Chapter 7

IMPLICATIONS AND ISSUES FOR
A BROADER SENIOR PRIME PROGRAM

When considering policy for a government program, the nature of the public welfare responsibility vested in the government entities involved should be guiding deliberations. For the subvention demonstration, and any permanent subvention programs that may emerge from it, the public welfare mission may be viewed as sustaining the welfare of Medicare-eligible DoD beneficiaries through responsible use of public funds. As discussed in Chapter 3, HCFA and the DoD share the commitment to these beneficiaries, and the subvention demonstration is testing two models to enhance their health care benefit choices.

With Medicare-eligible beneficiaries projected to be an expanding share of the DoD beneficiary population in the future, DoD is evaluating options to provide for their supplemental health coverage needs. Senior Prime and Medicare Partners are but two alternatives that might be appropriate for the older population, and several others are being explored by the Congress and DoD.¹ DoD recognizes that several options will be needed to respond to differing beneficiary preferences and to the variety of circumstances in local markets. Even if Senior Prime was offered in all MTF catchment areas, many beneficiaries living outside the catchment areas would never have access to this option, and some living within the areas would not find it attractive. The discussion in this Chapter acknowledges this larger perspective, while focusing on considerations regarding Senior Prime as an option, given what has been learned from the demonstration to date. With no Medicare Partners activity, no assessment can be made yet.

The possibility of permanent introduction of Medicare subvention (or other model) to the MHS impels consideration of a basic policy issue for the Congress and DoD. What is the health care mission of the military health system and how does serving the older DoD beneficiaries, and therefore subvention, fit into that mission? As we discuss in this chapter, there are tensions and tradeoffs between the MHS medical readiness mission and DoD’s obligations to Senior Prime enrollees, and the sites have reported that substantial resources are required to initiate and operate Senior Prime plans. Unless budgets increase, these resources of necessity are taken from other medical readiness or peacetime health care activities. If the Congress and DoD determine that serving this population is an important part of the DoD health care mission, after taking into consideration operational and financial lessons from this demonstration, then appropriate resources can be committed and financial tradeoffs made.

In examining Senior Prime issues and options, our focus is on the DoD health system because that is where Senior Prime implementation takes place. Because Senior Prime plans are under contract to HCFA as Medicare+Choice plans, they must comply with the Medicare+Choice rules set forth in statute and regulations, and HCFA and DoD together forge the provisions that are unique to the military health system and environment. We point out in

¹ Two examples are the demonstrations testing FEHBP and a TRICARE Senior Supplement as supplemental policies for Medicare-eligible DoD beneficiaries.
our discussion where shared decisions are required by HCFA and DoD, and we highlight the value of the balance that can emerge from careful negotiations.

The TRICARE Senior Prime demonstration still is in an early stage of operation, and we anticipate that new issues will arise and other issues be refined as the demonstration continues. Yet the early experiences of HCFA, TMA and the demonstration sites already can instruct us on some of Senior Prime’s successes and challenges and implications for the future. In this chapter, we discuss two categories of initial findings and issues: (1) policy issues that Congress, HCFA and DoD will need to address if Senior Prime becomes a permanent program in the MHS, and (2) lessons learned regarding how to strengthen program implementation.

POLICY ISSUES FOR PROGRAM DESIGN

Balancing Interactions Between the Readiness Mission and Senior Prime

All of the Services’ medical departments have a go to war mission and must be poised to support a major theater war (MTW). Further, with the Gulf War, the military has made a commitment to maintain peacetime beneficiary care while undertaking a major theater war. In addition, military medical personnel and units have other operational demands that they must be prepared to meet including contingency operations and ongoing training missions. One of the issues this demonstration is highlighting is the need to address how MTFs can balance the demands of peacetime care, training, and contingency operations if Senior Prime becomes a permanent part of peacetime care.

With recent changes in the National Military Strategy and the downsizing of the U.S. military, the Military Health System (MHS) has become more and more focused on the readiness mission. The operational tempo of U.S. forces, including combat service support units, has increased since the end of the post-Cold War. This increase in contingency operations includes a reliance on military medical assets to provide support to combat forces engaged in a wide range of military operations from peacekeeping and humanitarian missions to noncombatant evacuation operations, among other types of contingency operations.

Contingency operations such as Kosovo, Bosnia, Haiti, or Somalia have seen the recent deployment of medical assets and personnel from all three military services to a number of regions of the world, at times in support of joint medical missions. For example, all three Services have jointly shared the medical mission in support of peacekeeping forces in the Balkans region. Evans Army Community Hospital had approximately 20 of its medical staff deploy to the Balkans as part of the 10th Combat Support Hospital (CSH) during the start-up of Senior Prime. The USAF Academy also had one of its four internists who serves as a primary care manager for Senior Prime deploy to Saudi Arabia for 4 months during the same time period. Unlike routine training missions, contingency operations are unpredictable and are not currently planned for.

For contingency operations, military medical units are task organized and cross-leveled to support deploying maneuver units that at times may not be part of the post. For example, both Brooke Army Medical Center and Evans Army Community Hospital recently saw the deployment of medical personnel in support of troops from Fort Hood. So while a military treatment facility may lose medical personnel to a deployment, the troop population using the military treatment facility may remain at the same level. Further, contingency operations may equally impact primary and specialty care given the very nature of how the military medical system is designed; i.e., specialists may deploy in more generalist roles.
In addition, military medical units have ongoing training missions whether it be to undertake training exercises in preparation for specific types of operations or to support the routine training of units. Two of the military treatment facilities in the Senior Prime demonstration are Forces Command (FORSCOM) installations (Madigan AMC at Fort Lewis and Evans ACH at Fort Carson) and support large deploying, active-duty troop populations. When their maneuver units go into the field for training they take the PROFIS medical personnel assigned to the units to provide medical support to combat troops. Essentially, the military treatment facility loses these medical personnel for the 2-3 weeks duration.

The current system for providing medical personnel for deployments is somewhat similar across the three Services. For example, Air Force medical personnel have specific mobility assignments that can be activated in support of a contingency operation. Indeed, in recent years the Air Force has actively sought such assignments. Air Force deployable medical capabilities range from four-person Critical Care Air Transport teams that can provide intensive care to patients being transported, to air transportable hospitals that provide hospitalization care for peacekeeping or other types of contingency operations. The Navy too has deployable medical platforms that include medical battalions and surgical companies, fleet hospitals, casualty receiving and treatment ships, and several large hospital ships, among other capabilities. Navy Medical Augmentation Teams (MAT) personnel are assigned a billet and provide an augmentation package in support of such platforms when they are deployed. The Navy also provides medical support for the Marines. Army medical personnel designated as Professional Filler System (PROFIS) are assigned to deployable military medical units such as forward surgical teams, combat support hospitals, among others. For all three Services, military medical personnel provide peacetime care in fixed facilities when not deployed or conducting routine training missions.

All three Services also have Graduate Medical Education (GME) programs. In this demonstration, four of the sites have ongoing GME training programs in a variety of specialty and subspecialty areas. As the military health system moves increasingly towards population-based medicine (treating young healthy troop populations and their families), it will need to address how elderly, more complex patients (such as Senior Prime enrollees) may contribute to military physicians maintaining their clinical skills.

How does all this tie in with TRICARE Senior Prime? With respect to the readiness mission, there are three main areas of concern: recruitment and retention, training and sustainment of clinical wartime skills, and ability to deploy. We discuss the relationship between readiness and TRICARE Senior Prime in each of these areas and then offer some observations and recommendations regarding policy options for addressing the intersection between the two.

**Recruitment and Retention.** Historically, serving the senior population has been viewed by the three Services as having made a positive contribution to recruitment and retention of military physicians. Military physicians like treating this population because they have complex health care needs that allow the physicians to use their clinical skills fully. The readiness contribution of the senior population may be especially useful for Air Force MTFs, the majority of which are small clinics in relatively remote areas. Many of the Air Force physicians assigned to these clinics are young and fresh out of their medical training, and they want to practice a full scope of medicine to reinforce their new skills. Therefore, having access to the Senior Prime population at an outpatient clinic such as at Dover Air Force Base may serve as an important retention tool. The Army and Navy also have cited the elderly population as being important to their recruitment and retention of military physicians. However, it may be less important to have Senior Prime at Army and Navy MTFs with only
outpatient services, because both services have a mix of large medical centers, smaller community hospitals, and outpatient clinics through which their physicians rotate.

**Training and Sustainment of Wartime Clinical Skills.** The elderly population also has been cited by all three Services as being important to their training programs and for graduate medical education, although the three Services have differed in the degree of emphasis placed on GME. Overall, GME can be viewed as a requirements-based system intended not only to train military physicians, but also to serve as a recruitment and retention tool. For some subspecialty programs, a large patient population of elderly beneficiaries has been viewed by the sites as being essential for sustaining their training programs. This point is underscored by the fact that, before Senior Prime began, many of the demonstration sites already had impaneled a group of seniors or were providing care to military retirees on a space available basis. In our site visits, both primary care and specialty physicians from all three Services asserted the importance of the elderly population in terms of enabling them to maintain their clinical skills. MTFs have been losing this patient base, however, with declining space-available care.

**Ability to Deploy.** On the negative side, the establishment of a contractual obligation to serve the Senior Prime population, including compliance with access standards and other requirements, may compete with the MTFs’ mission to deploy military medical personnel when needed. We have seen some discordance between how medical units are task organized for contingency operations and the peacetime medical mission of the facility—a discordance that does not necessarily allow for a coherent medical care plan to be made for an entire community. For example, the deployment of medical units to support units that are not part of the MTF’s base population may result in losses of medical personnel without accompanying reduction in the size of the base population. Maintaining such flexibility has become more of an issue with the loss of redundancy as the medical force has been downsized.

Among the demonstration sites, some facilities have experienced the effects of deployment more than others. The timing of the startup of delivery of services for Senior Prime patients at this site coincided with the deployment of both Army and Air Force medical personnel.

**Policy Options.** Military retirees have demonstrated a strong loyalty to the Services and many currently enrolled in the Senior Prime Program recognize that the job of the military physician may require them to deploy now and then. Several policy options are being explored by the demonstration sites (and others) to help manage the potential conflict between deployments in fulfillment of the readiness mission and obligations to Senior Prime enrollees:

1. **Maintain flexibility in the system.** Mechanisms are needed that can respond to the unpredictable and rapid pace demands of contingency operations, but the temporary nature of deployments makes it difficult to find good options for achieving this. Further, with recent reductions in the size of the medical force, much of the redundancy in the system that would allow for this kind of flexibility no longer exists. A number of the options proposed all share problems of higher costs than MTF care and a limited ability to respond quickly to changing demands. Available options, include:
   - Referral of Senior Prime enrollees to civilian networks.
   - Use of reservists to backfill MTFs that have lost deployed medical personnel.
   - Cross-leveling of personnel from other MTFs to support the deployment of military medical personnel from another facility.
• Resource sharing agreements to utilize civilian providers where savings are shared between the managed care support contractor.²

• Resource support where the MTF pays for requested services up front.

The last two options, by their very definition, share several problems. Many civilian physicians are unwilling to participate for such short periods of time and on such an unpredictable basis. It also takes time to identify candidate providers, negotiate agreements, and get physicians credentialed and familiar enough with the MTF and its policies and procedures to be useful. Further, in markets where physicians are in high demand, or where civilian providers may view managed care negatively, it can be difficult to identify such civilian personnel within an adequate amount of time to be beneficial to the MTF.

2. Ensure the correct mix of skills. It is too early to determine whether the mix of clinical skills needed for sustainment training matches the set of skills required to provide care to Senior Prime patients. This question deserves careful consideration as more experience is accumulated with changing types of deployments and with Senior Prime, especially if this program becomes a permanent part of the MHS. We might see a divergence occurring between the skills necessary for the wartime mission and for peacetime care for the elderly. For example, the clinical skills necessary to treat chronic medical conditions in the elderly do not necessarily contribute to the overall readiness mission. Thus, it may be better for Senior Prime plans to outsource some specialties (e.g., geriatric pharmacist) than to expect participating MTFs to provide them.

Structuring and Managing Senior Prime Effectively

We draw upon the early experiences of the six demonstration sites to begin to explore options for organizational structure and participant roles under a broader Senior Prime program. This discussion is intended to provide some considerations and organizational approaches for policy decisions by HCFA and DoD. We will continue to develop these concepts as additional information is accumulated from the evaluation. We explore here design options for selection of markets and participating MTFs, governance and management structure, and strategy for phasing in a larger program.

Selection of markets and MTFs. The configuration of Senior Prime plans chosen for a larger system, and the MTFs that participate in them, will define the system’s profile of enrollees, service delivery, and financial performance. Therefore, it is important for the policy aims for such a system to be clear to ensure that the aims guide system design decisions. Per the discussion in Chapter 3, the DoD goals are to improve access to the DoD health system for dual eligibles, maintain budget neutrality, and strengthen managed care skills in TRICARE. The budget neutrality goal allows some flexibility to include a mix of profitable and unprofitable sites if some of the sites contribute to other goals, such as the readiness mission. HCFA’s goals also must be considered, as another major participant in subvention. For example, an unprofitable Senior Prime plan would harm HCFA’s goals for beneficiary

² In resource sharing, the MCS contractor provides staffing, supplies or other resources that allow work to be done in the MTF. The contractor gets credit for the workload, and savings are shared between the government and contractor during bid price adjustment. In resource support, the MCS contractor provides staff for cost plus a management fee, serving as a form of contracting officer with less federal contracting burdens. The MTF pays for requested services as they are provided.
protections and plan performance if services to enrollees began to deteriorate or the plan terminated operation. Therefore, HCFA would be expected to share with DoD a desire for the sites to succeed, within the constraint of protecting the Medicare trust fund.

In this context, we take a business orientation from the DoD perspective in our initial consideration of the factors and tradeoffs involved in selecting MTFs as providers in Senior Prime plans, looking for (1) the ability to serve a good size dual eligible population, (2) the potential for financial viability, and (2) a contribution to the DoD readiness mission. The characteristics of both the MTFs and the markets in which they are located will contribute to those factors. Table 7.1 summarizes the characteristics and related considerations that we have identified. The first step in analyzing the MTF options would be collection and analysis of data on these characteristics for MTFs in the MHS.

The early results of our process evaluation indicate that medical centers or community hospitals with a balanced mix of primary care and specialty care were able to move into Senior Prime most easily and quickly. Larger medical centers with the depth of clinical specialty capability to serve most health care needs may save money by avoiding referrals to network providers (if their costs are lower than the prices paid to network providers), but unless they already have an experienced PCM function under TRICARE Prime, they may have more trouble gearing up for Senior Prime than other facilities.

Table 7.1
MTF and Market Characteristics to Consider in Selecting Senior Prime Plans

<table>
<thead>
<tr>
<th>Characteristics</th>
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<tbody>
<tr>
<td><strong>Military Treatment Facility</strong></td>
<td></td>
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<tr>
<td>• Mix of primary and specialty care</td>
<td>Balance of active primary care with a mix of specialties is positive for Senior Prime success.</td>
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<tr>
<td>• Inpatient and specialty service capability</td>
<td>Presence of inpatient and specialty mix limits the amount of care that must go to network providers</td>
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<tr>
<td>• Production efficiency</td>
<td>Comparisons of MTF unit costs of care to capitation rates can identify potential financial performers.</td>
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<tr>
<td>• Readiness and deployment</td>
<td>Readiness may be sole Senior Prime value for small outpatient MTFs; for MTFs with heavy deployments, Senior Prime services may suffer.</td>
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<tr>
<td>• Medical education programs</td>
<td>Care for Senior Prime enrollees strengthens medical education programs and contributes to readiness.</td>
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<tr>
<td><strong>Local Market</strong></td>
<td></td>
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<tr>
<td>• Supply of community providers</td>
<td>It is easier to recruit network providers in communities with a rich provider supply.</td>
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<tr>
<td>• Size of eligible population</td>
<td>Larger dual-eligible populations offer potential for large enrollments; also economies of scale.</td>
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<tr>
<td>• Presence of managed care</td>
<td>In managed care markets, both enrollees and providers understand managed care and are more willing to participate in Senior Prime</td>
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<tr>
<td>• Medicare capitation rates</td>
<td>Capitation rates are the plan revenues, and higher revenues are desirable for financial performance.</td>
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A potentially challenging policy tradeoff for MTF selection is raised by the early experience of the Dover AFB demonstration site. The Dover site reports that it is losing money on Senior Prime, yet the clinicians at Dover tell us that Senior Prime is becoming important to their readiness mission by helping to retain physicians and keep their clinical skills honed. What are the retention gains? How much is the readiness role of Senior Prime worth to the DoD? Under what circumstances might losses on Senior Prime for smaller MTFs offer a payback in savings in the readiness mission? Another consideration in this example is the Service of the MTF. Most of the Air Force MTFs are clinics like Dover, unlike the Army and Navy that also have large MTFs that can support physicians skills. Perhaps it would be appropriate to include Air Force MTFs like Dover in an expanded system, but to exclude Army or Navy facilities that provide only outpatient services.

It would be useful to assess which factors are contributing to Dover’s reported losses, and their relative contributions. Some factors can be assessed in the evaluation cost analysis, which we plan to undertake. An understanding of those factors is necessary to assess how Dover’s experience might generalize to MTFs of similar characteristics. It is likely that a low capitation rate is among the factors, which is a common dilemma for rural locations, even after introduction of the payment floor in the new Medicare capitation method. The Dover site also highlights the importance of assessing the relative costs of care by MTFs and network providers, with comparisons across the MTFs, to understand the implications of network provider services for Senior Prime profitability.

We offer another selection criterion as an example of a broader public welfare perspective on the task of selecting MTFs for Senior Prime services. For a welfare goal to improve access to managed care for Medicare beneficiaries living in rural areas, HCFA and DoD might consider MTFs in rural locations as candidates for Senior Prime. The introduction of managed care through Senior Prime could make the community more receptive to managed care and encourage other health plans to enter the market. The demonstration is generating evidence from the Texoma and Dover sites that Senior Prime plans can attract enrollees in rural areas where they have a loyal retiree base, even in a larger population that does not like managed care. Full assessment of success, however, must await financial performance results.

**Governance and management structure.** The demonstration was established as part of the TRICARE regional structure, as the most reasonable organizational choice for Senior Prime plans. The regional LA Offices in the demonstration sites appear to be performing well in leadership roles that expand upon their more traditional TRICARE roles of coordination and facilitation. The Region 6 and Colorado Springs sites are generating examples of both the positive potential and challenges of initiating and operating a Senior Prime plan with more than one MTF, while maintaining responsiveness to HCFA’s external oversight function.

For a permanent program that potentially would involve all TRICARE regions in the U.S., HCFA and DoD would need to work together to identify any issues of concern as structural decisions are made. One alternative would be to integrate Regional Senior Prime plans into the TRICARE regional governance and management organization, extending the process that the sites started as they established Senior Prime governing boards within the TRICARE structure. The most obvious alternative would be to establish a separate plan for every local market area, which was the Medicare Section 1876 health plan model. Considering the number of MTFs in the system, organizing the plans by region for a permanent program could manage administrative overhead most effectively, when compared to other options, by avoiding duplication of Medicare certification and compliance processes.
The new Medicare+Choice rules allow the flexibility to establish such structures with noncontiguous service areas.

The subvention demonstration provides limited insights regarding the organizational and management challenges for plans with a large number of MTFs, because the largest demonstration site (Region 6) has only 4 MTFs. The Region 6 demonstration site thus far appears to have managed well in the absence of LA Office line authority over the MTFs, but this issue may make it much more difficult to manage a Senior Prime plan with many MTFs. If a regional plan had 10 or more participating MTFs, such a large structure also could place substantial workload demands on the LA staff, and coordination of patient services and administrative functions could be compromised. On the other hand, overhead costs for a larger plan could be spread across a larger enrollment base, assuming overhead inefficiencies did not increase costs inappropriately.

The heavy reliance on contractors to perform many of the administrative and financial functions of Senior Prime plans has stimulated some concern by the HCFA regional offices because contracts are vulnerable to non-performance and are more difficult to oversee than an organization’s own staff. Although the military has a long history of working with contractors, it would be appropriate to re-examine and test in some detail the functions specified for contractors under Senior Prime to be sure the contracts can be managed effectively.

**Phasing in a permanent program.** The demonstration sites were managing intense workloads during start-up of Senior Prime enrollment and service delivery. This experience argues for phasing in regions or MTFs as a larger system is activated (similar to TRICARE start-up strategy), as well as staging of enrollments within each plan, to manage the larger scale operation. The following are some possible strategies for building expanded plan structures, which are not necessarily mutually exclusive.

1. Expand the existing Senior Prime plans to bring additional MTFs and service areas in the regions into their governance and management structures. In principle, this option could move quickly because the governance, management, and clinical infrastructures already exist for the demonstration sites. In practice, change-over in staff at the LA Offices and MTFs participating in the demonstration, most of whom are military personnel, could result in loss of knowledge that could slow expansion activities (the issue of establishing a core of Medicare expertise in the TRICARE system is discussed below).

2. Establish new Senior Prime plans in the other regions that do not have demonstration sites. This option could be attractive in areas with large concentrations of dual-eligible beneficiaries who want to join Senior Prime, and the presence of acceptable market and MTF characteristics could reinforce the potential for success.

3. Create two or more separate Senior Prime plans within some regions that are very large or contain local areas that are very different from each other. The Central Region would be a candidate for this option because it covers almost 40 percent of the country’s land area in 15 states and contains a large number of MTFs. The LA Office could find it quite difficult to manage an organization of this size. On the other hand, separate plans within a region would require separate organizational structures and staffing, which could increase management complexity for the LA Office yet more. Any decision on subdividing any region for Senior Prime should be based upon a thorough analysis of data on MTF and market characteristics to determine if the markets in the region support such an approach.
Creating the Desired Financial Incentives

The carefully negotiated financial terms in the MOA are complex provisions that were still being refined as the subvention demonstration began operation. As discussed in Chapter 4, the sites have expressed dissatisfaction with many aspects of the payment formula, and they are frustrated by the absence of cash flow to help cover the costs of care the MTFs are providing to Senior Prime enrollees. Such an uncertain financial environment may discourage active management of costs of care, if MTFs believe that their actions have little influence on their financial outcomes and rewards or penalties for performance.

Given these findings, it would be appropriate to re-evaluate the payment system for Senior Prime to seek a design that can (1) reduce uncertainties for the sites regarding their potential financial performance and the consequences for them and (2) align the sites’ incentives so they can focus on providing quality care to their enrollees and managing the costs involved in doing so. Any modifications to the payment methods would be guided by the basic financial principles laid out by HCFA and DoD for the MOA (see Chapter 3) to protect the Medicare trust fund and maintain budget neutrality for the DoD. The establishment of the following conditions in a modified payment system would help achieve these goals:

- Provision of timely information on the methods and timing for distributing revenues to the LA Offices and MTFs, so that local commanders will have assurance of the receipt of funds (or not) and can plan for use of the resources for service delivery for enrollees.
- Absence of conflicting financial incentives regarding service provision for Senior Prime enrollees, non-enrollees who use space-available care, or other DoD beneficiaries.
- Simplicity in the payment methods so that both the methods and their consequences for site payments can be readily understood by participants.
- Confidence by the sites that the historic LOE accurately reflects appropriate baseline spending so the sites do not feel they are being penalized for over-estimates or incorrectly assisted by under-estimates.
- Confidence by the sites that payment rates reasonably reflect the sites’ expected costs of care for enrollees, including those incurred by network providers and charged to the plan.

Achieving Effective Clinical and Cost Performance

The sites appear to have achieved impressive early results in delivering care to Senior Prime enrollees, for which they have been rewarded by expressions of satisfaction from their enrollees. It is too early, however, to tell how cost effective the program will be. To achieve and maintain budget neutrality, actions are needed in several aspects of the management of health care delivery and costs. Several key issues emerged from our site visits and interviews with TMA staff that merit attention, both to enhance Senior Prime performance for the remaining life of the demonstration and for a future systemwide program.

Cost effective clinical care. The comprehensive management of the quality and costs of care for Senior Prime enrollees involves the following functions, which also are relevant for management of care for TRICARE Prime enrollees:

- Integration of consistent performance standards into health care delivery processes for key health conditions across the MTFs;
• Proactive case management for enrollees with chronic health conditions, multiple morbidities, or episodes of severe or costly illness;
• Focused pre-authorization and review activities to improve service components that have been identified as problem areas for inappropriate utilization; and
• Consistent quality and utilization monitoring across the Senior Prime sites (or programs in the future) with feedback reported regularly to providers.

After completing the Senior Prime start-up and enrollment activities, the sites now are focusing their efforts on many of these elements. The sites are taking the reasonable approach of working together to build one QM plan with a consistent set of performance standards and indicators that all Senior Primes will use to monitor progress and compare plans’ performance to demonstration-wide benchmarks. Yet they have been constrained in these efforts by problems with the availability and quality of needed data, as well as by conflicting measurement standards among multiple quality and utilization management initiatives across the DoD.

The sites are working independently on their UM plans and activities, and they are focusing efforts to varying degrees in two areas: implementation of case management techniques to proactively manage the complex health problems of the older enrollee population, and selective pre-authorization procedures that focus on services where this function will be most likely to reduce inappropriate utilization. The UM and case management roles are being performed by MTF staff in some regions, and by MCS contractor staff in other regions, as determined by the Chapter 20 Senior Prime provisions and the terms in the MCS contracts. In some cases, the contract terms appear to be restricting the ability of MTF and contractor staff to perform focused pre-authorizations and to design the flexible, creative case management and disease management approaches they desire. Contract revisions would be required to address this problem.

Both short-term and long-term challenges exist in this area. In the short term (for the remainder of the demonstration), the sites face the challenge to manage care proactively to ensure that MTFs are providing Senior Prime enrollees appropriate and efficient (i.e., cost effective) care. In the longer term, to prepare for a systemwide program, the DoD should continue its efforts to establish consistent practice standards that all MTFs may use, and it should explore ways to provide for greater UM flexibility into MCS contracts. The DoD data system capabilities also need to be built to generate timely and actionable information for the MTFs’ QM/UM activities and for DoD use to monitor the cost effectiveness of care in its facilities.

**Administrative costs.** Careful assessment is merited for two distinct aspects of the administrative costs that have been incurred during the demonstration. First, the resources invested by the LA Offices, MTFs, and MSC contractors to make Senior Prime operational may have been disproportionately large, when compared to the size of their dual eligible populations (in absolute numbers and as a share of the total beneficiary populations). The sites have taken justifiable pride in “doing the job well,” but they also are questioning whether such an investment is appropriate. They cite opportunity costs that have been incurred in the non-performance of other projects, tasks, or initiatives that also are important for patient care or MTF management. On the other hand, HCFA regional office staff reported to us that mobilization of resources of this magnitude is typical of start-up Medicare health plans, to help new enrollees learn the health plan and ensure that their health needs are being properly managed. In addition, the Senior Prime plans are quite small plans, when compared to other
Medicare plans that can spread their start-up and overhead costs over much larger enrollments.

The rigor of the Medicare certification requirements is one factor driving administrative costs, and other contributing factors included the speed of the demonstration start-up and the shifting Medicare rules as the new M+C program was implemented and HCFA introduced the new regulations to the demonstration sites. The sites believe that administrative costs will remain high as they fulfill Medicare compliance requirements and related tasks, although we expect there should be some decline over time as the sites become more proficient working with the program, even with compliance demands. If Senior Prime becomes an ongoing part of the TRICARE program, then appropriate investment in the organization and management of the plans is essential to ensuring their long-term effectiveness. The question is “how to do this as efficiently as possible?”

RAND’s evaluation will be examining the cost impacts of the demonstration, which will include some estimates of the administrative costs. Administrative costs will be compared to the overall service delivery costs and financial performance, and as well as to those of other Medicare managed care plans of similar size. Estimates will be generated of possible changes in administrative costs as plans gain operating experience and for larger plans that would include multiple participating MTFs. Additional assessments by TMA and the demonstration sites also are suggested, to obtain estimates that reflect operational details that they can identify best.

The following additional actions are suggested:

- TMA and the sites should work with HCFA central and regional offices to explore possible areas where procedures can be streamlined to reduce both start-up and long-term administrative costs. These interactions can be used as a vehicle to help HCFA staff become more familiar with the military health system and TRICARE Senior Prime.
- Improve the efficiency of new start-ups by building upon the expertise, systems, and procedures that have been developed by the sites during the demonstration;
- Provide reasonable time for new sites to prepare for HCFA certification and the start-up of Senior Prime enrollment and service delivery;
- Involve participants at both the national-level (HCFA Central and TMA) and regional and local level (HCFA regional offices, LAs, MTFs, MCS contractors) early in the planning for an expanded program and throughout the plan certification process.
- Maintain close communications between the sites and HCFA regional offices for efficient processing of materials, plans, and other documents during the certification process.
- Wherever possible, provide mechanisms for systemwide HCFA approvals for plans, materials, and activities to avoid duplication of efforts.

The second aspect of administrative costs that we explored is the increase in MCS contractor costs incurred to support the Senior Prime demonstration, and uncertainty regarding the extent to which those costs may continue under an ongoing program. Some of the personnel costs incurred by the contractors were for temporary staff to support the high volume of initial enrollments, which were eliminated after enrollment rates subsided. Other one-time costs were incurred for participation of MCS contractors in planning for the demonstration and
development of Chapter 20 provisions. Some portion of the new contractor costs will continue because they have hired additional BSRs, HCFs, and other staff to handle ongoing enrollee appointments and referrals, as well as provider network management. Recognizing the many program uncertainties, TMA is paying the contractors on a cost-plus basis for the demonstration, and payments have been delayed until costs can be accounted properly and billed. Delaying contractor payments will increase TMA costs because contractors will factor their costs for funding cash flow into their billings to TMA. As it becomes possible to specify clearly the set of tasks that MCS contractors are to perform under Senior Prime, a priority should be placed on defining a fixed-price contract, to be applied for the remainder of the demonstration and in a permanent program.

**Core Medicare expertise in DoD.** Perhaps one of the most important impediments during start-up of Senior Prime at the demonstration sites was the limited amount of Medicare expertise within the DoD system. Virtually all the staff in the sites’ LA Offices and MTFs were learning the Medicare managed care rules as they were organizing the Senior Prime plans. This learning curve added to the staff time required for start-up, although this barrier should decrease as a core of expertise develops within DoD. The Medicare consultants that TMA funded were an important resource, with the sites reporting that they relied on them heavily. For a larger system, TMA should consider assembling a team of military and civilian staff with Medicare knowledge and experience to help plan the new system, train personnel at participating sites, and serve as a technical resource during start-up and ongoing operation:

- Draw upon the knowledge and experience of the LA and MTF staff in the demonstration sites as a core for such a team.
- Establish a system for regular training of new military personnel as rotations occur.
- Place civilian employees with Medicare knowledge in selected key positions to provide stability as military personnel are re-assigned.
- Locate members of the expert team in both the TMA office and the regional LA Offices to ensure they become working partners with the sites’ staff.
- Use temporary exchanges of personnel between HCFA and DoD to build skills and knowledge within both organizations on how the other organization operates.

**Cost effective network of civilian providers.** The mix and locations of providers in the Senior Prime network affect both enrollee satisfaction with their health care and the costs of providing that care. Demonstration sites have encountered few problems in recruiting new institutional providers, but some sites have had difficulties finding sub-specialty physicians who are willing to contract with Senior Prime. The following strategies are suggested to strengthen linkages with community providers:

- For sites served by MTFs with limited inpatient or sub-specialty capabilities, analyze the costs of services for network providers relative to what it would cost the MTF (or other similar MTFs with the service) to provide the service. Using this information, explore strategies to attain the full mix of providers at reasonable costs, comparing costs for network providers, resource sharing for civilian physicians, MTF circuit riding by military sub-specialty physicians, or cooperative agreements with community clinics or hospitals.
- To reduce civilian provider resistance to military contracts, seek out some providers to learn their views and concerns. Develop a strategy to respond to those concerns, for example payment premiums or providing better medical chart documentation when
patients are referred. The concerns of community physicians about low rate structures can be assessed by comparing the CMAC rates and Medicare Fee Schedule rates for high volume procedures.

- Ensure that comprehensive management and coordination of enrollees’ care includes coordination of care by network providers. Strengthening of procedures to ensure timely appointments, and the transfer of clinical information between the PCM and network provider, can improve appropriateness of care and increase satisfaction on the part of both enrollees and the network physicians.
- Evaluate the cost effects and readiness tradeoffs of bringing into the MTFs some of the Medicare-specific services that are being contracted to civilian providers, e.g., DME or home health.

DEMONSTRATION LESSONS FOR EFFECTIVE IMPLEMENTATION

The reports from the demonstration sites highlighted many of the sites’ positive experiences and challenges during the start-up phase of TRICARE Senior Prime. We summarize here “key lessons learned” that the sites discussed with us during the site visits or that we identified in the course of analyzing information from the sites. The items are presented with the recognition that the relative usefulness of each item will depend on the unique circumstances of a specific Senior Prime plan. Additional detail is provided in the individual site reports in Appendix C. Some of these lessons can be applied quickly during the demonstration and, in some cases, the sites are doing just that. Others may be considered by HCFA Central and Regional Offices, TMA, and participating sites for any future expansions of Senior Prime.

Enrollment and Startup of Service Delivery

The following items address activities that Senior Prime plans may undertake as they plan for and carry out marketing and enrollment activities and begin service delivery for new enrollees. A good number of the lessons highlight the unique aspects of military health care and its interface with the Medicare program.

- Anticipate additional enrollment growth in existing sites under a permanent program, as some beneficiaries who were reluctant to enroll in a demonstration decide to join.
- To select an enrollment target for each Senior Prime plan, it is important to begin by assessing the plan’s competitive advantages and liabilities in the market and estimating possible effects on financial performance of different enrollment levels. One of the issues that should be considered when setting these targets is the requirements of the readiness mission at each MTF.
- Careful design and execution of a marketing plan, guided by staff members or consultants with marketing expertise, will enhance the ability to achieve enrollment targets, while complying with HCFA marketing and enrollment requirements.
- The enrollment processing system should be streamlined, to reduce some of the delays and risks of error that MCS contractors have encountered as a result of having to verify eligibility in both the DoD and HCFA enrollment systems and to work with multiple information systems to activate beneficiaries’ enrollment status. Ideally, effective dates of Senior Prime enrollment should mirror those of other Medicare health plans, which is
the first day of the following month after a specified application cutoff date. (See discussion of data system issues below).

- Staging new enrollments over the initial months of Senior Prime operation is reported by the sites to be preferable to accepting all new enrollments immediately. With this approach, MTFs can process new enrollees effectively while working within its primary care clinic staffing capacities and maintaining TRICARE access standards. Payment methodologies and budgets need to allow for staging and account for its financial consequences.

- The demonstration sites indicate there is value in careful and thorough orientation of beneficiaries to Senior Prime, followed by a program of education and health status screening for new enrollees and periodic educational activities on an ongoing basis. The benefits cited by the sites include early treatment and prevention of health problems, reduced confusion by beneficiaries, prevention of disruptions to care, and improved beneficiary satisfaction. Such an approach is resource intensive, however, and its long-term cost effectiveness is not yet documented. Both desired benefits and costs should be considered when designing a plan’s intake methods.

- To ensure that the health care needs of new enrollees are being addressed appropriately, while avoiding excess costs for services that yield little value, the sites have found demand management techniques to be useful, that is, triaging of the needs of new enrollees and provision of appropriate levels of initial care. Health assessment forms or surveys geared to the elderly can serve as effective tools.

- Effective introduction of Senior Prime is aided by ensuring that primary care physicians and other front line clinical and administrative staff are well informed about Senior Prime and are active participants in (or lead) the educational programs for new enrollees. Ongoing provider education should be provided to ensure they remain well informed, given rotations of military staff and frequent turnover of civilian front line staff.

- Space-available beneficiaries may require assistance from MTF staff to help them make the transition to community providers because of reduced access to MTF care as Prime and Senior Prime enrollments increased.

- During transitions to Senior Prime enrollment, it is important to identify early the enrollees who have existing treatment requirements (e.g., prescription medications, oxygen or other DME, home health care, ongoing therapies) and to make arrangements for continuing services without interruption. Strategies may include early queries of potential enrollees and working directly with the local service providers or suppliers to ensure that their records transfer patients to Senior Prime when enrollment is verified by HCFA.

- Considering the MTFs’ experiences thus far in the demonstration, the largest, most specialized teaching medical centers appear to have encountered some of the more difficult transitions to establishing PCM clinics as Senior Prime gatekeepers who manage specialty referrals, apparently because medical centers’ emphasis has been specialty care services and teaching. This issue appears to be more important in Senior Prime than TRICARE, perhaps because of the relatively more frequent referrals of older enrollees to specialists. With successful implementation of Senior Prime, the medical centers reportedly have gained benefits in improved patient care coordination and stronger support for GME.
Early Operation

The following items address the clinical care and administrative support activities that Senior Prime plans undertake as they provide services for enrollees. These items reflect our initial observations based on the very early operational experiences of the demonstration sites during the first 5 to 8 months of service delivery. We expect that other lessons will emerge as the demonstration proceeds and the sites mature as managed care plans.

- Given the complexity of Medicare+Choice rules, it would be useful for DoD and HCFA to review the compliance requirements to seek some systemwide approaches to reporting and monitoring that could reduce some overhead costs for HCFA regional offices and the LA Offices and MTFs.

- Physician productivity was improved in several of the site PCM clinics by re-configuring staffing patterns to include nurse manager functions, increases in support staffing depth, or re-allocation of functions. Particular emphasis was placed on coordination of intake activities and follow-up visits for Senior Prime patients to manage health problems that were identified during intake, with reduced physician involvement.

- The demonstration has highlighted anecdotally how strongly Senior Prime enrollees value being able to talk to a person to make provider appointments and obtain customer service. Telephone appointment systems with automated menus tend to irritate or confuse older users. Of particular concern are the regionally centralized systems. Efforts to make these systems more accessible could increase enrollee satisfaction, while reducing time demands on front-line clinic staff to respond to complaints or questions. Some sites found it useful to provide training and support for enrollees to help them learn to use the systems.

- It is advisable to monitor activity for ancillary services to gain an understanding of the impact of Senior Prime on these services, identify tests or procedures being done externally that are high volume for an older population and can be brought inside the MTF, and identify areas where inappropriate utilization may be occurring.

- Information about the Senior Prime program should be built into MTFs’ ongoing orientation and continuing educational programs for providers, to ensure that the program becomes fully integrated into the MTFs routine operations.

Data System Capabilities

Even as DoD is making progress in strengthening its data systems, including the refinement and expansion of the CEIS as an management decision support system, the sites express their frustration at not being able to get complete, accurate, or timely data to support their current Senior Prime plan activities. The basic - and very demanding - need is to bring together DEERS, CHCS, ADS, HCSR, pharmacy claims, and other service use data, to calculate a variety of measures for utilization management and quality indicators for processes and outcomes of care. These indicators need to be measured consistently across all participating MTFs and the network provider services, to support establishment of national benchmarks of performance. In addition, timeliness of data is essential, to enable clinical teams to work with current data as they monitor and manage service utilization and provider performance.

The CEIS system is positioned to ultimately achieve the comprehensive information capability required for clinical decision making. Yet users still lack confidence in the
completeness of the data that CEIS is capturing, and CEIS will not be fully useful for QM/UM monitoring and benchmarking until the systemwide data warehouse is broadly available to users.

Of course, the data in a system is only as good as the information being entered by users. The sites report highly varying levels of completeness of ADS data on outpatient encounters, ranging from less than 75 percent to more than 95 percent of outpatient visits having ADS sheets. Similar inconsistencies are reported for the quality of ADS sheet coding. Some sites report success in providing formal training for clinical staff on the importance of ADS and how to properly code diagnoses and procedures. Broader training initiatives are encouraged to improve the clinical integrity of the data in the systems.

The need for improvements in both the efficiency and accuracy of the processing of Senior Prime enrollments will become much more acute if Senior Prime becomes a permanent program with larger numbers of enrollees. An automation interface is needed that will allow MCS contractor staff to process enrollments with just one data entry and verification process that has automatic linkages among the DEERS, CHCS, and claims contractor systems (EAPP and CRIS), and the MCP. The introduction of such a capability can help standardize the Senior Prime enrollment processing methods across all participating MCS contractors.

**NEXT STEPS FOR THE EVALUATION**

As the first year of the subvention demonstration nears an end, RAND will be preparing to initiate several quantitative analyses of the impacts of the demonstration on beneficiaries and government costs, as summarized in Chapter 1 and described in detail in our Evaluation Plan (see footnote 8). The analysis of impacts on beneficiaries will focus first on examination of historical service utilization patterns for dual-eligible beneficiaries and any changes in those patterns after introduction of Senior Prime, with comparisons to control sites. The data used in this analysis also will be used in our cost impact analysis, which will begin to examine effects of Senior Prime on costs for both Medicare and DoD. Although it is too early to be able to detect most effects for quality of care, we plan to initiate this portion of our analysis as monitoring data become available from the sites.

Our analyses of enrollment demand and process evaluation work also will continue during the next year, including work in several specific areas.

*Enrollment Demand:*

- Continued documentation of enrollment trends for the demonstration sites, including patterns of age-in enrollments,
- Enrollment selection in Senior Prime enrollment as measured by risk scores based on the Medicare risk adjustment methodology,
- Analysis of frequency of disenrollments and possible contributing factors, and
- Multivariate analyses of factors influencing observed enrollment patterns.
Process Evaluation:

- Review of sites’ records for Senior Prime grievances or appeals, to analyze frequency of events, distributions by cause, and features that may be unique to military health care;
- Documentation of any Senior Prime provisions or practices that the sites are transferring for application to TRICARE Prime;
- Estimation of Senior Prime start-up and operational administrative costs for the sites, including those incurred by the LA Offices, MTFs, and MCS contractors;
- Documentation of sites’ activities in monitoring service utilization for Senior Prime enrollees, with specific focus on outpatient specialty visits and ancillary services;
- Analysis of beneficiary survey information to assess responses of dual eligibles to Senior Prime, reported satisfaction for those who enrolled, and reported effects on access to care. (detailed analysis of DoD beneficiary survey data and review of GAO survey reports);
- Continued analysis of market dynamics for Senior Prime plans, including interactions with other Medicare+Choice plans and with VA facilities serving the markets; and
- Monitoring of progress in implementing Medicare Partners in the demonstration sites.