

Evaluation of the Medicare—DoD Subvention Demonstration

Final Report

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SUMMARY

The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), and the Department of Defense (DoD) have been testing the feasibility of making Medicare-covered health care services available to Medicare-eligible DoD beneficiaries through the TRICARE program (the managed care program of the Military Health Service) and military medical treatment facilities (MTFs). The vehicle used was the Medicare-DoD Subvention Demonstration, which was established by the Balanced Budget Act of 1997 (BBA). The goal of the demonstration was to implement cost-effective alternatives for care for this dually eligible population while ensuring budget neutrality, that is, neither CMS's nor DoD's total costs increase. The Secretaries of the Department of Health and Human Services and of the Department of Defense executed a memorandum of agreement (MOA) that specified how the subvention demonstration was to be designed and operated. The memorandum provided for an independent evaluation of the demonstration, which RAND conducted. This report describes the final results of the RAND evaluation.

The demonstration tested TRICARE Senior Prime (TSP) plans, which were Medicare managed care plans that DoD operated at six demonstration sites. Senior Prime plans were certified by CMS as Medicare+Choice (M+C) health plans, which are alternatives to the standard fee-for-service Medicare program. The M+C program, which replaces the previous Medicare managed care program, allows a variety of managed care organizations to contract with CMS as capitated health plans. CMS pays these plans capitation payments, which are county rates adjusted by enrollees' risk factors. In the TSP model, enrollees received health care services through the TRICARE system, including primary care and other services at MTFs, and had access to civilian providers in the Senior Prime network when needed.

The demonstration included a second model, called Medicare Partners, which were to be formal agreements between civilian M+C plans and MTFs in the demonstration sites, under which the MTFs would provide specialty services for DoD beneficiaries enrolled in the civilian plans. The Medicare Partners model was not implemented by DoD because of limited interest by local M+C plans, as well as concerns by CMS and DoD regarding possible negative effects on access to care and financial issues for Senior Prime.

Under the terms of the memorandum of agreement, DoD had to spend at least as much on care for dually eligible beneficiaries as it spent in 1996, the baseline level-of-effort year, before it was eligible to receive capitation payments from CMS for Senior Prime enrollees. Furthermore, DoD spending for dually eligible beneficiaries had to meet several tests before it could retain any of those payments. DoD spending did not meet all the level-of-effort tests for the first period of the demonstration, which was a four-month period at the end of calendar year 1998. Therefore, it did not retain any capitation payments for this payment period. Although interim payments were made by CMS, DoD had to return these payments because of failure to meet the tests.¹

¹ We note here the distinction between calendar year and federal fiscal year (FY). The fiscal year begins on October 1. Because the subvention demonstration began operation close to the start of FY1999, we used the fiscal year as the time basis for our evaluation, where we compared costs and service utilization for FY1998 (before the demonstration) and FY1999 (the first year of the demonstration). Capitation payment calculations are based on calendar year.

DoD did not retain payments for calendar year 1999 either. In this case, low utilization of space-available care by non-enrollees reduced the amount of payments allowed, and the remaining payments were disallowed because there was positive selection in enrollment resulting in an average 7.6 percent reduction in payments when risk adjustment was applied. Computations for calendar year 2000 payments had not begun at the time this report was written.

The BBA provided for operation of the subvention demonstration through the end of 2000, and later legislation extended it through the end of 2001. The Senior Prime plans were discontinued at the end of 2001, as specified by legislation. DoD notified CMS that it was terminating the M+C contracts for the Senior Prime plans, and the two agencies carried out the necessary procedures to notify enrollees and provide for their smooth transition to other Medicare coverage.

KEY FINDINGS

Six key findings emerged from our evaluation:

- The demonstration sites successfully obtained Medicare certification for the Senior Prime plans, organized the plans, enrolled beneficiaries, and provided services for enrollees. Enrolled beneficiaries were reported to be pleased with improved access to MTF care and the services provided. However, the program involved a substantial administrative burden for staff in the MTFs, lead agent offices, and managed care support (MCS) contractors.
- Enrollment rates in the six Senior Prime plans generally were consistent with the planned enrollment levels, although a few sites did not reach those levels. Enrollments continued throughout the demonstration, including age-in enrollments by beneficiaries who were in TRICARE Prime and became eligible for Medicare when they turned 65. Evidence of weak positive selection was found for enrollments from the fee-for-service Medicare, but no risk selection was identified for enrollees who switched from M+C plans to Senior Prime.
- The overall government cost for health care services for the demonstration sites (excluding administrative costs) was an estimated \$659 million during the first year of Senior Prime (FY1999), which was 5.1 percent higher than the \$627 million in cost estimated for the baseline year (FY1998). (Refer to Table S.1.) When normalized to an estimated 4.3 percent increase in aggregate costs for the control sites, which is an estimate of what costs would have been in the absence of the Senior Prime plans, the demonstration yielded a slight cost increase (0.8 percent). Results might differ if a different set of MTFs had been selected as control sites. However, the observed changes in Medicare and DoD costs for the control sites between FY1998 and FY1999 are consistent with known service use trends, where access to MTF care was declining for Medicare-eligible DoD beneficiaries.
- Costs shifted from Medicare to DoD in the first year of Senior Prime. Aggregate Medicare costs for dually eligible beneficiaries in the demonstration sites declined by a modest 3.4 percent with the introduction of Senior Prime, while DoD costs increased by 29.8 percent (Table S.1). The size of the cost shift was mitigated because beneficiaries who chose Senior Prime were already heavy users of MTF services. Those who enrolled in Senior Prime in FY1999 had \$282 in DoD costs per beneficiary in the FY1998 baseline year compared to \$75 in baseline DoD costs for those who did not enroll (refer to Table S.2).

- The Medicare cost savings were obtained primarily from reductions in M+C capitation payments for beneficiaries formerly in M+C plans who switched to Senior Prime, and these savings were offset partially by increased fee-for-service expenditures for beneficiaries who did not enroll in Senior Prime.
- Any capitation payments made in the second or third payment periods of the demonstration would not affect overall government costs, but the payments would reduce the cost shift by increasing Medicare costs and reducing DoD costs (net of capitation revenue).

SENIOR PRIME MET ONE OF ITS GOALS

It is clear from the evaluation results that it would be costly to DoD, and to a lesser extent to the overall U.S. government, to continue Senior Prime in its current form. Despite the slight savings obtained for Medicare, the first year of Senior Prime increased government costs. Barring substantial reductions in service utilization by Senior Prime enrollees, we would expect these cost effects to continue in the second and third years of the demonstration.

It is important to consider these financial results in the context of overall performance relative to the goals of the subvention demonstration. Senior Prime had three basic goals: (1) provide accessible quality care to dually eligible beneficiaries, (2) maintain budget neutrality, and (3) provide cost-effective care. Senior Prime appears to have met the first goal for accessible and quality care, but it did not meet the financial goals.

Provide Accessible Quality Care to Dually Eligible Beneficiaries

There is weak evidence from the evaluation that the demonstration met this goal. At our initial site visits, providers and clinic staff reported that beneficiaries enrolled in Senior Prime were enthusiastic about having improved access to MTF services. The sites also reported that they maintained compliance with the TRICARE access standards for clinic appointments throughout the first year of operation. Our evaluation was not able to address this goal in greater depth, however, because the impact analysis for the second year of the demonstration was not funded. The analysis of effects on beneficiaries was scheduled for later in the demonstration to allow sufficient time for effects to occur and be captured in DoD survey data.

With respect to quality, the sites applied proactive quality management techniques for care to enrollees in compliance with the Medicare Quality Improvement System for Managed Care (QISMC) requirements, including a collaborative approach for disease management of diabetes. The sites reported low rates of grievances and appeals, suggesting that beneficiaries enrolled in Senior Prime were basically satisfied with their care. On the other hand, we found that dually eligible beneficiaries who did not enroll in Senior Prime experienced reduced access to MTF care because MTF capacity for space-available care declined. At the same time, they increased their use of Medicare providers in the community.

The General Accounting Office (GAO) documented similar beneficiary responses from its site visits and beneficiary survey, including survey findings that retirees expressed preferences for military health care and Senior Prime enrollees reported they could get the care they needed at no extra cost (GAO, 2002). Satisfaction with access and quality of care increased during the demonstration for Senior Prime enrollees but decreased for non-enrollees. However, the GAO survey results suggested that the TRICARE access standards were not met as consistently as reported by the sites.

Maintain Budget Neutrality

Senior Prime did not meet this goal of not increasing the federal government's net costs. Medicare service delivery costs declined by 3.4 percent in the first year of Senior Prime, but DoD net aggregate costs increased by 29.8 percent, with a resulting net increase in government costs. Furthermore, net Medicare savings in the first year were smaller than might be expected because of two opposing trends. Costs for capitation payments declined because payments were eliminated for M+C enrollees who switched to Senior Prime. At the same time costs for fee-for-service Medicare increased for beneficiaries who did not enroll in Senior Prime.

DoD administrative costs for startup and operation of the Senior Prime sites as M+C plans also were higher than expected. We report these costs separately because they are "high-level" estimates provided by the demonstration sites and DoD that are less precise than the estimated service delivery costs (see Section 5). These costs totaled an estimated \$41 million, of which \$33 million were for MCS contractor services, \$3 million were start-up costs for the demonstration sites, and \$5 million were first-year costs for the demonstration sites. The size of these estimated costs was 6 percent of the total of \$659 million in DoD service delivery costs for FY1999.

Provide Cost-Effective Care

The demonstration did not appear to meet this goal, based on observed changes in DoD service delivery patterns and costs. DoD costs increased substantially because greater numbers of beneficiaries used MTF care and those beneficiaries had higher per-capita utilization rates than those of dually eligible beneficiaries using space-available care in previous years. The high rates of use for clinic visits suggest that there was overutilization during the first year of the demonstration, although use rates began to decline slowly toward the end of the year. We did not have the data to track continuing trends in use rates, nor could we assess the extent to which the high utilization rates contributed to improved outcomes for enrollees or how declining access to MTF care for non-enrollees affected their outcomes.

The RAND evaluation could not assess this goal directly because it was not designed to perform a formal cost-effectiveness analysis. The evaluation focused on how Senior Prime affected DoD and CMS costs and utilization. Drawing conclusions about cost-effectiveness would require information about costs and outcomes of care for both Senior Prime enrollees and non-enrollees.²

BACKGROUND AND POLICY FRAMEWORK

An estimated 1.5 million U.S. military retirees and their elderly dependents are eligible for both Medicare health coverage in the private sector and health care services from military treatment facilities. Under current law, these dually eligible individuals are free to choose where they will obtain their health care. However, if they receive care in the military health system, Medicare is prohibited by law from reimbursing DoD for its services.

² Ideally, to assess effects on all potentially affected groups, the same information for other DoD beneficiaries using the MTFs and other Medicare beneficiaries in the service areas should be included in an analysis.

Many dually eligible beneficiaries prefer to use the military health system, but their access is limited under TRICARE, the managed care program established in 1995 by the Military Health System. The highest priority for care at MTFs is given to all active-duty military personnel, dependents, and other retirees enrolled in TRICARE Prime, the program's HMO option. Because elderly Medicare-eligible beneficiaries are excluded from TRICARE, they are in the lowest priority group and receive care only on a *space-available* basis.³ The situation for dually eligible beneficiaries age 65 or older has deteriorated as growing TRICARE Prime enrollments use increasing shares of the service capacity of MTFs. Consequently, these beneficiaries are obtaining larger portions of their health care in the civilian sector, despite their preferences to the contrary.

The subvention demonstration tested TSP, a Medicare managed care plan, as an alternative way to meet the health care needs of this population. For the demonstration, the BBA authorized Medicare to make payments to DoD for health care services provided for dually eligible beneficiaries, subject to requirements that DoD first meet its baseline level of effort for this group. The term *subvention* refers to these payments from CMS to DoD, that is, payments from one government agency to another.

Both CMS and DoD, the two major stakeholders in the subvention demonstration, had their own goals for program structure and performance. CMS has responsibility for the integrity of the Medicare program. From the CMS perspective, the demonstration needed to be structured to (1) protect the solvency of the Medicare trust funds, (2) provide for beneficiary choice and protections, and (3) ensure effective plan performance. DoD is seeking ways for the military health system to better serve its Medicare-eligible retirees and dependents. However, this goal has to be pursued within the framework of DoD's dual mission to maintain readiness for wartime medical care needs and to provide comprehensive peacetime health care services for active duty personnel, dependents, and retirees. From the DoD perspective, the subvention needed to (1) help fulfill DoD's moral obligation to provide DoD beneficiaries health care for life, (2) maintain budget neutrality in the military health system, and (3) strengthen DoD's capability to provide cost-effective managed care in the TRICARE program.

THE MEDICARE-DoD SUBVENTION DEMONSTRATION

The subvention demonstration established Senior Prime plans as Medicare+Choice health plans operated by DoD, in which participating MTFs were the principal health care providers for enrolled beneficiaries. The Senior Prime plans were certified by CMS, and they were subject to the same performance standards as all other Medicare+Choice plans, with some exceptions where requirements were waived because of the unique circumstances of military health care. A complex payment methodology was developed that determined capitation payments from CMS to DoD for services to Senior Prime enrollees.

The covered benefits were defined as the "richer of DoD or Medicare benefits." Senior Prime enrollees chose a military primary care manager (PCM) at a participating MTF where they would receive their primary care as well as most other covered services. For services the MTF did not provide, enrollees were referred to other MTFs or to civilian providers in the Senior

³ Those under age 65, including end-stage renal disease beneficiaries, are eligible for TRICARE coverage.

Prime network (network providers). Enrollees had no cost sharing for services provided by MTFs, but they did pay part of the costs for services obtained in the civilian provider network.

Beneficiary participation in Senior Prime was voluntary and did not involve any premium. Eligible beneficiaries who chose to participate agreed to receive all covered services through Senior Prime. DoD beneficiaries who were Medicare-eligible due to end-stage renal disease or who were younger than 65 and Medicare-eligible due to disability were excluded from the demonstration. These beneficiaries still could receive care from MTFs on a space-available basis, and those younger than age 65 could join TRICARE Prime.

Six demonstration sites with ten participating MTFs were selected by DoD with CMS approval. The sites represent a diversity of characteristics for the participating MTFs and the Medicare managed care markets in which they are located.

- Dover Air Force Base (AFB) in Delaware
- Keesler AFB in Biloxi, MS
- Region 6 site—two MTFs in San Antonio and two MTFs in the Texoma area on the Texas-Oklahoma border
- Colorado Springs—two MTFs
- Naval Medical Center (NMC) San Diego in California
- Madigan Army Medical Center (AMC) in Tacoma, WA

The total planned enrollment for these six Senior Prime sites was 27,800 Medicare-eligible DoD beneficiaries. The sites began enrollments soon after they met all the requirements for certification as Medicare health plans. The Madigan site was the first to start operation, enrolling beneficiaries for coverage effective September 1, 1998. All sites were operational by January 1999.

At each site, three organizations had important roles in operating Senior Prime: (1) The TRICARE regional lead agent (LA) office served as the official plan that CMS held accountable for plan performance and compliance with Medicare requirements; (2) the MTF(s) were the principal service providers for Senior Prime enrollees; and (3) the region's MCS contractor provided administrative support functions for marketing and enrollment, maintenance of provider networks, quality and utilization management, and claims processing.

SUMMARY OF EVALUATION RESULTS

Senior Prime Start-Up and Operation

Start-Up Experiences. Working within demanding time deadlines, the TSP plans were designed, certified, and into operation in about six to nine months. CMS and DoD completed the terms of the MOA and provided direction to the demonstration sites as they prepared for Medicare certification. The Medicare certification process required substantial investment of staff resources. Difficulties with the financial provisions of Senior Prime were encountered early because the payment methods were complex and the sites were uncertain they would ever see Senior Prime revenues, even if DoD obtained net payments from CMS after each year's reconciliation. Given these challenges, the sites initially focused on effective service delivery for their Senior Prime enrollees. Their primary yardsticks for success during early operations were quality of care, compliance with access standards, and satisfied enrollees. The participating MTFs were cautious about increasing staff, however, because they did not expect to get

additional financial support for new staff. Some staff reallocations were made to provide support to the enrollees as efficiently as possible.

Perspectives After One Year of Operation. A year later, the demonstration sites stated they continued support provision of services to the Medicare-eligible DoD beneficiaries, but they also expressed concerns that participation in Medicare involved a heavy administrative burden, especially in the absence of capitation payments. Despite these concerns, the demonstration sites reported they were transferring procedures and skills gained in Senior Prime to TRICARE Prime. Many of these capabilities are central to effective service delivery in a managed care environment, such as case management and disease management, quality monitoring, grievances and appeals procedures, and directing contractor activities for managed care support. The sites also recognized the value of having external oversight of their activities (by CMS), which provided performance accountability. With respect to readiness, when providers were involved in deployments and during annual rotations of military personnel, all the sites reported they had to balance conflicting demands and incur additional costs for temporary personnel. Care for Senior Prime enrollees continued to make a positive contribution to medical education.

Enrollment Demand

Positive early responses of the beneficiaries, as reported by site staff and representatives of military retiree associations, testify to the apparent success of the Senior Prime plans in delivering services. Although few of the sites reached their planned enrollments immediately, their enrollment rates generally were faster than Medicare enrollments in many private health plans. Those who chose not to enroll had a variety of reasons for their decisions, perhaps the most significant one being the short two-year life of the demonstration.

Sources of Senior Prime Enrollments. Beneficiaries switched at similar rates from both fee-for-service Medicare and other M+C health plans to enroll in Senior Prime. In some of the demonstration sites, Senior Prime drew large numbers of enrollees from single M+C plans. These beneficiaries represented substantial shares of total enrollments in M+C plans serving some of the sites, suggesting that Senior Prime was having noticeable effects on their local Medicare managed care markets.

Medicare Part B Coverage. To enroll in Senior Prime, dually eligible beneficiaries had to be enrolled in Medicare Part B. A small fraction of Medicare-eligible DoD beneficiaries in the demonstration sites had only Medicare Part A coverage. Of this group, about 13 percent enrolled in Part B by the start of the demonstration. Although many of these beneficiaries subsequently enrolled in Senior Prime, others did not. Those who did not enroll in Senior Prime may have picked up Medicare Part B coverage in anticipation of needing to use Medicare providers in the community because their already low priority for access to MTF direct care services would decline further after Senior Prime began.

Risk Selection. We found evidence that beneficiaries leaving fee-for-service Medicare to enroll in Senior Prime were slightly healthier than those who chose to stay in that sector (favorable selection). We found no evidence of selection for those leaving M+C plans to enroll in Senior Prime. Those switching to Senior Prime from M+C plans appeared to be of similar health status to those who remained in the M+C plans.

Age-in Enrollments. Enrollments by newly eligible Medicare beneficiaries (age-in enrollments) became an important component of total Senior Prime enrollment activity. The

popularity of the program with beneficiaries was reflected in the actions they took to position themselves for Senior Prime enrollment when they reached age 65, as reported to us by the demonstration sites.

Impacts on Service Utilization and Costs

We report in Table S.1 the overall costs estimated for the FY1998 evaluation population in the demonstration and control sites. Costs are presented for the year before the demonstration (FY1998) and the first year of the demonstration (FY1999). The FY1999 costs are discounted for inflation (described in the table footnote). A summary of our key findings follows.

Net Government Costs. For the first year of the demonstration, Senior Prime slightly exceeded budget neutrality for total government costs (Medicare plus DoD) for services to dually eligible beneficiaries in the demonstration sites, when normalized to the trend of increased costs for the control sites (estimated 5.1 percent cost increase for the demonstration sites between FY1998 and FY1999 versus 4.3 percent increase for the control sites). This result is the net effect of a small decrease in aggregate costs estimated for Medicare (–3.4 percent in constant FY1998 dollars) and a fairly large increase in estimated aggregate costs for DoD (29.8 percent).

Table S.1.
Total Medicare and DoD Costs for the FY1998 Index Population, Before (FY1998) and During (FY1999) the Demonstration, by Demonstration and Control Sites

	Demonstration Sites		Control Sites	
	Payments (\$1,000)	Payment Per Beneficiary Month	Payments (\$1,000)	Payment Per Beneficiary Month
<i>FY1998 spending</i>				
Total Medicare	\$466,080	\$338	\$441,385	\$314
Total DoD	161,058	117	179,895	128
Combined total	627,138	455	621,280	442
<i>FY1999 spending *</i>				
Total Medicare	\$450,177	\$325	\$478,846	\$339
Total DoD	209,049	151	169,436	120
Combined total	659,225	475	648,281	459
<i>Percentage change— in constant dollars</i>				
Total Medicare	–3.4%	–4.1%	8.5%	8.2%
Total DoD	29.8	28.9	–5.8	–6.1
Combined total	5.1	4.4	4.3	4.0

* Discounted to FY1998 dollars for Medicare payments and DoD network provider payments. DoD costs for MTF direct-care services in FY1999 did not have to be discounted because both FY1998 and FY1999 costs were estimated using unit costs developed in FY1998 dollars.

Shifts in Utilization and Costs. The cost shift from Medicare to DoD in the first year of Senior Prime was smaller than might have been the case because beneficiaries who chose to enroll in Senior Prime were already heavy users of MTF direct-care services during FY1998, as shown by the cost comparisons in Table S.2. Those who did not enroll were using services primarily in the Medicare sector in FY1998. After the introduction of Senior Prime, monthly

costs of care for enrollees increased 15.9 percent from \$478 per capita in FY1998 to \$553 per capita in FY1999. This increase was the net result of a 72.0 percent reduction in Medicare costs coupled with a 77.0 percent increase in DoD costs. Total costs per capita for non-enrollees increased only 2.4 percent, with cost for MTF services decreasing by 21.8 percent and costs for Medicare services increasing by 7.3 percent.

**Table S.2.
Medicare and DoD Costs Per Beneficiary Month for the Demonstration Site
Population, by Senior Prime Enrollment Status, FY1998 and FY1999**

	Payment Per Beneficiary Month	
	Senior Prime Enrollees	Non-Enrollees
	(enrolled at least 1 month)	(never enrolled)
<i>FY1998 spending</i>		
Total Medicare	\$196	\$375
Total DoD *	282	75
Combined total	478	450
<i>FY1999 spending</i>		
Total Medicare	55	402
Total DoD *	498	59
Combined total	553	461
<i>Percentage change— FY1998 to FY1999</i>		
Total Medicare	-72.0%	7.3%
Total DoD *	77.0	-21.8
Combined total	15.9	2.4

NOTE: The sample was divided into the groups of Senior Prime enrollees (enrolled for at least one month) and non-enrollees (never enrolled) to compare their utilization and costs for the two years.

* Estimated DoD costs include payments for network providers for the Senior Prime enrollees.

The estimated DoD monthly cost of care of \$498 per capita for Senior Prime enrollees in FY1999 compares reasonably closely with the GAO estimate of \$483 per capita (GAO, 2001b). The GAO also estimated monthly per-capita costs for enrollees for prescription drugs and administrative costs. When added to the estimated costs for care, the GAO estimated a total monthly cost of \$586 per beneficiary enrolled in Senior Prime.

To the extent that DoD retained any Senior Prime capitation payments in the remaining two payment periods of the demonstration, this transfer payment would reduce the cost shift from Medicare to DoD by offsetting DoD costs. However, even with the additional cost of payments to DoD, Medicare would probably continue to experience either budget neutrality or cost savings because CMS would pay only an incremental share of the DoD capitation rate above the DoD level of effort. Medicare would also save costs for M+C plan enrollees who switched to Senior Prime because the DoD capitation rates are lower than the rates that CMS would pay for these beneficiaries when enrolled in M+C plans. Thus, DoD health care costs can be viewed as the key determinant of net government budget neutrality.

Utilization of MTF Services. Before Senior Prime became available, beneficiaries in both the Medicare fee-for-service and M+C sectors used MTF direct-care services while also utilizing Medicare-covered services. During the first year of Senior Prime, use of MTF services by Senior Prime enrollees increased from their FY1998 use rates, while use rates fell for dually eligible beneficiaries who did not enroll in Senior Prime. Use of MTF outpatient visits by non-enrollees declined to 75 percent of their FY1998 use rates ($= 192/257$), and rates of MTF inpatient stays declined to 83 percent of FY1998 rates ($= 4.8/5.8$). (Refer to Section 5, Tables 5.15 and 5.18, for source numbers.) This reduction in use can be attributed to heavier use of MTF services by Senior Prime enrollees that further restricted access to space-available care for non-enrollees.

Sources of Medicare Savings. The M+C sector was the source of cost savings for Medicare under Senior Prime. In constant FY1998 dollars, M+C plan costs declined an estimated 6 percent [$= (201M - 214M)/214M$] because of elimination of M+C capitation payments for enrollees who switched to Senior Prime, whereas fee-for-service Medicare costs declined by only 1 percent [$= (249M - 252M)/252M$]. (Refer to Section 5, Table 5.4, for source numbers.⁴)

Counter-Balancing Fee-for-Service Medicare Costs. The small change in fee-for-service Medicare spending with implementation of Senior Prime is the net effect of two opposing spending shifts for dually eligible beneficiaries. Fee-for-service Medicare spending decreased for Senior Prime enrollees as they began to use MTF services. At the same time, dually eligible beneficiaries who did not enroll in Senior Prime moved away from MTF care to use of Medicare providers since declining space-available care restricted their access to the MTFs.

DoD Network Provider Costs. Payments to network providers represent a potentially important portion of the DoD costs, reaching an estimated 10.3 percent of the total DoD spending in FY1999 ($= 21.5M/209M$). (Refer to Section 5, Tables 5.3 and 5.4, for source numbers.) The demonstration sites reported that network providers were used more heavily when military providers were unavailable because of deployments or rotations. The current payment system also creates an incentive for the sites to refer patients to network providers to avoid MTF costs for their care (TRICARE Management Activity (TMA) pays the network providers directly). It will be important to assess empirically whether patients were actually shifted to network providers.

SHOULD DoD CONTINUE TO OFFER A PLAN SIMILAR TO SENIOR PRIME?

In considering whether Senior Prime should be continued in some form, it is important to understand the features and limitations of this model and how they differ from those of other models for enhancing health benefits for Medicare-eligible DoD beneficiaries. As decisions are made on which options to offer, the relative importance of the features of each option should be assessed (along with other criteria).

We illustrate the effects of differences in plan features by comparing the Senior Prime and TRICARE for Life models, as summarized in Table S.3. Senior Prime was a managed care model in which TMA and the MTFs incurred the costs for MTF and network provider services

⁴ The Medicare fee-for-service costs for each year are the sum of the Part A and Part B costs. The FY1999 costs are converted to FY1998 dollars by dividing by 1.014 (for 1.4 percent inflation).

provided to enrollees (net of any beneficiary copayment liability), and Medicare capitation payments were intended to generate new DoD revenues to offset these costs. In addition, the MTFs were to develop new managed care skills that could be transferred to providing care for TRICARE Prime enrollees.

Table S.3.
Applicability of Senior Prime and TRICARE for Life to DoD Goals

Goal	Senior Prime	TRICARE for Life
Improve benefits for beneficiaries, supplemental to Medicare benefits	Only for beneficiaries residing in MTF areas	For all Medicare-eligible beneficiaries
Improve access to MTF care	Yes, where offered	Unknown
Generate revenue to cover costs of care	Yes, but not achieved	No
Control size of new DoD costs	Liable for costs of all covered care	Liable for costs not covered by Medicare
Strengthen managed care capability	Yes (managed care)	No (fee-for-service care)

TRICARE for Life provides new fee-for-service benefits for all beneficiaries, regardless of location. Even a fully implemented Senior Prime program could not provide this kind of coverage because it is MTF-based. TRICARE for Life also controls the extent of DoD financial liability by covering only beneficiary cost sharing and costs of supplemental services not covered by Medicare. However, it is not designed to improve access to MTF care, to generate new revenue to offset costs of additional services, or to strengthen managed care capability.

The comparison in Table S.3 highlights how plan features affect the likelihood that DoD’s goals can be met. In the discussion below, we draw on our evaluation results to explore how Senior Prime or a similar DoD model might be designed to improve its feasibility. Specifically, we examine Senior Prime performance relative to the distinct sets of principles that guided CMS and DoD in negotiating its design and operation. We note any modifications that would improve the plan’s effectiveness and financial viability.

Performance Relative to CMS Principles

As discussed previously, CMS is responsible for the integrity of the Medicare program, including effective service to beneficiaries for Medicare-covered benefits, timely and appropriate payments to Medicare providers, protection against fraud and abuse, and the financial viability of the program. From the perspective of CMS, the subvention demonstration needed to conform to three basic principles that are important factors for all Medicare policy formation: (1) protect the solvency of the Medicare trust funds, (2) provide for beneficiary choice and protections, and (3) ensure effective plan performance.

The Senior Prime demonstration performed well on all three of these principles because the demonstration was designed to be responsive to them. CMS protected the Medicare trust funds through the capitation payment formula and the baseline level of effort (LOE) provisions, which were structured to maintain budget neutrality for Medicare. This is likely to remain a baseline requirement for any program affecting Medicare spending, given the priority placed on Medicare solvency by the Congress and U.S. public. Freedom of beneficiary choice and beneficiary protections have long been Medicare priorities, as reflected in the rules of the M+C program in which Senior Prime plans were participants. Beneficiary protections are provided

through the grievance and appeals processes and compliance monitoring for effective plan performance. As long as Senior Prime plans are certified M+C plans, CMS is likely to require them to meet the standards applicable for all M+C plans, with limited exceptions for issues that clearly are unique to military medicine (e.g., not requiring military physicians to be licensed in the state where they are practicing).

Performance Relative to DoD Principles

DoD encouraged authorization of the subvention demonstration to test how well Senior Prime (and Medicare Partners) could achieve three basic DoD goals: (1) contribute to fulfilling the moral obligation to provide military personnel health care for life, (2) maintain budget neutrality in the military health system, and (3) strengthen DoD's capability to provide cost-effective managed care in the TRICARE program. The goal of improving health care coverage for beneficiaries has two components: *improving benefits for beneficiaries* for services not covered by Medicare and *improving access to MTF care*. The goal of budget neutrality was to be achieved by *generating revenue* from Medicare capitation payments for beneficiaries enrolled in Senior Prime that would offset health care cost increases and by *controlling the size of new DoD costs*. We consider each of these four components.

Improve Benefits for Beneficiaries. This principle encompasses the scope of benefits provided by Senior Prime, the costs of these benefits to beneficiaries, and beneficiaries' response to the program. Benefits for Senior Prime enrollees were expanded by enhancing access to MTF care with no cost sharing and by offering additional benefits not covered by Medicare. As discussed above, Senior Prime enrollees appeared to be satisfied with what Senior Prime offered them. Those who did not enroll in Senior Prime did not have those expanded benefits, and they also experienced reduced access to space-available MTF care.

Improve Access to MTF Care. The Senior Prime model increased access to MTF care for enrollees by (1) establishing the participating MTFs as the primary sites of health care for enrollees and (2) giving enrollees priority for clinic appointments at the same level as TRICARE Prime enrollees. This effect is reflected in the large increase in aggregate and per-capita utilization and costs for MTF care. However, as discussed above, we also found that use of space-available care declined for other dually eligible beneficiaries.

Generate Revenue to Cover Costs of Care. One of the most informative outcomes of the demonstration was the failure of DoD to obtain capitation payments to offset costs for the incremental volume of care provided to Senior Prime enrollees. Three major factors contributed to this negative result: levels of the capitation rates, the baseline LOE, and the complex payment formula. For 1998, DoD did not retain any capitation payments because the sum of applicable capitation amounts and the costs of care for non-enrollees did not exceed the LOE. No payments were retained for 1999 either, with payments being cut because of low costs for space-available care by non-enrollees and risk adjustment for positive selection in enrollment.

The legislation set Senior Prime capitation rates at levels lower than the local M+C rates, which CMS sets annually for each county. For each county in the service area of MTFs participating in Senior Prime, a capitation rate was established at 95 percent of the county-level M+C rates, after removing components attributable to medical education and capital costs. In addition, the Senior Prime payments were adjusted for demographic factors and a retrospective adjustment was also applied for selection bias. Thus, only part of the standard M+C prospective

risk adjustment method (the demographic factors) was applied to Senior Prime payments. It is our understanding that these Senior Prime rates were designed to help control Medicare costs. Any changes in these provisions would have to be negotiated by CMS and DoD. It is not likely that CMS would agree to capitation rates higher than the local M+C rates, or to a risk adjustment method that treated DoD plans more favorably than the standard Medicare risk adjustment method.

The baseline LOE was the level of aggregate spending that DoD had to reach before capitation payments would begin to be credited for Senior Prime care. The LOE was determined using cost estimates based on 1996 service activity. However, between 1996 and the start of Senior Prime, DoD made numerous changes in the amount and mix of services provided to dually eligible beneficiaries. Some MTFs reduced or eliminated inpatient capacity and reconfigured their outpatient services. For example, Dover AFB closed its inpatient service effective 1998, and Brooke AMC opened a completely new hospital building in 1997. Furthermore, the new TRICARE program was being phased in by region during the years following 1996. The amount of space-available care the MTFs were able to provide declined, as TRICARE Prime enrollments grew while service capacity remained fixed. As a result, the baseline LOE was holding DoD accountable for a higher level of space-available care for dually eligible beneficiaries than what probably was being provided by 1998, the year immediately preceding the start of Senior Prime.

If Senior Prime were continued as a certified M+C plan, it is almost certain that DoD would be expected to continue to finance its historical level of health care for dually eligible beneficiaries, as measured by the LOE. To establish a more relevant LOE, the baseline year would need to be updated and the methodology for calculating DoD's LOE obligation should be adjusted for changes in MTF service mix over time.

Another factor that may have influenced revenue was the sheer complexity of the payment formula, provisions for interim payments, and rules for determining whether capitation payments will be made. In addition to being difficult for participants to understand, this multiplicity of rules offered opportunities for perverse payment outcomes. For example, the rules included thresholds that defined limits for the share of DoD costs attributable to Senior Prime enrollees and to non-enrollees receiving space-available care. The existence of these thresholds created some confusion and inappropriate financial incentives. However, they turned out not to be constraining factors in determining payment eligibility or amounts, in that DoD exceeded the minimum threshold for enrollee costs of care, thus meeting one test for payments. On the other hand, costs for space-available care were below the maximum threshold, which contributed to decreasing the amount of total payments that DoD could retain.

Control the Size of New DoD Costs. As discussed above, the substantial increase in DoD health care costs in the first year of Senior Prime was due to a combination of increased numbers of MTF users and increased use rates for those users. Much of the increased use stemmed from initial evaluation visits, which all M+C plans are required to provide for new enrollees. Furthermore, the sites reported that they expected the evaluation visits to identify health problems requiring follow-up care, but they found more problems than anticipated, which further increased visit rates. The monthly rates of DoD outpatient visits shown in Figure 5.1 reflect these early events in the operation of each site; use was slightly reduced during the later part of the year. It is not known if the Senior Prime sites were more proactive than other M+C plans in evaluation scheduling and follow-up for new enrollees.

The Senior Prime sites recognized the importance of effective utilization management, which they pursued to achieve more cost-effective levels of care. However, they were not uniformly successful in managing care during the first year of the demonstration. Barriers they identified included:

- problems coordinating utilization management (UM) activities performed by the MTFs and the MCS contractors
- ineffective UM provisions in some MCS contracts that took a long time to change
- MTF staffing levels and mix that were fixed by annual budgets
- lack of financial incentives to encourage effective management of care
- confusion regarding how reducing utilization would affect payments under the complex threshold provisions of the payment formula.

The financial incentive and payment formula issues may have contributed to increased utilization because the site teams reported that they focused on providing high-quality care for enrollees and had less concern about these financial issues. At the same time, MTF commanders reported that they were very concerned about the escalation of service delivery costs, but they lacked the authority to overcome the barriers and adjust the resources required.

Strengthen Managed Care Capability. The demonstration sites appear to have achieved improved capability in managed care techniques as a result of Senior Prime. Two factors seem to have driven this effect. First, the presence of an external CMS oversight function through the M+C contracts gave sites an incentive to implement new procedures to comply with Medicare requirements. The sites speculated that without this oversight, they might have made slower progress in such areas as quality assurance initiatives and care management. Second, all the sites reported they had begun to transport several of the new procedures required by Medicare for use in TRICARE Prime. Most of these were techniques for managing care. Although many improvements were accomplished at participating MTFs, some were also made by the MCS contractors because the Senior Prime plans were operating partnerships that included those led by the LA offices, MTFs, and MCS contractors.⁵

Seeking a Feasible DoD Managed Care Option

Senior Prime met all the CMS principles with respect to the Medicare program; it also met the DoD principles of improving benefits for some dually eligible beneficiaries and helping to strengthen the TRICARE managed care capability. However, despite these positive results, its failure to achieve budget neutrality for DoD suggests that Senior Prime, as designed for the demonstration, is a costly option for enhancing health care coverage for dually eligible beneficiaries. We summarize in Table S.4 the factors that contributed to this outcome and suggest changes that might be made to improve performance. We consider possible changes for both a modified Senior Prime model (Medicare certified) and for a DoD managed care plan model that does not involve Medicare.

⁵ As described in Section 1, each TRICARE region is commanded by a LA, and each service has designated responsibility for managing some of the regions. Senior Prime was operated out of the LA offices.

Table S.4.
Comparison of Senior Prime Performance Issues for a Modified Senior Prime and Similar DoD Plans Not Certified as Medicare+Choice Plans

Senior Prime Performance Issues	Status in a Modified Senior Prime	Other Form of DoD Managed Care Plan	
		Does Issue Apply?	Comments
<i>Limited DoD revenue</i>			
Medicare capitation formula	Revise closer to M+C rate	No	No capitation to offset new costs for a DoD-only plan
Baseline level of effort	Update	No	Not relevant
Payment formula rules	Simplify	No	Not relevant
<i>Escalation of DoD costs</i>			
Increased MTF enrollments	Limit sites and # of enrollments	Yes	MTFs serve enrollees; can limit sites and enrollments
High utilization rates	Strengthen management of care	Yes	Can decide on use of initial evaluations; should strengthen management of care
MCS contractor services	Use fixed price contract	Depends on design	Depends on use of network providers; less administration
<i>Administrative burden & costs</i>			
M+C plan qualification and start-up	Rules remain; lower burden w/experience	Yes	Start-up costs will occur but no costs for M+C application and certification process
Medicare compliance process	Same	No	Only internal compliance rules
Data system duplication	Same	Depends on design	No interface with Medicare enrollment data system; perhaps with MCS contractors

We discuss each performance issue briefly below. Note that the issues are stated from the perspective of DoD implementation because DoD would probably take the lead in choosing between a modified Senior Prime and a DoD-only plan. CMS policies would need to be considered as well for a plan that is Medicare certified.

Limited DoD Revenue. Only a Medicare certified managed care plan would give DoD the opportunity for revenues to offset health care costs. All the design elements affecting revenue could be revised to some extent to enhance DoD’s potential to obtain revenue under such a plan, subject to CMS policies designed to protect the Medicare program. In our opinion, the increase in revenue that could be achieved by such revisions would not be sufficient to offset the large incremental costs of care that DoD incurred for Senior Prime enrollees.

Escalation of DoD’s Costs of Care. We believe this is the single most important issue to be addressed in either a modified Senior Prime or a DoD-only managed care plan. If the MTFs’ care management capabilities were not strengthened, DoD would have high costs for any MTF-based model. The costs of care are driven by both the number of beneficiaries and their use rates, and explicit actions would need to be taken to address both factors.

Limiting either the number of sites or total enrollments could control the number of participating beneficiaries. Ways to monitor both use and quality of care for those enrolled could include the following actions:

- Integrating consistent performance standards into health care delivery processes for key health conditions across the MTFs and network providers.
- 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.
- Management of the structural issues the sites identified as barriers to their progress in strengthening care management processes.
- Updating MCS contract provisions to ensure that contractors are using the most effective care management techniques and are collaborating with the MTFs.
- Consistent quality and utilization monitoring across the Senior Prime sites (or programs in the future) with feedback reported regularly to providers.

Administrative Burden and Costs. Given the M+C regulations, most of the administrative costs experienced in the demonstration would continue in any modified Senior Prime that is Medicare certified. These costs include staff time to prepare applications, implement enrollment and startup, and document performance compliance, all of which are an integral part of being a M+C plan. If the current Senior Prime structure were continued, the LA offices, MTFs, and MCS contractors would have to spend time coordinating activities. Based on estimates of the Senior Prime administrative costs prepared by the sites and TMA, we have concluded that these costs would be measurably lower for a DoD-only plan because none of the activities required for M+C plans would be applicable, and the plan administrative structures could be simplified. Existing MTF care delivery provisions, e.g., quality management, would support care for all patients, including dually eligible beneficiaries enrolled in the DoD managed care plan.

It is difficult to assess how MCS contractor costs might change under a modified Senior Prime plan or a DoD-only plan. Some of the contractor costs incurred during the demonstration reflected the newness of the program and would not occur in an ongoing program. Contractors participated with TMA in defining the detailed scope of work that is documented in Chapter 20 of the *TRICARE Operations Manual*, and they also worked closely with the LA office and MTFs in developing the many enrollment and service delivery procedures involved in Senior Prime. Recognizing the many uncertainties involved, TMA paid the contractors on a cost-plus basis for the demonstration. To the extent that MCS contractors have a role in a future managed care plan for dually eligible beneficiaries, fixed-price contracts should be established for those services, and DoD might consider provisions to share some of the risk with the MCS contractors.

Geographic Scope of a Managed Care Model

If DoD decides to continue to offer an MTF-based managed care option for dually eligible beneficiaries, choices will need to be made regarding the geographic scale of the program. Two basic choices are available: (1) continue to offer a managed care model in the six

sites that participated in the subvention demonstration or (2) expand the program to enhance access to this model by including additional MTFs. We have learned from the evaluation that either option would involve some challenges, which are summarized here and discussed in greater detail at the end of Section 6.

Several of the demonstration sites expressed caution regarding the extent to which the program could be expanded in the existing facilities. The sites believe that a permanent program would create additional enrollment demand by beneficiaries who had been reluctant to sign up for the demonstration because it was temporary. The Madigan and the Region 6–San Antonio MTFs, for example, already have people on their Senior Prime waiting lists. Three possible constraints to expanding the Senior Prime model need to be considered: (1) the capacity of primary care clinics to serve additional patients, (2) the capacity of current MTF budgets to provide the administrative staff support, and (3) the ability to expand the number of network providers. Several site teams suggested that the policy of limiting PCMs to military providers needs to be reconsidered. The capacity limits of MTF clinics could be accommodated at some sites if enrollees could use network providers as PCMs, similar to TRICARE Prime. An assessment of such an approach should consider potential effects on the ability to manage care effectively.

If DoD decided to expand the program, it would need to choose the most feasible locations. Factors that should be considered include the size of the local dually eligible population, characteristics of the Medicare managed care market, and features of the MTFs that are candidates for participation. Choices regarding governance structure would also need to be made.

CONCLUSION

The Medicare-DoD Subvention Demonstration tested TSP as a managed care approach for enhancing access to affordable health care for Medicare-eligible DoD beneficiaries. While Senior Prime achieved solid beneficiary participation and satisfaction, it also raised a difficult set of challenges involved in applying managed care to the DoD health care system. These challenges included financial issues such as establishing equitable capitation rates and an appropriate level-of-effort baseline, as well as management issues such as effective care management and administrative processes for health plan sites. The basic structures of TRICARE and the DoD health system, including separate management jurisdictions and hierarchical budgeting methods, contribute to the challenges by creating incentives that discourage delivery of cost-effective care. MTFs need to be motivated not only to provide excellent care but also to manage appropriateness of care and related costs. Although DoD has decided to discontinue the Senior Prime model, many of the lessons learned from this demonstration are applicable to any managed care program that DoD may contemplate in the future.