Chapter 5

EARLY EXPERIENCES IN THE DEMONSTRATION

The first tasks undertaken by TMA and the demonstration sites were the design of the Senior Prime program, at both the corporate and site levels, and the preparation of written applications for certification as Medicare managed care plans. After the Medicare application for each Senior Prime plan had been submitted, and HCFA had deemed them complete, HCFA conducted a certification site visit to review the application and related documents at the site. As each application was approved by HCFA, a contract letter was sent to DoD confirming the establishment of the Senior Prime plan. The contract defined the plan’s service area by county and zip code, specified the waivers from Medicare rules established for the subvention demonstration, and approved the Senior Prime marketing materials and the form for civilian network provider contracts. Each site began marketing and enrollment activities as soon as the DoD received its Medicare contract from HCFA.

As specified in the MOA, no Medicare Partners activities were to be initiated at a demonstration site until at least 90 days after start of service delivery under its Senior Prime plan, subject to satisfactory progress of the Senior Prime program. Within these requirements, HCFA and DoD agreed that DoD would determine when to pursue Medicare Partners agreements at the sites. At this time, no Medicare Partners activity has been undertaken. We address the current status and issues related to Medicare Partners at the end of this chapter.

MEDICARE PLAN CERTIFICATION REQUIREMENTS

To participate in Senior Prime, the demonstration sites had to meet the conditions for participation required for all Medicare+Choice plans except where the requirements have been determined to not be applicable or have been waived by the HHS/DoD MOA under authority of the BBA. Inapplicable Medicare requirements include those for fiscal soundness and requirements related to Medicare employer group health plan enrollees. Waivers were granted from Medicare standards for (1) financial viability and planning, (2) DoD providers to meet statutory definitions and licensure requirements (as long as they are licensed in at least one state), (3) compliance with the 30-minute/30-mile primary care access standard (by obtaining waivers from enrollees who reside beyond this boundary), and (4) continued plan enrollment as Part B enrollees for those who lose Part A entitlement (because the demonstration requires that participants have both Part A and Part B coverage). Senior Prime plans complied with the following categories of standards:

- Satisfactory administrative and management arrangements, including a policy making body, adequate management systems, and an executive manager;
- Effective procedures for utilization management;

\[1\] Satisfactory progress is defined as meeting the DoD performance measures (Attachment F to the MOA) and evidence that adequate financial systems are in place to track level of effort and reimbursement.
• A service delivery system capable of providing all required services, including proper licensure or certification for providers;

• Appropriate access to services and continuity of care for enrollees, including provisions to cover services through another organization in urgent or emergency situations;

• Internal quality assurance programs and external reviews, including systematic collection and reporting of performance data;

• Non-discrimination in screening of enrollees and with respect to provider participation, payment, or indemnification;

• Full disclosure of information to enrollees on the plans’ benefits, features, service area, provider network, coverage policies, and other features, with all marketing materials submitted to HCFA for approval before use;

• Compliance with all requirements for processing enrollment applications, membership information, voluntary and involuntary disenrollments, payments by enrollees, and submittal of related records to HCFA;

• Compliance with standards for beneficiary protection, including grievances and appeals processes, confidentiality, and information on advance directives.

SENIOR PRIME PROGRAM DESIGN

TMA Functions and Responsibilities

The operational oversight for the Senior Prime plans is provided by TMA, which has overall responsibility for management of the TRICARE program. TMA established the Senior Prime benefits package, the basic program structure, and national marketing materials to be used by all sites, and it negotiated with HCFA the specifications for the payment system and LOE calculations. TMA developed a template for the Medicare application, which each site used to prepare the application to become a Senior Prime plan. At the same time, TMA developed the terms for roles and performance of the MCS contractor for the Senior Prime plans, which are delineated in an addition (section N) to Chapter 20 of the TRICARE Operations Manual. The contractors function under a combination of provisions in their existing TRICARE contracts and Chapter 20. The Chapter 20 provisions were reviewed in detail at a meeting with the sites’ management teams and MCS contractor representatives in Spring 1998, and revisions continue to be made as issues arise during the demonstration.

Regular videoconference meetings were held with the sites to communicate TMA activities, get the sites’ input on policies being developed, and help coordinate their work. Two full-time TMA staff, who have hands-on Medicare experience, provide technical support to the demonstration sites on a daily basis. TMA left to the sites the design details for the Senior Prime plans. The sites developed the local plan organizational structures and processes, guided by the HCFA Conditions for Participation for Medicare managed care and by the consultants the sites hired with TMA funding support to provide them Medicare expertise.

The MCS contractors are responsible for processing payments for network providers for their services, including the Senior Prime providers. TMA pays these claims directly and has set up a separate risk pool for Senior Prime network provider claims. The MCS contractors have subcontracted the claims processing function to two contractors, PGBA and WPS. As TRICARE was initiated in each region, there had been problems with the timeliness
of claims processing that led the network providers to express dissatisfaction with TRICARE and to the cancellation of contracts by some providers. Although these problems have been resolved in most locations, they continue to discourage some providers from participating as Senior Prime contractors, as discussed below.

The Senior Prime Plans

The six demonstration sites share many common elements in their organizational structure, benefits covered, and service delivery system, but they differ somewhat in the roles and relationships of the LA Office, participating MTF(s), and the MCS contractors. In particular, the Colorado Springs and Region 6 sites were organized to accommodate multiple MTFs.

**Infrastructure.** The Senior Prime plans have been integrated into TRICARE at the governance level. Each site has a Senior Prime governing board, although they differ in how that board fits into the overall TRICARE governance structure. Each Senior Prime governing board has a quality committee that typically has broad jurisdiction over quality, utilization, appeals, and grievance activities. Anticipating the possibility that Senior Prime may become a permanent part of TRICARE, the sites chose governance structures that could absorb an expanded program without having to reorganize.

The Senior Prime management team in each site reports to its governing board, and each management team is led by staff in the LA Office. The sites vary substantially in the depth of staffing committed to this program. The Region 6 site has 5 full-time LA staff who have developed in-depth technical knowledge of Medicare managed care and the Senior Prime program, which they make available as a technical resource to the site’s MTFs. The Colorado Springs site has a plan coordinator and 3 full-time staff to operate the program and coordinate work with the 2 participating MTFs. Other LA Offices have less staffing depth, reflecting their less complex structures, and in most of these sites, almost every LA staff person with Senior Prime responsibility also performs other TRICARE functions.

**Management Leadership.** The LA Office is responsible for overall management of the Senior Prime plans. The LA staff have established working teams consisting of staff counterparts from the LA, MTF(s), and MCS contractor, which work together on specific Senior Prime functions (e.g., utilization management, appeals and grievances). For clinical functions, such as quality management, the MTF staff typically have responsibility for MTF services and the contractor staff handle the network provider services. Monitoring, appeals, and Medicare compliance activities typically have been retained centrally by the LA staff with participation by the MTF(s) and MCS contractor staff. The LA Office for the Dover site (Region 1) has been implementing Senior Prime simultaneously with the entire TRICARE program. As a result, the MTF assumed a leadership role in organizing and leading Senior Prime early in the start-up, with the LA Office picking up the lead later.

The two sites with more than one MTF have more complex organizations than the other sites. The Region 6 LA Office has entered into written memorandum of understanding (MOU) with the 4 participating MTFs that formalizes the agreement between the LA and MTFs regarding their respective roles and responsibilities. The MOUs compensate for the absence of formal line authority by the LA Office. The LA Office in the Colorado Springs site is leading the program actively, drawing upon the two MTFs and the MCS contractor to build teams and collaborate on activities, but MOUs have not been used to formalize these relationships. The remaining sites also have not formalized their organizational relationships,
but they have identified and reached agreement on the responsibilities of the LA, MTF, and MCS contractor in each functional area.

**Benefit Package.** As discussed in Chapter 1, Senior Prime health care benefits are the “richer of the Medicare or TRICARE Prime benefits,” thus providing the same health benefits at all Senior Prime sites. Because outpatient pharmacy coverage is an open benefit for DoD beneficiaries, it is not a competitive advantage for Senior Prime plans, despite its popularity, because beneficiaries are free to enroll in another Medicare plan and still use this benefit.

In the more competitive Medicare managed care markets, this policy of national benefits may constrict the ability of the Senior Prime plan to compete on benefits with other Medicare plans. Non-competitiveness of benefits may be contributing to the lower-than-expected enrollment rates for the San Diego site, which is in a very competitive market with high Medicare capitation rates, and health plans offer rich benefits to attract enrollees. Capitation rates are lower in the other three markets with Medicare managed care competition - Madigan, Colorado Springs, and San Antonio - which may mitigate this issue for those locations because plans tend to offer fewer supplemental benefits. More information is needed before we can assess possible impacts on the plans’ ability to attract new enrollees, which we will continue to explore in our evaluation.

Another benefit issue is two-tier cost sharing, where Senior Prime enrollees receive MTF services at no cost but they are required to pay either copayments (fixed amounts) or coinsurance (percentage of charges) for services obtained from network providers. Senior Prime enrollees must use MTF services when available and otherwise must use network providers and pay the cost sharing. Because the vast majority of Medicare health plans cover all but a small amount of enrollee cost sharing, this provision may weaken the market positions of Senior Prime sites whose enrollees use network providers regularly (e.g. the Colorado Springs site). In addition, HCFA regional offices have expressed concerns that this policy may be confusing to beneficiaries, who may not be aware of their potential financial liability, which can become quite large for coinsurance for extensive treatment. Although this two-tiered structure may look similar to a private sector point-of-service plan, it is fundamentally different because Senior Prime enrollees are not free to choose providers and the associated cost sharing. In a point-of-service plan, insured persons have lower cost sharing when they use network providers, or they may choose non-network providers if they are willing to pay higher costs.

**Quality and Utilization Management System.** The placement of the quality management (QM) committee high in the sites’ Senior Prime governance structure reflects the importance placed on these functions by HCFA, TMA, and the demonstration sites. All sites have structured their Senior Prime QM plans and activities as extensions of the regional TRICARE quality assurance programs, and they have drawn upon existing monitoring protocols and sets of indicators to be monitored. The QM and utilization management (UM) functions are defined as distinct aspects of a unified care management function, with the goal to provide appropriate care for enrollees at reasonable costs. In all six sites, the QM/UM team consists of clinical and administrative staff from the LA Office, each MTF in the site, and the MCS contractor. In some regions (Dover, Keesler, San Antonio), some or all of the UM functions are purchased from the MCS contractor for TRICARE, and the contractor also performs these functions for Senior Prime. In the other regions, these functions are performed by MTF staff for MTF services and by the MCS contractor for network providers.

**Provider networks.** The basic design of the demonstration specifies that the site MTFs are the principal providers for Senior Prime enrollees, and civilian network providers will be
used only for services the MTFs do not provide. The sites differ widely in the scope of services provided by the MTFs. The medical centers (Brooke AMC, Keesler MC, Madigan AMC, San Diego NMC, and Wilford Hall MC) provide a full range of inpatient and outpatient services, including many sub-specialty services. At the opposite extreme, the clinic at Dover AFB provides only outpatient primary care and a few specialty services. The four community hospital MTFs (Evans ACH and USAF Academy Hospital in Colorado Springs; Reynolds ACH and Sheppard AFB in Texoma) provide inpatient and outpatient care, but they only have a limited number of specialty services. None of the MTFs officially provide skilled nursing facility care, home health, durable medical equipment services, or other services specifically needed by an older population.

The MCS contractors established, and now manage, contracts with the Senior Prime network providers. Community providers with TRICARE Prime contracts were the first providers tapped by the MCS contractors for participation in Senior Prime. Then they reached into the community to recruit other types of providers that were not available from the Prime network. All sites report that it was relatively easy to recruit institutional providers such as skilled nursing facilities, home health agencies, or DME suppliers because there were adequate supplies in the community and they all were Medicare-certified providers.

Challenges were faced by some sites in recruiting sub-specialty physicians who were not already participating in TRICARE Prime. Recruitment proceeded with relative ease in Region 11, San Diego, and the San Antonio portion of the Region 6 site, all of which were in large markets with managed care presence. The Dover, Keesler, and Colorado Springs sites, and the Texoma (Reynolds and Sheppard) portion of the Region 6 site, face continuing recruitment difficulties, although they were able to reach an acceptable depth of providers in their networks.

Many physicians with full private practices see no advantage to participating in Senior Prime. One reason cited for resistance by community physicians was general dislike of managed care arrangements, which was encountered in the Texoma, Dover, and Keesler markets. Physicians in the Dover, Keesler, and Colorado Springs markets also reported dissatisfaction with the low military fee schedule, late claims payments, and other negative experiences with CHAMPUS. Physicians in the Colorado Springs market remembered especially painful experiences with TRICARE. Soon after TRICARE was initiated in the region, physicians became so dissatisfied with low prices and slow payments that large numbers of them canceled contracts, and contractor had to rebuild the TRICARE provider network. Despite perceptions that military prices are low, we have been told that the prices have improved in the past few years and that they are quite similar to the Medicare Fee Schedule rates for physician services. This issue merits further attention to verify the status of the military rates, with relevant information communicated to the medical community.

Information System Requirements and Resources

Four major functions of the Senior Prime program depend on multiple data systems operated by the DoD itself, DoD contractors, and HCFA: (1) the processing of Senior Prime enrollments, (2) the quality assurance and utilization management programs of the sites and TMA, (3) processing of payment claims for network providers and non-network providers that provide out-of-area care for enrollees, and (4) the determination of DoD costs, level of effort, and capitation payments from HCFA. The DoD systems include data storage systems (DEERS enrollment system, CEIS, Ft. Detrick, MEQS, and HCSR database) and data capturing systems (the MTFs’ CHCS clinical data and ADS ambulatory care data systems,
and the MEPRS data on MTF workloads and finances). Contractors’ systems include the 
MCS contractors’ enrollment systems and the EAPP and CRIS claims processing systems 
operated by WPS and PGBA, respectively. The HCFA Medicare Processing Center (MPC) is 
an external system that processes applications for Medicare+Choice enrollments, including 
Senior Prime. The MPC generates reports on new Senior Prime enrollments and 
disenrollments for use by the MCS contractors in their enrollment functions.

As might be expected from the sheer number of systems listed, several data system 
challenges have been encountered since early in the demonstration. Specific issues are 
discussed below, in the context of the functions being performed.

EARLY IMPLEMENTATION EXPERIENCES

This section summarizes the stories of how the six demonstration sites prepared for and 
began operations as Senior Prime plans, and it identifies some of the key events and issues that 
emerged during those activities. This discussion had to draw parsimoniously from the wealth 
of information collected during the site visits and interviews with staff at TMA and the HCFA 
central and regional offices. Refer to the individual site visit reports in Appendix C for 
additional details. The richness of information was due to the openness of the sites’ leadership 
teams and their commitment to learning from this demonstration. Lessons learned from their 
experiences and implications for future Senior Prime operations are presented in Chapter 7.

Getting Certified as Senior Prime Plans

The preparations to establish the Senior Prime plans in the six demonstration sites were 
carried out in a compressed time period, given the short time available from passage of the 
BBA in late 1997 to the goal for all sites to start service delivery no later than January 1999. 
Negotiations to revise the MOA to reflect the BBA provisions proceeded through the end of 
1997, as TMA began work on the national Senior Prime marketing materials and the Chapter 
20 provisions for the MCS contractor roles and responsibilities.

With TMA support, the sites began to prepare the Medicare health plan applications in 
éarly 1998. The BBA specified that the sites were to be certified as M+C plans, but HCFA 
was still developing many of the M+C implementing regulations in early 1998 when the sites 
needed to begin preparing applications. To allow them to move ahead quickly, they worked 
under the rules and forms for Medicare Section 1876 risk-contracting plans, and HCFA 
provided the M+C rules to TMA and the sites as they became available. These changes in 
Medicare policy had differing effects on the sites. As shown in Table 1.1, the Madigan AMC, 
Region 6, and San Diego NMC sites began service delivery in 1998, before Medicare+Choice 
(M+C) was in effect. All of these sites had to revise and resubmit applications under the new 
M+C rules, in some cases within weeks before the scheduled HCFA certification site visit. 
The two sites that were processed for a January 1999 start dates had slightly more time to 
work with the M+C materials.

During the early period of preparation for Medicare certification, HCFA and TMA 
retained many of their respective functions and decisions at the national level. The HCFA 
regional offices entered the process to participate in the final application reviews and 
certification site visits. HCFA central office performed at least one round of application 
reviews, with requests to the plans for revisions or additional supporting materials, before 
bringing in the regional offices. The demonstration sites were instructed by TMA not to 
communicate directly with HCFA central office or regional offices during this period, which 
constrained their ability to get the information they needed to prepare acceptable applications.
TMA staff and several sites told us that some of the sites sought advice from HCFA regional offices, despite these instructions.

With little in-house Medicare expertise, the sites reported they had difficulties preparing the application. TMA committed financial support for the sites’ MCS contractors to hire consultants to provide the needed Medicare knowledge and experience. The consultants turned out to be critically important resources for the sites, helping them prepare the Medicare applications, guiding the plan’s design, and training them on the unique aspects of serving an older population. The consultants for some of the sites conducted mock site visits to prepare the Senior Prime teams for the HCFA certification site visits.

HCFA staff in the central office and regional offices reported to us that the final applications from the demonstration sites were of high quality, and HCFA staff participating in the site visits were impressed with the sites’ careful preparation, strong organization, and commitment to serving the Medicare-eligible DoD beneficiaries. The application process was the first time that the HCFA and DoD field staff had direct contact with each other, and it provided the start for their working relationships. HCFA staff reported that, with the perspective they gained from these contacts, they gained confidence in the commitment and ability of the DoD sites to perform as Medicare plans, and LA staff at the demonstration sites reported they were pleased with the responsiveness and support of the HCFA regional office staff.

Perhaps the most challenging part of the certification process was the sheer number of Medicare performance requirements that the Senior Prime plans are required to meet in their applications and practice.\(^2\) Accustomed to making their own decisions on MHS policies and practices, TMA and the sites had to adjust to complying with an external party’s rules, a process that was complicated by periodic frustration when they felt that some of the rules were unnecessary or not meaningful in the military health system. Negotiations of issues continue today, as the sites identify rules or written forms that do not work well for them in practice. At the same time, the sites are finding that some of the Medicare requirements (e.g., appeals and grievances) are effective tools, and they are applying them to TRICARE Prime operational practices as well. This transfer of practices may be a valuable product of the demonstration, which we plan to monitor as the demonstration progresses.

As Senior Prime moved from the certification process to enrollment and service delivery, the HCFA central office decreased its direct role in the demonstration and shifted the lead for compliance monitoring to the HCFA regional offices. The LA staff for several of the sites visited their HCFA regional offices after their Senior Prime plans became operational, to get better acquainted and provide the HCFA staff with more detailed information on their activities. The HCFA central office and regional office staff coordinate policy and activities through regular conference calls. Wherever possible, HCFA is trying to resolve issues and establish national policy for the Senior Prime plans.

**The Enrollment Process**

Staff of the sites’ LA Office, MTF(s), and MCS contractors worked as teams in conducting the start-up marketing and enrollment process. The MCS contractor provided the administrative support for the activities, hiring temporary staff to handle appointments and

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\(^2\) HCFA Central staff informed us that Senior Prime plans share this experience with other new Medicare plans, many of which complain about the amount of work required to become Medicare certified.
schedules for the orientation sessions. The sites all reported that they presented themselves to
the beneficiaries as “people who will serve them in Senior Prime,” making no distinction
between the different organizations. The MCS contractor is responsible for processing
enrollment applications and managing all other enrollment materials and activities.

**Marketing activities.** As soon as each site’s contract was executed by HCFA, the site
initiated marketing activities for Senior Prime enrollments. Marketing began with advertising
through the media that they determined would be effective at reaching the Medicare-eligible
DoD beneficiaries, including ads in local newspapers, press releases, public service
announcements, notices to elected officials, and communications with local retiree
associations. At least one site used direct mail marketing. Local military retiree associations
made important contributions to reaching this population, which is a large share of their
memberships, by running articles and notices in their newsletters and otherwise keeping their
members informed of Senior Prime.

National marketing materials were prepared by TMA for the sites’ use in enrollment,
and these materials were reviewed by HCFA and approved as part of the Senior Prime
applications. The materials included advertising materials as well as application forms,
statement of benefits, and other materials required by HCFA. As HCFA shifted to the M+C
rules during Senior Prime start-up, some information in the marketing materials became
outdated, and corrections were provided in errata sheets because supplies of the materials had
already been printed.

The sites ran intense schedules of orientation meetings for interested beneficiaries that
started within a week or two after the marketing began. Groups of 50 to 200 beneficiaries
were scheduled for meetings that were held as frequently as twice a day for the first few
weeks, with declining frequency in later weeks. Thousands of beneficiaries at the six sites
were reached through these sessions. Clinical and administrative staff briefed the attendees on
Medicare managed care and TRICARE Senior Prime and answered their questions. Staff
were available after the briefing to work individually with beneficiaries as they considered this
managed care option. This was the start of personalized support strategies that the sites had
organized to serve their beneficiaries and enrollees.

The sites have reported that an essential element of preparation for Senior Prime
enrollment and service delivery was the careful training of the MTFs’ front line clinical and
support staff, PCM physicians, and specialty physicians. These training activities typically
focused on informing providers about Senior Prime rules, techniques for working with older
patients, and managing intakes of new enrollees. A series of briefings was held for these staff
before marketing and enrollment activities began, and many of the PCM physicians had
leadership roles in conducting the beneficiary orientation meetings. The credibility of the
physicians at the meetings helped to build trust in the program because attendees knew these
physicians would be their primary care providers. This training also helped the staff work with
beneficiaries in the clinics because they could answer their questions and refer them to others
who could help them.

Other provider training activities also were being performed as the sites identified
needs. For example, physicians in all sites have been participating in QM/UM activities and
disease management initiatives, and at least one site provided training to physicians on proper
coding of diagnoses and procedures on ADS bubble sheets. In the larger medical centers,
some work was reported on improving referrals and communications between PCMs and
specialty physicians. Based on information the sites provided on early QM/UM activities and
plans for managing care, they likely will continue working with providers in these areas.
Given the compressed start-up schedule, some sites had little time for marketing activities. For example, the contract for Keesler AFB was finalized in September 1998, a hurricane hit the Biloxi area at the end of September, they started advertising in early October, and they began beneficiary orientation meetings in mid-October for an early November enrollment application date and start of service delivery in December 1998. Dover AFB was on a similarly tight schedule for a January start of service, and although they did not have to accommodate a hurricane, the LA Office was in the midst of implementing the Region 1 TRICARE program.

**Enrollment processing.** Madigan/Region 11 was the first site to begin enrollments, and Senior Prime was very much in demand by its beneficiaries. Over 2,900 new enrollees were processed for start of service delivery in September 1998, and the initial screenings and PCM visits for those enrollees almost swamped Madigan’s clinic capacity. Learning from this site, staged enrollments were used by Brooke AMC, Wilford Hall MC, Evans ACH, and Keesler MC, anticipating that the level of demand could overload their facilities. The remaining facilities had small enrollments that could be managed more easily, although they still had to manage peaks of activity when service delivery began. Only Madigan, Brooke, and Wilford Hall have reached their planned enrollments. As shown in Chapter 4, enrollments for some facilities have leveled off after the first few months, while those for other facilities have continued to grow at steady rates. All sites are getting age-in enrollments, but the numbers for Dover are small.

Senior Prime enrollments are processed by the sites’ MCS contractors. Beneficiaries must mail in their applications to the MCS contractors, which date and enter the applications through the Medicare Processing Center (MPC), an automated data system established by HCFA to process health plan enrollments (including Senior Prime). Each application is verified with the beneficiary by telephone, including review of the Senior Prime rules for eligibility and service delivery. With the need to verify eligibility for both DoD and Medicare benefits, and to get beneficiaries correctly recorded in the DoD enrollment and claims processing data systems, the contractors’ enrollment staff must work with 3 to 4 independent data systems. They enter the application data into the MCP, then work through CHCS to record the beneficiary status in DEERS and, finally, enter the record into the data systems (EAPP or CRIS) of the claims processing subcontractor that will process network provider claims for the beneficiary. Such a system is cumbersome and vulnerable to errors.

**Service Delivery**

The information on service delivery experiences of the sites offers but a glimpse into the early service needs, and it is not clear from these experiences how service patterns will evolve as the enrollee population stabilizes and as care management practices mature. This is another area we will continue to follow in the evaluation.

**MTF Services.** PCM clinics at each site were busy in the first few months after Senior Prime began service delivery. Each site and MTF established a distinct strategy for educating their new enrollees, for example, the 5-hour training and screening sessions held by Evans ACH, the Enrollee Education and Health Assessment Strategy (EEHAS) meetings conducted by Keesler MC, and comprehensive rounds of PCM initial clinic visits performed by the remaining sites. These strategies were undertaken to educate enrollees on how to use Senior Prime services, assess health status and identify health problems that needed attention, and prepare for existing health care needs during the transition into Senior Prime.
PCM choices made by new enrollees reminded the sites of the strong preference that older beneficiaries have for internists as their primary care physicians. In some sites, the supplies of internal medicine PCMs were exhausted early, and later enrollees had to be enrolled with family practice or nurse practitioner PCMs. Some of the later enrollees had health problems that were better served by internists, while some early enrollees were healthy and their care could be managed effectively by nurse practitioners. The PCM teams worked with enrollees to change their provider choices, when appropriate, to match provider to enrollee’s need and to distribute enrollees more evenly across the available clinics.

The clinic teams relied on nurse coordinators to process and educate new enrollees, and to help coordinate visit appointments. The coordinators, clerks, and other front line staff found they had to spend substantial time with enrollees, responding to demands for instant appointments, coaching them in making the appointment telephone calls, and reinforcing their medical instructions. The Senior Prime enrollees complain a great deal about using “800” numbers or telephone systems with electronic menus. In some regions, the MCS contractors handles TRICARE appointments centrally, including those for Senior Prime. Other sites make appointments locally, which front-line staff report to be the preference of many enrollees.

Early service delivery experiences of the Region 11 and Region 6 sites highlighted the importance of preparing to protect enrollees’ ongoing care during their transition to the Senior Prime plan. Services of concern include oxygen and other DME, prescription medications for chronic conditions, and patients undergoing a current course of therapy. Some sites initiated contact with applicants even as their enrollments were being processed to gather this information, and some sites contacted local DME suppliers to prepare for transitions.

Although the sites’ PCM clinics expected the intense workload that occurred as Senior Prime began service delivery, they also had expected a subsequent decline as initial visits were completed and enrollees health care needs were treated. When they discovered the enrollees had a high prevalence of untreated health problems, they realized that service activity could remain elevated longer than they had planned. In addition, peaks of activity in the PCM clinic were being transferred to some of the specialty clinics as patients were referred for treatment of their health problems. Some of the specialty clinics (e.g., dermatology, neurology, pulmonology) experienced increased activity. Ancillary departments also reported increases in service volumes when Senior Prime started, with the exception of pharmacy in some sites, where the older population already had been using the benefit extensively.

**Referrals to Network Providers.** When enrollees require services not provided by the MTFs, they may be referred to network specialty practitioners or institutional providers, such as hospitals, SNFs, or home care providers. Some sites also referred to other MTFs nearby that were not in the Senior Prime network. For example, enrollees at the Dover site have the option of using one of the large, specialty MTFs in the National Capital area, which is a two-hour drive away. The Region 6 site may refer to other Senior Prime MTFs in the site, other nearby MTFs, or civilian network providers, depending on the enrollees’ needs and preferences and the geographic proximity of the providers.

There was limited network provider activity early in the demonstration, with the exception of Dover, which has only primary care in its MTF. In recent months, some sites report that referrals for network provider services have been increasing. Few problems with access or satisfaction have been reported, although the MTF physicians reported that improvements could be made in the communication and transfer of patient records between the PCM and network physicians, to develop a greater sense of professional partnership.
Some enrollees at Keesler have complained about long travel distances to network providers, reflecting the site’s difficulty in recruiting physicians close to Biloxi (discussed above).

The sites reported few problems thus far with referrals to civilian institutional providers, although some of them stated that they wanted to perform closer oversight and coordination of care for enrollees using those services. Dover AFB is the only site that uses civilian community hospitals because Dover has no inpatient capacity; three hospitals are in Dover’s network. Dover physicians have staff privileges at one of these hospitals so they can extend their care for enrollees to the hospital setting and avoid referring to network physicians.

Plan Performance

**Quality and Utilization Management.** The demonstration sites’ Medicare applications included plans for quality management (QM) and utilization management (UM), which were extensions of the TRICARE Prime plans. All of the sites have established QM and UM teams consisting of the staff responsible for these functions in the LA Office, the MTFs, and the MCS contractor. These teams have met regularly since the inception of Senior Prime, and they report their activities and monitoring results to the quality committee of the plans’ governing boards.

With the introduction of the M+C program, HCFA is implementing its Quality Improvement System for Managed Care (QISMC) requirements with which all M+C plans must comply. The Texas professional review organization (PRO) is performing the diabetes quality study for HCFA, and all the sites are to work with their PROs for QM reviews. In response to the HCFA requirements, TMA contracted with FMAS Corp., the contractor for the National Quality Review Program, to establish measures on selected quality topics, which the sites learned about in February 1999.

This spring, the six sites filed updated QM plans with HCFA in preparation for QISMC implementation. Yet they continued to struggle with selection of monitoring indicators and the second of two special studies (diabetes is the first) required by QISMC, measurement issues involving the limitations of the DoD data systems, and obstacles to coordination of a variety of quality initiatives within DoD. The sites concluded that they could work more effectively if they jointly established a consistent plan for all the demonstration sites, and they now are designing a demonstration-wide quality assurance plan. Staff in the HCFA regional offices were pleased to learn about this approach because it can reduce duplication of effort and establish metrics to be compared across sites and to national benchmarks.

Approaches to utilization management have differed somewhat across the sites, although they share the goal of improving the appropriateness of services delivered for Senior Prime enrollees. The sites recognize the need to manage the multiple health problems and chronic conditions that are prevalent in the older population, and they are at differing stages in expanding case management and disease management activities. Work remains to be done to achieve coordinated case management functions that are seamless across clinics in an MTF and between services provided by MTFs and network providers. In some sites, case management activities are being performed by both the MTF staff and MCS contractor, which may be overlapping in some areas and leaving gaps in others. The sites also are assessing existing pre-authorization policies and procedures and are revising them to discontinue pre-authorizations that are documented to bring little or no added value to practice improvement. For case management and pre-authorizations performed by the MCS contractor, improvements in procedures likely will require modifications to the Chapter 20 provisions or TRICARE contracts.
Appeals and Grievances. The rigor of the Medicare appeals and grievance requirements has caused the sites to focus closely on effective implementation of their appeals and grievance processes. The sites reported that they had to adjust the philosophy of the MTF customer service activities to fulfill the grievance process requirements. Typically, the MTF staff are strongly conscious of customer service, and they are accustomed to taking action in response to a problem reported by a patient and then considering the matter resolved. For Senior Prime enrollees, the staff now are keeping logs of the complaints reported and are communicating in writing to the enrollees about actions taken to resolve the complaint and the enrollee’s grievance rights. The appeals process also has caused changes in the sites procedures. In most sites, appeals are handled by the LA Office, to prepare documentation of cases that arise from service denials at the MTF or for network providers. Some sites report that they are considering extension of these provisions to TRICARE Prime.

At this early point in the demonstration, few appeals have been filed for the Senior Prime plans, and the rates of grievances appear to be low. We plan to follow the sites’ experiences in this area as the demonstration proceeds.

Compliance Activities. HCFA’s compliance review process involves a 4-person site visit conducted within 1 to 2 years after plan contract date, where they perform full review of the plan’s performance, working with the monitoring Review Guide. The demonstration sites began to prepare for the HCFA compliance process in the first quarter of 1999, and work is underway in preparing the materials and report formats they will use. HCFA regional offices report that the sites have been given the existing Review Guide, which will be replaced this summer with the new M+C Review Guide that is based on HCFA’s QISMC requirements. The regional offices are keeping the sites advised of progress and providing information as they obtain it.

Based on our interviews with the HCFA regional office staff, it appears that some of the sites may not have a review site visit until close to the end of the demonstration, although some of the regional offices have been monitoring specific aspects of the plans’ operations on a smaller scale and more frequently. If the subvention demonstration does not continue operation beyond 2000, the lateness of the first round of compliance reviews could reduce the incentives of the sites to perform the compliance monitoring function effectively, with a potential loss of useful information on the effects of the program.

SENIOR PRIME FINANCIAL PERFORMANCE

The financial realities of relatively fixed budgets for the MTFs provide the backdrop for this discussion of financial performance. As new costs are incurred for Senior Prime, the MTFs reported that they must either accept financial losses or forego other activities to remain within budgets. For patient care, this means that every encounter for a new Senior Prime enrollee replaces another encounter, probably for a beneficiary seeking space-available care. Because Senior Prime enrollees use more health care than a younger population, each enrollee potentially displaces more than one younger retiree or dependent. In addition, growth in both Prime and Senior Prime enrollments has led to shrinkage in revenues from third party reimbursements, as Prime enrollees drop private insurance coverage and Senior Prime enrollees no longer use supplemental insurance. The MTFs stated that they have not yet received incremental revenue for services to the Senior Prime enrollees, and few of them are prepared to expand staffing to accommodate new service activity without it.
Effects of The Payment Method on the Sites

The components of the Senior Prime payment method include modified Medicare capitation rates paid by HCFA to DoD for Senior Prime enrollees, a requirement that the aggregate baseline LOE for the six sites be exceeded before DoD may retain payments, minimum percentages of LOE that spending on enrollees must reach before DoD may retain payments, maximum percentages of LOE for spending on non-enrollees, rules for triggering interim payments, and year-end reconciliation and risk adjustment. The sites expressed concerns regarding possible negative effects of many of these factors on their Senior Prime financial performance. We also sensed that the sites were leaving many of the financial considerations to TMA, and were focused on performing well on the clinical and administrative aspects of the demonstration, perhaps because of their concerns and because TMA was performing much of the financial work centrally.

**Complexity of the financial provisions.** The intricacy of the methods for determining Senior Prime payments has confused many participants at the demonstration sites, and the sites tend to be suspicious of how these rules may be affecting their financial performance. Without clear understanding of the financial consequences, the sites find it difficult to discern which management strategies are appropriate. Interactions between the enrollment and service activities of TRICARE Prime and Senior Prime make it yet more difficult to manage under the Senior Prime financial rules. For example, enrollment growth in Prime may have a strong effect on squeezing out non-enrollee costs for space-available care, which would reduce sites’ allowed payments under the LOE thresholds. The only effective way to compensate for that loss due to Prime growth would be to increase Senior Prime enrollments (and associated revenue), which may not be feasible in some markets.

**Interim payments, reconciliation, and cash flow to the sites.** The sites expressed frustration that they have not received any share of the interim payments made by HCFA for their Senior Prime enrollees, along with doubt that they would ever see any payments. As discussed above, the MTFs bear at least some risk (as does TMA) for enrollee services, and they do so within fixed budgets. TMA has been reluctant to distribute funds from the interim payments because the funds may have to be refunded if the year-end reconciliation determines that DoD has to return payments to HCFA. DoD has not yet released a plan for distributing any payments.

**LOE calculation.** The LOE is based on FY96 MEPRS data for the participating MTFs. In addition to the complexity of the LOE, several of the sites reported that the FY96 estimates do not represent their most recent baseline LOE accurately because their facilities or services were altered between FY96 and the start of the demonstration. Discrepancies in LOE could hold some downsized sites accountable for past levels of service that would be impossible to meet in their current configurations, in the absence of Senior Prime. Other sites might not be held sufficiently accountable for higher service levels immediately preceding introduction of Senior Prime, although this is less likely than the other scenario because most changes have been downsizing.

**Thresholds to determine payments.** In the last few months, the sites have become more aware of the potential financial effects of the threshold limiting the LOE credited for space-available beneficiaries to the minimum of actual costs or a percentage of the LOE. The sites state that (given enrollees’ service needs) they have limited flexibility to adjust space-available service utilization, for which they may be penalized financially. Sites are analyzing their service use data to understand the threshold’s effects for their operations, and there are concerns about the threshold’s potential constraint on financial performance for sites that have
low Senior Prime enrollments (but high enough to meet the 30 percent enrollee cost threshold to qualify for payments) and have not experienced much reduction in space-available care for non-enrollees.

**Capitation payment adjustments.** The exclusion of GME, disproportionate share payments, and a portion of capital costs from the capitation payments is an appropriate adjustment for MTF services because these costs already are included in the MTF budgets. This approach ignores services purchased from network providers, however, and providers with these costs likely have set their fees to cover the costs. This inconsistency has a disproportionate effect on smaller facilities with fewer specialty services that rely upon community providers for those services. The Dover site is particularly affected because much of the inpatient care for its Senior Prime enrollees is provided by network hospitals (although some patients obtain inpatient care from the specialty MTFs in the National Capital Area).

**Risk adjustment.** The retrospective method that HCFA and DoD will be using to adjust 1999 and 2000 capitation payments for positive or adverse selection in enrollment has the advantage of generating payments that closely mirror expected costs for differing patient mixes. Its disadvantage is that, like other provisions in the payment methods, the sites will not know how risk adjustment will affect them until the end of each fiscal year, again creating uncertainty regarding their financial performance. Although the sites have a qualitative sense of the acuity of their Senior Prime enrollees, they will not be able to verify their assessment until risk adjustment results are reported to them.

**Simulation of Payment Method Effects**

To test the independent effects of each of several key payment method components on plan financial performance, we simulated Senior Prime payments from HCFA to DoD using a simple model with one plan. We assumed that a total of 6,700 dual-eligible beneficiaries were using space-available services at the MTF before introduction of the Senior Prime plan. We also assumed the MTF had an annual average cost of $3,000 per user for providing their health care services, which is half of a total cost of $6,000 that we estimated using a monthly Medicare capitation rate of $500 (multiplied by 12 months), which represents the expected total costs per month per Medicare beneficiary. This rate falls within the range of Medicare capitation rates for the demonstration sites (Table 4.2), although we note that the Senior Prime rates are lower than these market rates. Thus, the baseline LOE for the MTF was $20,100,000 (6,700 x $3,000), and we assumed that no adjustments were made to this amount per the MOA provision.

When Senior Prime was introduced, some percentage of the MTF’s fixed set of users chose to enroll in the plan, and the relative costs of care for the enrollees were some ratio of the baseline costs per user. In the simulations, we varied the percentages of enrollees, the relative costs of enrollees to non-enrollees, and the DoD monthly capitation payment from HCFA to assess the impacts of these factors on DoD payments and financial return.

Net payments to DoD and net return (or cost) are calculated for the simulation according to the payment rules described in Chapter 1, using the first-year LOE thresholds:

1. If total expenses for enrollees and non-enrollees exceeds the LOE—*and*—the expenses for enrollees exceed 30 percent of the LOE, then DoD may retain payment from HCFA.

2. The allowed cost for non-enrollees is the minimum of actual cost or 70 percent of LOE.
3. The net payment made to DoD =
   gross capitation payments + allowed cost for non-enrollees – baseline LOE.
4. Net return (or cost) = net payment – expenses in excess of LOE.

Scenarios 1 and 2 simulate net payments and financial returns to the Senior Prime plan when the costs of care for enrollees are twice the costs for non-enrollees, or an average annual cost of $6,000 per enrollee. The capitation rate is set at $510 for the first scenario and at $480 in the second scenario, so the plan has revenues higher than enrollees costs in the $510 scenario and lower than enrollee costs in the $480 scenario. For scenarios 3 and 4, we reduced the costs for enrollees to 1.5 times the non-enrollee costs, or an average annual cost of $4,500 per enrollee, with the same capitation rates of $510 and $480. The plan’s revenues are higher than enrollee costs for both of these scenarios. The results of the simulations, shown in Table 5.1, reveal some undesirable incentive conflicts associated with the enrollee/non-enrollee thresholds for percentages of LOE.
Table 5.1
Simulation of Payment Effects for a Hypothetical Senior Prime Plan

<table>
<thead>
<tr>
<th>Percentage of Users Who Enrolled in Senior Prime</th>
<th>50%</th>
<th>40%</th>
<th>30%</th>
<th>20%</th>
<th>10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual cost for non-enrollees</td>
<td>10,050,000</td>
<td>12,060,000</td>
<td>14,070,000</td>
<td>16,080,000</td>
<td>18,090,000</td>
</tr>
<tr>
<td>Allowed cost non-enrollees (min. of 70% LOE, cost) *</td>
<td>10,050,000</td>
<td>12,060,000</td>
<td>14,070,000</td>
<td>14,070,000</td>
<td>14,070,000</td>
</tr>
<tr>
<td>Relative cost of enrollee/non-enrollee = 2.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portion of expenses &gt; LOE</td>
<td>10,050,000</td>
<td>8,040,000</td>
<td>6,030,000</td>
<td>4,020,000</td>
<td>2,010,000</td>
</tr>
</tbody>
</table>

1. Monthly capitation = $510
   | Gross capitation payments | 20,502,000 | 16,401,600 | 12,301,200 | 8,200,800 | 4,100,400 |
   | Enrollee costs > 30% LOE? | yes        | yes        | yes        | yes       | no        |
   | Net payment to DoD        | 10,542,000 | 8,361,600  | 6,271,200  | 2,170,800 | 0         |
   | Net return (cost)         | 402,000    | 321,600    | 241,200    | (1,849,200) | (2,010,000) |
   | Return (cost), no 70% LOE | 402,000    | 321,600    | 241,200    | 160,800   | (2,010,000) |

2. Monthly capitation = $480
   | Gross capitation payments | 19,296,000 | 15,436,800 | 11,577,600 | 7,718,400 | 3,859,200 |
   | Enrollee costs > 30% LOE? | yes        | yes        | yes        | yes       | no        |
   | Net payment to DoD        | 9,246,000  | 7,396,800  | 5,547,600  | 1,688,400 | 0         |
   | Net return (cost)         | (804,000)  | (643,200)  | (482,400)  | (2,331,600) | (2,010,000) |
   | Return (cost), no 70% LOE | (804,000)  | (643,200)  | (482,400)  | (321,600)  | (2,010,000) |

Relative cost of enrollee/non-enrollee = 1.5

| Portion of expenses > LOE | 5,025,000 | 4,020,000 | 3,015,000 | 2,010,000 | 1,005,000 |

3. Monthly capitation = $510
   | Gross capitation payments | 20,502,000 | 16,401,600 | 12,301,200 | 8,200,800 | 4,100,400 |
   | Enrollee costs > 30% LOE? | yes        | yes        | yes        | no        | no        |
   | Net payment to DoD        | 10,452,000 | 8,361,600  | 6,271,000  | 0         | 0         |
   | Net return (cost)         | 5,427,000  | 4,341,600  | 3,256,200  | (2,010,000) | (1,005,000) |
   | Return (cost), no 70% LOE | 5,427,000  | 4,341,600  | 3,256,200  | (2,010,000) | (1,005,000) |

4. Monthly capitation = $480
   | Gross capitation payments | 19,296,000 | 15,436,800 | 11,577,600 | 7,718,400 | 3,859,200 |
   | Enrollee costs > 30% LOE? | yes        | yes        | yes        | no        | no        |
   | Net payment to DoD        | 9,246,000  | 7,396,800  | 5,547,600  | 0         | 0         |
   | Net return (cost)         | 4,221,000  | 3,376,800  | 2,532,600  | (2,010,000) | (1,005,000) |
   | Return (cost), no 70% LOE | 4,221,000  | 3,376,800  | 2,532,600  | (2,010,000) | (1,005,000) |

*Models assume that a total of 6,700 dual eligibles were using space-available care at the MTF before subvention, and that some fraction of those users enrolled in Senior Prime. The annual cost of MTF services for these users was $3,000 per person. Therefore, the historical LOE is $20,100,000 (6,700 x 3,000), and 70% of LOE is $14,070,000.

In our hypothetical model, the effect of the 30 percent LOE threshold for enrollee costs is quite substantial at low enrollment rates, leading to large losses because no payments are made to the plan. This rule creates opposing incentives, where the plan does not want to control enrollee health care costs when enrollment rates are low but wants to reduce enrollee costs at higher enrollment rates. The conflict is shown by the loss of payment at 20 percent
enrollment when the relative costs of enrollees is 1.5 but not when the relative costs are 2.0. Yet at enrollment rates of 30 percent or more, net return is much higher when relative costs are 1.5.

We also calculated DoD net payments and net return (or cost) after removing the cap on allowed cost for non-enrollees at 70 percent of the LOE to assess the financial impacts of that requirement. The non-enrollee costs are equal to 70 percent of LOE at the 30 percent enrollment rates. Scenarios 1 and 2 show the large effect of the cap at 20 percent enrollment rate levels, where the allowed cost for non-enrollees is less than 70 percent of LOE. Relaxing this rule improves net return substantially and eliminates discontinuity in financial performance at the non-enrollee cost threshold. The combined effect of the two thresholds (30 percent LOE for enrollees and 70 percent for non-enrollees) creates induced losses for a Senior Prime plan, which is not a desirable incentive.

Another obvious effect that this simple hypothetical model highlights is the importance of the level of the capitation rates relative to the cost of care for enrollees. Where Senior Prime plans are receiving payments for their enrollees, it is essential to manage and monitor medical care costs actively to keep costs within payment rate revenues. It also is important for participants to have confidence that the capitation rates are grounded in reasonable service delivery experience, which they can achieve through responsible management.

For simplicity, we assumed in this model that the cost for non-enrollees remained at $3,000 per year regardless of the percentage of users who enrolled in Senior Prime. We took this approach to pare away some of the complexity of payment methods so that we can observe the independent effects of a few key components—the thresholds, enrollment rates, and capitation rates. There is apparent (reasonable) consensus among demonstration participants that the average cost for non-enrollees should decline because the introduction of Senior Prime enrollees to MTF services increasingly will squeeze them out of space-available care. We can adjust the average cost per non-enrollee downward in this model, at the same time increasing the relative cost of enrollees to non-enrollees to achieve the levels of cost per enrollee used in the scenarios presented here. This shift would decrease payments to the plans, if the threshold for enrollee costs allowed them to receive payments. The first finding from the simulation, however, identifies an incentive for a plan with low enrollment to increase costs of care per enrollee so that total costs reach the enrollee cost threshold and the plan can retain some payments. This issue is independent of the level of costs for non-enrollees using space available care, which contributes to how much payment the plan actually receives.

**Financial Strategies of the Sites**

In the face of the various financial uncertainties summarized above, and the availability of only limited financial information, the sites have focused initially on making Senior Prime the best possible program for their enrollees. Quality of care, compliance with access standards, and satisfied enrollees have been their primary yardsticks for success during early operations. This strategy has the advantage of encouraging enrollments (within the constraint of a time-limited demonstration), which will help generate capitation payments. The participating MTFs are being very cautious in increasing their staff, however, because they assume they will get no additional financial support for new staff. Some staff reallocations have been made, especially within the primary care clinics, to provide support to the enrollees as efficiently as possible. Early service delivery costs are reported to have been high, reflecting large numbers of initial PCM office visits and follow-up visits to the PCMs or
specialty physicians. Many sites believe that these early operating levels are not sustainable financially.

As service delivery proceeds, the MTFs are beginning to monitor service activity and costs for the Senior Prime enrollees. Many of the MTFs plan to begin detailed analyses after they have 6 to 8 months of service delivery experience. They are waiting to accumulate sufficient service activity to obtain stable estimates of service use and costs. They also want to obtain reasonable estimates of ongoing average costs for enrollees, which are not represented well by the initially high rates of service use by new enrollees during Senior Prime intake and follow-up visits. They are examining where changes in service volumes are occurring, and whether rates of service use are declining after the initial flurry of clinic visits for new enrollees.

We plan to follow the financial activities of the sites during the remainder of the demonstration, particularly seeking to document decisions and actions they take after knowing the results of the first-year reconciliation. Some of the concerns expressed at this early stage of the demonstration may be resolved at that time, and some issues may mature into problems that require closer attention. As we discuss in Chapter 7, the next operational challenge is for the sites to establish priorities for their Senior Prime activities and pursue active management of costs.

EARLY RESPONSES OF BENEFICIARIES TO SENIOR PRIME

Military retirees and dependents have long been seeking initiatives like Senior Prime with the hope of regaining access to the military health care system. There is strong sentiment among this population that the military has broken its promise to provide them health care coverage for life. After a series of military installation closures and introduction of TRICARE, older beneficiaries found they were last in line for MTF services on a space-available basis. As described in Chapter 3, retiree associations have been pushing DoD hard to fulfill that promise, and they have lobbied Congress for legislation to create programs they feel are their due. These associations have supported subvention as one means to improve access to military health care for Medicare-eligible beneficiaries, and some have questioned the need to do a demonstration to test the models before full implementation.

Information about beneficiaries’ responses to Senior Prime, and how it has affected them, was obtained from interviews with retiree association representatives, MTF patient representatives, Senior Prime marketing staff, and front line clinical and administrative staff involved in delivering care to Senior Prime enrollees. Although this information did not come directly from the beneficiaries, the various sources interviewed shared what they were hearing, and some consistent themes emerged about beneficiaries’ reactions to the demonstration.

After years of seeing changing signals from the government, many older beneficiaries do not trust the government and remain suspicious that the subvention demonstration will be short-lived. Given this history, it is not surprising that responses from dual eligibles ranged from enthusiastic embrasure of Senior Prime to adamant refusal to enroll because it is only a partial response and many of their peers still have no real access to the MHS. The short two-year life of the demonstration was an important reason why people did not join Senior Prime. Many feared they would have to return to Medicare fee-for-service or switch to another Medicare+Choice plan when the demonstration ended, and they could lose their supplemental insurance coverage. Other reasons cited were simply the choices they made among available options. Some beneficiaries were satisfied with the health care they were getting from fee-for-
service civilian providers or VA facilities, and they did not want to change providers. Others were enrolled in Medicare health plans and preferred the benefit coverage they had to what was offered by the Senior Prime plan.

The beneficiaries who chose to enroll in Senior Prime typically did so either because they could return to military health care, or it compared favorably to other choices of Medicare health plans or fee-for-service (or both). Many enrollees retained their Medigap policies to protect themselves against the end of the demonstration. Virtually everyone interviewed reported that enrollees are expressing their satisfaction with Senior Prime services and are very pleased to be back in military health care. The sites’ extensive orientation activities and personal approach to support beneficiaries appear to have prepared enrollees well for service delivery. These subjective results are supported thus far by records of few complaints, grievances, and appeals, either filed within the Senior Prime plans or reported directly to HCFA regional offices.

We also heard that Senior Prime enrollees often were confused about how Senior Prime works, what providers they could use, and how to make appointments. Many enrollees have trouble using the electronic appointment systems, and some enrollees who were referred to network providers were unhappy when the providers were not located close to where they live. The front line MTF staff reported they spend a lot of time with enrollees to help them through these concerns and teach them how to use the system.

**DISCUSSION ON SENIOR PRIME EXPERIENCES**

Working within demanding time deadlines, all of the participants in the subvention demonstration have achieved a remarkable accomplishment in getting the TRICARE Senior Prime plans designed, certified, and into operation in less than 6 to 9 months. HCFA and DoD invested untold hours of effort in completing the terms of the MOA and providing direction to the demonstration sites as they prepared for Medicare certification. The sites themselves were committed to successful operation of Senior Prime, and they applied their military skills to mobilizing efforts to get it done. Service delivery has been responsive, and efforts are being made to apply care management techniques to avoid unnecessary care.

The early responses of the beneficiaries apparently testify to the success of the Senior Prime plans in delivering services. Although enrollments did not reach the planned levels immediately for some of the sites, their enrollments occurred faster than Medicare enrollment rates often are for private health plans. Many of those who enrolled have expressed to providers and retiree association colleagues their pleasure with their early experiences with the health plan and MTF services. Those who chose not to enroll appeared to have rational reasons for their decisions, perhaps the most significant one being the short life of the demonstration. We look forward to comparing these qualitative findings with results of the DoD Annual Beneficiary Survey and the GAO survey of dual eligibles in the demonstration sites, which will provide measurable information on the attitudes and experiences of dual-eligible beneficiaries.

One of the difficult issues emerging from the early life of the demonstration is the inadequacy of the financial provisions. The backdrop for these financial issues is the high visibility of Senior Prime within DoD and communication to the sites of a high priority to perform well. The sites reported this priority to be a motivator to do what was necessary to “stand up” Senior Prime effectively and to the satisfaction of their clients – the dual-eligible beneficiaries. Parallel with this message were two financial problems that, thus far, may have discouraged the sites from managing Senior Prime costs as aggressively as their operational
and clinical sides: (1) the complexity of the payment methods that makes it difficult for the site staff to understand the effects of payments on their operations, and (2) the absence of assurance that the sites will ever see Senior Prime revenues, even if DoD obtains net payments from HCFA after each year’s reconciliation. With the start-up activities behind them, the Senior Prime service delivery activities are moving to an ongoing operational stage, and the sites’ management activities will be changing accordingly. We plan to monitor these issues as our process evaluation continues, as well as in our quantitative analyses of utilization patterns and costs for dual eligibles.

POTENTIAL FOR MEDICARE PARTNERS

Even as the Medicare Partners portion of the DoD subvention demonstration was being specified in the MOA, HCFA and DoD did not fully agree on the desirability or feasibility of this subvention model, which allows a Medicare health plan to contract with MTFs to provide specialty and inpatient services for plan enrollees who are DoD beneficiaries. Such a partnership would be feasible only if it offered some gain for both the Medicare plan and the MTF, and thus far, there has been little indication of interest by either party. Disincentives for the site MTFs are created by the MOA financial terms for Medicare Partners, which specify that DoD is required to return all Medicare Partner revenues to HCFA (along with any Senior Prime payments) if the sites do not exceed the aggregate LOE.3 With the financial performance of Senior Prime still uncertain, some sites indicate they are reluctant to pursue Medicare Partner agreements.

The Medicare health plans serving subvention site markets also have little incentive to contract with MTFs. Dual eligibles enrolled in a Medicare health plan have the right to use MTFs for space-available services. HCFA has been given a legal opinion that, if the health plan paid the MTF for those services, the health plan would be using Medicare funds to pay the DoD, which is prohibited by statute. With no obligation to pay the MTFs for services provided for their Medicare enrollees, local health plans would not be inclined to negotiate an agreement where they would begin to pay for those services. The only scenario we can identify where Medicare health plans might consider contracting is if their enrollees no longer had access to the MTF because the combined enrollments of TRICARE Prime and Senior Prime crowded out space-available care for other dual eligibles. In this case, the Medicare plan might be able to obtain lower rates in a contract with the MTF than from a private provider in its network.

3 In addition, costs for services provided under Medicare Partners do not count toward the demonstration’s total LOE, and Medicare Partners revenues are counted as part of Medicare reimbursement to determine if the maximum reimbursement has been reached each year.