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Report to Congressional Committees

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MEDICARE SUBVENTION DEMONSTRATION

DOD's Pilot HMO Appealed to Seniors, Underscored Management Complexities

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Contents

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Historically, the Department of Defense (DOD) health system and Medicare were entirely separate. DOD's TRICARE health plans covered military retirees to age 65.[1] However, once eligible for Medicare, retirees were no longer eligible for TRICARE and could not enroll in DOD's managed care plan, TRICARE Prime. As nonenrollees, Medicare-eligibles had access to care at military treatment facilities (MTF) only to the extent that space not utilized by TRICARE's enrolled population was available. By law, DOD could not receive payments from Medicare and was not responsible for providing the full range of benefits to Medicare-eligibles. Recently, the situation has changed.

In 1997, Congress authorized the DOD Medicare subvention demonstration for a 3-year period.[2] Under this demonstration, DOD formed Medicare managed care organizations that enrolled and served Medicare-eligible military retirees at six sites. The DOD Medicare plan, which was called TRICARE Senior Prime, combined TRICARE with Medicare benefits and requirements. The demonstration also authorized DOD to receive payment from Medicare if certain conditions were met. Senior Prime gave enrollees the same priority for military care as younger retirees enrolled in TRICARE Prime, with minimal out-of-pocket costs. With TRICARE Prime as its foundation, Senior Prime illustrated issues that arose in bringing older retirees into DOD managed care. A major change in health care arrangements for Medicare-eligible retirees from the uniformed services will take place October 1, 2001. Under provisions of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001,[3] these retirees will become eligible for TRICARE and will be able to use their Medicare benefit within TRICARE. The new program is commonly termed TRICARE For Life. Experience under Senior Prime illustrated some issues that TRICARE might face in serving Medicare beneficiaries.

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

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

[3] P.L. 106-398, sec. 712

The Balanced Budget Act of 1997 (BBA),[4] which established the demonstration, also directed us to evaluate it during its initially authorized 3-year period.[5] Our evaluation covers three key areas: effects on beneficiaries in terms of access and quality of care; the feasibility of the demonstration and the difficulties in implementing it; and costs to Medicare and DOD. We have issued several interim reports, including a report on implementation issues during the demonstration's start-up phase, and will issue further reports—including a final report on the demonstration—later this year.[6]

This interim report focuses on implementation of the demonstration once its start-up phase was completed. Our objectives are to describe (1) the status of the demonstration after roughly 2 years of operation, (2) its effect on enrollees, sites, and providers, and (3) challenges encountered in managing Senior Prime. To do so, we visited each of the demonstration sites and interviewed military and contractor officials. We reviewed site documents and examined legislation, agency policies, and other reports concerning Medicare and the military health system. We interviewed health care and contracting officials at DOD headquarters, and spoke with Medicare officials. We also reviewed performance information available to managers at the sites but did not analyze or verify the underlying data. In this report, we do not address cost or financing issues; those issues will be covered in later reports. We conducted our review from April 2000 through April 2001 in accordance with generally accepted government auditing standards.

Results in Brief

The demonstration sites were successful in operating Medicare managed care plans. Officials put substantial effort into meeting Medicare managed care requirements and, according to HCFA reviewers, were generally as successful as other new Medicare managed care plans in this regard. Most sites reached the enrollment limits they had established for retirees already covered by Medicare. In addition, so many younger retirees who belonged to TRICARE Prime enrolled in Senior Prime upon turning age 65 that some MTFs became concerned about their capacity to accommodate

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[4]P.L. 105-33, sec. 4015

[5]The demonstration was extended for 1 year by the Floyd D. Spence National Defense Authorization Act of 2001. However, our evaluation is confined to the initial 3-year period.

[6]See "Related GAO Products" at the end of this report.

additional growth if Senior Prime were continued. Relatively few enrollees have chosen to leave the program, suggesting that, after joining, most enrollees were satisfied.

DOD officials indicated that, on balance, the demonstration's effect was positive. Enrollees received a broader range of services from DOD than in the past, when they got care only when space was available in DOD facilities. Officials also noted that providing more comprehensive care to seniors helped sharpen the skills of military clinical staff, which contributed to their readiness for supporting combat or other military missions. Although somewhat less care was provided to nonenrolled seniors than previously, site officials were divided over whether this was the result of the demonstration, or simply continuation of a previous trend. At its small scale, according to military officials, the demonstration had little adverse effect on active duty members or other younger DOD managed care enrollees. Although sites found that meeting Medicare managed care requirements required considerable effort, contact with HCFA and private Medicare managed care plan officials was educational for DOD officials and generated ideas for improving military managed care in general.

Some challenges encountered in the demonstration reflect larger DOD managed care issues and may have implications for DOD managed care generally. Although access to care was generally good, the demonstration experienced some problems in maintaining adequate clinical staff. The separation between MTF and network delivery systems complicated care coordination, which made it harder to maintain continuity of care from, for example, the hospital to other settings. In addition, DOD's inefficient contracting process made it difficult to modify support contracts expeditiously as Medicare requirements changed.

In commenting on a draft of this report, DOD and HCFA said the report contained an accurate description of implementation issues encountered in the demonstration.

Background

The DOD Medicare subvention demonstration created a link between the DOD health care delivery system and Medicare, a health insurance program for the elderly and disabled, which is operated by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS). DOD and HCFA implemented this demonstration during a period of change in both Medicare and military health care.

DOD's TRICARE System	Since its beginning in 1995, DOD's health system, called TRICARE, has offered care to active duty members of the uniformed services, retired members under age 65, and their respective families and survivors—a population of about 6.6 million. An additional 1.5 million retirees (including dependents) aged 65 and older could receive limited health care. DOD delivers care through about 600 MTFs worldwide. TRICARE covers a broad range of outpatient and inpatient services, including home health, hospice, and skilled nursing facility care. Services not available at an MTF are purchased through a network of civilian specialists and hospitals. TRICARE includes a managed care option, TRICARE Prime, which offers care at the MTF augmented by the civilian network. TRICARE Prime enrollees, including all active duty members of the armed services, have priority for care at the MTFs. There is also a fee-for-service option called TRICARE Standard that offers a broader choice of civilian providers, and a preferred provider option called TRICARE Extra.[7] These options offer generally similar benefits but differ considerably in the nature and amount of costs to beneficiaries. Pharmacy services are available at most MTFs for all TRICARE eligibles as well as for retirees on Medicare. MTF pharmacy services are free-of-charge but limited to the medications carried at each MTF.

TRICARE is managed at multiple levels. The Office of the Assistant Secretary of Defense for Health Affairs sets TRICARE policy – which governs both MTF and civilian care – and establishes regulations in coordination with the Army, Navy, and Air Force. Responsibility for policy execution is delegated to the TRICARE Management Activity (TMA) but is shared with the military Surgeons General, who are responsible for implementing TRICARE policies within their respective services. TMA performs programwide support functions, such as managing TRICARE's information technology and data systems, preparing the budget and managing the accounts. In addition, TMA selects, directs and pays managed care support contractors, who maintain the private provider network and perform many services assisting beneficiaries and supporting management. In each TRICARE region within the United States, MTF and contractor activities are coordinated by a lead agent, usually the commander of the region's largest MTF. At the MTF level, MTF commanders report to the Surgeon General of their respective service, who allocates part of the service's appropriated funds to each MTF. MTF

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[7]Under TRICARE Extra, beneficiaries receive a discount if they see specialists from a selected network.

officials have input into network size and composition but lack direct authority over these providers or the network, which the managed care support contractor manages.

Medicare

Medicare is a federally financed health insurance program for people aged 65 and over, some people with disabilities, and people with end-stage kidney disease. Eligible beneficiaries automatically are covered under Part A, which covers inpatient hospital, skilled nursing facility, and hospice care as well as home health care that follows a stay in a hospital or skilled nursing facility. They also can pay a monthly premium to join Part B, which covers physician and outpatient services as well as those home health services not covered under Part A. Traditional Medicare allows beneficiaries to choose any provider that accepts Medicare payment and requires beneficiaries to pay for part of their care as well as for any services not covered by Medicare. To help meet these costs, some beneficiaries purchase supplemental "Medigap" policies from private insurers. Beneficiaries can choose from up to 10 standard policies. The less expensive cover Medicare deductibles and coinsurance, while the more expensive policies offer broader coverage, including prescription drugs. The alternative to traditional Medicare, Medicare+Choice, offers beneficiaries the option of enrolling in managed care or other private health plans. All Medicare+Choice plans cover basic Medicare benefits, and many also cover additional benefits such as prescription drugs. Typically, these plans have limited cost sharing but restrict members' choice of providers and may require an additional monthly premium.

The Subvention Demonstration

Under the Medicare subvention demonstration, DOD established and operated Medicare+Choice managed care plans, called TRICARE Senior Prime, at six sites. Senior Prime added benefits and network providers to those already in place for TRICARE Prime, where needed to meet Medicare managed care requirements. Enrollment in Senior Prime was open to military retirees enrolled in Medicare Part A and Part B who resided within the plan's service area. Open enrollment for those already in Medicare was capped at a number that DOD selected—roughly 28,000 for the demonstration as a whole. In addition, retirees enrolled in TRICARE Prime could "age in" to Senior Prime upon reaching age 65, even if the cap had been reached. Beneficiaries enrolled in the program paid the Medicare Part B premium but no additional premium to DOD. Senior Prime enrollees received the same priority for care at the MTFs as younger retirees enrolled in TRICARE Prime. Care at the MTFs was free, but

beneficiaries had to pay any applicable cost-sharing amounts for care in the civilian network (for example, $12 for an office visit).

The demonstration authorized Medicare to pay DOD for Medicare-covered health care services provided to retirees at an MTF or through private providers under contract to DOD. HCFA calculated capitation rates for the demonstration areas, discounted from what Medicare would pay private managed care plans in the same area. However, to receive payment, DOD had to spend at least as much of its own funds in serving this dual-eligible population as it had in the recent past.[8]

The six demonstration sites are each in a different TRICARE region and include 10 MTFs [9] that vary in size and types of services offered. (See table 1.) The five medical centers offer a wide range of inpatient services and specialty care as well as primary care. These centers also have graduate medical education (GME) training programs. The community hospitals are smaller, have more limited capabilities, and can accommodate fewer Senior Prime enrollees. At these smaller facilities, much of the specialty care is provided by the civilian network. At the Dover site, the MTF is a clinic that offers only outpatient services, thus requiring all inpatient and specialty care to be obtained at another MTF or purchased from the civilian network. For all the sites, Senior Prime's share of total enrollment (TRICARE Prime plus Senior Prime) was relatively small—an average of about 9 percent of all enrollees toward the end of 2000.

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[8]For more information on the payment mechanism, see *Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns* (GAO/HEHS-99-39, May 28, 1999).

[9]Two sites have more than one MTF.

Table 1: Medicare Subvention Demonstration Sites

Demonstration site, location of military treatment facilities	Facility type	TRICARE Prime enrollment[a]	Senior Prime enrollment[b]	Senior Prime enrollment cap[c]
Colorado Springs				
Fort Carson Colorado Springs, CO	Community Hospital	29,470	2,371	2,000
U.S. Air Force Academy Colorado Springs, CO	Community Hospital	42,351	1,750	1,200
Dover				
Dover Air Force Base Dover, DE	Clinic	12,468	1,062	1,500
Keesler				
Keesler Air Force Base Biloxi, MS	Medical Center	27,495	3,507	3,100
Madigan				
Fort Lewis Tacoma, WA	Medical Center	54,100	4,674	3,300
San Antonio				
San Antonio area				
Fort Sam Houston San Antonio, TX	Medical Center	30,688	5,928	5,000
Lackland Air Force Base San Antonio, TX	Medical Center	32,164	6,523	5,000
Texoma area				
Sheppard Air Force Base Wichita Falls, TX	Community Hospital	15,091	1,074	1,300
Fort Sill Lawton, OK	Community Hospital	28,938	1,467	1,400
San Diego				
San Diego, CA	Medical Center	54,072	4,751	4,000
Total		**326,837**	**33,107**	**27,800**

Note: Although the demonstration treats the San Antonio and Texoma areas as one site, for the purposes of analysis we treated these areas as separate sites.

[a]Enrollment as of September 2000. Counts include enrollment at the main MTF as well as at MTF satellite clinics that enroll Senior Prime age-ins. Counts do not include enrollment at nondemonstration satellite clinics or providers in the civilian network.

[b]Senior Prime enrollment as of December 2000. Senior Prime enrollment includes age-ins as well as open enrollees.

[c]An MTF's total Senior Prime enrollment may exceed the cap because the cap does not apply to age-ins.

Sources: TRICARE Prime enrollment data were provided by DOD's TRICARE Management Activity office. Senior Prime enrollment and cap figures are from DOD's TRICARE Senior Prime Plan Operations Report, January 29, 2001.

Before the demonstration, seniors at all demonstration sites received MTF care when space was available, but at some sites seniors had more regular or formalized access. At the medical centers, seniors had been a substantial part of the workload to support GME in specialty care. In particular, centers with GME programs in internal medicine had formed panels of retirees who regularly received primary care at the MTF. However, at most of the smaller sites, MTF care for seniors was more limited.

Changes in Medicare and TRICARE

Senior Prime began delivering services just as a period of major change started in both Medicare and DOD managed care. The BBA replaced Medicare's previous managed care program with Medicare+Choice, which brought many administrative changes, including a new process for demonstrating compliance with Medicare managed care requirements. Medicare+Choice also established a more structured quality improvement program than had been in effect previously. Medicare+Choice officially began January 1, 1999, but the process of issuing regulations and guidance continued into 2000. During this same period, DOD initiated its Military Health System Optimization Plan, a wide-ranging effort to re-engineer many facets of military health care. Among the issues addressed in the plan are adjustments in primary care staffing, adoption of productivity benchmarks for primary care, and use of clinical best practices and other initiatives to improve health service delivery.

More sweeping changes in retiree benefits and military health care are occurring in 2001 as a result of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. This legislation gave Medicare-eligible military retirees two major benefits:

- Pharmacy benefit—Beginning April 1, 2001, Medicare-eligible retirees from the uniformed services were given access to prescription drugs through TRICARE's national mail order pharmacy and at retail pharmacies as well as through pharmacies at MTFs.[10]
- TRICARE eligibility—Beginning October 1, 2001, retirees enrolled in Medicare Part B will also become eligible for TRICARE coverage—commonly termed TRICARE For Life.

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[10]Beneficiaries who turned 65 prior to April 1, 2001, automatically qualify for this benefit. Those who became 65 on or after that date must be enrolled in Medicare Part B to obtain the pharmacy benefit.

Under TRICARE For Life, military retirees who use traditional Medicare will be able to stay with their current private sector providers, while being relieved of most of their Medicare cost sharing. TRICARE will pay nearly all out-of-pocket costs for Medicare-covered services that these retirees previously had to pay. The law also authorizes continuation of Senior Prime—with Medicare paying DOD for seniors' care, including care received in MTFs—for 1 additional year (through 2001), with the possibility of further extension and expansion. Any such continuation will require agreement between DOD and HHS as well as congressional approval. DOD is reviewing its options for providing military managed care to seniors under this legislation and is holding discussions with HCFA.

DOD Successfully Operated Medicare Managed Care Plans, Enrolled Many Retirees

The Senior Prime sites were successful in operating Medicare managed care plans. Sites expended substantial effort to meet Medicare+Choice requirements, and HCFA reviewers said that they generally did as well as other new health plans in meeting these requirements. The demonstration showed that there is a demand among retirees for DOD managed care with low out-of-pocket costs. Strong enrollment, and particularly the large number who joined the program when they turned 65, generated concerns about MTFs' capacity for further growth. Enrollees were generally satisfied and relatively few left the program.

Sites Were Successful in Operating Medicare Managed Care Plans

Meeting Medicare+Choice requirements was a challenge for site officials, who had no prior experience doing so. However, HCFA reviewers found no major problems in the sites' compliance and said that such deficiencies as they did note were generally typical of new plans.

Senior Prime sites put considerable effort into complying with Medicare regulations.[11] The sites

- became familiar with Medicare+Choice policies and procedures;

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[11]Some Medicare+Choice regulations were waived because of unique DOD circumstances. For example, many military physicians do not have licenses to practice in all states in which they are stationed, so the requirement for physicians to obtain state licensure was waived. In addition, all regulations relating to plans' financial soundness were waived as not relevant to a federal agency.

- added benefits and network providers as needed to meet Medicare requirements;
- obtained Medicare+Choice certification, which required developing policies and procedures consistent with Medicare+Choice requirements in such areas as enrollment and quality assurance; and
- implemented grievances and appeals, claims processing, and performance measurement procedures that differed from TRICARE Prime's.

Sites had to perform new tasks and functions to meet these requirements with no additional funds from DOD for Senior Prime administration. This was a particular challenge for smaller MTFs that had limited administrative resources.

However, TMA performed some administrative tasks centrally. For example, TMA prepared informational materials for retirees. TMA also selected and paid for contractors to do the special studies on quality that Medicare+Choice requires[12] as well as to report data on health status and HEDIS (the Health Plan Employer Data and Information Set) performance measures.[13] Nonetheless, several sites observed that, even with this help, they faced additional work because they had to make medical records available to the contractors, which was time-consuming and, in some cases, disruptive to normal operations.

By December 2000, HCFA had performed an initial review of each site and full monitoring reviews at three sites. The reviews examined each site's compliance with Medicare+Choice regulations, including documentation and data submitted by the sites. HCFA staff and our review of HCFA reports indicated that no major compliance problems were identified. HCFA reviewers did identify deficiencies in administrative procedures that are common among new Medicare+Choice plans. For example, HCFA found instances of incomplete documentation and correspondence and failure to meet timelines for action on enrollment, grievances and appeals, and claims. However, HCFA said the deficiencies rarely had a direct impact on the services that beneficiaries received.

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[12]These studies measured performance, using standard indicators, for high-volume services to seniors. Areas that DOD studied included community-acquired pneumonia, congestive heart failure, and immunization.

[13]HEDIS is a set of standardized measures used to compare health plans.

Sites Attracted and Kept Medicare Enrollees

Senior Prime attracted enrollees throughout the demonstration period. By December 2000, enrollment in Senior Prime was only about 1,600 short of the demonstrationwide cap of roughly 28,000 for open enrollment. Six of the 10 MTFs had waiting lists and two others were at 90 percent of their enrollment caps. The two MTFs that fell significantly short of the cap—Dover and Sheppard—were among the smallest and were located in nonmetropolitan areas.

In addition, more than 6,500 younger retirees enrolled in Senior Prime when they turned age 65. Under demonstration rules, TRICARE Prime enrollees who had a primary care manager at a Senior Prime MTF could "age-in" to Senior Prime, and MTFs could not limit the number of such age-ins. In fact, the majority of those eligible to age-in did so. All but one MTF enrolled more age-ins than expected, and by December 2000 age-ins accounted for about one-fifth of overall Senior Prime enrollment. (See table 2.) This increased concern among MTF officials about MTFs' capacity to accommodate future growth, especially at sites that had reached their enrollment caps early in the demonstration. TMA asked sites to examine their capacity in light of continuing growth because of age-ins, but decided against any major change in enrollment policy. However, it did, with HCFA's concurrence, start requiring that age-ins live within the Senior Prime service area.

Table 2: Age-ins Were One-Fifth of Total Senior Prime Enrollment

Demonstration site, location of military treatment facilities	Enrolled beneficiaries		Total Senior Prime enrollment	Age-ins as percent of total
	Open enrollment	Age-ins		
Colorado Springs				
Fort Carson Colorado Springs, CO	1,988	383	2,371	16.2
U.S. Air Force Academy Colorado Springs, CO	1,190	560	1,750	32.0
Dover				
Dover Air Force Base Dover, DE	963	99	1,062	9.3
Keesler				
Keesler Air Force Base Biloxi, MS	2,806	701	3,507	20.0
Madigan				
Fort Lewis Tacoma, WA	3,303	1,371	4,674	29.3
San Antonio				
San Antonio area				
Fort Sam Houston San Antonio, TX	4,974	954	5,928	16.1
Lackland Air Force Base San Antonio, TX	4,953	1,570	6,523	24.1
Texoma area				
Sheppard Air Force Base Wichita Falls, TX	851	223	1,074	20.8
Fort Sill Lawton, OK	1,257	210	1,467	14.3
San Diego				
San Diego, CA	3,958	793	4,751	16.7
Total	**26,243**	**6,864**	**33,107**	**20.7**

Note: Senior Prime enrollment data are as of December 2000.

Source: GAO analysis of data from DOD's TRICARE Senior Prime Plan Operations Report, January 29, 2001.

While Senior Prime's growing enrollment indicates that retirees found its benefits attractive, enrollees also appeared relatively satisfied with Senior Prime. Relatively few enrollees left the program. In addition, both DOD data and our survey of enrollees,[14] as well as site officials' observations,

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[14]Our survey methodology will be described in a forthcoming report on beneficiaries' access to care under the demonstration.

suggest that enrollees were generally satisfied with Senior Prime. Site officials said that features such as limited out-of-pocket costs and a substantial drug benefit made the program attractive compared to other Medicare+Choice plans. The demonstration also appealed to many retirees because it would give them better access to MTF care. However, the demonstration does not allow us to tell definitively which feature of Senior Prime—its low out-of-pocket costs or access to MTF care—was more important to enrollees.

DOD Officials Indicated That, On Balance, Demonstration Had Positive Effects

DOD officials said that providing coordinated care for limited numbers of retirees yielded benefits for both retirees and medical staff. In addition, given its small scale, Senior Prime had little adverse effect on younger TRICARE Prime enrollees. While noting that it took considerable effort to meet Medicare requirements, officials also said that working with HCFA had spurred improvements in DOD administrative and clinical practices.

Site Officials Said Demonstration Benefited Seniors, Enhanced Readiness Skills, Had Little Adverse Effect on Other Beneficiaries

Site officials reported that Senior Prime enrollees received coordinated care and a broader range of services in contrast to the episodic space-available care or the mix of military and private care that many had received prior to Senior Prime. In Senior Prime, enrollees were assigned to primary care managers who were responsible for their patients' care in both the MTFs and civilian networks. Also, those with complex problems were given case managers who coordinated and helped arrange services. Senior Prime also augmented its network to provide services such as skilled nursing facility care that DOD did not provide to seniors under space-available care.

Site officials said that providing a broad range of primary and specialty care to seniors also benefited MTF clinical staff. Providing a broader set of services to seniors exposed staff to a wider range of conditions than seen under space-available care for seniors or among younger patients. At smaller MTFs, Senior Prime offered clinicians more experience providing inpatient care. MTF providers also reported that they were more satisfied because they could be assured that follow-up and other services would be available when needed.

Site officials also identified ways in which seniors' care contributed specific skills that are important for medical readiness. For example, surgeons need practice in joint and vascular surgery, and intensive care

teams need to learn how to work together under pressure. Seniors' joint and circulatory problems and the conditions that put them in intensive care are not the same as would be experienced on the battlefield but, site officials explained, treating such conditions keeps staff familiar with relevant medical procedures. Experience with the elderly can also be directly relevant to peacekeeping and humanitarian missions, where staff may deal with chronically ill or older individuals. Officials at one medical center, however, noted that despite these benefits, they were seeing fewer seniors overall because they were providing more comprehensive services to Senior Prime enrollees and offering less space-available care to nonenrolled seniors. These officials noted that, in some specialties, this smaller pool of seniors did not provide as many of the complex cases that are important for readiness training.[15]

Site officials found little evidence that, at its current small scale, Senior Prime had affected TRICARE Prime enrollees' satisfaction or access to care. Even where enrollment met the cap, Senior Prime remained a small portion of each MTF's enrolled population. By late 2000, the demonstration accounted for 9 percent of the enrolled population, although it reached 16 percent at two MTFs. Through their routine monitoring, officials identified some decreases in satisfaction and access among younger TRICARE Prime enrollees, but attributed them largely to factors other than Senior Prime. These included a sudden increase in TRICARE Prime enrollment, changes in appointment systems, and decreases in available MTF services.

Site officials had varying views about the extent to which Senior Prime affected nonenrolled retirees' access to space-available care. Some said that space-available care had declined largely due to Senior Prime enrollment and health care use. (Many of those who enrolled in Senior Prime were previous users of space-available care.) However, other officials indicated that the decline would have occurred even in the absence of Senior Prime. Many officials emphasized that the growth in TRICARE Prime resulted in less capacity for space-available care. Other factors that predated Senior Prime, including staffing reductions, also limited space-available care.

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[15]Even prior to the demonstration, seniors had been a substantial part of workload at the medical centers, where their care was important to GME programs.

Involvement With Medicare Spurred Certain Improvements

Despite the effort required to implement a Medicare+Choice managed care plan, DOD officials at every site readily acknowledged that working with HCFA was educational and spurred improvements. Requiring DOD to take a close look at its administrative and clinical procedures for a small population led to insights that could be applied more generally. For example, HCFA requirements and oversight highlighted the importance of accurately recording all care a patient receives and led to improvements in coding and patient records. Implementing requirements, such as Medicare+Choice appeals and grievance rules, suggested improvements for similar TRICARE processes, and several sites planned to implement parts of the Medicare procedures in TRICARE Prime. Similarly, the quality improvement studies undertaken for Medicare+Choice revealed opportunities for improving patient care that site officials said could be applied to the TRICARE Prime population.

Working with HCFA also brought MTF officials into contact with private Medicare+Choice plans, practices, and data. Staff at two sites met regularly with private Medicare+Choice plan representatives and said that they found it useful to discuss Medicare+Choice issues with them and HCFA staff. Participation in Senior Prime also led sites to compare their performance with that of private plans. The Madigan and San Diego sites purchased data on private plans in their market area from a private firm, including benchmarks for utilization of services.[16] The private plan data provided DOD with a basis for comparing performance as well as for understanding how patient care and data recording practices differ between the two sectors.

Demonstration Challenges Reflected, In Part, Larger DOD Managed Care Issues

Although some difficulties that DOD encountered in implementing Senior Prime reflected Medicare+Choice requirements or factors specific to the subvention demonstration, others highlighted underlying features of DOD managed care. These included maintaining sufficient staff, given military medical staff turnover and deployments; managing care that is delivered in two separate systems—the military system and the contractor-managed network; and working within the confines of a slow and cumbersome contracting process.

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[16]Statistical adjustments for differences in patient demographics as well as adjustments for different clinical practices and reporting were necessary to make meaningful comparisons. (For example, DOD's "outpatient visit" measure includes telephone consults and its emergency room statistics from some MTFs include some acute care visits that were not counted in the private firm's data.)

Sites Faced Challenges in Securing and Maintaining Adequate Medical Staff

Ensuring the availability of MTF and network providers and maintaining continuity of care are issues in TRICARE generally, but sites' experiences showed that these issues are more pressing when seniors are involved. This is because seniors typically have more health care needs than younger beneficiaries and use certain specialists and services more intensively. While Senior Prime enrollees generally had good access to care and sites managed to provide the full range of services, sites had difficulty in arranging some resources that were particularly critical for seniors.

MTF Providers

Maintaining adequate staff at MTFs is an ongoing challenge because of routine turnover, military deployments, and readiness training. In the demonstration, replacement staff needed due to routine turnover did not always arrive when they were needed, sometimes reporting months after the previous staff had left. Staff deployments and readiness training also led to gaps in provider availability, although this varied among MTFs. Some MTFs experienced mostly short-term deployments during the demonstration, while others contributed staff for assignments lasting several months. The resources deployed ranged from individual staff members, including specialists important for senior care, to an entire operating room team. Some of the larger MTFs were also responsible for filling positions at other MTFs that were short-staffed, increasing the pressure on staff resources at those sites.

Sites took several steps to mitigate the effect of military staff absences on patient care. Some absences could be unpredictable, but sites often had advance notice and could plan to minimize interruptions. For short-term training absences, at least one MTF was able to adjust schedules so that not all members of a particular team were away at once. For temporary assignments, MTFs could sometimes send specialists rather than primary care providers, thereby minimizing the impact on primary care management. To cover for absent Senior Prime primary care managers, some MTFs used other primary care team members or specialists to fill in, some arranged for civilian providers to fill in temporarily, and one was able to arrange for a temporary replacement from another MTF. For specialty care, larger MTFs generally had more staff to cover short-term gaps, but smaller MTFs with few providers in a specialty had to rely more on network providers.

Obtaining staff for the longer term was more problematic. First, DOD procedures for assigning staff to MTFs are not generally geared to making

needed adjustments quickly. MTFs sometimes could not meet their authorized staffing levels because no one was available. Second, when MTFs tried to hire civilian personnel, their ability to do so was generally dependent on the local market, and several reported that recruiting civilians to fill certain positions was difficult. Although another option, TRICARE's "resource sharing" program, allows MTFs to use civilian staff provided by the managed care support contractors to deliver care with the MTFs, only a few MTFs were using resource sharing providers to treat Senior Prime enrollees. At the time of our visits, site officials did not share a common understanding of when resource sharing could be used within Senior Prime.[17]

Network Providers

Despite managed care support contractors' recruiting on an ongoing basis to ensure network adequacy, several sites had problems securing local providers for their network and had to send patients outside the network for care. Pulmonology, dermatology, and rheumatology were areas in which more than one site encountered problems. Also, site officials reported that some providers were reluctant to contract with Senior Prime. For example, some did not want to accept the contracted payment rate, which was lower than the out-of-network rate they could otherwise receive.

Officials noted that network development was generally more difficult for TRICARE in rural areas, where the supply of specialty providers is limited. Rural sites were able to build networks that met most of their referral needs, although their networks sometimes had only one or two providers in certain specialties. Seniors who were enrolled at more rural MTFs at times had to travel significant distances to reach certain specialist providers. However, in some areas longer travel times were common. For example, an official from the Texoma area commented that beneficiaries are accustomed to traveling some distance for care, and that Senior Prime

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[17]DOD's policy on how resource sharing could apply to Senior Prime changed during the demonstration. In late 2000, the sites and TMA were working to achieve a common understanding of this policy.

still met Medicare's standards regarding access to care for their communities.[18]

Dual Delivery Systems Added to Sites' Difficulties

TRICARE in general has difficulty integrating MTF and network care, but sites' experience showed that this is a larger issue for seniors, who have more extensive needs than the TRICARE Prime population. From the start of the demonstration, sites' ability to integrate care at the MTF with care purchased through the network was limited. In particular, sites had to find ways to coordinate those services that the military health system has not traditionally provided to seniors as well as to resolve issues common to TRICARE of integrating MTF and network data.

Coordination of Care

Most MTFs encountered problems in coordinating care to Senior Prime enrollees, especially when they were in a skilled nursing facility or nursing home.

- A central issue for the sites was the provision of case management services by nurses or social workers. Senior Prime required a shift in focus for case management,[19] from managing primarily catastrophic cases in a younger population to coordinating chronic medical care for an older population. This included support in assisting families and patients in transitioning from the MTF to an institutional setting or to home. Particularly for older patients, case managers are often pivotal in coordinating care. Officials at five MTFs reported having added case managers for Senior Prime or changed the case manager's role. In addition to providing case management, some MTFs had another problem: coordinating information when an enrollee had two case managers—one at the MTF, the other, a managed care support contractor responsible for the enrollee's network care.
- Sites also had to determine who would oversee the medical care of the Senior Prime patient while he or she was in a skilled nursing facility or a rehabilitation hospital—the MTF's primary care physician who was

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[18]HCFA guidance on Medicare+Choice generally requires that beneficiaries have to travel no more than 30 minutes to receive primary care and commonly used specialty care. However, it recognizes that in some parts of the country this is not feasible; longer travel times are allowed in places where this is customary, such as in rural areas.

[19]Case management is a service function directed at coordinating existing resources to assure appropriate and continuous care for individuals on a case-by-case basis.

responsible for the enrollee's care or a physician associated with the civilian institution. This issue was complicated by the fact that MTF physicians are typically not licensed to practice medicine in the state where the MTF is located. As a result, they cannot be given medical privileges at the local health care facilities. Most sites used the institutional staff or network physicians to see the admitted Senior Prime patients and relied on the managed care support contractor's case managers to communicate with the patient's MTF physician.[20]

- For patients who were in skilled nursing facilities or rehabilitation facilities or receiving most of their care from network physicians, sites had to decide who would provide needed lab tests and routine appointments— the MTF or the network physicians. Some of the larger sites elected to return Senior Prime patients admitted at local institutional facilities to the MTF for lab tests ordered by the network physician or for routine clinic appointments. This practice could help ensure that medical information, such as the results of a lab test ordered by a network physician, was shared between the MTF physician and the network physician. However, transporting patients back and forth is not always feasible, cost-effective, or convenient for the patient, and one MTF reported it was considering other options.

Integration of Data

In managing patient care, MTF primary care physicians faced two additional difficulties in bridging the gap between network and military care. First, they needed to ensure that patients followed through on referrals—making and keeping their appointments with network providers. TRICARE appointment and referral procedures did not necessarily record this information, which required good communication with providers outside the MTF. Second, MTFs needed to ensure that clinical results of referrals were shared with the patient's primary care physician. One site, observing that the referral process needed improvement, established centers to coordinate referrals. The centers' staff created a database to track the status of referrals, so that they could inform primary care physicians when patients had not made or kept their referral appointments. The staff also monitored whether primary care physicians had received the clinical results.

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[20]One site, Dover, ensured that its physicians were licensed in the state of Delaware so they could continue to care for their Senior Prime patients admitted to the local civilian health care facilities.

Integration of data on MTF care with data on network care was a problem for overall management of Senior Prime as well as for physicians' management of their individual patients' care. Different data systems were involved—one for network care, maintained by the managed care support contractor, and one for MTF care, maintained by DOD. To obtain a comprehensive picture of care that individual patients or groups of patients (for example, all patients with diabetes) received, sites had to manipulate the data in the two systems extensively. This hindered the sites' obtaining such information routinely.

Both the sites and DOD are undertaking initiatives to improve the integration of data from different sources. For example, DOD now maintains three separate pharmacy data systems –one for prescriptions filled at an MTF, one for prescriptions filled through DOD's national mail order pharmacy, and one for those filled at network pharmacies. DOD has begun implementing a pharmacy data transaction system, which will create an integrated record of all prescriptions received by TRICARE beneficiaries. In general, however, DOD has encountered persistent problems in its efforts to integrate other types of health care information (including data on network care, MTF inpatient care, and MTF outpatient care).

DOD Contracting Process Hindered Response to Necessary Changes

Modifying managed care support contracts in a timely way was a significant problem in the demonstration. Negotiating contract changes has been a longstanding problem for DOD in managing TRICARE. The problem was more acute for the demonstration because a significant number of additional contract modifications had to be negotiated specific to subvention.

Shortly after Senior Prime's startup, HCFA began implementation of Medicare+Choice, which resulted in far-reaching changes in Medicare regulations. These changes, which were released over more than a year, required Medicare+Choice plans to implement new practices and procedures—generally, within 90 days of receiving the changes. Many of these changes affected contractor-performed activities including enrollment, reporting, and network contracting. Senior Prime involved six "change orders"—modifications to the TRICARE managed care support contracts—to set up the demonstration and make it conform to the evolving Medicare+Choice rules.

Handling these changes was cumbersome in several ways, detailed in figure 1, and highlighted how ill-suited the contract change order process was to making changes expeditiously. The problems encountered in Senior Prime were typical of TRICARE change orders generally, except for the delay in requesting proposals, which reflected the special circumstances of the demonstration.

Figure 1: Features of the Contract Change Order Process

Lengthy process: The change order process takes over 6 months to complete.

Backlog of changes: The office that handles such change orders was understaffed and had a backlog of several hundred TRICARE changes during the demonstration period.

Delays in receiving cost proposals: Although TMA asks managed care support contractors to submit cost proposals within 60 days of receipt of the change order, responses typically take much longer. Time may be taken to clarify the details and scope of the change, as it was for the Medicare+Choice compliance training requirement, and collect data from subcontractors. (Cost proposals for Senior Prime were further delayed by TMA's decision to wait until the Medicare+Choice changes were complete before asking contractors to respond to them. In February 2000, TMA decided it could not wait any longer and requested cost proposals for the first batch of changes.)

Interim authorization of work: TMA can authorize managed care support contractors to implement changes before costs are negotiated and settled, and has typically done so. For Senior Prime, DOD incorporated Medicare+Choice changes into the operations manual that spells out managed care support contractor responsibilities. This action authorized contractors to proceed with the HCFA-required activities while cost issues were being resolved.

Delays in payment: DOD cannot pay managed care support contractors for their efforts until the contractors submit an acceptable cost proposal—and even then, can only make provisional payments at less than the proposed cost. For Senior Prime, it was about May 2000 before the first contractors began to receive provisional payments for Medicare+Choice changes. Full payments could be completed once cost negotiations had been concluded.

This system had several disadvantages. First, delays in the process meant that Medicare+Choice requirements went into effect before TMA could authorize contractors to implement them. In order to achieve the demonstration's timely compliance with Medicare+Choice requirements, lead agent staff wanted contractors to move forward without a formal change order—which they sometimes did—although TMA contracting officials cautioned against this practice. Second, lack of timely payment was a major concern at the managed care support corporate level. Third, the fact that contractors had already incurred actual costs may have put

DOD at a disadvantage when negotiating change orders. Finally, TMA was authorizing changes without knowing what they would actually cost. Unsettled change orders could represent a significant future liability for the Defense Health Program if they are settled at higher amounts than DOD estimated.

The backlog in processing contract changes and the practice of implementing changes before their costs were negotiated have long been problems for TRICARE.[21] Efforts initiated in 1997 to remedy the problem were not successful. In July 2000, TMA began an effort to negotiate and pay for all of its outstanding change orders. This effort eliminated most of the backlog, but the $900 million cost of the settlements contributed to a shortfall in funding for the Defense Health Program for fiscal year 2001. TMA has instituted a new process that requires costs to be negotiated and settled before changes are implemented, but evidence of the effectiveness of this process is not yet available.[22]

Concluding Observations

Senior Prime, while demonstrating that DOD can operate a Medicare+Choice plan, also illustrated the complexities of offering managed care within the military health system. Some lessons from the demonstration apply to military managed care generally. These include the difficulties of linking MTFs with network care and the importance of re-engineering the previous managed care support contract change order process. Other lessons apply specifically to military managed care for seniors. These include the importance of accurately estimating MTFs' capacity for enrolling seniors, especially given the potential for age-ins; the need to provide seniors with more complex care, including case management and post-acute care; and the value of contacts with HCFA and private Medicare+Choice plans. Much of Senior Prime's experience in providing care to seniors may be applicable to the new TRICARE For Life program. DOD officials may be able to draw on lessons learned from Senior Prime as they define the new program's options for seniors.

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[21]See *Defense Health Care: Actions Under Way to Address Many TRICARE Contract Change Order Problems* (GAO/HEHS-97-141, July 14, 1997).

[22]See *Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly* (GAO-01-513, April 30, 2001).

Agency Comments

DOD and HCFA provided written comments on a draft of this report, which are reprinted in appendixes I and II. Both agencies said the report contained an accurate description of implementation issues encountered in the demonstration. DOD noted that expanding Medicare subvention or making it permanent should be approached cautiously, with an understanding of cost and funding issues. We will address cost issues in future reports. The two agencies also provided suggestions for clarity and technical comments, which we have incorporated as appropriate.

We are sending copies of this report to the Secretary of Defense and the Administrator of HCFA. We will make copies available to others upon request.

If you or your staffs have questions about this report, please contact me at (202) 512-7114. Key contributors to this assignment included Gail MacColl, Robin Burke, and Lisa Rogers.

William J. Scanlon
Director, Health Care Issues

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Appendix I: Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

JUN   1 2001

Mr. William J. Scanlon
Director, Health Care Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Scanlon:

This is the Department of Defense (DoD) response to the GAO draft report, Medicare Subvention Demonstration: DoD's Pilot HMO Appealed to Seniors, Underscored Management Complexities, (GAO-01-671).

Overall, the Department of Defense finds the report to be accurate and thorough. It adequately describes the complexities and challenges inherent in the implementation, administration, and management of the Medicare Subvention Demonstration. I recommend, to ensure clarity, TRICARE For Life should be distinguished in the report from other TRICARE programs.

The Department of Defense continues to support efforts to provide retired beneficiaries all possible access to quality health care. Any effort to expand, extend, or make Medicare Subvention permanent should be approached cautiously, with a clear understanding of the real cost of providing the service and ensuring sufficient funding is available.

The Department of Defense appreciates the opportunity to comment on the draft report. Our technical comments on the draft report are enclosed.

Please feel free to address any questions or concerns to my project officers on this matter, Dr. Richard D. Guerin, Director, Health Program Analysis and Evaluation (Functional) at (703) 681-3636 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Sincerely,

J. Jarrett Clinton, MD, MPH
Acting Assistant Secretary

Enclosure
As stated

Appendix II: Comments From the Health Care Financing Administration

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: MAY 2 5 2001

TO: William J. Scanlon
Director, Health Care Issues

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: General Accounting Office (GAO) Draft Report – *Medicare Subvention Demonstration: DOD's Pilot HMO Appealed to Seniors, Underscored Management Complexities* (GAO-01-671)

We appreciate the opportunity to review and comment on the above subject report.

The GAO reports that the demonstration sites were successful in operating Medicare managed care plans. The Department of Defense (DOD) officials reported to GAO that, on balance, the demonstration's effect was positive. The GAO further notes that some challenges encountered in the demonstration reflect larger DOD managed care issues and may have implications for DOD managed care generally.

We have no comments pertaining to the specific contents within the report. It is an accurate description of the issues that arose during the initial operating phase of the demonstration in which DOD implemented Medicare managed care entities.

In the introduction or results sections of this report, GAO should state that the information does not pertain to cost effectiveness or the financial implications of subvention. Additionally, with respect to the demonstration's effectiveness, we suggest that the statement be clarified to indicate that the report does not address broader issues dealing with level of effort financial calculations and analyses of DOD and Medicare costs resulting from the demonstration.

We look forward to working with GAO on this and other issues.

Related GAO Products

Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly (GAO-01-513, April 30, 2001).

Medicare Subvention Demonstration: Enrollment in DOD Pilot Reflects Retiree Experiences and Local Markets (GAO/HEHS-00-35, January 31, 2000).

Medicare Subvention Demonstration: DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues (GAO/GGD/HEHS-99-161, September 28, 1999).

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

Defense Health Care: Actions Under Way to Address Many TRICARE Contract Change Order Problems (GAO/HEHS-97-141, July 14, 1997).

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