Chapter 1

INTRODUCTION

The Health Care Financing Administration (HCFA) and Department of Defense (DoD) are implementing the Medicare-DoD Subvention Demonstration to test the feasibility of making Medicare-covered health care services available to Medicare-eligible DoD beneficiaries through the TRICARE program and military treatment facilities. The goal of the demonstration is to “implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either HCFA or DoD.”\(^1\) The demonstration is being undertaken in six sites in response to direction by the Balanced Budget Act of 1997 (BBA).

The Secretaries of DHHS and DoD have executed a Memorandum of Agreement (MOA) that specifies how they will establish and operate the Medicare Subvention Demonstration, subject to BBA provisions. Two mechanisms are to be implemented. The first is a new Medicare managed care plan option—TRICARE Senior Prime—through which DoD, under contract with HCFA, operates Senior Prime plans at the six demonstration sites as Medicare health plans. Senior Prime plans are administered under both Medicare and TRICARE rules and regulations, although wherever possible, they build upon the infrastructure of the TRICARE Prime program that is the managed care option for military beneficiaries under age 65. The second mechanism is Medicare Partners, an arrangement through which Medicare+Choice organizations can contract with military treatment facilities (MTFs) in the demonstration sites to serve as providers for dual-eligibles enrolled in the plans. No Medicare Partners agreements have been established as of the date of this report.

In September 1998, HCFA awarded a contract to RAND to perform an evaluation of the demonstration. This Interim Report contains the early results of this evaluation, including results of the first round of the process evaluation, analysis of enrollment demand, and preliminary methodological studies for the cost analysis.

THE MILITARY HEALTH SYSTEM

The peacetime military health strategy of the DoD is to provide comprehensive, cost-effective care to active duty members, their families and other eligible beneficiaries in all the Uniformed Services. Much of this health care is provided directly through several hundred military hospitals and clinics that constitute the system of military treatment facilities. MTFs provide care to all military beneficiaries free of charge as capacity permits. Each MTF has a defined service area called a catchment area, which generally includes the zip code areas within a 40 mile radius of the MTF. Although most military beneficiaries live within such a catchment area, less than half of the older, Medicare-eligible beneficiaries are in catchment areas.\(^2\)

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1 From the Memorandum of Agreement for conduct of the demonstration that was executed by the Department of Health and Human Services and the Department of Defense.
2 Testimony of the Military Coalition on Health Care Concerns of the Uniformed Services Community provided to the Senate Appropriations Committee, Subcommittee on Defense, May 11, 1998.
The Military Health System (MHS) currently provides health care to approximately 8.2 million beneficiaries. In FY97, elderly military beneficiaries (those age 65 or older) represented an estimated 15.5 percent of the total MHS beneficiary population. Younger retirees and their dependents were an additional 24.5 percent of the total FY97 beneficiary population, and the elderly retiree population will increase as these military beneficiaries age into Medicare-eligibility.

The DoD health service mission has been challenged by the rapid rise in health care costs, closures of military bases and their medical facilities, and shifts in the beneficiary population. For instance, as a result of Base Realignment and Closure (BRAC) actions, 35 percent of MTFs providing services in 1987 had closed by the end of 1997. During the same time period, the number of people eligible for care in the MHS decreased by only 9 percent. As the number of active duty personnel and dependents decreased, there was growth in numbers of retired members and their families. The reduction in number of MTFs has curtailed access to military health care for retirees living in areas affected by BRAC actions.

The TRICARE health insurance program, which began operation in 1995, was developed as the DoD response to the challenges facing the MHS. Each of the 11 TRICARE service regions in the United States, Europe, the Pacific, and Latin America is managed by the military in partnership with civilian managed care support (MCS) contractors. A senior military health care officer is designated as the TRICARE Lead Agent (LA) for each region, and the Lead Agent’s office is responsible for coordinating the delivery of health care to eligible beneficiaries living in that region. Day-to-day service delivery and clinical decision-making is done by the primary care managers (PCMs) in the MTFs, with oversight by local MTF commanders. The TRICARE Management Activity (TMA) contracts directly with a MCS contractor for each region to provide support services for the region’s LA Office. Thus the terms of the MCS contracts are established between TMA and the contractors, in consultation with the LA Offices.

The TRICARE system aims to offer expanded access to care, a choice of health care options, consistent high quality health care benefits, and reduced health care costs for beneficiaries and taxpayers alike. TRICARE is a managed care program modeled after civilian standards. The program offers beneficiaries three choices for their health care: TRICARE Standard, a fee-for-service option that replaced CHAMPUS; TRICARE Extra, a preferred provider option; and TRICARE Prime, an HMO model option. MTFs are the principal sources of health care for TRICARE Prime enrollees, and their services are supplemented by civilian network providers. All active duty members and their families, retirees and their families, and survivors who are not eligible for Medicare may participate in one of the three TRICARE options. Additionally, those individuals under age 65 who are eligible for Medicare because of disability or end-stage renal disease (ESRD) may participate. Medicare beneficiaries who are age 65 and over and otherwise eligible for military benefits may not enroll in TRICARE Prime.

Under TRICARE, access for MTF services is offered to beneficiaries in the following order of priority: (1) active duty service members, who are enrolled in TRICARE Prime automatically; (2) family members of active duty service members enrolled in Prime; (3) retirees, their family members and survivors enrolled in Prime; (4) family members of active

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duty service members who are not enrolled in Prime; and (5) all other beneficiaries. Because Medicare-eligible beneficiaries are excluded from TRICARE, they are in the lowest priority group.

All beneficiaries not enrolled in TRICARE Prime, including Medicare-eligibles, have access to MTF services only if space is available after the MTF serves its Prime enrollees (called space-available care). A combination of an MTF’s service capacity limits (usually clinic staffing levels) and the volume of services provided to Prime enrollees determines the amount of space-available care an MTF can provide. As Prime enrollment has grown and budgets have not, space available care has tended to decline, although at varying rates across MTFs.

MEDICARE MANAGED CARE

Managed care options have been an official part of the Medicare program since 1983, when the Tax Equity and Fiscal Responsibility Act (TEFRA) established provisions for risk and cost contracting HMOs. Medicare beneficiaries living in areas served by Medicare HMOs could elect to join one of these plans, and they also could disenroll from a plan at the end of any month. HMOs could participate as either a risk contractor—by far the most common type—a cost contractor, or a health care prepayment plan. Managed care plans have grown rapidly in recent years—as of December 1998, 6.1 million Medicare beneficiaries were enrolled in 346 risk contracting plans, accounting for 16 percent of the total Medicare population. This represents more than a 16 percent increase in risk plan enrollment since December 1997.

The Balanced Budget Act of 1997 (BBA) replaced the existing Medicare managed care program with the Medicare+Choice program established under a new Medicare Part C. As of January 1999, a variety of managed care organizations are authorized to contract as capitated Medicare+Choice organizations. Existing risk plans may convert to the new program, and the two cost-based options are discontinued (with few exceptions such as union-based plans). The BBA used the TEFRA risk contracting program as a template for the Medicare+Choice program, including a number of beneficiary protections, conditions for participation for contracting plans, and Adjusted Community Rate (ACR) requirements intended to limit windfall profits for health plans in areas with high capitation rates.4

The BBA also adopted a new methodology for establishing capitation rates, which went into effect in 1998. HCFA calculates a health plan’s capitation payments each month as the sum of the product of the capitation rate for each enrollee’s county of residence and the enrollee’s risk factor. The BBA requires development of an improved risk adjustment method, to be implemented in January 2000.

THE MEDICARE SUBVENTION DEMONSTRATION

The impetus for a Medicare-DoD subvention mechanism, whether as a demonstration or as a permanent part of the Medicare and DoD health insurance programs, is rooted in federal statute. Under current law, when Medicare beneficiaries obtain health care services at

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4 Adjusted community rates (ACR) are rates that plans estimate they would have received for their Medicare enrollees if they had been paid at levels of their private market premiums, adjusted for demographic differences. Each year, plans are required to return to enrollees any excess of Medicare revenue in excess of their ACRs by reducing premiums or increasing benefits for the following year.
treatment facilities operated by the DoD or Department of Veterans’ Affairs (VA), Medicare cannot reimburse either organization for those services. Furthermore, individuals who are eligible for both Medicare benefits and benefits from the DoD, the VA, or both, are free to choose where they will obtain their health care. As a result, the health care costs of dually (or triply) eligible beneficiaries have been shared by Medicare, DoD and VA according to the mix of service sectors that beneficiaries have chosen to use. Yet because Medicare-eligible DoD beneficiaries are space-available patients for MTFs, their access to services by DoD treatment facilities has been squeezed out as TRICARE Prime enrollees have used increasing shares of MTFs’ service capacity. Although these older beneficiaries do not have a military managed health care option, they may enroll in other Medicare health plans serving their local markets.

Two Subvention Models Being Tested

The subvention demonstration tests two distinct models that allow DoD to receive payments for expanded services to Medicare-eligible DoD beneficiaries. The first model, TRICARE Senior Prime, establishes Medicare managed care plans operated by the DoD, in which participating MTFs are the principal health care providers for enrolled beneficiaries. The Senior Prime plans are certified by HCFA as Medicare health plans, and they are subject to the same performance standards as all other Medicare plans, with some exceptions where requirements are waived because of the unique circumstances of military health care. (Refer to Chapter 5 for details on waivers of the Medicare performance standards for Senior Prime.)

The second model, Medicare Partners, allows local Medicare health plans serving the demonstration sites to contract with MTFs to be providers in the plans’ networks. According to the BBA, these contracts will be for MTF specialty and inpatient services provided to DoD beneficiaries enrolled in the Medicare plans. HCFA performs the same oversight for these contracts as for other provider contracts executed by Medicare health plans. To use MTF services under a Medicare Partners agreement, enrollees of a Medicare health plan must be eligible to receive care from the DoD, be residents of the demonstration sites’ catchment areas, and used an MTF prior to January 1, 1998 or became dual-eligible after December 31, 1997. The MOA stipulates that DoD will not initiate any Medicare Partners activities in a demonstration site until at least 90 days after the site’s Senior Prime plan has started service delivery. No Medicare Partners activity has been undertaken by DoD at this time.

Provisions for TRICARE Senior Prime

The barriers to military health care are removed for Medicare-eligible DoD beneficiaries who enroll in a TRICARE Senior Prime plan. Senior Prime enrollees choose a military primary care manager (PCM) at a participating MTF and they receive their primary care at the MTF, as well as all other covered services that the MTF provides. For services the MTF does not provide, enrollees are referred to civilian providers in the Senior Prime network.

TMA established national Senior Prime benefits and cost sharing provisions that apply for all sites. By law, the minimum benefits required to be covered were the Medicare-covered benefits, and the MOA gave DoD discretion to expand coverage. The covered services are defined as “the richer of TRICARE benefits or the standard Medicare benefits,” and they include some Medicare-specific post-hospital care, such as limited skilled nursing facility

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5 Section 1814(c) of the Social Security Act.
(Senior Prime covers up to 100 days of care) or home health visits, as well as other TRICARE Prime benefits (e.g., pharmaceuticals) not covered by Medicare. Senior Prime enrollees do not have to pay any copayments or coinsurance for services provided in the MTFs, but they do have to pay part of the costs for network provider services. Copayments for network provider outpatient services range from $12 to $30 per unit of service, and for acute inpatient services, there is a copayment of $11 per day with a minimum of $25 per admission. Enrollees also pay $40 per day for partial hospitalization or inpatient mental health or substance abuse services by network providers. For ostomy supplies, prosthetic devices, therapeutic shoes, and durable medical equipment (DME), the cost sharing is 20 percent of the negotiated fee.

Beneficiary participation in Senior Prime is voluntary and does not involve any premium. To be eligible, beneficiaries must be age 65 or older, eligible for Medicare Part A and enrolled in Medicare Part B, be residents of a demonstration site’s service area, and have used the MTF services prior to January 1, 1998 or became dually eligible for TRICARE and Medicare Part B after December 31, 1997. In addition, enrollees must agree to receive all of their covered services through Senior Prime. DoD beneficiaries who are Medicare-eligible due to end-stage renal disease (ESRD) or who are younger than 65 and Medicare-eligible due to disability are excluded from the demonstration. These beneficiaries still may receive care from MTFs on a space-available basis, and those younger than age 65 may join TRICARE Prime.

The capitation payment rates for Senior Prime enrollees are based on the Medicare capitation rates for the counties in which the enrollees reside. The Senior Prime capitation rates are set at 95 percent of these county rates, after deducting the cost of direct and indirect medical education, disproportionate share payments, and a portion of hospital capital payments. In addition, Medicare will pay for enrollees’ care only after the DoD has spent as much for health care services to dual-eligibles in the demonstration sites (enrollees and non-enrollees) as it spent in the past, which is called the level of effort (LOE). The MOA defines the baseline LOE as the FY96 DoD expenditures for dual-eligible beneficiaries at each site. The LOE is kept constant for the duration of the demonstration, except if overall defense health spending changes substantially or BRAC actions reduce DoD’s ability to serve dual-eligibles.

The MOA also establishes expense thresholds for Senior Prime enrollees and non-enrollees that are used to determine whether HCFA will make payments to DoD and the levels of those payments. The thresholds were set originally at 30 percent of LOE for enrollee expenses and 70 percent for non-enrollee expenses in the first year of the demonstration, which moved to a 40/60 split in the second year and a 50/50 split in the last year. Because the demonstration will operate for only two years, an MOA clarification applied these thresholds to shorter time periods: a 10-month period from September 1998 to June 1999, followed by a 9-month period through March 2000 and another 9-month period through December 2000.

Given these basic payment method elements, net payments to DoD for Senior Prime are calculated each year according to the following rules:

1. If total expenses for enrollees and non-enrollees exceeds the LOE—and the expenses for enrollees exceed relevant threshold (30/40/50), then DoD will receive

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6 For clarity, we note that the county capitation rates are grounded in the historical AAPCCs, which were set at 95 percent of the average per capita costs for Medicare fee-for-service beneficiaries; thus the Senior Prime rate is discounted to 95 percent of the “95 percent Medicare capitation rates.”
payment from HCFA (also expressed as DoD keeping interim payments already made by HCFA).

2. The allowed cost for non-enrollees is the minimum of the actual cost or the relevant threshold (70/60/50).

3. The net payment made to DoD =
   
gross capitation payments + allowed cost for non-enrollees – baseline LOE.

Based on these payment rules, net return (or cost) for Senior Prime can be estimated as the net payment made to DoD minus any expenses in excess of LOE that were incurred by the sites for serving dual-eligible beneficiaries.

The BBA authorized HCFA to make interim payments to DoD, and it established annual limits on Medicare spending for Senior Prime enrollees. The MOA defines thresholds to trigger interim payments, methods to determine these payments, provisions for retrospective risk adjustment of payments, and methods for annual reconciliations of payment amounts.

The MOA also specifies how Medicare Partners is to be implemented, stating that: (1) no costs associated with Medicare Partners are counted toward LOE, (2) DoD cannot retain Medicare Partners payments unless the LOE is exceeded, and (3) no more than half of the spending cap each year is available for Medicare Partners.

DoD and HCFA selected the six demonstration sites that include 10 MTFs operated by the Army, Air Force, and Navy, which are listed in Table 1.1. The total planned enrollment for the six Senior Prime plans is 27,800 Medicare-eligible DoD beneficiaries. The sites identified these enrollment levels using a variety of techniques, some of which are targeted enrollments based on market analyses and others are more measures of MTF treatment capacity than expected enrollments. The sites began enrollments soon after they met all the requirements for certification by HCFA as Medicare health plans. Early rates of enrollments have varied across sites, and some - but not all - of the sites have achieved their planned enrollments. (Refer to Chapter 4 for characteristics of the sites and markets and our analysis of enrollment patterns.)

7 Examples are the Region 6 site that set enrollment targets based on expected market penetration as well as MTF capacities, and the Dover site that views its level as its maximum MTF capacity - not a “target.”
Table 1.1
Subvention Demonstration Sites and Planned Enrollment Levels

<table>
<thead>
<tr>
<th>Demonstration Site</th>
<th>TRICAR E Region</th>
<th>Start Service Delivery</th>
<th>Planned Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado Springs site:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evans ACH, Ft. Carson, CO</td>
<td>8</td>
<td>January 1999</td>
<td>2,000</td>
</tr>
<tr>
<td>Air Force Academy</td>
<td></td>
<td>January 1999</td>
<td>1,200</td>
</tr>
<tr>
<td>Dover Air Force Base</td>
<td>1</td>
<td>January 1999</td>
<td>1,500</td>
</tr>
<tr>
<td>Keesler AFB Medical Center</td>
<td>4</td>
<td>December 1998</td>
<td>3,100</td>
</tr>
<tr>
<td>Madigan Army MC/Region 11</td>
<td>11</td>
<td>September 1998</td>
<td>3,300</td>
</tr>
<tr>
<td>Southwest Region (Region 6) site:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brooke Army Medical Center</td>
<td>6</td>
<td>October 1998</td>
<td>5,000</td>
</tr>
<tr>
<td>Wilford Hall Medical Center (AF)</td>
<td></td>
<td>October 1998</td>
<td>5,000</td>
</tr>
<tr>
<td>Reynolds ACH, Ft. Sill, OK</td>
<td></td>
<td>December 1998</td>
<td>1,400</td>
</tr>
<tr>
<td>Sheppard AFB Hospital</td>
<td></td>
<td>December 1998</td>
<td>1,300</td>
</tr>
<tr>
<td>San Diego Naval Medical Center</td>
<td>9</td>
<td>November 1998</td>
<td>4,000</td>
</tr>
</tbody>
</table>

THE RAND EVALUATION

The MOA for the demonstration begins with a goal statement that is the driving force for the evaluation being performed by RAND for HCFA and DoD:

“The goal of this demonstration is, through a joint effort by DHHS and DoD, to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either agency.”

With this goal as the starting point, Attachment E to the MOA specifies questions in four areas that define the scope of the evaluation: benefits for enrollees, cost of program, impact on other DoD and Medicare beneficiaries, and enrollment demand. Within each area, the evaluation is to assess whether the demonstration succeeded and it is to analyze details of program dynamics. HCFA and DoD also have emphasized the importance of obtaining information and tools from the demonstration to enhance their ability to expand Senior Prime plans and Medicare Partners agreements effectively across the military health system, should such a decision be made. Working with these specifications, we designed our evaluation to include:

- a process evaluation of implementation activities
- analyses of enrollment demand and disenrollments
- effects of the demonstration on beneficiaries and
- effects on government costs.

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The process evaluation gathers and analyzes information on the implementation activities of demonstration participants. Sites’ experiences with Senior Prime and Medicare Partners are documented, and operational successes and challenges in program implementation are identified. Implications for a permanent, systemwide program are assessed. This qualitative information also guides interpretation of findings from our quantitative outcome analyses.

This evaluation is one of two independent evaluations of the subvention demonstration. In creating the demonstration, the BBA directed the Inspector General to perform an evaluation, which is being carried out by the General Accounting Office (GAO). The parties involved in the two evaluations are communicating regularly, and the GAO and RAND coordinated schedules for their respective process evaluations. Although both of the evaluations are addressing the same central issues of the processes and outcomes of implementing the demonstration, they differ in the emphasis they place on certain topics. Therefore, the combined findings of these evaluations should yield richer information and perspectives than those of one evaluation alone.

SCOPE OF THE INTERIM REPORT

Proposals to make subvention permanent were placed before Congress in this session with the filing in April of H.R. 1413 in the House and S. 915 in the Senate. These essentially matching bills would expand the number of sites to 16 effective January 2001 and would repeal the limitation on the number of sites effective January 2002. Whether or not legislation is passed this year, these bills highlight the need to document lessons from the demonstration and evaluate how this information can be applied to the design of a permanent program. It is important to examine the sites’ experiences in the context of the policy framework established by the Congress, HCFA, and DoD. The BBA and HHS/DoD MOA define policies and methods that may function on the scale of the demonstration. Yet some of these provisions may not adapt effectively to a larger Senior Prime program, and modifications to HCFA or DoD policies may be appropriate.

This Interim Report contains early results from RAND’s evaluation, focusing on the early experiences with program design, enrollment, and initial service delivery for the TRICARE Senior Prime plans in the six demonstration sites. Implications for a larger system are considered. Emphasis is placed on Senior Prime because no Medicare Partners activity has occurred yet.

We describe in Chapter 2 the methods used in the evaluation work reported here. The policy framework for the subvention demonstration is examined in Chapter 3, focusing on the principles and aims of HCFA and DoD as they negotiated provisions that guide subvention activities. In Chapter 4, we describe the sites, their local markets, and their enrollment patterns through June 1999. Building upon this factual foundation, Chapter 5 presents results of our process evaluation regarding the experiences of HCFA, TMA, and the demonstration sites in implementing TRICARE Senior Prime. In preparation for the next steps of our evaluation – examination of the demonstration’s impacts on beneficiaries, utilization, and government costs - we present in Chapter 6 some preliminary findings from our analysis of the estimated costs of

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9 The bills also would establish Medigap protection for disenrollees that is available to other Medicare+Choice plan enrollees, and they would permit HCFA to pay DoD on a fee-for-service basis at rates that do not exceed the rate of payment that otherwise would be made.
care by DRG, which is a component of the Patient Level Cost Allocation. Finally, Chapter 7 discusses some of the issues that decision makers will face if TRICARE Senior Prime becomes a permanent program, along with lessons learned thus far from the demonstration to help build a stronger program. We also offer, at the end of this chapter, a preliminary discussion of the prospects for Medicare Partners and related policy issues.