enroll could not count on receiving space-available care. This information might spur retirees who prefer military care to enroll in Senior Prime. At other sites, space-available care was less of an issue. At these sites, prospective enrollees who believe that they can continue to receive space-available care may not see an advantage in enrollment but rather a disadvantage—especially because enrolling in Senior Prime locks them out of other Medicare-paid care.
- Sites may differ in the amount of space-available care they have given in the past and in beneficiaries' satisfaction with that care. These factors could also affect the decision to enroll.
- Some retirees expressed reluctance to enroll because the demonstration is due to end in December 2000. They also noted that they did not get information about how, after the demonstration ends, enrollees would transition back to space-available care, traditional fee-for-service Medicare, or a Medicare managed care organization.

Table 1: TRICARE Senior Prime Enrollment

	Enrolled[a]	Capacity[b]	Enrolled as a percentage of capacity	Total eligible	Enrolled as a percentage of eligibility
Madigan Army Medical Center, WA	3,296	3,300	99.9%	21,709	15.2%
San Antonio, TX	11,534	12,700	90.8%	41,215	28.0%
Naval Medical Center, San Diego, CA	2,767	4,000	69.2%	35,619	7.8%
Keesler Medical Center, MS	2,563	3,100	82.7%	7,361	34.8%
Colorado Springs, CO	2,744	3,200	85.8%	13,689	20.0%
Dover, DE	661	1,500	44.1%	3,905	16.9%
Total	**23,565**	**27,800**	**84.8%**	**123,498**	**19.1%**

Note: Status as of April 26, 1999.

[a]Includes only people who were 65 years old at the beginning of the demonstration.

[b]Capacity at the beginning of the demonstration. Does not include capacity for those who turned 65 after the demonstration started.

Managed Care Issues

The subvention demonstration for military retirees aged 65 and over is a new endeavor that highlights challenges for DOD to operate as a Medicare managed care organization. The first is operational—putting in place procedures, organization, and staff to deliver a managed care product to these seniors. The second is economic and organizational—creating the business culture that reconciles delivering services to this illness-prone population with cost-consciousness.

DOD's reliance on contractors (like Foundation Health and Humana) has both enabled it to accomplish key managed care tasks and brought risks with it. DOD overcame obstacles in launching TRICARE Senior Prime as a managed care organization. Specifically, to establish and run a managed care plan requires infrastructure—the ability to market the plan, enroll members, and recruit, manage, and pay a provider network. In building Senior Prime organizations at the six sites, DOD has benefited from its TRICARE Prime experience, and from its contractors who help with or perform many of these tasks.[7] Sites with well-established TRICARE Prime organizations that had worked with the same contractor for several years seemed to us to have a sizeable advantage in establishing Senior Prime. It is not yet known what effect DOD's extensive use of contractors will have on DOD costs for Senior Prime. But an expanded, permanent subvention program would require establishing and monitoring contractors at many new sites. That would make contractor quality, relationships, and costs a pivotal and uncertain feature of a potential DOD subvention program.

Cost-consciousness matters greatly to managed care plans, especially because they do not use much cost-sharing by enrollees to curb excess use of services. Managed care plans have an incentive to control costs because they are paid a fixed rate per member per month. If the plan cannot provide all services within that amount, it will not survive. However, in the DOD setting, several factors undermine this incentive to be cost-conscious. First, as long as facilities are still providing some space-available care, they have a safety valve: if resources become too strained, they can reduce the amount of space-available care—spreading a fixed appropriation over fewer patients. This gives facilities considerable flexibility to cover costs that are higher than expected, but the downside is that they have less incentive to be efficient. Second, military treatment facility commanders do not have as much control over their budgets as their civilian counterparts. Many decisions about budgets and personnel are made independently of the local facility, and it can be difficult, for example, to

[7]The DOD sites relied on the TRICARE contractors for handling enrollment, claims processing, and network management. They have also, to varying degrees, assisted with the application, site visit, quality assurance, and utilization review areas.

get more military primary care doctors or to set up a new program with large up-front costs, even if these actions would promote longer-term efficiency.

Payment Issues

DOD and HCFA have devised payment rules to meet the statutory requirement that Medicare should pay DOD only after its spending on retirees' care reaches predemonstration levels—that is, after it has met its baseline, or LOE. These rules have added to the difficulty and the complexity of the demonstration. Furthermore, they have resulted in Medicare payments to DOD not being immediately distributed to the sites. As a result, DOD site managers tend to view DOD appropriations as the sole funding source for all Senior Prime care delivered at military health facilities; the managers are likely to consider Medicare subvention payments as irrelevant to their plans for dealing with capacity bottlenecks or other resource needs in TRICARE Senior Prime.

The demonstration's payment system requires extensive cost and workload data—data that are often problematic and difficult to retrieve and audit. It also involves a complicated sequence of triggers and adjustments for interim and final payments from Medicare to DOD.

Interim payments are made to DOD for care delivered at each site that is above a monthly LOE threshold. A reconciliation after the end of the year to determine final Medicare payments can result in DOD returning a portion of those interim payments if the LOE for all sites for the entire year is not reached. DOD would also return Medicare payments if data showed that the demonstration population was in better health than that allowed for in the Medicare payment rates, or if payments exceed the statutory cap ($50 million in the first year, $60 million in the second, and $65 million in the third).[8]

Because of the potential for adjustments after the close of the year, the payment rules create some uncertainty for DOD. DOD cannot be certain that it will retain all—or even part—of the monthly interim payments at the end of the year. DOD has been slow to distribute interim payments to the sites, in part because some of the money may have to be returned to HCFA. This creates great uncertainty for DOD sites and means that care under subvention is currently paid for with DOD's appropriated funds. The demonstration's payment method differs significantly from the Medicare

[8]The enrollment targets for each site reflect the statutory caps. Consequently, rebates (from DOD to Medicare) as a result of payments exceeding the cap are unlikely.

managed care payment system, in which payments are made at the beginning of the month to cover care delivered during the month.

Based on experience to date with the demonstration, any payment approach for subvention must be even-handed (that is, it should favor neither HCFA nor DOD); straightforward and readily understandable; and prospective (DOD and its sites should receive payment in advance of delivering care to enrollees). The demonstration's payment mechanism, which relies on LOE, is functional in the short term—although the calculation of LOE has weaknesses.[9] However, this payment mechanism may not be appropriate over the longer term for an extended or expanded subvention program. Moreover, a credible long-term payment system should start with a zero-based budgeting approach: first, determining the cost to DOD of providing TRICARE Senior Prime care to dual eligibles and then deciding how much care will be provided from DOD's appropriations and how much from Medicare reimbursement.

Proposed VA Demonstration Can Benefit From DOD Experience

One of the key issues for VA under the proposed demonstration would be how to market subvention and persuade veterans in subvention sites to enroll in the demonstration. This issue is complicated by VA's own enrollment process and the broad benefits package it offers to all priority groups. VA is committed, as a matter of policy, to serving all enrolled veterans in 1999 and has indicated a desire to do so next year. As a result, it has relatively few options if veterans in a subvention demonstration consume so many resources that they crowd out—or at least put pressure on VA's capacity for serving—other veterans. Two models are possible for the demonstration—fee for service and managed care. Although fee for service is, in principle, easier to implement and operate, VA's past difficulties with billing third-party payers raise concern. Proposals for a VA demonstration could be strengthened by taking account of DOD's difficulties in establishing a subvention demonstration. In particular, DOD experience shows that implementation is difficult and that enough time should be allowed to undertake the numerous operational steps needed to get a demonstration started. Furthermore, payment rules need to be as simple as possible, and data systems are key to managing and evaluating a subvention demonstration.

Veteran Enrollment in Demonstration

For VA, an important issue is why veterans would want to enroll in a subvention plan that would not give them significantly more services than

[9]Our first interim report on the demonstration will discuss the payment rules and LOE.

they can currently receive from VA. Priority Group 7 veterans—the only ones eligible for subvention—can now get all services in VA's broad Uniform Benefits Package. Veterans who are eligible for Medicare can also get care from non-VA providers—either under fee-for-service or through a managed care plan. If it needed to make subvention benefits more attractive, VA could either reduce copayments or increase benefits.

However, VA officials tell us that, due to resource constraints, VA may not serve Priority Group 7 veterans in the future. If this happens, these veterans could only get VA services through a subvention demonstration and hence would probably be more likely to enroll. (To make this exception possible, legislation would be required, as eligibility for VA enrollment is uniform nationally.) Some VA officials have suggested to us that, to give Priority Group 7 veterans a reason to enroll, it may be necessary to exclude them from VA services—except through the demonstration.

The greatest risk in a VA subvention program is that subvention enrollees could consume so many services that VA patients in higher priority groups would be "crowded out." However, VA, according to its policy, cannot deny care to an enrolled veteran (that is, one who is registered with VA), even if it does not have sufficient capacity. In the short term, waiting times for appointments would probably increase, or care could be limited to certain facilities, which might be inconvenient for some veterans. VA could also reduce its benefits package, although that would require a change in regulations. In the longer term, some veterans could be denied all VA care if VA excludes one or more priority groups. This would be particularly serious for veterans who lack other insurance.

Managed Care and Fee-for-Service Models

Current proposals for a VA subvention demonstration permit both managed care and fee-for-service sites. Of the two, fee for service appears to be easier to implement, because it only requires submitting claims for covered services to HCFA for payment. However, in the past, VA has had difficulty in collecting from insurance companies because its bills have not had enough detail (for example, diagnosis, service, procedure, and individually identified provider).[10] While VA is moving toward a billing system that will more closely approximate private sector counterparts, its success remains to be seen.

[10]See VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult (GAO/HEHS-98-4, Oct. 17, 1997).

Managed care, by definition, places VA at financial risk, and it is also, as DOD's experience demonstrates, difficult to implement. On the other hand, managed care is highly compatible with the direction in which VA is currently moving. Moreover, VA does not have the experience that DOD gained from TRICARE, and it does not have broad-based managed care contractors that appear to have greatly facilitated implementing and managing the DOD demonstration.

If a VA subvention demonstration were to include both managed care and fee-for-service sites, a phased implementation, with one type of delivery system being successfully implemented before the other started, would allow both HCFA and VA to focus their resources. The requirements for Medicare fee for service and managed care differ considerably. As a result, implementing both types of sites simultaneously may place significant strains on both HCFA and VA staffs, particularly at the national level.

Lessons From DOD Subvention Demonstration

We see three main lessons for VA in DOD's experience in establishing its subvention demonstration.

- Officials at every DOD site told us that establishing a Medicare managed care organization was more difficult and required more effort than they had expected. Months into the implementation, they continue to encounter new issues. Even though the sites took 13 to 17 months after the legislation was passed to establish Senior Prime, hindsight suggest that the goals to get it running earlier were unrealistic. If a VA demonstration is authorized, it should have 12 to 18 months to implement its plans for the demonstration; both VA headquarters and the sites will need that much time.
- The complexity of the LOE definition and Medicare payment rules, as well as ambiguity about what sites could earn and whether earnings would be distributed to the sites, were issues for DOD. These factors caused many site managers and physicians to largely disregard the potential changes in available financial resources and focus their attention primarily on implementation and patient care issues. As a result, the demonstration may not produce the cost savings and efficiencies that are expected from managed care. VA and HCFA have tentatively agreed to rules that are consistent with the DOD rules and still contain many of the elements that have made it difficult for DOD to manage the demonstration. In particular, payments would be retrospective and an annual reconciliation process could lead to VA returning money to HCFA.

- DOD's experience shows that data systems are a point of vulnerability for a successful and credible program. The extent to which data quality would pose an obstacle to a VA demonstration depends in part on how the payment rules are specified. Good data, consistent across sites, would also be needed to manage and evaluate the demonstration. Data quality problems would probably vary by site, with some sites having better data than others. The types of data systems needed would depend in part on the subvention model that is selected. For example, in a fee-for-service model, billing systems are critical.

  In addition, both DOD and VA will need to develop a strategy to inform and assist beneficiaries with their options in the postdemonstration period. Further, as Medicare enrollment in managed care plans is shifting to an annual open season, it would be desirable to coordinate enrollment in and termination of the demonstration with Medicare's open season.

Concluding Observations

Subvention holds significant potential for giving military retirees and veterans an additional option for health care coverage, for giving DOD and VA additional funds, and for saving Medicare money. However, at this point—with little systematic data yet available—these outcomes are uncertain. This uncertainty underlines the value of demonstrations of subvention, such as the one that the BBA established for DOD. If a VA demonstration were authorized, VA would clearly need sufficient time to plan and initiate it. VA could also increase its chance of successfully establishing the demonstration if it took advantage of DOD's experience.

Mr. Chairman, this concludes our prepared statement. We will be happy to answer any questions that you or Members of the Committee may have.

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