Appendix C
Reports from the First Round of Site Visits

The Memorandum of Agreement (MOA) executed by the U.S. Department of Defense and Department of Health and Human Services provide for an independent evaluation of the demonstration, for which HCFA awarded RAND the contract in September 1998. One component of the evaluation is a process evaluation that is designed to:

- Document the activities and experiences of HCFA, DoD, the demonstration sites, beneficiaries, and other stakeholders as TRICARE Senior Prime and Medicare Partners are implemented;
- Generate qualitative information to help interpret the findings of quantitative analyses of the demonstration’s effects on utilization patterns, access and quality, and costs; and
- Evaluate the implications of the documented experiences of stakeholders for broader implementation of Senior Prime or Medicare Partners across the military health system.

The process evaluation includes two rounds of visits to the subvention demonstration sites. The site visits are structured as shared learning activities, with the goal of learning from the sites’ successes and challenges during the demonstration. In the first round of site visits in early 1999, we are collecting information on start-up and early operational experiences. In the second round of visits in late 2000, we will document structures and operations after the sites have had two years of experience with the subvention program. Between the two rounds of site visits, we will maintain quarterly contact with the sites to document changes in operation of the Senior Prime plans or Medicare Partner agreements and to identify issues that arise during the demonstration.

This Appendix contains site visit reports that highlight findings from the first round of site visits to subvention demonstration sites. In each report, we first provide a brief description of the site and its Senior Prime activities. We then discuss key points that we have identified with respect to the Senior Prime implementation and early operations, and we summarize lessons that the site stated they have learned thus far. Finally, we present implications and issues raised from our site visit findings. The reports are presented in the order in which the site visits were performed.

A central issue regarding data systems arose in all the site visits, which we identify here rather than in each site visit report because the sites share the issue. The multiple data systems involved in the collection and processing of data required to operate and monitor the Senior Prime plans has created a complexity that is vulnerable to errors and operational inefficiencies. These systems include the DoD DEERS enrollment system, CHCS clinical data and ADS ambulatory care data systems at the MTFs, the MEPRS data system on MTF workloads and finances, the MCS contractors’ enrollment and claims processing systems, and the HCFA Medicare Processing Center that processes Medicare eligibility and Senior Prime enrollments. Successful implementation depends not only on valid data from each of these systems, but also on successful integration of activities across systems.
OVERVIEW OF THE SENIOR PRIME PLAN

The three key participants in the San Diego Senior Prime plan are the Office of the Lead Agent for TRICARE Region 9, the San Diego Naval Medical Center, and Foundation Health Federal Services (FHFS), the Region 9 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, executed the Medicare+Choice plan contract with HCFA. The Medical Center is the sole military treatment facility (MTF) participating in the plan, and it serves as the primary provider of health care services to Senior Prime enrollees in this site. FHFS carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, and administrative services. Of the over 257,000 DoD beneficiaries in the San Diego market, about 14 percent are Medicare eligible and another 20 percent are retirees less than 65 years of age. The San Diego area is a highly penetrated managed care market, including 5 or 6 Medicare managed care plans that are serving 48 percent of the Medicare population. The Senior Prime plan is new competition for these existing Medicare plans.

The Naval Medical Center is a comprehensive tertiary facility with multiple clinical teaching programs. It has a combined mission of readiness, active duty support, and integrated health care delivery. The medical center has a bed capacity of approximately 300 beds, with an average daily census of 220 patients and more than 90,000 outpatient visits per month. Its pharmacy fills more than 3,800 drug prescriptions every day. The MTF can provide all standard outpatient and inpatient acute care services for Senior Prime enrollees, but it does not provide some Medicare-covered services that are required primarily by an older population. Civilian providers in the Senior Prime network provide these services.

PROGRAM DESIGN

Although the 6 demonstration sites share many common elements in their organizational structure, benefits covered, and service delivery system, the Naval Medical Center and the San Diego market have unique features that are reflected in the design of this TRICARE Senior Prime plan. FHFS brought in consultants with Medicare managed care expertise from elsewhere in the FHFS system, who advised the 3 sites it serves on designing Senior Prime and preparing for enrollment and operations.

**Plan Leadership** - With the establishment of the Office of the Lead Agent as the Senior Prime plan, the plan policy and management leadership were established at the TRICARE region level. This approach was done deliberately by the site in order to position the region for the possible expansion of Senior Prime in the future, through extension of the basic structure established for the demonstration.

**Infrastructure** - The San Diego Senior Prime plan was established within the Region 9 TRICARE framework as an adaptation of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted to its requirements. The Senior Prime Management Committee brings together the key organizational participants (Lead Agent, MTF, and FHFS) for coordination of policy and management. This Committee reports to the Executive Council of the TRICARE Regional Board of Directors. The site reports that such a unified corporate structure supports consistent decision making, reporting, and orderly response to issues, and it also helps integrate Senior Prime into the Region 9 TRICARE program.

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1 The functions and responsibilities of the contractors for the TRICARE Senior Prime plans in all 6 demonstration sites are specified in Chapter 20 of the TRICARE Support Office Operations Manual.
Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the “richer of the Medicare or TRICARE Prime benefits,” thus providing consistent health benefits at all Senior Prime sites. Yet this policy may constrain the ability of the San Diego plan to compete on benefits with other health plans, many of which are offering quite rich benefits to position themselves in a competitive Medicare managed care market.

Quality and Utilization Management System - The Senior Prime management team has adapted the region’s well-established TRICARE quality and utilization management programs for the Senior Prime plan. The QM/UM team is a collaborative effort among the staff responsible for QM and UM within each organization - the Lead Agent, MTF, and FHFS. There is a formal QM/UM committee within the TRICARE structure that oversees these activities for both TRICARE Prime and Senior Prime.

Provider Network - The four PCM clinics offer distinct options for Senior Prime enrollees, with an internal medicine clinic and a family practice clinic within the medical center and two clinics in other Naval facilities in the area. Many secondary and tertiary services also are provided in specialty clinics and inpatient units within the MTF. For services the MTF does not provide, the first sources of civilian care are the existing TRICARE Prime network providers. FHFS then contracts with new providers for services that are not available in the Prime network, including skilled nursing facility care, home health care, durable medical equipment, physical rehabilitation care, chiropractic care, burn care, and organ transplants.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - The San Diego site faced uncertainty periodically during the planning phase of the demonstration, as HCFA and DoD negotiated key decisions on program policy and design. One example of this issue was HCFA’s introduction of the new Medicare+Choice rules to the Senior Prime plans. As the site was preparing for HCFA’s site visit for its Medicare contract application, HCFA applied the Medicare+Choice rules to Senior Prime, thus changing the Medicare conditions for participation. In response to the new rules, the San Diego site revised its application, marketing, and enrollment materials immediately before the site visit. These “real time” events compressed the time available for the site to prepare for orientation of beneficiaries and program initiation.

Start-Up Activities - Education and training were an important part of starting up Senior Prime in San Diego. The site trained the MTF staff first and then provided orientation for beneficiaries. Training meetings were held for all providers in July 1998, which were mandatory for physicians and open to all other staff. A reported 95% of clinicians attended the meetings. In addition the PCMs received 1-on-1 training. FHFS trained network providers at its central office for the 3 sites that FHFS serves. The site also undertook extensive outreach to provide information and orientation for dual eligible beneficiaries about the Senior Prime plan and their Medicare coverage options. More than 65 orientation meetings were held that were attended by almost 2,700 beneficiaries. Although their educational activities were broad-based, they were conducted in a compressed time period as a result of the time demands involved with switching to Medicare+Choice rules.

Enrollment - The rates of Senior Prime enrollment in San Diego have been slower than expected. Only 2,100 of the targeted 4,000 enrollees had enrolled by the end of January 1999, but new enrollees continue to join at a rate of about 100 per month. Many are Medicare-eligible beneficiaries who are taking time to decide whether to join Senior Prime, and plan managers expect that these enrollments will continue for a while. The remainder are TRICARE Prime enrollees who are aging in to Senior Prime at a steady pace of 50 or more each month. The site reported that retiree associations in the area had advised their members to be cautious about enrolling in a two-year demonstration and not to give up their Medicare supplemental courage. These activities may have contributed to the slower rates of enrollment. In addition, PCM physicians and front-line clinical and support staff reported that many beneficiaries were confused initially regarding the
enrollment process, and non-enrollees were concerned about whether they would lose access to space-available care.

There is strong consensus that the slower enrollment was good for the Senior Prime plan and the Medical Center. More flexibility was available to gear up service delivery and manage enrollees’ initial PCM visits without severely compromising access to care for other beneficiaries. Full enrollment immediately would have stressed the clinics’ capacity to their limits or beyond.

**Service Delivery** - All new Senior Prime enrollees were scheduled for first visits at the PCM clinics, at which they were screened for health status. This process identified many people with unmanaged health problems who needed follow-up care. In contrast to earlier expectations that clinic activity would decrease after the initial visits, follow-up services for enrollees with health problems now are expected to place continuing demands on the clinics, thus reducing capacity for space-available care. Transitions to Senior Prime providers were reported to be made smoothly for many enrollees who had existing services for chronic conditions. FHFS added new network providers or specialty services as demand documented the need. For some enrollees who were using non-network providers, and had to switch to network providers, the temporary unavailability of some services (e.g., DME) was reported to interrupt access during the transition.

**Quality and Utilization Management Processes** - As the Senior Prime staff are preparing to meet HCFA’s QISMC quality requirements, they have adopted a data-driven approach to define priorities based on documented need for improvements in clinical processes or efficiency. The site is working with the Senior Prime compliance committee at the DoD level to establish consistent indicators across the sites. Data limitations, especially ADS data, are hampering their ability to measure indicators readily.

**Financial Performance** – The financial impact on the MTF from the administrative demands of implementing Senior Prime were small, relative to the facility’s overall budget. They report that no funds were allocated for start-up because all the work at the MTF was done by existing staff. Senior Prime is being introduced at a time of declining third party reimbursements to the MTF, where reimbursements have decreased $1.5 million from previous years. They plan to estimate the financial impact of Senior Prime on service delivery costs at mid-year. Specialty clinics are not liable for new specialty care costs generated by older patients, but the costs are reported on their financial statements so they can see what they are. With recognition that LOE reconciliation credits and cash flow decisions are handled at the service level within DoD, little concern was expressed about whether the medical center would see any cash for the Senior Prime services it provided.

**Dynamics of the Local Medicare Managed Care Market** – The Senior Prime plan is a new entry to an extremely competitive managed care market, including health plans with high rates of Medicare enrollments. Many of the Senior Prime enrollees previously had been members of other Medicare plans. These enrollees are already accustomed to a managed care environment and are savvy consumers of medical care. Because these plans have such large enrollments, however, the impact on them likely is small even if they lose hundreds of enrollees to Senior Prime.

**Early Lessons Learned by the Site**

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees’ service needs.
   - A large number of enrollees signed up immediately for the Internal Medicine Clinic, resulting in almost immediate filling of the clinic’s service capacity.
   - Approximately 80% of the enrollees were new patients for the PCM clinics, but not necessarily new to the MTF because many were patients of specialty physicians.
   - Enrollee satisfaction is high due to improved access to care and TRICARE benefits.
   - Through flexibility and expansion of clinic capacity, the MTF has met TRICARE access standards for both Prime and Senior Prime enrollees.
   - Group orientations for new enrollees are a functional tool in educating them regarding providers, processes, and contact information; and may be a key in the future.
   - Providers had a critical role in marketing Senior Prime and increasing enrollments.
• Providers and Health Benefits Advisors have important roles in working with space-available beneficiaries whose access to MTF care has decreased and with eligible beneficiaries who have not yet enrolled.

2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
• The transitional impact on space-available beneficiaries is not yet known.
• During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) and be flexible in managing their care.
• Care to Senior Prime enrollees provided outside of the hospital needs to be monitored carefully.
• Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.
• Strong communication among the MTF, Lead Agent, and FHFS is essential to managing compliance issues that require resolution and documentation.
• Use of Resource Sharing assets should be permitted for Senior Prime.
• Extensive coordination between the MTF and network case management teams is required for continuity of patient care.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management.
• No mental health benchmarks are available for use in monitoring.
• System-generated reports should be available for utilization management for civilian providers (data currently is collected manually).
• Benchmark quality and access data for the dual eligible population is needed in CEIS.
• Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
• Additional physician training is needed on HCFA rules for documentation and coding.

IMPACTS ON BENEFICIARIES
Although this site visit did not include focus groups with beneficiaries or leaders of retiree associations, focus groups were conducted with front line PCM physicians and other clinical and support staff. These sessions generated information about the feedback that MTF staff have been hearing from beneficiaries who received care at the medical center, as follows:
• Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
• Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
• Some feel forced into Senior Prime as the only way to gain access to the Medical Center, as they observe shrinkage of space-available care.
• Senior Prime enrollees appear to have gained better access to care and continuity of services.
• Substantial confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee.
• Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions are losing specialists who were providing both their specialty and primary care.
• Beneficiaries need continuing support and education as they make changes in enrollments and service providers; some of the initial confusion will abate, but much probably will continue.
IMPACTS ON SENIOR PRIME ORGANIZATIONS

Naval Medical Center

- Because the Medical Center already had served many older patients, introduction of Senior Prime has had only modest effects on MTF administrative and operating costs or shifts in patient mix toward an older population.
- PCM clinics’ service patterns have changed from provision of episodic care to active care management for their enrollees.
- Emphasis on case management has grown and may extend into care for Prime enrollees.
- Communication between primary care clinicians and specialists has improved as patients are referred and treated, and it is being accelerated by case management activities.
- The specialty care needs of older populations are supporting the medical education mission.
- Impacts of Senior Prime on the MTF’s readiness mission are reported to be small because the MTF has an established backfill plan, tends not to have large deployments, and the beneficiaries understand the importance of readiness and are willing to adjust health care use when deployments occur.
- Efforts are increasing to improve data resources to support QM/UM activities.
- Some confusion and negative views of Senior Prime have been expressed by physicians, clinical, and support staff due to introduction of new service delivery methods under managed care and an incomplete understanding of the Senior Prime program.

Lead Agent

- Leadership responsibility has increased, accompanied by re-definition of the Lead Agent functions and an increase in resource requirements.
- The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
- Lead Agent staff resources have been increased in response to these expanded roles.

Foundation Health Federal Services

- Workload has increased as FHFS has supported the new enrollee population.
- The FHFS enrollment system has been expanded and modified for Senior Prime enrollments.
- New demands are placed on FHFS staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- Contracting activities have increased as FHFS has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.
- FHFS has added staff in both its home office and Region 9 office to accommodate these new responsibilities and caseloads. Because FHFS is the TRICARE contractor for 3 subvention sites, they have achieved some efficiencies in their new Senior Prime functions.

Other Organizations

- The VA may lose some beneficiaries to Senior Prime, but at the same time gain some who do not join and are crowded out as space-available care decreases.
- Other Medicare health plans in the market are experiencing observable loss of enrollment, but the losses appear to have limited effects on the very large plans.

IMPLICATIONS AND ISSUES

The early experiences of the San Diego site have revealed that the following factors are important for successful implementation of a Senior Prime plan:
• Timely addition of new specialty providers specific to Medicare populations,
• Training of specialty physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
• Responsive actions to identify and correct operational problems during enrollments,
• Ensuring access to case managers for all PCM clinics,
• Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
• Preparation for timely handling of grievances and appeals,
• Access to the data needed to monitor program activities and manage quality and utilization. Many of these factors become critical in the context of system-wide implementation of Senior Prime, where a regional Lead Agent office will be managing start-up and operational processes across multiple MTFs. To establish the program across a region successfully, the Lead Agent will need to have a combination of the necessary authority and adequate resources.
OVERVIEW OF THE SENIOR PRIME PLAN
The three key participants in this Senior Prime plan are the Office of the Lead Agent for TRICARE Region 11, Madigan Army Medical Center (MAMC), and Foundation Health Federal Services (FHFS), the Region 11 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, executed the Medicare+Choice plan contract with HCFA. The Medical Center is the sole military treatment facility (MTF) participating in the plan, and it serves as the primary provider of health care services to Senior Prime enrollees in this site. FHFS carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, and administrative services.

Of the over 138,000 DoD beneficiaries in the Seattle-Tacoma market, about 14 percent are Medicare eligible and another 37 percent are retirees less than 65 years of age. The Seattle-Tacoma area is a highly penetrated managed care market, including 6 Medicare managed care plans that are serving 28 percent of the Medicare population. The Senior Prime plan is new competition for these existing Medicare plans.

Madigan Army Medical Center is the demonstration site with the most experience in managed care. Reorganization of their organizational structure and service delivery systems occurred in 1995 with the start-up of healthcare delivery under the first TRICARE contract. Prior to that, in 1992 MAMC had begun implementing managed care under the Army’s Gateway to Care. Thus, the beneficiaries served by MAMC are accustomed to managed care concepts, so transition to Senior Prime as a Medicare health plan was accomplished fairly easily.

Madigan Army Medical Center is a comprehensive tertiary facility with multiple clinical teaching programs. It has a combined mission of readiness, GME, active duty support, and integrated health care delivery. The medical center has a bed capacity of approximately 172 beds, with average daily admissions of 45 patients and more than 950,000 outpatient visits per year. The MTF can provide almost all of the standard outpatient and inpatient acute care services for Senior Prime enrollees, but it does not provide some Medicare-covered services that are required primarily by an older population. Civilian providers in the Senior Prime network provide these services.

PROGRAM DESIGN
Although the 6 demonstration sites share many common elements in their organizational structure, benefits covered, and service delivery system, Madigan Army Medical Center and the Seattle-Tacoma market have unique features that are reflected in the design of this TRICARE Senior Prime plan. FHFS brought in consultants with Medicare managed care expertise from elsewhere in the FHFS system, who advised the 3 sites it serves on designing Senior Prime and preparing for enrollment and operations.

Plan Leadership - With the establishment of the Office of the Lead Agent as the Senior Prime plan, the plan policy and management leadership was established at the TRICARE region level. This approach was done deliberately by the site to position the region for the possible expansion of Senior Prime in the future, building upon the basic structure established for the demonstration.

Infrastructure – The Senior Prime plan was established within the Region 11 TRICARE framework as an extension of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted to its requirements (one example being the quality management function). The ground work for the success of this site in starting up Senior Prime was laid by having an existing TRICARE management structure and working relationships, as well as familiarity with a managed care environment. The TRICARE Senior Prime Management Committee brings together the key organizational participants (Lead Agent, MTF, and FHFS) for coordination of policy and management. This Committee reports to the Executive Council of the TRICARE Regional Board of Directors, helping to integrate Senior Prime into the Region 11 TRICARE program.
Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the “richer of the Medicare or TRICARE Prime benefits,” thus providing consistent health benefits at all Senior Prime sites. This policy may constrain the ability of the Madigan/Region 11 plan to compete on benefits with other health plans in a highly competitive market, although the supplemental benefits offered by other plans may also be constrained by the relatively low Medicare capitation rates in this market. There is a strong consensus at the site that TMA needs to clarify the details of what specific services and limits are covered by the Senior Prime benefits.

Quality and Utilization Management System - The Senior Prime management team has adapted the region’s well-established TRICARE quality and utilization management programs for the Senior Prime plan. The QM/UM team is a collaborative effort among the staff responsible for QM and UM within each organization - the Lead Agent, MTF, and FHFS. There is a formal QM/UM committee within the TRICARE structure that oversees these activities for both TRICARE Prime and Senior Prime.

Provider Network - Two PCM clinics within the medical center - an internal medicine clinic and a family practice clinic - offer distinct options for Senior Prime enrollees. Many secondary and tertiary services also are provided in specialty clinics and inpatient units within the MTF. For services the MTF does not provide, the first sources of civilian care are the existing TRICARE Prime network providers. FHFS then contracts with new providers for services that are not available in the Prime network, including skilled nursing facility care, home health care, durable medical equipment, physical rehabilitation care, and chiropractic care.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - The Region 11 site was the first to be processed for Medicare certification, and the Medicare standards and processes changed during this time as HCFA established the Medicare+Choice rules and HCFA and DoD continued negotiations on program policy and design. When HCFA applied the new Medicare+Choice rules to the Senior Prime plans, this site revised its Medicare certification application and modified procedures to comply with the new rules.

Start-Up Activities - Education and training were an important part of start-up for Senior Prime in Region 11. This site started early with electronic education sent to the MTF staff. The Lead Agent and Commander of Madigan Army Medical Center briefed the MTF’s Department Chiefs, who in turn were responsible for briefing their personnel. Ongoing staff education continues on features of the Senior Prime Program and the Medicare+Choice program, using “TSP nuggets” on CHCS and a staff newsletter with tips on how to better serve the Senior Prime population. FHFS trained network providers at its central office for the 3 sites that FHFS serves.

The site also undertook extensive outreach to provide information and orientation for dual eligible beneficiaries about the Senior Prime plan and their Medicare coverage options. The approach used was to educate as many as possible across the service area about Senior Prime. FHFS hired temporary staff to assist with the beneficiary orientations. The educational activities were broad-based, but they were conducted in a compressed time period as a result of the time demands involved with implementation of the Senior Prime program. Marketing overall appeared to have been a success on several different levels:

- controlled personalized marketing to the beneficiaries
- maximum use of community resources (e.g., retiree associations, informing congressional liaison)
- multi-pronged approach to marketing and education
- employment of a train-the-trainer methodology to educate the providers

This site had the strong support of local retiree associations that enabled marketing efforts to focus on beneficiaries’ needs and requirements. As comprehensive as the marketing process was, there were small pockets of individuals (e.g., those who speak English as a second language, widows,
those not affiliated with a retiree association) who were not reached, which might be expected in the start-up of any such program.

**Enrollment** - The rate of Senior Prime enrollment in the Region 11 Senior Prime Program was high. This MTF was serving approximately 3,800 impaneled elderly patients. Although they had expected many of these beneficiaries to enroll in Senior Prime, only 50 percent of them actually enrolled and the remaining enrollees previously were episodic users of the MTF. A number of Medicare-eligible beneficiaries decided not to enroll due to concerns regarding the temporary nature of the demonstration. Others could not enroll because they were not eligible for Senior Prime (e.g. did not have Part B or were located outside of the designated zip code areas). Primary care managers (PCMs) reported there was some initial confusion about how the beneficiaries were going to be accepted into Senior Prime, either by a lottery or on a first-come/first-served. There also were instances where families were split up, with a spouse being accepted into Senior Prime, but not the veteran. Some beneficiaries had not received enrollment information early enough to sign-up for the program. Confusion on the part of some beneficiaries continues, e.g. as to whether they are enrolled in the program or what their PCM clinic is.

A key lesson from the Madigan enrollment experience was the logistical difficulties involved in opening enrollment for a large number of beneficiaries as a “bulk” enrollment. The Medical Center had 3,300 Senior Prime beneficiaries enroll at once, which severely tested its clinics’ capacities. Given the decision to use bulk enrollment, the Region 11 site provided exceptional responses to get the Senior Prime enrollees integrated into its managed care system. In addition, TRICARE Prime beneficiaries are aging in to TRICARE Senior Prime at a steady pace of about 25-30 or more each month. At the time of the RAND site visit, approximately 600 Senior Prime enrollees had not been able to attend the orientation sessions with some being either in a SNF or in custodial care. Currently, there is no mechanism for readily identifying those who might be in group homes or in assisted living arrangements.

**Service Delivery** – All new Senior Prime enrollees were scheduled for first visits at the PCM clinics, at which they were screened for health status and existing health conditions. This process identified many enrollees who had not been seen for some time by any provider, had unmanaged health problems requiring follow-up care, or required medication refills. PCM providers found that some new patients did not have their medical records from their civilian providers. During the orientation process, flu and health screens were conducted and Put Prevention into Practice (PPIP) flow sheets were given out to the beneficiaries. Follow-up was not possible, however, due to limited resources. A new program for the elderly was initiated by the MTF entitled the Sensational Senior group open to all over 65 year olds. The program emphasizes health programs to meet the needs and desires of the SENIOR PRIME population followed by a social hour and the opportunity to participate in focus group discussions aimed at addressing questions or concerns regarding the Senior Prime Program or services in general.

Transitions to Senior Prime providers were reported to be smooth for many enrollees who had existing services for chronic conditions. Every eligible beneficiary was given a questionnaire developed by the Social Work Department to identify those who had special needs; lived alone or had poor support systems; or had other special needs such as personal care, household chores, and transportation. FHFS added new network providers or specialty services as demand documented the need for doing so. For some enrollees who were using non-network providers, and had to switch to network providers, the temporary unavailability of some services (e.g., DME) was reported to interrupt access during the transition.

The pharmacy benefit currently is open to all beneficiaries no matter where their care is received. The MTF's pharmacy data show increased usage of the pharmacy by Senior Prime enrollees. The pharmacy staff postulate that some patients receiving care from civilian providers might have prescriptions that are not on the formulary, which normally are not filled by the MTF pharmacy. However, as Senior Prime enrollees, patients now can get a non-formulary medication should their provider deem it necessary.
The medical staff had the perception that a number of enrollees had high acuity health problems. Therefore, rather than declines in clinic activity after the initial visits, follow-up services for enrollees with health problems are expected to place continuing demands on the clinics, thus reducing capacity for space-available care over the long-term. Specialty providers highlighted the differing capacity across specialty and subspecialty clinics to absorb referrals of Senior Prime enrollees. The unevenness of availability across given specialties and subspecialties has been a problem for a while, and it has become even more pronounced since Senior Prime started. Some specialty care clinics are essentially closed to Medicare patients, whereas other specialty clinics may have unused capacity.

Madigan Army Medical Center continued to provide care to Medicare-eligible beneficiaries who did not enroll in Senior Prime for three months after the start-up, to give them adequate time to find other primary care providers. These individuals also were provided assistance by MTF staff to help them understand their other options. The Medical Center would still like to be the preferred specialty care provider for these elderly beneficiaries to help support its GME programs. There are not sufficient Senior Prime enrollees to sustain subspecialty training programs such as general surgery, or urology, so it is important to be able to continue to serve space-available elderly patients. However, without Medicare Partners there is no mechanism for reimbursement for these services.

**Quality and Utilization Management Processes** – Before implementation of Senior Prime, this site already had a strong quality and utilization management process for TRICARE, which was extended to include the Senior Prime program, including conduct of quarterly performance meetings to meet specific HCFA requirements. Under the TRICARE model, Madigan organized into various multidisciplinary managed care teams that serve individuals’ health care needs on a continuum. Separating the age 65+ population from the TRICARE Prime population has been a challenge. The site is working with the DoD-level Senior Prime quality management committee to establish consistent indicators across the sites. Data limitations, especially problems with the ADS data, are hampering their ability to measure such indicators readily. The site also plans to collect QM/UM data for the non-enrolled population.

**Financial Performance** - A strong concern expressed by Region 11 site participants was the financial impacts of the administrative costs required to implement Senior Prime. No funds were allocated for start-up, and existing staff at the MTF and Lead Agent office performed all the work. In addition, Senior Prime is being introduced at a time of declining third party reimbursements to the MTF. This site plans to estimate the financial impact of Senior Prime on service delivery costs at mid-year. Concern was expressed about whether the medical center would see any funds for the Senior Prime services it provided. Further, the data systems are not in place to provide timely financial performance information.

Concern also was expressed that Senior Prime may be a financial liability at this site, given the low Medicare capitation rates (averaging $265 per member per month), to which TMA has applied a $90 withhold for SNF and home health care. This site also is concerned that enrollee demographics may work against the MTF in risk adjustment of payments, which they cannot verify yet because the adjustment will not occur until the year-end reconciliation. Other concerns included the increasing LOE thresholds over time, understanding the LOE methodology, and the higher acuity of enrollees that may result in high costs for SNF and home health care. The AMEDD financial office has not been able to provide good financial reports yet, so the MTF cannot verify and validate their financial performance and impacts.

**Dynamics of the Local Medicare Managed Care Market** - The Senior Prime plan is a new entry into a highly competitive managed care market, including health plans with high rates of Medicare enrollments. Some of the Senior Prime enrollees previously had been members of other Medicare plans. Thus, many enrollees were already accustomed to a managed care environment. The impacts on these health plans as enrollees switch to Senior Prime will depend on how many enrollees the plans lose relative to the sizes of their total Medicare enrollments. It is worth noting that the bulk enrollment done by this site did result in a one-time loss of several hundred enrollees by the largest health plan in the area.
EARLY LESSONS LEARNED BY THE SITE

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees’ service needs.
   - Enrollee satisfaction is high due to improved access to care and TRICARE benefits.
   - Non-enrollees are concerned about their ability to continue to access the facility on a space-available basis and will require education as well.
   - Through flexibility and expansion of clinic capacity, the MTF is meeting TRICARE access standards for both Prime and Senior Prime enrollees.
   - Controlled personalized marketing and group orientations for new enrollees are important tools in educating beneficiaries regarding providers, processes, and contact information.
   - Bulk enrollment is not an effective intake strategy if the site has large enrollments that could overload clinic capacities. Phased-in enrollments enable a facility to better accommodate new enrollees within available capacity.
   - Providers and Health Benefits Advisors have important roles in working with space-available beneficiaries whose access to MTF care has decreased and with eligible beneficiaries who have not yet enrolled. Assistance should be provided to those beneficiaries who will need to make the transition to a community providers.
   - The train-the-trainer methodology utilized by this site was successful due to the top priority given to Senior Prime at the command-level and the multiple strategies employed for educating providers.
   - Certain “pockets” of retirees who are difficult to reach through normal marketing mechanisms may require particular attention during outreach efforts if Senior Prime was implemented more widely.
   - The enrollment application should include questions to identify Senior Prime enrollees who may be living in group homes or assisted living arrangements.
   - If Senior Prime is rolled out nationwide, it will be important to educate both the Medicare beneficiaries and other DoD beneficiaries who may no longer be using the site’s MTF.

2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - The impact of Senior Prime on space-available beneficiaries is not yet known.
   - During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) and be flexible in managing their care.
   - Care to Senior Prime enrollees provided outside of the hospital needs to be monitored carefully.
   - Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.
   - Strong communication partnering relationship among the MTF, Lead Agent, and FHFS is essential to managing compliance issues that require resolution and documentation.
   - Use of resource sharing personnel should be permitted for Senior Prime. A mechanism for reimbursement must be developed.
   - Extensive coordination between the MTF and network case management teams is required for continuity of patient care.
   - A number of Senior Prime patients have multiple medication needs that make them high risk for adverse drug interactions; particularly if they receive the medications from multiple sources. The pharmacy options for these patients should be limited to the MTF so that they may be properly managed. The addition of a geriatric pharmacist to the MTF staff would also be beneficial.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS),
coding inaccuracies, limitations of cost data, and lack of integration of data systems is barriers to effective QM/UM management.

- Benchmark quality and access data for the dual eligible population is needed in CEIS.
- Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
- Additional physician training is needed on HCFA rules for documentation and coding.

IMPACTS ON BENEFICIARIES
We summarize here what we learned during our focus groups with the leaders of retiree associations, PCM physicians, specialty providers, and other front line clinical and support staff. These sessions generated information from the feedback that MTF staffs have been hearing from beneficiaries who received care at the medical center, as follows:

- Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
- Senior Prime enrollees appear to have gained better access to care and continuity of services.
- Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
- Some feel "forced" into Senior Prime as the only way to gain access to the Medical Center, as they observe shrinkage of space-available care, which they may perceive as a “breaking of trust” with them, especially for those who previously had been impaneled.
- Senior Prime enrollees are reporting to their retiree association representatives that they are very satisfied with the care they were receiving, and they feel that the health care program at Madigan Army Medical Center is outstanding.
- There are some concerns about the limited enrollment for the demonstration and many would like to see Senior Prime opened up to all elderly retirees in the area as soon as possible.
- Some confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee.
- Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions have lost the specialists who were providing both their specialty and primary care.
- Beneficiaries need continuing support and education as they make changes in enrollments and service providers; some of the initial confusion will abate, but much probably will continue.
- There is concern about what will happen to Senior Prime enrollees when the demonstration ends, and what will be the impacts on those who dropped their Medicare supplemental insurance.
- Retiree organization leaders noted concerns about the long-term impact of Senior Prime and the availability of funding to continue the program, and even increase its size in the future.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

Madigan Army Medical Center

- Introduction of Senior Prime has had substantial effects in certain areas of the MTF. Administrative and operating costs for the MTF have increased with a shift in patient mix toward an older population.
- PCM clinics’ service patterns have changed from provision of episodic care to active care management for their enrollees.
- Communication between primary care clinicians and specialists has improved as patients are referred and treated.
- The specialty care needs of older populations are positive for the MTF’s training/GME mission. However, some GME programs are at risk of losing the patient mix and volume needed to support their program due to shrinking capacity for space-available care.
- Impacts of Senior Prime on the MTF’s readiness mission are reported to be of some concern.
- Efforts are increasing to improve data resources to support QM/UM activities.
If this program is to be expanded to all MTFs, each MTF would require a dedicated staff for Senior Prime, given the administrative burden.

Lead Agent
- Leadership responsibility has increased, accompanied by re-definition of the Lead Agent functions and an increase in resource requirements.
- The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
- If this program is expanded to all MTF’s in the region then the Lead Agent office would request additional mobile staff.

FOUNDATION HEALTH FEDERAL SERVICES
- New workload demands are placed on FHFS staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- The FHFS enrollment system has been expanded and modified for Senior Prime enrollments.
- Contracting activities have increased as FHFS has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.
- FHFS has added staff in both its home office and Region 11 office to accommodate these new responsibilities and caseloads. Because FHFS is the TRICARE contractor for 3 subvention sites, they have achieved some efficiencies in their new Senior Prime functions.

Other Organizations
- Other Medicare health plans in the market are experiencing observable loss of enrollment, but it is not yet known what effects this may be having on the other health plans.

IMPLICATIONS AND ISSUES
The early experiences of the Region 11 site have revealed that the following factors are important for successful implementation of a Senior Prime plan:
- Controlled personalized marketing to build confidence on the part of enrollees,
- Timely addition of new specialty providers specific to Medicare populations (e.g. Geriatric Clinic, Geriatric pharmacist),
- Training of specialty physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
- Responsive actions to identify and correct operational problems during enrollments,
- Ensuring access to case managers for all PCM clinics,
- Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
- Preparation for timely handling of grievances and appeals,
- Access to the data needed to monitor program activities and manage quality and utilization.

The initiative by the Region 11 site was an important component of the overall success of its Senior Prime start-up. For example, the Senior Prime management committee at the Region 11 site was able to influence the implementation timeline. The management committee also understood the complexity of the startup process and were proactive in making sure that key design and administrative issues were being addressed. The Region 11 administrative leadership was persistent in ensuring open communication early on with the HCFA Regional Office, and they helped to bring together the other sites to work on common issues and processes.
SUMMARY REPORT OF THE REGION 6 (SAN ANTONIO/TEXOMA) SITE VISIT
Site Visit Conducted on 22-25 March 1999

OVERVIEW OF THE SENIOR PRIME PLAN

The Region 6 site is the largest and most complex of the six subvention demonstration sites. The organizations participating in the Region 6 Senior Prime plan are the Office of the Lead Agent for TRICARE Region 6, four military treatment facilities (MTFs), and Foundation Health Federal Services (FHFS), the Region 6 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, is accountable to HCFA for the site’s performance as a Medicare+Choice plan. The four participating MTFs are Brooke Army Medical Center and Wilford Hall Medical Center in San Antonio and Reynolds Army Community Hospital and Sheppard Air Force Base Hospital by the Texas-Oklahoma border (Texoma). These MTFs serve as the principal providers of health care services to the site’s Senior Prime enrollees. FHFS carries out various functions on behalf of the Lead Agent, including the enrollment process, network management, portions of utilization management (UM)/case management (CM), and administrative services.

The site encompasses two geographically distinct service areas. San Antonio is an active managed care market, including 4 Medicare health plans that are serving 34 percent of the Medicare population. The Senior Prime plan is new competition for these existing Medicare plans. By contrast, there is little managed care in the Texoma market, with only 2 Medicare managed care plans serving 4 percent of the Medicare population. Over 999,100 DoD beneficiaries reside in Region 6, and about 17 percent (162,300) of these beneficiaries are Medicare eligible and another 42 percent are retirees or dependents less than 65 years of age. About 20 percent of the Medicare-eligible DoD beneficiaries in Region 6 live in the San Antonio Senior Prime service area and 4 percent live in the Texoma service area.

TRICARE was implemented in Region 6 in 1995, so the Lead Agent office and MTFs have experience with managed care, and the DoD beneficiaries in most parts of this region are accustomed to managed care concepts. Beneficiaries in San Antonio made a fairly easy transition to Senior Prime as a Medicare health plan, but the site faced a few challenges in establishing Senior Prime service delivery in the Texoma service area because of some resistance to managed care in that market.

The MTFs serving the San Antonio and Texoma service areas differ substantially in their characteristics and service mix. As shown in Table 1, Brooke AMC and Wilford Hall MC are large, comprehensive tertiary facilities that operate multiple clinical teaching programs. These MTFs have the capability to provide all but a few sub-specialty services for their Senior Prime enrollees. Reynolds ACH and Sheppard AFB Hospital are smaller community hospitals that provide a balanced mix of primary care and specialty services and they do not have medical education programs. There is more use of Senior Prime network providers in Texoma than in San Antonio because the Texoma MTFs provide fewer specialty services.

PROGRAM DESIGN

The Region 6 TRICARE Senior Prime plan provides a useful test case of how regional Senior Prime plans might operate if subvention was implemented more broadly across the DoD health system. Although TMA established this site as a four-MTF plan, TMA left decisions regarding the site’s organization and procedures to the site itself. In the model developed by the site leadership, the Lead Agent office plays a strong role in managing and coordinating enrollment and service delivery among the 4 MTFs and FHFS as the support contractor. FHFS brought in consultants with private-industry Medicare managed care expertise from within the FHFS system, who advised the Region 6 site and two other demonstration sites served by FHFS on designing Senior Prime and preparing for enrollment and operations.
Table 1
Profiles of the Military Treatment Facilities in the Region 6 Senior Prime Plan

<table>
<thead>
<tr>
<th></th>
<th>San Antonio Service Area</th>
<th>Texoma Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brooke Army Medical Center</td>
<td>Reynolds ACH, Ft. Sill</td>
</tr>
<tr>
<td></td>
<td>Wilford Hall Medical Center</td>
<td>Sheppard AFB Hospital</td>
</tr>
<tr>
<td>Military Service</td>
<td>Army</td>
<td>Army</td>
</tr>
<tr>
<td></td>
<td>Air Force</td>
<td>Air Force</td>
</tr>
<tr>
<td>MTF service profile:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed capacity</td>
<td>238</td>
<td>150</td>
</tr>
<tr>
<td>Dispositions (discharges)</td>
<td>10,410</td>
<td>3,792</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>610,516</td>
<td>458,122</td>
</tr>
<tr>
<td>Ambulatory surgeries</td>
<td>9,523</td>
<td>1,122</td>
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</table>

Provided by MTF:

<table>
<thead>
<tr>
<th>Specialty care</th>
<th>Most</th>
<th>Most</th>
<th>Some</th>
<th>Some</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary care</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Medical education (GME)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Plan Leadership - With the Office of the Lead Agent serving as the Senior Prime plan, policy and management leadership were established at the TRICARE region level, and 5 full time staff operate the project with additional part-time support from several other staff. The Lead Agent office prepared a written Memorandum of Understanding with each MTF that specified the roles and responsibilities of the Lead Agent and the MTF for enrolling and serving Senior Prime beneficiaries at that MTF. The site used this approach to position the region to build upon its basic organizational structure at such time Senior Prime is expanded in the future.

Infrastructure – The Senior Prime plan was established within the Region 6 TRICARE framework as an extension of TRICARE Prime, and already existing TRICARE systems and processes were adapted to its requirements. The commanders of the 4 MTFs and Intermediate Service Command representatives serve on the Senior Health Plan Board of Directors, reflecting the military chain of command where resources flow through the MTF command structure to the MTFs, rather than through TRICARE. Representatives of the Lead Agent office and FHFS serve as non-voting members of the board. This board reports to the national TRICARE Board of Directors. The TRICARE Senior Prime Management Committee is led by Lead Agent office staff and brings together the key organizational participants (Lead Agent, MTF, and FHFS) for coordination of policy and management. This committee reports to the Senior Health Plan Board of Directors. A Quality Council reports to the Senior Health Plan Board. Under the originally planned structure, two Consumer Advocacy Committees would have reported to the Quality Council. However, based on recent feedback from MTF personnel and beneficiaries, the Board determined it would be more appropriate to incorporate Senior Prime representation into existing MTF Healthcare Consumer Councils (HCC). This approach affords MTF Commanders the opportunity to address Senior Prime concerns while ensuring all PRIME categories receive appropriate representation on the MTF’s HCC.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the “richer of the Medicare or TRICARE Prime benefits,” thus providing consistent health benefits at all Senior Prime sites. This policy may constrain the ability of the Region 6 plan to compete on benefits with other health plans in a highly competitive market, although the supplemental benefits offered by other plans may not be much richer than the Senior Prime benefits because Medicare capitation rates in this market are not high (as they are in San Diego).

Quality and Utilization Management System - The QM/UM teams are collaborative efforts among the staff responsible for QM and UM within the participating organizations - the Lead Agent, MTFs, and FHFS. The Quality Council of the Senior Health Plan Board oversees these activities. The Senior Prime management team has relied on the existing QM and UM measurement systems.
wherever possible and has worked to establish consistent policies for the entire plan. The site’s QM plan was first organized under the Medicare Section 1876 rules, but then was revised to comply with new Medicare+Choice rules. Utilization review is a contractual responsibility of FHFS, and FHFS Health Care Finders located at each MTF perform these functions.

**Provider Networks** - The San Antonio MTFs offer Senior Prime enrollees several choices of PCMs, including three clinics at Brooke AMC (family care, adult primary care network, and internal medicine) and two clinics at Wilford Hall MC (adult medicine and internal medicine). Most secondary and tertiary services also are provided in specialty clinics and inpatient units within the MTFs. In Texoma, Reynolds ACH has three PCM clinics (internal medicine and family practice 1 and 2) and Sheppard AFB has two PCM clinics (family practice 1 and 2). Both MTFs offer some specialty care services, and enrollees requiring specialty care that the MTF does not provide are provided by network providers. Ft. Sill provides chiropractic care as a chiropractic study site. For services not offered by the MTFs, FHFS establishes Senior Prime contracts with civilian providers, turning first to existing TRICARE Prime network providers, and then to new providers when necessary. Contracts also are established for Medicare-specific services, including skilled nursing facility care, home health care, durable medical equipment, and physical rehabilitation care. Provider recruitment has been difficult in the two Texoma market areas because of suspicion of managed care and unpleasant memories of slow payments from the military as TRICARE was being implemented. When enrollees need a service the enrolling MTF cannot provide, FHFS turns for referrals first to other MTFs in the area, then to Senior Prime network providers, and lastly to non-contracted providers.

**SENIOR PRIME IMPLEMENTATION**

**Summary of Activities**

**Executing Medicare+Choice Contracts** - The Region 6 site was the second to be processed for Medicare certification, and it began service delivery in late 1998 (October for San Antonio and December for Texoma). The Medicare standards and processes changed during this time as HCFA established the Medicare+Choice rules and HCFA and DoD continued negotiations on program policy and design. When HCFA applied the new Medicare+Choice rules to the Senior Prime plans, this site revised its Medicare certification application and modified procedures to comply with the new rules.

**Start-Up Activities** - Education and training were key to successful start-up for the Senior Prime Program in Region 6. A professional marketing person at FHFS took the lead in preparing the marketing plan, which included advertising in local media and extensive series of orientation meetings at numerous locations within the San Antonio and Texoma service areas. Direct mail was used to reach as many people as possible, which required special approvals by TMA and HCFA. A presentation of the orientation meeting was given to the retiree associations before marketing began, and feedback was obtained on how to improve the briefing. They found they often walked a “fine line” between marketing and compliance with HCFA rules, as they aimed to provide information to potential enrollees. The approach in each location was tailored to the specific needs of the local beneficiary populations and MTFs.

A telemarketing company was hired to schedule appointments for the orientation meetings held during the 45 days before start of service delivery. Meetings were scheduled daily at a minimum, but as frequently as 3 times a day early in that period, decreasing to a less intense schedule toward the end. MTF staff who were speakers for the orientation meetings were trained on what to say and how to answer questions. FHFS sent staff to each MTF to perform this training, and they provided ongoing support to the MTFs during the start-up period. FHFS also brought in 50 to 70 temporary speakers for the meetings, and sent them to week-long training on Senior Prime and practice briefings. Some of these staff remained with FHFS as permanent staff for continuing Senior Prime support services.

**Enrollment** - Enrollments at the two San Antonio MTFs quickly reached their planned enrollments of 5,000 per facility. Learning from the Madigan site’s experience about the burden of large bulk enrollments, the Region 6 site staged enrollments for Brooke AMC and Wilford Hall MC at a rate of
1,700 per month for each facility. By contrast, enrollment demand at Reynolds ACH and Sheppard AFB was lower than their planned enrollments, and all eligible beneficiaries who applied at these MTFs were enrolled readily in the first month or two of service delivery. Enrollments at Reynolds ACH and Sheppard AFB continue to grow slowly. Reynolds ACH expects to reach its planned enrollment level, while achieving the enrollment level at Sheppard is questionable. Larger enrollments had been expected at Reynolds ACH because the MTF already had a Silver Care program that served seniors, but less than two-thirds of the Silver Care beneficiaries chose to join Senior Prime. Other reasons for low enrollment in Texoma are resistance to managed care in the community and concern about the short two-year life of the subvention demonstration. TRICARE Prime beneficiaries are aging in to TRICARE Senior Prime at a steady pace. Some Prime enrollees in the San Antonio area are reported to have changed their PCMs to the Senior Prime MTFs, so they will be eligible to join when they become Medicare eligible. At the time of the RAND site visit, approximately 600 Senior Prime enrollees had not been able to attend the orientation sessions with some being either in a SNF or in custodial care. Currently, there is no mechanism for readily identifying those who might be in group homes or in assisted living arrangements.

**Service Delivery** – The processing of large numbers of new Senior Prime enrollees during the first few months of service delivery created a substantial workload burden for Brooke AMC and Wilford Hall MC, but the smaller numbers of enrollees at Reynolds ACH and Sheppard AFB were processed with less difficulty. Clinical staff at all the MTFs were pleased with the Senior Prime training they received, which allowed them to work effectively with the new enrollees. FHFS added new network providers or specialty services as demand documented the need to do so. Each MTF had its own approach to the intake of new Senior Prime enrollees and start of service delivery: 

**Brooke AMC** hired additional staff into all its PCM clinics to manage the initial visits and follow-up care for Senior Prime enrollees. The internal medicine clinic filled up first because older patients tend to prefer internists as their primary physicians. Clinic staff worked with enrollees who were willing to change clinics, with the goal of achieving a better match between enrollees’ needs and clinic capabilities. Internal medicine enrollees were contacted by telephone to educate them about Senior Prime processes and perform a health assessment. Depending on the assessment results, appointments were scheduled as immediate or within 7 to 30 days. The internal medicine clinic found that patient acuity was twice what they had expected to find. The adult primary care network and family care clinics both had “Meet Your PCM” activities for new enrollee intake. The clinics learned to do group intakes to ease the clinics’ workload. Nursing staff played key roles in coordinating the early care for the new enrollees.

**Wilford Hall MC** held 30 orientation sessions for new Senior Prime enrollees, with personal invitations sent by mail. PCM clinic staff asked new enrollees to complete a questionnaire about health status and current medications, and they talked with them about rules and ways to use the system. A total of 3,400 enrollees attended the orientation sessions, many of them with companions. The clinics used nurse triage as enrollees came in for their initial PCM visits, to field questions and reduce physician workload. Staffing requirements in the PCM clinics were handled by re-engineering and reallocations rather than hiring additional personnel. Start-up of service delivery for **Sheppard AFB** was relatively painless because the 800 new enrollees they processed was a small volume compared to their overall patient activity. New enrollees were given a Registered Nurse health screening using protocols developed by Internal Medicine providers. Patients were then scheduled for an Internal Medicine appointment, and appropriate laboratory, x-ray, and other diagnostic tests were collected prior to the appointment. This approach helped reduce physician workload. Although there was some initial confusion by enrollees, issues were easily resolved. Most of the questions were about physicians in the provider network outside the MTF. They allowed 60 days for transition of specialty care services over to the provider network. In the early months, Senior Prime enrollees used referrals at about the same rate as Prime members.

**Reynolds ACH** also used nurse triage to help achieve smooth enrollments and intakes into service delivery. Impacts on the PCM clinics and specialty services were small because Senior Prime enrollees are a small fraction of total MTF enrollment. Both the family practice clinics and the
Internal medicine clinics had to work with enrollees to change specialty physicians. Recruiting network physicians was difficult because of negative attitudes toward managed care and a strong resistance to discounted reimbursement rates.

An issue shared by the four MTFs was some interruption in access for some enrollees with existing health care needs during the transition into Senior Prime from another Medicare health plan or fee-for-service providers. Some enrollees were using non-network providers, and had to switch to network providers, and others were using medications or other services (e.g., DME) that were at risk of being discontinued. The site acted immediately to remedy these problems as they were identified, and advised other demonstration sites to plan for early identification of these individuals during the application process to ensure continuity of care.

**Quality and Utilization Management Processes** – Before implementation of Senior Prime, this site had a strong TRICARE quality and utilization management process, which was extended to include the Senior Prime program. They have been focusing on defining a common set of metrics to monitor consistently across all the MTFs in the site. The monitoring experience that Reynolds ACH gained in the Silver Care program has contributed to their progress in building Senior Prime measures. The site is working to integrate the Senior Prime QM and UM monitoring with other DoD quality initiatives, such as the DoD/VA guidelines and related metrics and the study that FMAS is doing of Senior Prime measures. They also are coordinating with the state PRO, which has responsibility for external quality monitoring of Medicare health plans. At the time of the site visit, the site was still awaiting clarification on the QISMC standards being published by HCFA, and the leadership staff were beginning to work with the other sites to establish a demonstration-wide quality planning and monitoring activity.

To fulfill its UM and case management functions, FHFS has two UM nurses and one case manager each for Wilford Hall MC and Brooke AMC (six total in San Antonio). In the Texoma area, FHFS hired one UM nurse and one case manager each for Reynolds ACH and Sheppard AFB (four total). Criteria to qualify patients for case management, which are specified in the FHFS contract, include the DoD-mandated list of conditions, a chronic illness, the need for physical rehabilitation, and financially based case management (also called large or catastrophic case management). For all enrollees, including Senior Prime, the site wants to expand definitions for case management candidates to include certain clinical areas, and ultimately, to move to a disease management model. However, this requires significant change to the current FHFS contract.

**Financial Performance** – The Region 6 site participants expressed a strong concern about the financial impacts of the administrative overhead required to implement Senior Prime. In addition, increases in service activity for Senior Prime enrollees for pharmacy prescriptions and clinic visits translate into MTF costs. Despite doing well on the Level of Effort requirement, for example, Brooke AMC attributes to Senior Prime half of the $6 million loss that is anticipated for this year. Another contributor has been loss of third party reimbursements as beneficiaries enrolled in TRICARE Prime and Senior Prime. Reynolds ACH and Sheppard AFB noted that administrative costs do not vary much with the size of the facility, so these costs have proportionally larger impacts on the financial performance of smaller MTFs. Administrative costs, however, are quite small compared to service delivery costs.

This site has been modeling the financial impact of the payment system under which HCFA pays DoD for serving Senior Prime enrollees. They feel that this complicated system will not be feasible on a regional level, and they have highlighted that the cost thresholds for space-available care create undesirable incentives for the MTFs. Concern was expressed about whether the medical center would see any funds for the Senior Prime services it provides. There has been no word from TMA about when or how cash will flow from TMA through the Services to the individual Lead Agent offices and MTFs.

**Dynamics of the Local Medicare Managed Care Market** – In San Antonio, the Senior Prime plan is a new entry into a competitive managed care market, including health plans with high rates of Medicare enrollments. Thus, many enrollees are accustomed to a managed care environment. It is worth noting that 10,000 new Senior Prime enrollees at Brooke AMC and Wilford Hall MC is a large number even in a highly penetrated market, and some of the enrollees previously had been
members of other Medicare plans. The impacts on these plans as enrollees switch to Senior Prime will depend on how many enrollees they lose relative to the sizes of their total Medicare enrollments. A different situation exists in Texoma, where there was virtually no managed care before the introduction of TRICARE Prime, followed by Senior Prime. Thus, the key market dynamics are the reactions - both positive and negative - of the beneficiary and provider communities to Senior Prime as a managed care product.

EARLY LESSONS LEARNED BY THE SITE
1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees’ service needs.
   - Enrollee satisfaction is high due to improved access to care and TRICARE/Medicare benefits.
   - Personalized group orientations for potential enrollees are important techniques to educate them about Senior Prime. Time should be allowed for one-on-one discussions of information and considerations about health care options.
   - Senior Prime orientation may be easier in markets with active managed care because beneficiaries tend to be familiar with managed care concepts and know what to look for when choosing a plan.
   - For an effective enrollment and intake process, start preparation early and anticipate staff resource requirements, which may be met by adding staff, re-engineering to shift staff assignments, or using flexible staffing strategies.
   - Training of PCM providers and front-line staff is important, both to establish trust as providers talk with beneficiaries during the orientation meetings and to help providers respond to questions from enrollees during the initial clinic visits following enrollment.
   - The existence of previous relationships with older beneficiaries who are impaneled at an MTF does not guarantee enrollment in Senior Prime because beneficiaries will consider available options and tradeoffs as they make health plan choices.
   - Education and assistance should be provided to non-enrollees, many of whom are concerned about their ability to continue to obtain care at the MTFs as space-available care declines, and will need to make transitions to community providers.
   - Structure the types and levels of PCM choices offered to allow flexibility in matching new enrollees to the best type of PCM providers for their health care needs and distributing enrollees evenly across PCM clinics.
   - Carry out an organized intake strategy for new Senior Prime enrollees that includes health screening and triage for PCM intakes, identification of existing conditions that require transition support, and instructions and support in using telephone appointment systems. Health screening methods should be appropriate for the older population. A variety of approaches can succeed, depending on the number of enrollees entering an MTF’s program.
   - MTFs with large numbers of new enrollees should consider using staged enrollments at the PCM level to ensure that enrollees can be accommodated within available PCM clinic capacities.
   - Effective coordination of roles and activities between the MCS contractor and MTFs supports implementation because many of the contractor’s activities take place in the MTFs or in TRICARE Service Centers located in the MTFs or nearby, and MTF staff are directly involved in many of those activities.
   - The MCS contractor incurs a large share of the administrative costs because of its substantial roles in marketing, enrollment, and enrollee services.

2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
• It is important to identify potential enrollees with existing care requirements (DME, home health, etc.) to assist them to maintain needed services during transition to Senior Prime and to manage their care flexibly as they change to new specialty providers.

• Case management should have a central role in Senior Prime, to achieve cost effective care for the multiple chronic conditions and other health problems of an older population. Provider education may be needed to ensure there is an understanding of this role.

• When the MCS contractor performs the utilization review and case management functions, these activities need to be coordinated closely with the MTF clinical and support staff activities.

• The establishment of an effective civilian provider network is more difficult in smaller markets with limited managed care because community providers typically have full practices and do not need new patients, and they tend to resist participating in managed care.

• Providers at medical centers with a specialty focus and teaching programs will require training and support for functioning in a managed care environment that is directed by PCM providers.

• Introduction of Senior Prime will increase service activity for specialty clinics as PCMs refer enrollees for follow-up care, although the impacts on clinics will differ by specialty and will occur at differing times following start-up.

• VA hospitals and clinics are active participants in the service networks of many MTFs, and their absence from Senior Prime networks may be restricting access or continuity of care for some enrollees.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management.

• Benchmark quality and access data for the dual eligible population is needed in CEIS, especially data and reports required to meet Medicare QISMC requirements.

• Physician training on HCFA rules for documentation and coding is important to enhance data quality, which should be made available across sites.

IMPACTS ON BENEFICIARIES
We summarize here what we learned during our focus groups with the leaders of retiree associations, specialty providers, PCM physicians, and other front line clinical and support staff. These sessions generated information about the feedback that MTF staffs have been hearing from beneficiaries who received care at the medical center, as follows:

• Beneficiaries are pleased that Senior Prime helps fulfill the promise of health care for life.

• Senior Prime enrollees appear to have gained better access to care and continuity of services.

• Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and, which they fear will be taken away again. There also is some resistance in the Texoma market to the restrictions of managed care, which are characterized by some beneficiaries as a type of monopoly on service delivery.

• With reductions in space-available care, as a result of both TRICARE Prime and Senior Prime enrollments, access to MTF care for beneficiaries who do not join Senior Prime is declining.

• Senior Prime enrollees are reporting to their retiree association representatives that they are very satisfied with the care they were receiving.

• There are some concerns about the limited service area and enrollment for the demonstration and many would like to see Senior Prime opened up to all elderly retirees in the area as soon as possible.

• Some confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee. Although some of the initial confusion will abate, much probably will continue.
• Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions have lost the specialists who were providing both their specialty and primary care.
• There is concern about what will happen to Senior Prime enrollees when the demonstration ends, and what will be the impacts for those who dropped their Medicare supplemental insurance.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

Impacts Common to All MTFs
• Introduction of Senior Prime has increased administrative and operating costs for the MTFs not only during the enrollment and start-up period, but also as a result of a shift in patient mix toward an older population who require more support services and utilize more health care services.
• The MTFs are concerned about their financial liability for Senior Prime enrollees, which they are not able to ascertain because the needed financial information is not yet available.
• Efforts are increasing to improve and coordinate data resources to support QM/UM activities.

Specific Impacts for the San Antonio MTFs
• The large volumes of new Senior Prime enrollments caused the PCM clinics to temporarily shift resources toward intakes of new enrollees, away from space available care.
• The specialty care culture has made it difficult for specialty providers to adjust to PCM-guided management and coordination of care for enrollees. Communication between primary care clinicians and specialists has improved, however, as patients are referred and treated.
• The specialty care needs of older populations are positive for the MTF’s GME mission. Senior Prime enrollees may not be sufficient to support GME programs, however, and programs are at risk of losing the additional needed patient activity due to shrinkage in space-available care.

Specific Impacts for the Texoma MTFs
• Introduction of Senior Prime had limited effects on the daily delivery of health care services for the Texoma MTFs because the new enrollees were a small fraction of their total beneficiary populations.
• With smaller enrollments than planned, Senior Prime financial performance for these MTFs may be negative.
• Increases in utilization of health care services is lower than expected, including rates of referrals to specialty MTF and network providers.

Lead Agent
• Leadership responsibility has increased, accompanied by re-definition of the Lead Agent functions and an increase in resource requirements. However, responsibilities for the Senior Prime program were assumed by existing staff resources.
• The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.

FOUNDATION HEALTH FEDERAL SERVICES
• Workload has increased as FHFS has supported the new enrollee population.
• The FHFS enrollment system has been expanded and modified for Senior Prime enrollments.
• New demands are placed on FHFS staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
• Contracting activities have increased as FHFS has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.
• FHFS has added staff in both its home office and Region 6 office to accommodate these new responsibilities and caseloads. Because FHFS is the TRICARE contractor for 3 subvention sites, they have achieved some efficiencies in their new Senior Prime functions.

Other Organizations
• Other Medicare health plans in the market are experiencing observable loss of enrollment, but it is not yet known what effects this may be having on the other health plans.

IMPLICATIONS AND ISSUES
The early experiences of the Region 6 site have revealed that the following factors are important for successful implementation of a Senior Prime plan:
• Careful planning and execution of personalized marketing for eligible beneficiaries,
• Training of PCM providers, specialty physicians and front line staff on Senior Prime and care management techniques,
• Preparation for staged enrollments for MTFs with large numbers of new enrollees,
• Establishment of teams with staff from all participating entities working together to design and carry out the start-up and operations of the Senior Prime program,
• Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
• Preparation for timely handling of grievances and appeals,
• Access to the data needed to monitor program activities and manage quality and utilization.

An important component of the operational success of Senior Prime in Region 6 has been the initiative by the Lead Agent office to coordinate implementation efforts across four MTFs and the MCS contractor. The early experiences of this site point toward strategies for broader implementation of Senior Prime across larger numbers of MTFs within a region, and they also highlight the complexity of running a regional plan and the importance of designing it to be manageable.
OVERVIEW OF THE SENIOR PRIME PLAN
The Dover AFB site is the smallest of the six subvention demonstration sites. The organizations participating in its Senior Prime plan are the Office of the Lead Agent for TRICARE Region 1, the 436th Medical Group at Dover AFB, and Sierra Military Health Services, the Region 1 TRICARE managed care support (MCS) contractor. The Lead Agent office, which is defined as the Plan, is accountable to HCFA for the site’s performance as a Medicare+Choice plan. The Dover MTF is the primary care provider for the site’s Senior Prime enrollees. Sierra carries out various administrative functions for the Lead Agent, including the enrollment process, management of the network providers, and administrative services. The MTF and LA office are distinct entities. The LA office is located at Walter Reed AMC in Washington, DC, and the MTF is in Dover, Delaware, a small community in a rural area with little managed care penetration. Three Medicare health plans had been serving the market but discontinued their Medicare contracts at the end of 1998, and one new health plan began a Medicare contract effective January 1999. These plans serve about 6 percent of the local Medicare population.

The 436th Medical Group is an outpatient facility that provides primary care and limited specialty services. The facility has three PCM teams, and it also provides the primary care services of a minor surgical procedure unit, allergy and immunology, patient education, and a wellness center. Ancillary services of radiology, pharmacy, laboratory, and physical therapy also are provided, as well as the specialty outpatient services of obstetrics/gynecology, dental services, and mental health services. All inpatient services for MTF patients are provided by civilian hospitals in the local communities. In particular, primary care physicians at Dover have medical staff privileges at Kent General Hospital in Dover, which allows them to continue to manage care for patients who are hospitalized there.

In addition to being the only site with just outpatient MTF services, the Dover AFB demonstration site is unique in several other ways. Although rural, it is located within a 2-hour drive from pre-eminent military medical facilities in the National Capital Area. It also is one of the sites for the FEHBP demonstration. In addition, TRICARE was being implemented in Region 1 in 1998 at the same time the Senior Prime demonstration was being designed and initiated. As a result, the two activities competed for resources in the Lead Agent’s office, and the staff at the Lead Agent office and MTF were learning managed care for TRICARE Prime and Senior Prime simultaneously.

PROGRAM DESIGN
The Dover Senior Prime plan offers some useful insights regarding the feasibility of Senior Prime in small MTFs that do not provide specialty or inpatient services. Dover was the last site to be designated for the subvention demonstration, requiring it to work on an extremely tight schedule to begin service delivery by the January 1999 target date. The Region 1 Lead Agent office was managing the workload of TRICARE implementation at the time the Dover site was gearing up Senior Prime, and the Sierra MCS contract had only recently been implemented. Given these circumstances, the MTF took the lead for much of the early preparation, and the Lead Agent then moved more fully into it leadership role as the HCFA certification process was underway. During the development phase, Sierra brought in a consultant, Pacific Health Policy Group, who had Medicare managed care expertise and advised the Dover site on designing Senior Prime, getting certified, and preparing for enrollment and operations.

Plan Leadership - With the Office of the Lead Agent serving as the Senior Prime plan, policy and management leadership were established at the TRICARE region level. The Region 1 Lead Agent office lacked the resources to assign more than one full-time staff to Senior Prime. The staff members that dedicate the most time are the Senior Prime chief operating officer, who is full time, and the Senior Prime administrator, who spends 50 percent of her time on Senior Prime. The staff
of the three organizations (Lead Agent, Dover AFB, and Sierra) work collaboratively to perform the functions required to operate a Medicare health plan, guided by the LA office.  
**Infrastructure** – The Senior Prime plan was established as an extension of the Region 1 TRICARE Prime program, and already existing TRICARE Prime systems and processes were adapted to its requirements. A Senior Prime Plan Board of Directors was established that reports to the national TRICARE Board of Directors. The board membership consists of the three commanders (one from each Service) who alternate as the Region 1 Lead Agent and the commander of the Dover AFB MTF, and a Sierra executive serves as a non-voting member.  Reporting to this board is a Senior Prime Management Committee consisting of the current Lead Agent, Director of the LA Office, the Dover MTF commander, and the Sierra Vice President of Operations. A Quality Improvement Committee was established that reports to the management committee. This structure was designed to anticipate future expansion. 

**Benefit Package** - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the “richer of the Medicare or TRICARE Prime benefits,” thus providing consistent health benefits at all Senior Prime sites. This policy may place some financial stress on the Dover AFB site, relative to the other sites, because Medicare capitation rates in this market are lower than they are in other subvention site markets, yet Dover covers the same scope of services as the other sites. 

**Quality and Utilization Management System** - The QM/UM teams are collaborative efforts among the staff responsible for QM and UM within each organization - the Lead Agent, MTFs, and Sierra. The Quality Improvement Committee oversees and carries out these activities. Committees for utilization management, member services, and health services delivery report to this Quality Improvement Committee, as do subcommittees for medical records and peer review, credentialing, clinical indicators and studies, health promotion and disease management, and grievances and appeals. The LA office takes the lead in developing the QM plan, and the MTF and Sierra perform the QM functions within their respective service delivery activities. Utilization review is a contractual responsibility of Sierra, which drafts the plan’s annual UM program plan and performs the utilization reviews and case management functions as specified in that plan, with oversight by the LA office and the utilization management committee. 

**Provider Networks** - Three teams at the Dover 436th Medical Group provide primary care services. The galaxy team provides flight medicine services for active duty personnel only. The gold and blue teams are interdisciplinary teams with family practice, pediatrics, internal medicine, and obstetrics/gynecology. These two teams are the PCM providers for Senior Prime enrollees, and beneficiaries are enrolled to individual providers on these teams. Most specialty services and all inpatient services are provided by Senior Prime network providers located in the community or National Capital Area. The site serves three distinct communities within its service area, and Sierra has established provider contracts in all these locations to ensure access for enrollees. Sierra turns to the TRICARE Prime network providers as the first sources of civilian care. Then it recruits new providers to contract for services that are not available in the Prime network, including Medicare-specific services such as skilled nursing facility care, home health care, durable medical equipment, and physical rehabilitation care. It has been difficult to recruit local community physicians for the network because of community resistance to managed care and previous bad experiences by physicians with the military health system, including low payment rates and delays in processing payments for services rendered. Inpatient services are provided by local community hospitals and major military treatment facilities in the National Capital Area. Sierra has contracted with 3 community hospitals in the Dover service area. One of these is Kent General Hospital where the MTF physicians have clinical privileges as an external resource sharing agreement, which provides continuity of care for patients and reduces costs for network provider services. Although the National Capital Area military facilities are not part of the Dover site, some patients prefer to use them and Dover makes the referrals (and provides shuttle bus service). The Dover site also wanted to include the VA hospital in the Senior Prime network because it is a TRICARE Prime network provider and many beneficiaries use the hospital. HCFA denied its request, unless Dover could document that its absence would compromise access to needed services, and Dover did not pursue the request further.
SENIOR PRIME IMPLEMENTATION

SUMMARY OF ACTIVITIES

Executing Medicare+Choice Contracts - The Dover AFB site was the last to be processed for Medicare certification, and it began service delivery in January 1999 as a Medicare+Choice plan. The new HCFA rules for Medicare+Choice were introduced as the site was being reviewed for Medicare certification. The HCFA site visit was conducted under the Medicare Section 1876 regulations, and the site had 10 days after the site visit to modify its application and procedures to comply with the new rules. Some of the uncertainty experienced by other sites, as negotiations between HCFA and DoD took place earlier in the year, may have been avoided by the Dover site because it was the last to be processed. The Dover site also was able to draw upon the documents and experiences of other sites as it designed its plan and prepared for certification. Given the concurrent schedule for TRICARE Prime and Senior Prime, every attempt was made by the Dover site to roll out similar policies for the two programs.

Start-Up Activities - The Senior Prime marketing and enrollment activities were compressed because of the lateness of the Dover certification and the time required for HCFA to approve marketing materials. Ads were placed in local newspapers in late October 1998, a month after the site visit, and the full marketing activities began in mid-November. Beneficiary briefings were held at an initial rate of 2 briefings per week, declining to 2 per month, and finally one per month. Most attendees of the briefings were MTF patients or former enrollees of the Medicare health plans that had left the market. The local retiree associations were very supportive of Senior Prime, and they placed notices in their newsletters, which had been reviewed by the site for accuracy. Some members also are supportive of the FEHBP option, recognizing that the overall capacity of the military health system is constrained by budget limitations and not able to support full service provision for Medicare-eligible DoD beneficiaries.

Staff and provider training preceded the start of marketing. MTF providers were brought into preparation for Senior Prime from the start, with training provided on Senior Prime benefits, how the program works and its special requirements. Knowledge has been refreshed through ongoing briefings and fact sheets. Providers also participated in the beneficiary orientations, which strengthened their knowledge and buy-in to the program. Sierra provided training for its staff on the functions they perform for Senior Prime, including training on how to interact with the older population, use of the CHCS appointment processes, beneficiary orientation meetings, and utilization management. A small group of staff were trained in the use of the Medicare Processing Center for enrollments.

Enrollment - The planned capacity for the Dover site represents the number of enrollees the site has the capacity to serve, but they expected to see limited demand for Senior Prime, resulting in smaller enrollments of 700 to 800 beneficiaries. Actual enrollments were less than 700 as of April 1999 and growing slowly. Indeed, the site reports that it has enrolled many of the beneficiaries who were using the MTF regularly but not many others who had been more episodic users. The open enrollment period has been extended until mid-July 1999. There is a limited supply of primary care providers in the Dover community so Senior Prime is attractive to eligible DoD beneficiaries. Yet demand has been constrained by the short life of the demonstration, travel distances to Dover for many in the service area who can obtain care locally, limited trust in the reliability of DoD policies, and resistance to managed care in the community. Age-ins of TRICARE Prime beneficiaries to Senior Prime also are occurring at slow rates.

Service Delivery – Nurse managers held initial evaluation meetings for new enrollees to record upcoming appointments with specialists, identify use of DME or medications, check for immunizations, and have enrollees complete the HEAR health screening forms. They also discussed preferred providers and checked the appropriateness of the PCM selected, and they gave information on appointments, advance directives, preventive services. All new enrollees then were scheduled for one-hour initial visits with their PCMs, with the information from their evaluations ready for the PCM to review. A number of appointment times routinely are designated on the calendar for Senior Prime enrollees to ensure access to services, and follow-up appointments can be booked at the end of a current PCM visit. Inpatient services are provided by local community
hospitals as well as other military facilities. Sierra handles referrals to network hospitals and specialty physicians, which includes pre-authorization requirements under the UM function. A nurse practitioner follows the patient through the specialty care process.

**Quality and Utilization Management Processes** – As the Dover site team prepared its Senior Prime QM/UM plan, it drew upon the plans already developed by other demonstration sites. Work groups were formed for different areas, and the Dover AFB clinic took the lead for much of the QM development work. Educational sessions were held on policies and procedures, including new ones established for the Medicare+Choice rules in November 1998. Sierra added an addendum to its existing TRICARE QM/UM plan for network providers to cover the Senior Prime requirements, and it plans to conduct a physician satisfaction survey. Sierra also serves as the interface with the PRO, as specified in the memorandum of understanding with the Lead Agent office. It is difficult to perform quality studies with the small number of enrollees at Dover (as well as most of the other sites), so much of the analyses will be aggregated for all sites. Region 1 has a comprehensive utilization management program that Sierra manages fully. They are changing “best practices” definitions as they learn new management methods. Efforts are underway to standardize QM activities across sites.

**Financial Performance** – The site estimates that it is losing money on every Senior Prime enrollee because of a combination of high administrative costs for a small population and low capitation payments that do not cover the average cost of health care for its enrollees. The amount of work required by Senior Prime also is detracting from other service delivery and support activities by the MTF. Given the estimated average loss per enrollee, the smaller enrollments are helping to mitigate financial losses.

**Dynamics of the Local Medicare Managed Care Market** – The Dover Senior Prime plan is virtually the only Medicare health plan in the site’s market, and the departure of the three plans in late 1998 was independent of the entry of Senior Prime the following month. Some DoD beneficiaries who had been enrolled in one of those plans decided to switch to Senior Prime when it began operation. Thus, the dynamics in this market are the reactions of the community - both positive and negative - to Senior Prime as a managed care product, and the corollary impacts on the site’s ability to recruit civilian providers to the Senior Prime network.

**Early Lessons Learned by the Site**

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees’ service needs.
   - Senior Prime enrollee satisfaction, as reported to their retiree association representatives and to Dover MTF providers, is high due to improved access to care, TRICARE benefits, and responsive customer services.
   - Personalized group orientations for potential enrollees are important techniques to educate them about Senior Prime. Time should be allowed for one-on-one discussions of information and considerations about health care options.
   - Training of PCM providers and front-line staff is important, both to establish trust as the providers talk with beneficiaries during the orientation meetings and to help providers respond to questions from enrollees during initial clinic visits following enrollment.
   - Carry out an organized intake strategy for new Senior Prime enrollees that includes health screening and triage for PCM intakes, identification of existing conditions that require transition support, and instructions and support in using telephone appointment systems.
   - The enrollment procedures are cumbersome, requiring enrollment staff to enter data into several automated systems, and involving a 3 week delay until the site is notified about new enrollments, which leaves only a few days to send materials to enrollees and begin service delivery.
   - Beneficiaries object to menu-based telephone appointment systems, especially those that are not operated locally by the MTF or TRICARE service center, leading to complaints about poor service and use of additional MTF staff time to assist them with appointments.
2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.

• Care to Senior Prime enrollees provided outside of the hospital needs to be coordinated carefully, especially when the site must rely heavily on network providers because the MTF does not provide a full range of services.

• Case management should have a central role in Senior Prime, to achieve cost effective care for the multiple chronic conditions and other health problems of an older population. Provider education may be needed to ensure there is an understanding of this role.

• When the MCS contractor performs the utilization review and case management functions, these activities need to be coordinated closely with the MTF clinical and support staff activities.

• The establishment of an effective civilian provider network can be difficult in smaller markets with limited managed care because community providers typically have full practices and do not need new patients, and they tend to resist participating in managed care.

• Historical problems with network provider payments during TRICARE startup are remembered by community physicians and contribute to later difficulties in recruiting them into new networks.

• VA hospitals and clinics are active participants in the TRICARE service networks, and their absence from Senior Prime networks may be restricting access or continuity of care for some enrollees.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management. This site is using CHCS as its system of choice for Senior Prime data.

• Benchmark quality and access data for the dual eligible population is needed in CEIS.

• Small numbers of enrollees limits power for statistical inference on benchmarks and trends.

• Additional physician training is needed on HCFA rules for documentation and coding.

• Centralized coordination to establish standard Senior Prime reports would assist monitoring and compliance activities.

IMPACTS ON BENEFICIARIES

We summarize here what we learned during our focus groups with the leaders of retiree associations, PCM physicians, and other front line clinical and support staff. These sessions generated information about the feedback from beneficiaries who received care at the clinic, as follows:

• Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.

• Senior Prime enrollees appear to have gained better access to care and continuity of services.

• Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration, which they fear will be taken away again. There also is some resistance in the market to the restrictions of managed care and distrust about this being only a partial effort to fulfill the DoD promise.

• There is concern by beneficiaries about what will happen to Senior Prime enrollees when the demonstration ends, and what will be the impacts for those who dropped their Medicare supplemental insurance.

• Despite educational efforts, some confusion remains among beneficiaries about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee. Although some of the initial confusion will abate, much probably will continue.
IMPACTS ON SENIOR PRIME ORGANIZATIONS

THE 436TH MEDICAL GROUP AT DOVER AFB

- The administrative requirements of Senior Prime have increased MTF costs and created opportunity costs where resource constraints prevented other work from getting accomplished.
- Introduction of Senior Prime had substantial temporary effects on the MTF gold and blue team clinics, as new enrollees were processed during intake and initial evaluations. Long term effects are expected to be readily managed, once service delivery equilibrium is attained.
- PCM clinics’ service patterns have changed as strategies were implemented, with nurses serving as care managers to coordinate patients’ preventive health activities and care by PCM providers.
- Senior Prime is contributing to the MTF’s readiness mission by helping to maintain physicians’ clinical skills in serving the health care needs of older populations, at both the clinic and the local hospital, and by contributing to professional satisfaction that may encourage retention of young clinicians in military service.

Lead Agent

- Leadership responsibility has increased, accompanied by re-definition of the Lead Agent functions and an increase in resource requirements.
- The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
- Working relationships between the Lead Agent office and the MCS contractor have been strengthened, with long-term collateral benefits anticipated for TRICARE Prime.

SIERRA MILITARY HEALTH SERVICES

- Sierra has added staff to accommodate its new responsibilities and caseloads, and it has expanded and modified its enrollment system for Senior Prime enrollments. The local TRICARE Service Center facility was expanded to provide dedicated space for the new staff serving Senior Prime enrollees.
- New customer service demands are placed on Sierra staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
- Provider contracting activities have increased as Sierra has modified existing Prime contracts for Senior Prime, added new institutional providers and clinical practitioners to the Senior Prime network, and managed transfers to network providers for new enrollees.

IMPLICATIONS AND ISSUES

The early experiences of the Dover AFB site have revealed that the following factors are important for successful implementation of a Senior Prime plan:

- Careful planning and execution of personalized marketing for eligible beneficiaries;
- Training of PCM providers and front line staff on Senior Prime and care management techniques;
- Use of designated care managers to manage new enrollee intakes, including health status screening and triaging for initial visits by PCM providers, and to coordinate care by network providers;
- Establishment of teams with staff from all participating entities working together to design and carry out the start-up and operations of the Senior Prime program;
- Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them;
- Preparation for timely handling and documentation of grievances and appeals;
- Access to the data needed to monitor program activities and manage quality and utilization.

The uniqueness of the Dover site highlights some issues that merit consideration if Senior Prime is implemented more broadly in the DoD system. The prospect for poor financial performance is real.
for sites in rural areas, given the small size of the population and the typically low Medicare capitation rates for rural counties. When the scope of MTF health services is limited, requiring extensive use of civilian network providers, the site’s costs may escalate if the payments to these providers are higher than the costs of providing the same services in an MTF. Yet the enthusiastic response to Senior Prime by the Dover clinical staff indicates that Senior Prime can play a positive role in retention and maintenance of skill levels of military clinical personnel, thus serving the medical readiness mission. Are likely financial losses on Senior Prime in such settings balanced by the value of the contribution to readiness?
OVERVIEW OF THE SENIOR PRIME PLAN

The four key participants in the Colorado Springs Senior Prime plan are the Office of the Lead Agent for the TRICARE Central Region, Evans Army Community Hospital at Ft. Carson, the 10th Medical Group at the USAF Academy, and TriWest Healthcare Alliance (the Central Region’s TRICARE Managed Care Support (MCS) Contractor). The Lead Agent office, which is defined as the Plan, is accountable to HCFA for plan performance and compliance. Evans Army Community Hospital and the USAF’s 10th Medical Group are the two main military treatment facilities participating in the plan, and serve as the primary providers of health care services to Senior Prime enrollees in this site. Peterson AFB clinic, which is affiliated with the 10th Medical Group, serves as PCM for USAF Academy enrollees who age into Senior Prime. TriWest Healthcare Alliance carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, and administrative services.

Of the over 134,431 DoD beneficiaries in the Colorado Springs market, about 10 percent are Medicare eligible and another 35 percent are retirees less than 65 years of age. The Colorado Springs area is a moderately penetrated managed care market, including two Medicare managed care plans that are serving 38.6 percent of the Medicare population. The Senior Prime plan represents new competition for these existing Medicare plans.

Evans Army Community Hospital is a 140-bed facility with a combined mission of readiness, active duty support, and integrated health care delivery. This facility, along with three troop medical clinics, supports a large deploying population based at Ft. Carson of approximately 15,000 active-duty troops in at least eight command units. There also are approximately 26,000 active-duty family members within Ft. Carson’s catchment area. Evans ACH also is responsible for supporting the recently stood up 7th Infantry Division (Light) (an integrated AC/ARNG division), for medical proficiency training (MPT), and for AT site support of the RC/NG within a multi-state area. Approximately, 95 percent of the MTF’s physician staff and 90 percent of its nursing staff are Professional Officer Fillers (PROFIS) assigned to deployable military units.

The USAF Academy has a smaller 40-bed facility that includes several outpatient clinics (e.g., internal medicine, family practice) and on the inpatient-side, a medical/surgical unit and a special care unit with 15 same-day surgical beds. In addition, the USAF has an outpatient clinic at Peterson Air Force Base. The USAF Academy hospital’s mission is to support a young cadet population. Approximately 80 percent of the facility’s medical staff also have mobility assignments.

PROGRAM DESIGN

The Colorado Springs site and market have unique features that are reflected in the design of this TRICARE Senior Prime plan. Recent deployments and routine training demands make this site particularly important for understanding interactions between Senior Prime and the readiness mission. To help initiate Senior Prime, TriWest brought in a consultant with Medicare managed care expertise, who advised the Lead Agent management team on HCFA rules and regulations, and assisted in preparing the application and for start-up of enrollment and operations.

Plan Leadership - With the establishment of the Lead Agent Office as the Senior Prime plan, the plan policy and management leadership were established at the TRICARE regional level. This approach would position the site for the possible expansion of Senior Prime within the TRICARE Central Region, through extension of the basic structure established for the demonstration. However, because the TRICARE Central Region is the largest of all the regions with a number of remote clinics, expansion of TSP region-wide may present some unique implementation challenges.

Infrastructure - The Colorado Springs Senior Prime plan was established within the TRICARE Central Region framework as an adaptation of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted where possible to its requirements. The Senior
Prime Board of Directors for the TRICARE Central Region brings together the key organizational participants (Lead Agent, Evans Army Community Hospital, USAF Academy Hospital, and TriWest Healthcare Alliance) for coordination of policy and management. Reporting to this Board is the Senior Prime Management Team, consisting of a team coordinator and three full-time military personnel. In addition, two ad hoc members were added to cover financial management and information systems issues as needed. A Senior Prime Advisory Council has been established, with members from local military retiree associations, congressional offices, and others.

**Benefit Package** - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the “richer of the Medicare or TRICARE Prime benefits,” thus providing consistent health benefits at all Senior Prime sites. Although this policy may constrain the ability of the Colorado Springs plan to compete on benefits with other health plans, the moderate capitation rates in this market may preclude plans from offering rich supplemental benefits.

**Quality and Utilization Management System** - The Senior Prime management team has adapted the Colorado Springs Region’s well established TRICARE quality and utilization management programs for the Senior Prime plan. The overall objective was to keep as similar as possible to the existing QM/UM system, modifying existing processes and procedures only as necessary. The QM/UM team is a collaborative effort among the staff responsible for QM and UM within each organization - the Lead Agent, the two MTFs, and TriWest Healthcare Alliance. At this site, the contractor’s role includes tracking of grievances. There is a formal QM/UM committee within the TRICARE structure that oversees these activities for both TRICARE Prime and Senior Prime.

**Provider Network** - The two military treatment facilities offer distinct options for Senior Prime enrollees. Evans ACH provides a mix of primary care and some specialty care services, and it has a Wellness Center and a disease management clinic for chronic medical conditions. The USAF Academy’s hospital provides primary care services (internal medicine and family practice) as well as a limited number of specialty services. Fort Carson and the USAF Academy also share a number of services between them (e.g., urology, neurology), with Army and Air Force beneficiaries accustomed to receiving care at either location. The MTFs do not provide Medicare-covered services that are required primarily by an older population (e.g., SNF, hospice, home health, chiropractic services), or some specialty services.

When contracting with civilian Senior Prime providers, TriWest first recruits from among the existing TRICARE Prime network providers, and then contracts with new providers in the community for services that are not available from Prime network providers. Because Colorado Springs is an expanding business market with a growing population, civilian physicians are in high demand and have busy practices. They also dislike the military reimbursement rates. Therefore, it has been somewhat difficult to recruit physicians to the network or put resource sharing agreements into place to allow the MTFs needed flexibility to readily adjust staffing to accommodate recent deployments.

**SENIOR PRIME IMPLEMENTATION**

**Summary of Activities**

**Executing Medicare+Choice Contracts** – The Colorado Springs site faced uncertainty periodically during the planning phase of the demonstration, as HCFA and DoD negotiated key decisions on program policy and design, and the new Medicare+Choice rules to the Senior Prime plans were introduced. As the site was preparing for the site visit, HCFA applied the new Medicare+Choice rules to Senior Prime. In response to the new rules, the Colorado Springs site revised its application, marketing, and enrollment materials immediately before the site visit. These “real time” events compressed the time available for the site to prepare for program start-up activities. The site’s Medicare consultant conducted two mock site visits for the site in preparation for the HCFA certification site visit.

**Start-Up Activities** - Education and training were an important part of starting up Senior Prime in Colorado Springs. The site trained the MTF staff first and then provided orientation for beneficiaries. Training meetings were held for all providers during the summer and fall 1998.
TriWest trained the network providers and brought in DME businesses as part of the provider education process. TriWest also moved their experienced TRICARE beneficiary service representatives (BSRs) over to Senior Prime, and these BSRs then worked with and trained the temporary BSRs hired for the startup phase, including potential Senior Prime enrollees. The Advisory Council provided input on the implementation process. The site undertook extensive outreach to provide information and orientation for dual eligible beneficiaries about the Senior Prime plan and their Medicare coverage options, as described below. They received excellent media coverage, at least partly due to the district’s Congressman, including TV coverage and articles in the local newspaper with interviews with the commanders and beneficiaries. Over 20 public service announcements were made on local radio and television stations. During a two-week period, beneficiary briefings were provided to over 3,300 attendees. Two briefings per site were given daily with representatives from the Lead Agent, the two military treatment facilities, and TriWest Healthcare Alliance in attendance at the briefings.

**Enrollment** - Enrollment at the Colorado Springs site was targeted to a January 1999 service delivery start date. The overall rate of Senior Prime enrollment has been slower than initially expected. The projected enrollment for the two facilities was 2,000 for Evans Army Community Hospital and 1,200 for the USAF Academy. As of April 1999, a total of 2,841 applications had been accepted by HCFA. Although the two facilities had been serving older beneficiaries in the past, a significant number of the Senior Prime enrollees were new patients. The site has acquired HCFA’s McCoy System allowing them real-time access to HCFA’s enrollment information. They felt that this system would help to resolve the time lag the site has experienced between HCFA approving enrollment and notification, due to MPC batch processing. At the time of Senior Prime implementation, two local Medicare HMOs terminated services on December 31, 1998, leading to “dual enrollments” (Senior Prime plus another plan) by approximately 150 beneficiaries who were concerned about loss of coverage. They were denied enrollment because of the conflicting information entered into the processing system, and the site had to work individually with these cases to get them properly enrolled in Senior Prime. In order to retain flexibility needed for their readiness mission, the site allowed enrollees to select the MTF but not their PCM. The USAF Academy’s hospital enrolled into its internal medicine clinic, which quickly filled to capacity, so Peterson AFB clinic is taking their age-in enrollees. Evans ACH enrolled into its internal medicine clinic, using a staged enrollment with the goal of 500 enrollees per month over 4 months. There is strong consensus that the slower enrollment allowed more flexibility to gear up service delivery and manage enrollees’ initial PCM visits, although it also tied up personnel for an extended period of time. At the time of the site visit, the MTF still had capacity for 374 enrollees. One surprise has been the large number of age-in enrollments, with Evans ACH reporting three times its expected rate of 30 per month. The facility expects total enrollments to exceed its enrollment target because of age-ins.

**Service Delivery** - The Colorado Springs site had the benefit of the earlier experiences of other sites, anticipating possible disruption of some services (e.g., DME) as enrollees switched from existing coverage to Senior Prime. They also were concerned about problems related to starting service delivery right after the New Year holiday. A cover letter was sent to each new enrollee in their membership packet asking them to contact the TriWest Service Center if they were currently undergoing any kind of treatment. In addition, representatives from local DME firms were included in provider education sessions, and they were asked to notify TriWest of any new Senior Prime enrollees they may be providing DME services, to facilitate coordination for these patients. Staff from all 4 organizations (2 MTFs, Lead Agent, and TriWest) were on-call during the holiday weekend to address any problems that may arise. They report that no service delivery problems arose.

The two MTFs had different approaches to orientation sessions for new enrollees. The USAF Academy hospital held hour and a half orientation sessions for the seniors and then scheduled many of them for a 20 minute “get acquainted” appointment with their PCM. Evans ACH held 5-6 hour orientation sessions for up to 50 beneficiaries at a time. To date, 953 enrollees have attended the sessions. Enrollees were introduced to the concept of managed care, recent changes in the Military Health System (MHS), screened for case management, asked to complete a Personal
Wellness Profile (Senior) (PWP) health survey, and went over the self-care manual and what services were available at the MTF.

The intake processes enabled the two MTFs to identify many people with unmanaged health problems who needed follow-up care. Because the site is still in the early stages of service delivery, it is difficult to say whether the clinic activity will decrease after the initial visits. Follow-up services for enrollees with health problems are expected to place continuing demands on the clinics, thus reducing capacity for space-available care. Transitions to Senior Prime providers were reported to be made smoothly by many enrollees who had existing services for chronic conditions. TriWest Healthcare Alliance added new network providers or specialty services as demand documented the need.

TRICARE Region 11 has a centralized appointment center run by TriWest Healthcare Alliance, which serves all the TRICARE activities including Senior Prime. There also is a dedicated support telephone number that Senior Prime enrollees can call with questions about the program. The physician staff noted that having a centralized appointment center with the schedulers located outside of the MTFs has made it difficult for them maximize efficient use of their specialty clinics.

**Deployment Effects.** Recent deployments of Army and Air Force medical personnel have coincided with the start-up of the Senior Prime Program. The Air Force Academy saw the deployment of one of its four internists to Saudi Arabia, which slowed the hospital’s ability to serve Senior Prime patients. Deployments have had the most noticeable effects for Evans ACH. At the time of the RAND site visit, this MTF had lost approximately 25 of its medical personnel due to deployment of an element of the 10th Combat Support Hospital (CSH) to the Balkans. The loss of personnel was felt across both primary care and specialty care services. They expect deployment of additional elements of the 10th CSH to the Balkans in January 2000, and the facility’s on-going training mission requires that PROFIS personnel be sent for 2-3 week periods to support field training exercises.

The facility identified resource sharing as one option for ensuring the necessary flexibility to adjust to personnel losses due to deployments. However, they note that the providers are difficult to recruit for resource sharing agreements and the short turnaround time necessary to put these into place don’t make them amenable to meeting deployment demands.

**Quality and Utilization Management Processes -** As the Senior Prime staff are preparing to meet HCFA’s QISMC quality requirements, they have adopted a data-driven approach to define priorities based on documented need for improvements in clinical processes or efficiency. Data limitations, especially ADS data, are hampering their ability to measure indicators readily. This site has made HEDIS the primary focus of their QM efforts although they note that HEDIS takes on different nuances when applied to the military health system. They also recognize the importance of having a common set of indicators standardized across the sites. Reporting has been a challenge due to coding differences across the two Services and the information system support staff necessary to do analyses. They have consolidated the reporting mechanism at the Lead Agent level. Current efforts center on improving coordination between the MTFs and the network facilities.

**Financial Performance** – The financial impact due to administrative demands associated with implementing Senior Prime were expected to be fairly high at the MTF, Lead Agent, and managed care support contractor-levels. The Lead Agent and MTFs report, however, that no funds were allocated for start-up, and all the work was done by existing staff. They anticipate that administrative demands will remain relatively high. They also commented that they considered it problematic to use 1996 as the baseline to calculate the LOE for the Colorado Springs site, because the number of beneficiaries age 65 or older being seen by the MTFs declined with the introduction of TRICARE Prime in April 1997.

Network costs were expected to be high because a number of specialty services are being sent out to civilian providers. Yet the MTFs did not feel they had good visibility on what those costs may be due to the claims lag time. Senior Prime also is being introduced at a time of declining third party reimbursements due to reductions in space-available care. They plan to estimate the financial impact of Senior Prime on service delivery costs at mid-year. Obtaining a good estimate of the financial impact is expected to take some time, however, due to the enrollment ramp-up and claims lag. With recognition that LOE reconciliation credits and cash flow decisions are handled at the
service level within DoD, concern was expressed about whether the military treatment facilities would see any cash for the Senior Prime services they provided.

**Dynamics of the Local Medicare Managed Care Market** – The Senior Prime plan is a new entry into a moderately penetrated managed care market, and some of the Senior Prime enrollees had switched from other Medicare health plans. The loss of two local Medicare plans that terminated services on December 31, 1998, caused a great deal of concern for some beneficiaries who feared loss of coverage. In addition, several years ago this region experienced a disruption of its provider network due to concerns regarding timely payment, which the contractor had to rebuild. The site reported that one of the local Medicare HMOs had mentioned to retirees in the area the temporary nature of the demonstration, reminding them of the benefits the civilian HMOs could offer. This marketing effort was hypothesized to have resulted in some disenrollments from Senior Prime.

**Early Lessons Learned by the Site**

1. The following are observations by site visit participants regarding lessons learned about managing enrollments and accommodating enrollees’ service needs.
   - It is difficult to predict enrollment rates and patterns. A large number of enrollees signed up immediately for the Air Force Academy’s facility, resulting in almost an immediate filling up of its internal medicine clinic’s service capacity. At the same time, enrollment was slower at Evans ACH, and approximately 50 percent of its enrollees were new patients. This MTF experienced three times the aging in rate than had been originally predicted.
   - Enrollee satisfaction is high due to improved access to care and TRICARE benefits.
   - Through flexibility and expansion of clinic capacity, the MTFs have met TRICARE access standards for both Prime and Senior Prime enrollees.
   - Group orientations for new enrollees are a functional tool in educating them regarding providers, processes, and contact information; and may be a key in the future.
   - The Personal Wellness Profile health survey was an effective assessment/demand management tool for Evans ACH, allowing them to identify health needs and in particular, social and mental health support needs of the Senior Prime population. In contrast, the HEAR survey doesn’t stand up as well in terms of assessing the health and wellness needs of an elderly population.
   - Providers and Beneficiary Service Representatives have important roles in working with space-available beneficiaries whose access to MTF care has decreased and with eligible beneficiaries who have not yet enrolled.
   - Given the high utilization of this population, the site recommends that enrollment capacity be based on access standards rather than simply counts.

2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   - The transitional impact on space-available beneficiaries is not yet known.
   - During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) and be flexible in managing their care.
   - Care to Senior Prime enrollees provided outside of the hospital needs to be monitored carefully.
   - Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.
   - Use of Resource Sharing assets should be permitted for Senior Prime.
   - Extensive coordination between the MTF and network case management teams is required for continuity of patient care.
The demand for services by this population was higher than expected. A number of enrollees had not been seen by a civilian provider for several years, and they had unmanaged medical conditions and preventive services also were lacking.

Given apparent pent-up health care needs of new Senior Prime enrollees, adequate time needs to be allocated for the comprehensive physicals and follow-up visits required to establish stable care for them. To do so, additional resources, including ancillary support staff, would be beneficial to allow optimal use of clinic resources and space.

Although the retiree associations would like to see the demonstration expanded, several leaders recognized the recent increase in deployments and wondered if it would in reality make it infeasible to expand the Senior Prime Program at this time.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management.

- There is a need for a common set of indicators standardized across all of the sites.
- System-generated reports should be available for utilization management for civilian providers (data currently is collected manually).
- Benchmark quality and access data for the dual eligible population is needed in CEIS.
- Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
- Additional physician training is needed on HCFA rules for documentation and coding. Additional coders are also required.

4. The site visit participants felt it was important to address the flexibility needed to accommodate the readiness mission, including deployments and on-going training missions. They expressed concern about the limited depth of the network. Resource sharing was not viewed as being a good option for this purpose because a treatment facility may require the physician’s services quickly and for short period of time, yet it would take a longer time to negotiate agreements.

IMPACTS ON BENEFICIARIES

Focus groups with leaders of retiree associations, specialty physicians, PCM physicians, and other clinical and support staff were conducted. These sessions generated information about the feedback that they have been hearing from beneficiaries who received care at the two facilities, as follows:

- Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
- Many beneficiaries remain cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
- Senior Prime enrollees appear to have gained better access to care and continuity of services. The retiree representatives reported a high level of satisfaction among their members with the care they were receiving under the program.
- Substantial confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom). The phased-in enrollment process at Evans ACH led to some confusion about beneficiaries as to their actual start date for delivery of services.
- Some interruptions in care have occurred as Senior Prime enrollees have changed from existing specialists to network providers, and some enrollees with chronic conditions are losing specialists who were providing both their specialty and primary care.
• Beneficiaries need continuing support and education as they make changes in enrollments and service providers; some of the initial confusion will abate, but much probably will continue.
• Beneficiaries were uncertain as to whether they should their Medicare supplemental insurance if they enrolled in TSP. At this site, the TSP team and retiree associations advised beneficiaries to keep their supplemental insurance at least for the first few months to see how things were going and then decide whether or not they were satisfied with the program.
• Delays in start-up at this site effectively shortened the life of the demonstration and this may have contributed to the caution retirees used in signing up for the program.
• Beneficiaries required education on how managed care works and recent changes in the Military Health System.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

Evans Army Community Hospital
• PCM clinics’ service patterns have changed from provision of episodic care to active care management for their enrollees.
• Evans ACH use of the Personal Wellness Profile (Senior) (PWP) health survey proved to be an effective demand management tool over the HEAR survey. The PWP assessment enabled this MTF’s staff to identify early on individuals requiring immediate care and some social health needs of this population.
• The increase in service use by the seniors and requirement for follow-up care continues to place demands on clinics and has served to tie up some personnel for an extended period of time with staff having been pulled in from other clinics.
• The administrative burden of Senior Prime is high and the facility does not foresee it declining.
• The specialty care needs of older populations serves to maintain clinical skills and directly contributes to the readiness mission.
• Recent deployments, which have coincided with the start of service delivery, have posed a challenge in terms of being able to integrate this patient population into the facility’s overall mission. Phased-in enrollment was critical for this MTF to achieve this.

USAF Academy Hospital—10th Medical Group
• The high service use of the enrollees was not anticipated, with many requiring comprehensive physicals and histories and follow-up visits. The loss of one internist due to a deployment affected the rate at which the USAF could see Senior Prime patients initially.
• It was a challenge to take Senior Prime patients on without additional resources. It would have been useful to have additional ancillary help such as nursing assistants, individuals to process these patients, to optimize clinic space, and to maintain efficient visit flow.
• Senior Prime has a high administrative burden, and the facility does not foresee it declining.
• The specialty care needs of the older population supports the readiness mission in terms of providing clinicians access to more complex patients to treat.
• Under Senior Prime, patient acuity has increased, relative to the young cadet population the MTF was previously seeing.

Lead Agent
• Leadership responsibility has increased, accompanied by re-definition of the Lead Agent functions and an increase in resource requirements. The Lead Agent Office has taken the primary role in implementing Senior Prime in this site, with the two military treatment facilities and the MCS contractor playing more of advisory roles and intersecting primarily at key decision points.
• The Lead Agent Office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
• The Lead Agent has three full-time staff and one team coordinator dedicated to Senior Prime management. In addition, the Lead Agent has two ad hoc management team members on an as needed basis. The workload was not expected to decrease over time.

**TriWest Healthcare Alliance**

• Workload has increased as TriWest has supported the new enrollee population.
• The TriWest enrollment system has been expanded and modified for Senior Prime enrollments.
• New demands are placed on TriWest staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
• Contracting activities have increased as TriWest has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.

**Other Organizations**

• Other Medicare health plans in the market are experiencing observable loss of enrollment, but the losses appear to have limited effects on the very large plans. Marketing to local military retirees by one health plan is a sign of concern about competitive pressure from Senior Prime.

**IMPLICATIONS AND ISSUES**

The early experiences of the Colorado Springs site have revealed that the following factors are important for successful implementation of a Senior Prime plan:

• A robust provider network to support the needs of the senior population and to enable the military treatment facilities to retain the flexibility needed to meet their readiness mission,
• Training of specialty physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
• Responsive actions to identify and correct operational problems during enrollments,
• Ensuring access to case managers for all PCM clinics,
• Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
• Preparation for timely handling of grievances and appeals,
• Access to the data needed to monitor program activities and manage quality and utilization.
• Concerns about readiness and how TSP fits into the overall mission will need to be addressed.

The Colorado Springs site provides information on the Senior Prime experiences of two community-based hospitals that rely on their provider network for many specialty services, where two military Services are responsible for covering health care benefits to enrollees. The TRICARE Central Region is the largest of the TRICARE regions with 26 geographically dispersed clinics alone located within its TRICARE Prime service areas. The sheer size and distribution of military medical facilities within this region may pose certain challenges if TSP is expanded region-wide. Importantly, recent deployments and routine training demands make the experience of this site particularly useful for understanding the potential effects of Senior Prime on the readiness mission, particularly for installations that may support a large deploying population. Most of the Army and Air Force medical personnel at this site are assigned to deployable military medical units. Deployments during Senior Prime enrollment and intakes, as well as subsequent service delivery to enrollees, place pressure on the program. These effects may occur for both primary and specialty care services, given that specialists often deploy in generalist positions. In addition, support of contingency operations can pose an unique challenge, when military medical units are tasked to support deploying maneuver units that are not part of the installation, as was the case for the 10th Combat Support Hospital at Fort Carson. Loss of MTF medical personnel due to a deployment, without an accompanying reduction in the troop population on post, creates staff shortages that could reduce access for Senior Prime enrollees. Given planned upcoming deployments and the fact
that they are becoming increasingly a way of life for medical personnel, the issue of how to balance these competing demands warrants further examination.
OVERVIEW OF THE SENIOR PRIME PLAN
The Senior Prime plan for this site is named the Keesler TRICARE Senior Health Plan. The three key participants in this plan are the Office of the Lead Agent for TRICARE Region 4, the 81st Medical Group at Keesler AFB Medical Center, and Humana Military Healthcare Services, the Region 4 TRICARE Managed Care Support Contractor. The Lead Agent office, which is defined as the Plan, is accountable to HCFA for the site’s performance as a Medicare+Choice plan. The Medical Center is the sole military treatment facility (MTF) participating in the plan, and it serves as the principal provider of health care services to its Senior Prime enrollees. Humana carries out various functions on behalf of the Lead Agent, including the enrollment process, management of the network providers, utilization and case management, and administrative services.

Of the over 58,600 DoD beneficiaries in the Biloxi market, about 7,300 (12.5 percent) are Medicare eligible and another 19,500 (33.3 percent) are retirees and their dependents less than 65 years of age. The Biloxi area has virtually no managed care, although a small number of Medicare health plans serve zip codes in the Alabama portion of site’s service area market. Therefore, Senior Prime is the only managed care plan in this area.

Keesler Medical Center is a teaching hospital that provides comprehensive inpatient and outpatient services and operates five residency programs and more than 80 other training programs. The medical center has a bed capacity of approximately 100 beds, with annual admissions of 5,500 patients and more than 419,000 outpatient visits per year. The MTF can provide many of the standard outpatient and inpatient acute care services for Senior Prime enrollees, but it does not provide some Medicare-covered services that are required primarily by an older population. Civilian providers in the Senior Health Plan network provide the services that are not available from the MTF.

PROGRAM DESIGN
The design of the Senior Prime plan at the Keesler site reflects the unique features of Keesler MC as a facility, the close relationship between the Lead Agent office and the medical center, and the relative absence of managed care in the Biloxi area. The commander of the medical center serves as the Region 4 Lead Agent, which allows close coordination of work between the two organizations. Staff from the Lead Agent office and medical center have worked closely together to organize and operate Senior Prime. Humana brought in Integrated Health Services as a consultant with private sector Medicare managed care expertise, who advised the site on Senior Prime design and preparing for enrollment and operations.

Plan Leadership - The Office of the Lead Agent was established as the Senior Prime plan, thus placing plan policy and management leadership at the TRICARE region level. Operationally, they began with the MTF taking the lead, but quickly switched to Lead Agent office leadership, consistent with its role as the Medicare plan. This approach was taken to position the region for the possible expansion of Senior Prime in the future, building upon the basic structure established for the demonstration. They view the Keesler program as a core resource that can support the introduction of Senior Prime at several other MTFs in Region 4.

Infrastructure – The Senior Prime plan was established within the Region 4 TRICARE framework as an extension of the TRICARE Prime model, and already existing TRICARE systems and processes were adapted to its requirements, where appropriate. TRICARE began in Region 4 in 1996. The Keesler TRICARE Senior Health Plan Governing Board brings together the key organizational participants (Lead Agent, MTF, and Humana) for coordination of policy and management. This free-standing Board reports to the Region 4 Lead Agent.

Benefit Package - The health care benefits offered by all Senior Prime plans follow the DoD rule of offering the “richer of the Medicare or TRICARE Prime benefits,” thus providing consistent health benefits at all Senior Prime sites. The Keesler plan appears to be able to maintain financial
performance under these benefits, at least partially because of the high Medicare capitation rates for its service area. The competitiveness of these benefits is not an issue for this site because no other Medicare health plans are serving its market.

Quality and Utilization Management System - The Lead Agent office has oversight for the Senior Prime QM/UM activities, reporting to the Quality and Utilization Oversight Committee of the Governing Board. Quality activities, including data collection for monitoring, are delegated to the medical center staff for all services provided there, and to Humana for monitoring of network providers. TRICARE Region 4 purchases utilization management from Humana for both TRICARE Prime and Senior Prime. The site also has begun to introduce a disease management approach, with the intention to shift service patterns through coordinated management of individuals’ health problems.

Provider Network - Three PCM clinics in the medical center serve Senior Prime enrollees, each of which has a mix of internal medicine and family practice providers to provide cross-coverage capability. The MTF also provides many specialty outpatient services, as well as inpatient care. For services the MTF does not provide, Humana first contracted with some of the existing TRICARE Prime network providers to participate in Senior Prime. Humana then contracted with new providers for services that are not available in the Prime network, including skilled nursing facility care, home health care, durable medical equipment, physical rehabilitation care, and chiropractic care. Recruitment of new providers worked well except for specialty physicians in the Biloxi area. The community providers resist managed care, do not like the low CMAC payment rates, and previously had bad experiences with slow DoD payments for services to military patients. As a result, many of the network specialty providers are located either east or west of the immediate Biloxi market area, and enrollees have complained about the distances they have to travel for these services. Senior Prime shares this problem with the TRICARE Prime program. The site wanted to include the two local VA facilities and the Gulfport Naval Home as network providers. Keesler MC works closely with these facilities including sharing of services with the VA facilities, especially mental health services that the VA facilities provide. HCFA did not permit inclusion of the VA facilities because they are not Medicare-certified providers. The site did not request participation of the Gulfport Naval Home for two reasons. First, its skilled nursing unit is not Medicare-certified and, second, its primary care providers cannot be PCMs because all Senior Prime PCMs must be located at the MTF.

SENIOR PRIME IMPLEMENTATION

Summary of Activities

Executing Medicare+Choice Contracts - During the time the site was processed for Medicare certification, the Medicare standards and processes changed as HCFA established the new rules for the Medicare+Choice program and HCFA and DoD continued negotiations on Senior Prime policy and design. The site revised its Medicare certification application when HCFA applied the new Medicare+Choice rules to Senior Prime, and it is in the process of modifying procedures to comply with these rules.

Start-Up Activities - The site’s marketing and enrollment activities began on 1 October, following the HCFA site visit in August and subsequent certification. Service delivery started on 1 December. In this short time period, they undertook intense activities to achieve the targeted start date, which were challenged by a hurricane that hit the Gulf Coast at the end of September. The first step was education provided for clinical and management staff regarding Senior Prime and Medicare health plan regulations, in which the Command team was actively involved. About 30 briefings were held at the medical center over several weeks, preparing staff to handle questions from patients and be able to refer them to other information sources. The beneficiary briefing was presented to the staff, which both educated them and informed them about what the beneficiaries would be hearing at their orientation sessions. Humana established dedicated staff for Senior Prime. A two-week training was conducted for the Humana staff, including 3 days on Medicare benefits, and a HCFA person was brought in to train them about Medicare. The Beneficiary Service Representatives (BSR) got additional special training.
Marketing began with advertising and communications activities. The advertising used included placement of posters in public locations, newspaper ads in Sunday papers, ads in the base newspapers, press releases, and information booths in the commissary and BX on weekends. They did not use direct mail. They also worked with the retiree associations, inviting them to a meeting to inform them about the program. When marketing materials were available, they provided copies to the retiree associations to disseminate to their memberships. Retiree association representatives report that they reached over 3,000 members with Senior Prime information. Congressional staffers also were briefed to keep them up to date on the program. The advertising and marketing activities continue at a maintenance level.

The beneficiary briefings began on 1 October, with over 2,200 beneficiaries attending the meetings. Attendance was limited to 200-250 at each meeting. They used an educational approach, discussing all options available to beneficiaries so they could make informed choices. Some time also was available for one-on-one discussions. They advised beneficiaries to keep their Medigap policies until the future of Senior Prime is more clear. They believed this approach may have resulted in fewer enrollments, but it also should reduce disenrollment rates. They report positive feedback from beneficiaries on the marketing campaign.

**Enrollment** – At the time of the site visit, 2,699 beneficiaries had enrolled at the Keesler site, and another 85 were becoming effective in May. Although there are only 7,300 eligible beneficiaries in the Keesler site service area, their enrollment continues to grow steadily and they eventually expect to fill the targeted 3,100 slots. Learning from other sites about the impact of bulk enrollments on clinics’ resources, the Keesler site staged its enrollments at a rate of 1,100 per month for the first two months (December and January), and then enrolled remaining enrollees as they applied. Humana processes enrollments at its headquarters in Louisville KY. This process entails use of 4 separate data systems, with separate data entry into each system. Humana dedicated two BSRs, one health care finder, and one patient care coordinator to Senior Prime. The BSRs are housed in the MTF instead of the TSC, which is 2 miles from the medical center.

They identified four groups of dual eligibles at Keesler who might enroll: a pool of 3,000 who regularly had used the MTF before, people who were using MTF specialists as their main providers, episodic users of primary care clinics and pharmacy, and users of only pharmacy services. When TRICARE Prime began, Keesler MC created a panel of 1,500 older beneficiaries assigned to PCMs as part of the medical center’s GME mission, and many of the remaining dual eligibles received episodic care because of declining space-available care. The most common issues raised by beneficiaries were (1) what are the Senior Prime benefits, (2) a desire to use VA facilities, (3) desire for vision and hearing care, (4) concern about the short 2-year life of the demonstration, and (5) a need to retain their Medigap policies.

**Service Delivery** – Preparation for intake of new enrollees started even before HCFA had verified their enrollments, to prepare for continuation of DME and prescription medications and possible changes in specialty physicians in the transition to Senior Prime. They tested use of telephone follow-ups with beneficiaries who submitted an enrollment package to identify their current health status, services being used, and medications. They completed telephone screening with about 600 beneficiaries, but they experienced difficulties in contacting people and getting inadequate information by telephone, which led them to discontinue this approach. Medical center staff also worked with DME suppliers to make transitions for new enrollees. They found that these efforts helped reduce discontinuities in care.

Enrollee Education and Health Assessment for Seniors (EEHAS) sessions were held for new enrollees, which were attended by 80% of enrollees. Clinical staff led these sessions, at which they presented information on Senior Prime rules and covered benefits, performed health assessments, and provided individual counseling for medical care needs. Enrollees were triaged to determine needs for PCM appointments, with the goal of scheduling appointments within one month for those who needed them. Many of the “panel” patients who had been seeing PCMs regularly did not need special initial visits. Those who had been using the facility episodically tended to have greater needs for care. The medical technicians and nurses continue to manage enrollees’ care, answer questions, and help them move through the system. Staff in both PCM and specialty clinics have
heard complaints from enrollees about problems with making appointments and their dislike of telephone consults or appointments and “800” numbers. The specialty physicians report that the impacts of Senior Prime on their clinics vary widely depending on the specialty and the clinic’s policy for handling referrals. For some clinics, patients just changed classifications when they joined Senior Prime. Other clinics have experienced a large influx of patients, with the timing of the referrals also varying by type of specialty. Some of the specialty physicians stated they liked the PCM role of triaging patients so the specialists can concentrate on the care they provide.

**Quality and Utilization Management Processes** – The Keesler site initiated the cross-site work on QM/UM metrics by suggesting this approach to the Lead Agent staff for the Region 6 site. The site staff saw that the complexity of the tasks merited joint efforts, and they understood that problems with completeness and quality of data from the DoD systems would make the work yet more difficult. With TMA agreement to this approach, the sites are working together to define measures and special studies, and TMA is organizing data collection with its contractors. The site still collects its own data to compare with these findings and to continue its work with the site’s QM/UM clinical teams. Concerns were expressed about some of the Medicare QISMC standards, such as the enrollee’s right to demand a service even if it is against medical judgment, and extension of the out-of-area allowance from 3 to 12 months. Due to problems with data accuracy and availability from the central systems, the site relies on local data generated in its CHCS and ADS systems for its monitoring activities.

The Keesler site already had several QM activities underway, which they expanded with the introduction of Senior Prime. These include a diabetes special study, monitoring of HEDIS-like measures, and self-reported health status information. Working groups have been established for several health conditions. They also held coding seminars for doctors to improve data on diagnostic and procedure codes. Clinicians are very receptive to the metrics being generated. They understand the limits of the data, but they find the information useful to flag problems where they then drill down into charts to find the clinical stories.

Utilization management activities are being performed by both the medical center and Humana. They have determined that traditional UM pre-authorizations are becoming less useful, and they are moving to proactive management of care. In Humana’s case management function, one ambulatory care case manager has been designated for Senior Prime case, and because this person is carrying a full caseload, they have added another person. Within the medical center, in-house clinical staff are doing case management for inpatient care. They also monitor both outpatient and inpatient care, and make arrangements for transition from outpatient to inpatient care for patients being admitted.

**Financial Performance** - Although the Keesler site has been following the interim payment reports, it has focused more on getting people enrolled and tracking performance, and as a result, they say the site is doing well operationally. The relatively high Medicare capitation rates in the Biloxi area are an advantage for the site. The payment rules are difficult to understand, which makes it hard for them to assess how the rules affect this site. The space-available LOE threshold for determining payments is not liked - it is a complex formula and hard to operationalize. They are concerned about the site’s status relative to this threshold because their FY99 space-available visits for Medicare-eligible patients have declined substantially, and they do not see any actions they can take to manage it. They also want to receive the site’s share of any Senior Prime cash flow from HCFA payments. Although these funds would not affect staffing levels, the resources would be fed into infrastructure. There also is a question regarding which fiscal year the funds are for, because the site cannot spend previous year funds. They recommend that an easier method for calculating the LOE be developed, and the baseline year should be reconsidered for new plans, if Senior Prime goes systemwide.

**Dynamics of the Local Medicare Managed Care Market** - Because the Keesler TRICARE Senior Health Plan is the only Medicare plan serving the Biloxi market, it has no direct competition for enrollment of dual-eligible beneficiaries. The absence of managed care is accompanied by limited knowledge in the community about managed care as well as negative attitudes toward this model of
care. Challenges created by these issues include the need for education for beneficiaries and the resistance of local specialty physicians to participating as network providers.

EARLY LESSONS LEARNED BY THE SITE
1. The following are observations by site visit participants regarding lessons learned about managing Senior Prime enrollments and accommodating enrollees’ service needs.
   • The entire start-up process should be given adequate time to perform the tasks effectively.
   • Enrollee satisfaction is high due to improved access to care and access to TRICARE benefits.
   • Non-enrollees are concerned about their ability to continue to have access to the facility on a space-available basis and will require education as well.
   • Controlled personalized marketing and group orientations for new enrollees are important tools in educating beneficiaries regarding providers, processes, and contact information. They found it was important to limit the number of attendees at each meeting and allow time for one-on-one discussions in the sessions.
   • Continuing support for enrollees needs to be provided by the PCM clinics, including not only clinical counseling but also coaching on use of the system and listening to concerns.
   • The “informed choice” approach for beneficiary orientation to Senior Prime was constructive, and resulted in positive feedback from beneficiaries that they can trust what they are told.
   • If the site anticipates large enrollments, staged enrollment should be used to avoid undue stress on clinic capacities.
   • Local retiree associations need to be involved in developing the program, but bringing them in too soon may violate Medicare rules on enrollment activities.
   • The enrollment processing system is vulnerable to enrollment errors or delays because data from applications must be entered separately into multiple systems, and such a system could cause substantial problems if Senior Prime is implemented more broadly.
2. The following are observations by site visit participants regarding lessons learned about service delivery and management of quality and utilization.
   • During transition of patients to Senior Prime, it is important to identify potential enrollees with existing requirements (DME, home health, etc.) to achieve a smooth transition into Senior Prime with minimal service disruption. Pre-enrollment telephone screening for existing service needs, however, was found to be only marginally useful for gathering this information.
   • Recruitment of network specialty physicians is difficult in areas with little managed care, and memories of low DoD rates and slow payments during the early days of TRICARE make the task harder. These memories remained even after many of the problems were resolved.
   • Care to Senior Prime enrollees provided outside of the hospital needs to be coordinated carefully to support exchange of charts and other information between military and network providers, and to ensure continuity of care as the patient moves between the two sectors.
   • Education for Senior Prime providers at the MTF and in the network needs to continue as changes occur in the program.
   • Strong communication and partnering relationships among the MTF, Lead Agent, and MCS contractor are essential to effective management of Medicare compliance issues.
   • The utilization and case management activities should be supported by staff education, and strategies should be explored to create incentives for providers to want to use these practices. The MTF and MCS contractor activities should be coordinated to protect continuity of patient care.
   • An important aspect of the Medicare appeals and grievances requirements is careful documentation of complaints received from enrollees and the site’s responses to those
complaints, both for the customer service aspect of care and for identification of potential problems for QM or UM monitoring and action.

3. The site visit participants also confirmed the importance of having valid data for quality and utilization management. They report that incompleteness of service use data (especially ADS), coding inaccuracies, limitations of cost data, and lack of integration of data systems are barriers to effective QM/UM management. As a result, this site has chosen to use its own local data systems (CHCS and others) for its monitoring activities, and not rely on CEIS.
   • Benchmark quality and access data for the dual eligible population is needed in CEIS.
   • Small numbers of enrollees limits power for statistical inference on benchmarks and trends.
   • Additional physician training is needed on HCFA rules for documentation and coding.

IMPACTS ON BENEFICIARIES

We summarize here what we learned during our focus groups with the leaders of retiree associations, PCM physicians, specialty providers, and other front line clinical and support staff. These sessions generated information about the feedback that these groups have been getting from beneficiaries who received care at the medical center, as follows:
   • Beneficiaries are expressing relief that the promise of health care for life is being fulfilled.
   • Senior Prime enrollees appear to have gained better access to care and coordination of services.
   • Many beneficiaries remain quite cautious about signing up, however, because of the short life of the demonstration and restrictions of managed care.
   • Enrollees’ reactions may differ by how much they used the MTF before Senior Prime. Staff report that those who had been using the MTF regularly (the panel) tend to be disgruntled because Senior Prime is managed care, and those who were denied care before are pleased to be using the MTF.
   • Retiree association representatives report that Senior Prime enrollees are saying they are very satisfied with the clinical care and customer service they are receiving at the medical center.
   • Some confusion remains about the rules for enrolling in Senior Prime and how to obtain services (and from whom) as a Senior Prime enrollee. In particular, many enrollees dislike the telephone appointment system and do not understand how to use it correctly. Beneficiaries need continuing support and education; some of the initial confusion will abate, but much probably will continue.
   • The space-available beneficiaries have lost access to primary care clinics, but it is not yet clear how much of that was due to intake activity during the early Senior Prime enrollment period. Some specialty clinics still are serving space-available care patients.

IMPACTS ON SENIOR PRIME ORGANIZATIONS

81st Medical Group at Keesler AFB Medical Center
   • Introduction of Senior Prime has had substantial effects in the primary care clinics and some of the specialty clinics of the MTF. Administrative costs to start the program have been high, and operating costs may be increasing with a shift in patient mix toward an older population.
   • Effects of Senior Prime vary by specialty clinic, but the program does increase caseloads for many specialty services and it may contribute to increased ER use by space-available patients.
   • The specialty care needs of older populations are positive for the MTF’s training/GME mission.
   • Senior Prime supports the readiness mission by helping providers maintain skills in surgical procedures, ICU procedures, and critical care transports (there are 20 C-CAT teams at Keesler). Specialty providers report that the ICU would be under-utilized without Senior Prime.
   • Senior Prime is competing with the readiness mission in other ways because managed care requires tremendous coordination, and deployments and rotations of physicians make it hard to fulfill the clinical obligations to Senior Prime patients.
• Senior Prime is reinforcing the MTF’s activities to strengthen its overall QM/UM activities.
• The MTF has lost revenues from Medigap insurers for Senior Prime enrollees.
• If this program is to be expanded to all MTFs, each MTF would require a dedicated staff for Senior Prime, given the administrative burden.

Lead Agent
• Leadership responsibility has increased, accompanied by re-definition of the Lead Agent functions and increased demand on available resources. With these demands, coupled with existing staff shortages, the Lead Agent office staff reported substantial workloads as Senior Prime was implemented.
• The Lead Agent office performs a coordination role to resolve issues where it does not have direct jurisdiction, including greater interaction with the MTF for program oversight.
• If this program is expanded to all MTF’s in the region, the Lead Agent office indicates it is considering the need to establish satellite offices at the participating MTFs.

HUMANA MILITARY HEALTH SERVICES
• New workload demands are placed on Humana staff to respond to the needs of older beneficiaries during enrollments, disenrollments, and service delivery.
• The Humana enrollment system has been expanded and modified for Senior Prime enrollments, and staffing has been increased to support Senior Prime enrollees. The TRICARE Service Center has been expanded to accommodate these increased activities.
• Contracting activities have increased as Humana has modified existing Prime contracts for Senior Prime, added new network providers, and managed transfers to Senior Prime specialty providers for new enrollees.

Other Organizations
• Because the VA facilities in the Keesler site service area were denied participation as Senior Prime network providers, and these facilities share services extensively with the medical center, there may be discontinuities in care for beneficiaries who have been using both types of facilities.
• The Gulfport Naval Home cannot participate as a primary care provider in Senior Prime, thus restricting access to Senior Prime for its residents and potentially disrupting continuity of care when the residents need to use the medical center on a space-available basis.

IMPLICATIONS AND ISSUES
The early experiences of the Keesler AFB site have revealed that the following factors are important for successful implementation of a Senior Prime plan:
• Controlled personalized marketing to build confidence on the part of enrollees,
• Establishing a provider network in the community that offers ready access to nearby providers,
• Training of physicians and front line staff on Senior Prime and care management techniques for Medicare beneficiaries,
• Close working relationships with the HCFA regional offices throughout the certification, start-up, and operational phases of Senior Prime operation.
• Coordination of utilization and case management activities by the MTF and MCS contractor,
• Ongoing support for beneficiaries and the front-line clinical and support staff who are serving them,
• Preparation for timely handling of grievances and appeals,
• Access to the data needed to monitor program activities and manage quality and utilization.

The Command team at the Keesler site provided feedback based on their experiences thus far with Senior Prime, highlighting that if DoD really wants to serve the older population, then it is necessary to put the resources behind it to do it correctly. The following major issues were identified: (1) substantial staff resource requirements for Senior Prime, along with rotations of military personnel that hamper program continuity, where it is especially important to retain
Medicare expertise; (2) difficulties in achieving an adequate provider network in the Biloxi market to provide geographically reachable services; and (3) desire to receive its share of any funds paid by HCFA for Senior Prime enrollees.