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MEDICARE SUBVENTION

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BEFORE THE

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UNITED STATES SENATE

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MEDICARE SUBVENTION

TUESDAY, MAY 4, 1999

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:27 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Jeffords, Moynihan, Baucus, Rockefeller, and Robb.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order.

I regret the delay, but, as I am sure everybody here knows, we had a vote, and the prime minister of Japan, as well, at a breakfast, so a few of us had to stop to pay our respects.

But it is my pleasure to welcome the witnesses from our first panel. I am going to skip opening statements, including my own, but they all will be included as if read.

But before we begin with the testimony, the committee is pleased to have Hon. Togo West, Jr., Secretary for the Department of Veterans Affairs. Secretary West, I understand you have many competing obligations this morning, so I extend a special opportunity for your statement before the committee. Please come forward. It is a pleasure to welcome you.

STATEMENT OF HON. TOGO D. WEST, JR., SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, DC

Secretary WEST. Thank you, Mr. Chairman, for this opportunity, and members of the committee, to speak on behalf of what is, in effect, Mr. Chairman, the top legislative priority of the Department of Veterans Affairs.

It is also, we believe, an opportunity for the Congress to enact legislation that will have a very positive impact on a Nation's veterans, as well as the Medicare population as a whole.

For several years now, the administration has proposed a demonstration project to authorize Medicare reimbursement for VA health care services provided to higher income Medicare-eligible veterans without compensable disabilities.

This is a proposal, Mr. Chairman, Senator Moynihan, and members of the committee, that will benefit veterans who can now use

their Medicare benefits anywhere but at a VA facility. It will benefit the Medicare trust fund by reducing the costs of care to those affected veterans.

Under current law, the VA cannot now seek reimbursement from the Medicare system for services provided to Medicare-eligible veterans. In many instances, particularly in cases of higher-income veterans without compensable disabilities, this makes it much more difficult for these veterans to have access to the VA health care system.

The importance of enacting a Medicare subvention pilot program for VA this year cannot, Mr. Chairman, be overstated. Our World War II, Korean War, and Vietnam era veterans' populations are rapidly entering retirement age and Medicare eligibility—indeed, our World War II veterans are already there—creating an increased demand and need for medical treatment, as well as an increased demand and need to form partnerships to meet our Nation's needs.

Currently, 37.6 percent of the veterans population of this Nation is over age 65, as contrasted with 16 percent of the national population as a whole. As this population, our veteran population, ages, the benefits of providing a VA Medicare option will grow for all parties.

VA expertise in treating the medical conditions that affect the aging make VA ideally suited to providing these services to our veterans. Indeed, Mr. Chairman, for many disabilities, particularly those that afflict older individuals, the VA health care system sets the standard for health care.

We believe that the greater the number of veterans who use the VA health care system, the greater the benefit. Veterans with current VA entitlement benefit because VA facilities and assets can be optimally used, ensuring the robust viability of the health care system.

When Medicare-eligible veterans utilize the VA system, they benefit from its quality, and there is also a positive impact on the financial viability of the Medicare trust fund itself.

Equally as important, allowing a pilot program for Medicare reimbursement will provide the VA an excellent opportunity to explore new avenues for delivery of care and access. I am particularly concerned, Mr. Chairman and members of the committee, that we explore the impact of subvention in protecting health care for veterans in rural and remote areas.

Dr. Kizer, our Under Secretary for Health Care, will discuss the specifics in his testimony, but I think it important for us to remember that, if we can assure rural or medically underserved populations are included in any pilot, we will have done a great service.

And, because the VA is the Nation's largest health care provider, with facilities located throughout the country, VA is in a unique position to provide health care services in those areas where lack of competition has frozen many of our veterans out of adequate, affordable, and accessible medical care.

No veteran should be penalized because of his or her zip code. By partnering with HHS, we in VA believe we will be able to ensure that we meet this obligation to those who have been willing to give their lives for our Nation's freedom.

As we remember our veterans, we can remember as well that they, too, benefit from fiscal responsibility. Therefore, they will join the rest of the Nation's taxpayers in another benefit from this proposed pilot program: for VA plans to offer medical services under this program at a discount to the Medicare trust fund, that is, at 95 percent of Medicare normal payments to the private sector, thereby generating significant savings for the Medicare trust fund.

Mr. Chairman, Senator Moynihan, members of the committee, this is a win-win opportunity for the Nation. Not only will veterans be given another, better health care option, but cost savings accrued through the use of the VA system will benefit the trust fund as a whole.

Our department has been working closely with veterans, the Congress, and other administration entities to formulate an acceptable proposal that augments health care to veterans and protects the Medicare trust fund. We greatly appreciate the efforts, Mr. Chairman, of the Senate, and especially several members of this panel, Senator Specter and the members of his committee, for all of your efforts and contributions in moving this pilot program toward reality.

Hopefully, working together we can develop a protocol which is not only acceptable to all decision makers, but benefits all parties who will have access to the VA and Medicare systems.

I look forward to working with you, Mr. Chairman. Thank you for this opportunity. Dr. Kizer, our Under Secretary, will represent the department from this point forward with further testimony, and, with your permission, I will withdraw.

The CHAIRMAN. Thank you for being here, Mr. Secretary. We appreciate it.

Now, we will call upon Senator Specter. I would ask that you keep your remarks as brief as possible, because we, unfortunately, are running very late because of the vote and other matters.

But it is a pleasure to have you here.

STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM PENNSYLVANIA

Senator SPECTER. Thank you, Mr. Chairman. With the promotion to Secretary, I will be briefer than usual.

I am glad to see Senator Moynihan's back is back. It is nice to see you back in the Senate, Pat.

Senator MOYNIHAN. Thank you, sir.

Senator SPECTER. The issue of making Medicare funds available for veterans is not only win-win, it is three wins: win-win-win. It is a win for Medicare because it costs less at the VA, with a maximum of 95 percent. It helps the VA, which is vastly underfunded, by putting some $470 million in the VA from Medicare, which really owes it to these people in this age category.

It is a win for the veterans, because many of them cannot go to the VA because of income limitations, but they could if it were paid for by Medicare. As a matter of fundamental fairness, somebody who qualifies for Medicare ought to be able to get Medicare at the VA as well as any other hospital. By going to the VA, it helps the VA by additional funds.

Senator Jeffords has been the leader on this matter. In fact, there is quite an overlap between the two committees, veterans having Senators Rockefeller, Murkowski, Graham, and Jeffords. We practically have a quorum, or a majority, on your committee.

Of course, this is something that I work with in great detail, not only as chairman of the Veterans Committee, but as chairman of the Appropriations Subcommittee, which has jurisdiction over funding for the Department of Health and Human Services.

This is such an obviously potent case, that I rest it. I am going to speak no longer, and yield back the balance of my time, Mr. Chairman.

The CHAIRMAN. Well, thank you, Arlen, for being here. We appreciate your leadership in this very important matter.

Senator SPECTER. And I have a long statement, which I would ask be made a part of the record.

The CHAIRMAN. Without objection.

Senator SPECTER. I just read it myself. I do not think anybody else will, but I would like to have it in the record.

The CHAIRMAN. Very good. Thank you for being here.

[The prepared statement of Senator Specter appears in the appendix.]

The CHAIRMAN. Now we will move forward with our first panel of witnesses. We are very pleased to have here Dr. Bob Berenson, who is director of the Center for Health Plans and Providers at HCFA, the focal point in HCFA for managed care payment policy and operational issues.

We are pleased to welcome Admiral Tom Carrato, who is head of the Tricare Management Activity at the Department of Defense, a program serving 8.4 million beneficiaries worldwide.

And Dr. Ken Kizer is the Under Secretary for Health from the Department of Veterans Affairs, where he oversees the Nation's largest integrated health care system.

Again, thank you for joining us. We ask each witness to limit his testimony to 5 minutes.

Dr. Berenson, we will start with you, please.

STATEMENT OF ROBERT A. BERENSON, M.D., DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Dr. BERENSON. Thank you. Good morning, Chairman Roth, Senator Moynihan, and distinguished committee members. Thank you for inviting us to discuss our Medicare subvention demonstrations.

I also want to thank the General Accounting Office for its very valuable evaluation of the Department of Defense demonstration project.

The DoD demonstration for military retirees and their families has been up and running since last August. We expect to sign a memorandum of agreement with the Department of Veterans Affairs on the VA demonstration in about a week.

Subvention has the potential to benefit all parties involved, most importantly the beneficiaries who are eligible for both Medicare and military or veterans' benefits.

The Clinton administration strongly supports these demonstrations, and we are committed to meeting the challenges these important projects present.

In both, we are focusing on two imperatives: protecting beneficiaries and protecting the Medicare trust funds. The VA demonstration is modeled on the DoD demonstration. It is important that both rely on a coordinated care model.

Demonstration sites must meet all conditions of participation required of Medicare+Choice coordinated care plans, except for those such as fiscal soundness requirements that are clearly not applicable to the military or to the VA.

Focusing on coordinated care will promote higher quality, it will limit costs in the administrative burden, and it will provide consistency between the two demonstrations.

The GAO has identified important concerns about the DoD's data systems and estimate of its level of effort for the demonstration. That estimate is critical to protecting the trust funds and ensuring that taxpayers do not pay twice for the same services. We are working with the DoD to address these concerns, and we are hiring an outside contractor to help us make sure the level of effort estimate is correct.

We are also heeding the lesson learned in focusing more on data systems and the level of effort estimate up front as we move forward with the VA demonstration. We are committed to learning as much as we can from these projects.

We have hired an outside contractor to assess the DoD's demonstration impact on cost, access, and quality, as well as any effects on providers and other Medicare beneficiaries in the surrounding community. We will have a similar evaluation conducted for the VA demonstration.

We look forward to working with the committee, the DoD, and the VA as we continue. Together we can limit the risks and ensure top-quality care, and in the end, we will all benefit. Thank you very much.

The CHAIRMAN. Thank you, Dr. Berenson. Dr. Kizer?

[The prepared statement of Dr. Berenson appears in the appendix.]

STATEMENT OF KENNETH W. KIZER, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, DC

Dr. KIZER. Good morning, Mr. Chairman, members of the committee. In the interest of time, I am going to make my remarks very brief. I merely would like to echo what Secretary West and Senator Specter said, that this really is, we believe, a win-win situation for the veteran user, as well as the taxpayer and the Medicare trust fund.

I would also ask that my complete statement be included in the record, and I would also underscore that, in that statement, there is a considerable amount of detail underscoring the fact that the veterans' health care system of today is a very different system than five years ago.

And we, based on the changes that have occurred over the last several years, feel quite confident that the administrative and

other demands of the Medicare program is something which VA can certainly rise to the challenge of providing.

The CHAIRMAN. Thank you, Dr. Kizer. Admiral Carrato?

[The prepared statement of Dr. Kizer appears in the appendix.]

STATEMENT OF REAR ADMIRAL THOMAS F. CARRATO, CHIEF OPERATING OFFICER, TRICARE MANAGEMENT ACTIVITY, FALLS CHURCH, VA

Admiral CARRATO. Good morning, Mr. Chairman, distinguished members of the committee. Thank you for the opportunity to be here today to discuss our progress in implementing the Tricare Senior Medicare subvention demonstration program.

This demonstration allows dual military and Medicare-eligible beneficiaries in select sites to participate in the Tricare program. The medical mission of the Department of Defense is to provide medical services and support to the armed forces during military operations, and to provide medical service and support to members of the armed forces, their family members, and others entitled to military medical care.

Tricare is a regionally-managed health care program for active duty and retired members of the uniformed services, their families, and survivors. Tricare brings together the health care resources of the armed forces and supplements them with networks of civilian health care professionals to provide better access and high-quality service, while maintaining the ability to support military operations.

Tricare offers expanded access to care, a choice of health care options, consistent, high-quality health care benefits, and reduced costs for beneficiaries.

Despite our successful worldwide implementation of Tricare, Tricare will always be incomplete until we have the capability to enroll retirees over the age of 65. The Department of Defense feels a sincere and enduring responsibility for the health of our retired beneficiaries, and will do all it can to meet its moral commitment to provide health care for our military retirees and their families.

Our higher priority for keeping our commitment is Tricare Senior. DoD worked closely with the Congress to achieve the Balanced Budget Act provision authorizing a 3-year demonstration of Medicare subvention under which the Medicare program treats the military health system like a risk-type HMO for dual-eligible beneficiaries.

The legislation also authorized Medicare HMOs to make payments to DoD for care provided by military hospitals participating in the demonstration to HMO enrollees. This part of the demonstration, called Medicare Partners, will allow DoD to enter into contracts with Medicare HMOs and to provide specialty and inpatient care to dual-eligible beneficiaries.

A memorandum of agreement addressing the provisions for the demonstration and the applicable conditions of participation was written and signed by the Secretary of Defense and the Secretary of HHS.

The provisions and conditions for participation as Medicare managed care organizations required the selected sites to meet the requirements for certification and award as a Medicare+Choice orga-

nization. DoD met all requirements, other than a few specifically waived by HCFA in recognition of the unique aspects of dealing with a Federal health care program.

Meeting the statutory requirements for approval as a Medicare+Choice plan was a major undertaking for DoD. Qualification of the sites required DoD and HCFA to devote extensive resources over a nine-month period. The application approval process was expedited significantly by HCFA in order to accommodate the demonstration time frames.

Since January of 1999, all of our sites are providing health care delivery under the Tricare Senior prime demonstration program. To date, enrollment in the program exceeds 25,000 enrollees.

I am quite pleased with the excellent progress that we have made in implementing this important program. Success in this endeavor will be critical in enabling the Department of Defense to keep its health care commitments to its senior beneficiaries to whom we owe so much. Thank you.

[The prepared statement of Admiral Carrato appears in the appendix.]

The CHAIRMAN. Thank you, Admiral Carrato.

My first question is for the entire panel. It is my understanding that establishing an accurate level of effort is critical in ensuring that Medicare dollars are not paying for health care services already supported by an appropriate budget.

In addition, sufficient data systems for managing the demonstration and assessing its cost efforts are equally important. Could each of you please describe the ability of your department's data system to establish an accurate level of effort and capture critical cost, access, and quality information for managing and evaluating a demonstration? Dr. Berenson?

Dr. BERENSON. Yes. Well, most of the requirements for determining a level of effort actually come from the VA, and the DoD needs to have their data systems in place to determine level of effort.

We will be able to, in our Y2K upgrades, to be Y2K compliant. It will put us in a position where we can accept the data that will be provided to us. But I think the other two departments need to address the issue of capability of submitting the data to us. We are working with them.

With DoD, we have specifically jointly agreed, based on the urging of the GAO, to select an outside contractor which will work with DoD and HCFA to make sure that we can determine an accurate level of effort, and that work is proceeding.

The CHAIRMAN. Dr. Kizer?

Dr. KIZER. I would note a couple of things. One, is we have obviously worked with HHS in this regard and believe we have an agreed-upon methodology to determine this. Of course, that is contingent upon having the data systems available.

While VA has historically a variety of data systems to track and account for costs, I was not satisfied with what we had and, in the beginning of 1995, we have put system-wide, now, a cost accounting system in place in all of our facilities. We call it DSS, or Decision Support System. It is a commercial product that is used commonly in the private sector, where it is known as a TSI system.

This is a tried-and-true system that should provide the information, or any information, both as far as cost, as well as for quality, and a number of other issues that may come to bear here.

The CHAIRMAN. Admiral Carrato?

Admiral CARRATO. Yes. Mr. Chairman, we believe that we do have a system that can capture accurate level of effort information. As Dr. Berenson noted earlier, the GAO was very helpful in their review of our level of effort calculation. They did point out a couple of areas where we needed to be more vigilant. One was in the standardization of data across our system so that Air Force, Army, Navy facilities are counting data the same way.

They also identified a few issues related to data accuracy and, as those issues were identified, we did correct the level of effort calculation, and have actually done so on four occasions.

Again, to underscore a comment that Dr. Berenson made, the other thing that we were urged to do by the GAO was to get some additional outside accounting review of the level of effort calculation, which, jointly with HCFA, we are doing. We are anxious to have that effort started, and, whatever findings are reported out, we certainly will accommodate in the level of effort.

The CHAIRMAN. Dr. Berenson and Dr. Kizer, can you describe the differences in how a managed care versus fee for service demonstration would impact your organization, specifically addressing administrative and operational readiness, implementation, and reimbursement? Could you provide a recommendation as to which type of demonstration would be most suitable for your organization given the circumstances? Dr. Berenson?

Dr. BERENSON. Yes. I will start. First, I would make a point that we would refer to this as coordinated care, and not managed care. The difference is that managed care often implies a separate insurance company that then contracts with hospitals and physicians and others, whereas the VA already has—and Dr. Kizer will talk more about it—a coordinated care concept in which we would be contracting directly with the VA and there would not be a third party involved. So, it is coordinated care.

There are a number of practical reasons. We feel that conducting two demonstrations, one coordinated care and one fee for service, simultaneously would add administrative complexity to the process.

Some of the data requirements for fee-for-service reimbursement exceed what is required for a coordinated care demonstration, particularly in the area of developing cost reports for hospital care, which is how Medicare reimburses.

We think there would be a diversion of effort to try to undertake that set of issues, in working with VA and us, to have them understand what our payment requirements are and for them to get those systems in place.

We think there is a benefit in having both demonstrations use a coordinated care model so we can learn more. It would be helpful to us in interpreting the results to have similar kinds of demonstrations in place.

I guess, finally, a coordinated care rather than a fee-for-service demonstration provides more guarantee of protection of the trust funds. We can determine up front what the capitation payments are, we can establish firm caps on the payment that are made in

any given year, whereas, in fee-for-service, it is much less certain about how much you are paying and what you are paying for.

We would probably have to introduce program integrity requirements to deal with what we have to do on the fee-for-service side, up-coding, and similar kinds of issues. So, for a series of reasons, we think it makes sense to start with coordinated care as the mechanism, and we think that that is consistent with where the VA is going. Dr. Kizer will respond.

The CHAIRMAN. Thank you. Dr. Kizer?

Dr. KIZER. I think Dr. Berenson has given a good overview for multiple reasons why a coordinated care approach would be the preferred approach.

I would underscore a couple of points by noting that the premise, or the whole philosophical underpinnings of the transformation of the veterans health care system and the implementation of integrated service networks and other things that have occurred in the past 5 years, is predicated on the notion of coordinated care.

So the notion of providing a coordinated care model under the Medicare subvention proposal is very consistent with what we have been doing, and certainly the philosophy and where the VA has been going over the past several years.

I would also note that I think we, from an administrative point of view, would be less prepared to do a fee-for-service model that would take, probably, longer to gear up to do that because of the additional administrative requirements.

Finally, I would also note that I think, from a medical care point of view, just the service provided to the patient, the coordinated care approach is certainly preferable.

The CHAIRMAN. Admiral Carrato, would you want to comment on your experience?

Admiral CARRATO. I would agree with what Dr. Kizer and Dr. Berenson have said. Our approach is much like a coordinated care approach, the Tricare Senior, where we focus on prevention, and we do have a primary care provider who is coordinating all of the care for our enrollees.

An added feature of our demonstration program, which is something that we have not yet implemented but we will be looking at, is what I referred to in my oral statement, the Medicare Partners provision.

That provides a little bit of a different wrinkle to the demonstration, where it allows military hospitals to enter into agreement with Medicare HMOs to actually sell some service to them. So, I think that will provide us an additional feature to test.

The CHAIRMAN. It is now my pleasure to call on Senator Moynihan. It is good to have you back. He is our intellectual baseline of the Finance Committee. Welcome.

Senator MOYNIHAN. Well, sir, it is the lower back rather than base that bothers me. I want to say that I was happy to have Medicare and, if I needed it, I could have had the VA as well. So, I was covered well in that regard.

I think, Mr. Chairman, we have a rewarding idea here. It is my impression that the Veterans Administration has been wasting a bit, has it not? It has been thinning down. Medicare provides an

alternative and a different way of health care than is available for veterans through the Veterans Administration hospital system.

Now that you have this dual opportunity, things are, for various reasons, more agreeable than the VA hospitals. This would reverse some of that decline and give some advantages to hospitals that they do not now have.

Could I ask an informed panel if this somewhat uninformed remark is about right?

Dr. KIZER. Actually, I would take considerable exception to the remark, and I do not believe it is actually on target.

Senator MOYNIHAN. My term wasting would have bothered you, and I think that is fair.

Dr. KIZER. Well, if you consider that, over the last 4 years, that the Department of Veterans Affairs has provided care for 520,000 more people in 1998 compared to 1994, a 22 percent increase in the number of individuals served, then that hardly reflects a system that is wasting.

Indeed, the biggest problem that we have today is that the demand for care exceeds our ability to provide it because of the funding constraints on the system, recognizing that VA is a discretionarily funded program and not an entitlement, that we can only provide care up to the extent that we have funds. The demand for care is increasing markedly, both in acute care and long-term care.

Senator MOYNIHAN. Is this phenomenon from a bulge in the eligibility of persons from the second World War entering into their 70's?

Dr. KIZER. It is due to a couple of things. One, is that the World War II population is requiring more acute care services because of their age, their long-term care needs are skyrocketing, which is a particular issue for us today.

But, concomitant with that, the Vietnam era veteran, which is the largest single group of veterans today, slightly more than the World War II veterans, is in their 50's and 60's, which is a time when they are now presenting for care.

Many of these individuals historically did not seek care, they were relatively healthy, but now they have their heart disease, or emphysema, their other problems. So, at least for the next decade, we see continued marked increased demand for VA care, both acute care and long-term care.

Senator MOYNIHAN. I stand corrected. I thank you very much, Dr. Kizer.

Thank you, Mr. Chairman.

The CHAIRMAN. Next, we will call on Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Gentlemen, I think it is a great idea. I would like to see it work in rural America as well as urban America. Admiral, I wonder if you could describe, in your demonstration projects with the VA, how much you focused on rural America and what lessons you have learned from those demonstration projects compared with the others.

Admiral CARRATO. All right. I can comment on our focus on rural America. I cannot comment a great deal on our experience yet in the rural America sites.

In developing the criteria for site selection for this demonstration program, and HCFA and the department developed the criteria, we wanted to focus on a broad spectrum of sites. So we wanted to look at urban sites, rural sites, large military medical facilities, and smaller community hospitals.

We do have some sites, Fort Sill in Lawton, Oklahoma, Sheppard Air Force Base in Wichita Falls, Texas, which I think could be considered semi-rural. We are just really into the demonstration. We just started health care delivery at our very first site last September, and we are still collecting information.

One comment I can make, is we did have to meet all of the requirements that any other HMO would have to meet in terms of availability and accessibility of providers. We were successful in meeting those requirements in both urban areas and rural areas.

Senator BAUCUS. I would just like Drs. Berenson and Kizer to comment on this. It is very important to have at least one demonstration project that focuses very much on rural America. Obviously, all parts of the country, urban, suburban, but also rural America.

Let me just give you a little sense of my State. Veterans in Montana often have to travel hundreds of miles—not tens, hundreds; in fact, that is the rule, that is not the exception—in order to get an x-ray. Fortunately, now we are getting an x-ray facility in Billings so that Miles City veterans do not have to go all the way to Billings.

Many times—and we are getting this corrected, I hope—veterans will drive hundreds of miles for an appointment, only to find that the appointment is canceled, the doctor is not there, and then has to drive back another couple of hundred miles home and try to set another appointment. That is a problem we are working with within Montana.

Our per capita income in Montana is 50th, or it is 49th. It has fallen dramatically over the last 10, 15 years. Our cost of living is about 25th or 27th in the country. So, as our per capita income is at the bottom of the barrel, on average, in Montana, our cost of living, on average, is in the middle of the pack. Generally, veterans are not the top income earners. Sometimes they are, but very often they are not.

And add the great distances, I will tell you that veterans in my State, and in very rural States, are facing particularly—pardon the expression—acute problems.

When I talk about rural America, I am not talking about east of the 100th meridian, I am talking about west of the 100th meridian, where it does not rain, where there are immense distances. I do not think people in the east who have not really been west understand it until they are there and they see it, they feel it, they sense it, they taste it, and smell it.

So I strongly encourage you, when you set up this demonstration project—which I think is an excellent idea—to include an urban project in the real west, not the pseudo-west. The real rural, not the pseudo-rural, which some people just do not know what it is until they get out into the west.

Could you two comment on that, doctors?

Dr. KIZER. Senator Baucus, as you know, I have visited many of the Montana facilities from the west and appreciate your comments very well. It is a very real issue, providing care, in these areas of low population density with immense distances between facilities.

The one comment that would be most relevant is that, as we define sites in these rural areas, I think we have to be very inclusive in what we define as a site to make sure that we have an appropriate array of assets within that so that we can provide as complete an array of services as possible, which may involve more than one specific facility.

Particularly with our current operational structure of the integrated service network, a site may well include a hospital, multiple clinics, and a number of other points of care as well.

Senator BAUCUS. Dr. Berenson?

Dr. BERENSON. Yes. I would like to comment as well. I am sure the committee knows we are trying very hard in the Medicare+Choice program to provide incentives for rural HMOs and similar coordinated care plans to come in, and that has resulted in the floor payments coming up.

But one of the differences, and why I am optimistic that we will have a few rural sites in the VA demonstration, is that HMOs who are not part of the community, who do not have their own delivery system, find barriers in contracting with hospitals, or physicians, or other providers.

What the VA will provide, is their own infrastructure—at least a large part of the infrastructure—directly. They will not face some of those barriers. We should be able, in fact, to put up coordinated care demonstrations, at least one or two, as part of this agreement that we are working on.

Senator BAUCUS. Well, I hope so. I want to say, too, that VA has been very helpful. Secretary West came to Montana a short while ago. At least, he did not come personally, but he sent some staff out. Ms. Sheila McGready did a great job in helping in the State.

I know I sound like a "Johnny One Note" sometimes, and just beating a dead horse here. But people from the far west just do not have the resources to travel to Washington to talk to the VA, to talk to HCFA, whereas, people from the east do because they are already here.

So I feel I have a responsibility, and one I am very much proud of, to make sure you hear the western point of view too, because they are part of America as well. Thank you.

The CHAIRMAN. Senator Jeffords?

Senator JEFFORDS. Thank you, Mr. Chairman. I think I would just like to say a few words in appreciation of your holding this hearing today.

On February 23, I introduced legislation to establish a pilot program to allow veterans to go to the VA for their Medicare-covered services. Twenty-seven Senators have joined me in co-sponsoring S. 445. The day after my bill was introduced, it was adopted 100 to nothing by the Senate as the amendment to S. 4, the Military Bill of Rights.

Mr. Chairman, the veterans want this legislation, the VA wants it, and the Senate wants it. So, I am hopeful that we will proceed on the appropriate path.

I understand both Dr. Kizer and Dr. Berenson's interest in just going with a coordinated care model for the demonstration project. However, I believe there is value in running pilot sites on both the fee-for-service and coordinated care model.

The current capabilities of VA centers very significantly and the preferences of veterans may also vary quite similarly. The veterans beneficiaries of the VA health system who are 65 years old currently have the ability to seek their health care in the private sector of the VHA on a space-available basis.

Under the fee-for-service subvention model, the veterans' choice would be preserved, while under the managed care model the veteran would be required to go where directed by the veteran's VHA.

We have learned from our experience at Medicare that that choice is very important to beneficiaries. Would the loss of choice under a managed care model serve as a disincentive for eligible veterans to enroll at a managed care demonstrate site? Dr. Kizer?

Dr. KIZER. I think, probably in some cases, it might for some individuals. I think, in the aggregate, at least what we are feeling and what we are hearing from potential users, is that there is a very large number of veterans who would like to be able to use their Medicare benefit at the VA.

The sense, at least, that I have at this point is that it would not present a barrier to accruing sufficient numbers to participate in the pilots as they are laid out at this point. I cannot comment on some individuals who may want to preserve maximal choice. For some, that may be an issue, yes.

Senator JEFFORDS. It is my understanding that the managed care capitated reimbursement from the DoD Medicare subvention demonstration project goes to the DoD centrally for distribution rather than directly through the DoD facility providing the health care services. Am I correct?

Dr. KIZER. Yes, sir.

Senator JEFFORDS. How would the distribution of the Medicare reimbursement dollars work under each type of subvention model for veterans?

Dr. KIZER. We have not clarified that in finality. Intuitively, it is going to go to the facility or the network, depending on what is chosen. Whether there is a pass-through at headquarters or not is something that we have not worked through.

I would note that, in the case of the Federal care collection funds, those go back to the network that accrues the funds. I do not have any problem with that same concept because that is where they are going to be used.

Senator JEFFORDS. I am concerned about that because I do not know how the budgets work, but I know it is difficult. If the funds all go centrally instead of on a fee-for-service system, say, through the institution that is serving, how does that affect, or would that affect, budgets? Or is that something you have not considered yet?

Dr. KIZER. Well, I can tell you what we do currently under the Medical Care Collection Fund. Just in the way of background, at present, about 5 percent of VA operational funds come from third party collections in what we cal the MCCF fund. Now, those go back to the network, the 22 integrated service networks that we have. They go back to the network from which the funds accrue.

On average, probably three-quarters to 80 percent of them go back directly to the facility, and then a portion, 20 to 25 percent, is retained at the network for network-wide use, which in many cases a significant portion of those will, in turn, go back to the facility. But that is not an up-front. That may occur later in the year as other issues are addressed.

Senator JEFFORDS. Well, thank you. I want to thank you, Dr. Kizer, for your attention to this issue and to the effort you have put in to making sure our veterans get the best possible care. It has been a pleasure working with you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Jeffords.

Senator Chafee, please.

Senator CHAFEE. Thank you very much, Mr. Chairman.

Dr. Kizer, on page three of your unnumbered pages there are some remarkable statistics that you have there. I would like to pay tribute to you and those who are running the VA hospital arrangement.

Just statistics like, since September of 1994, 54 percent of all acute care hospital beds have been closed. That is a remarkable achievement. Twenty-eight thousand beds have been closed. The number of inpatient admissions has decreased by 32 percent, while ambulatory care visits have increased by 35 percent.

So there is no question but what you are with this whole trend that is going across the Nation of less use of hospitals, more outpatient services. Ambulatory surgeries have increased from 35 percent of all surgeries to 75 percent of all surgeries. You are right in step with what is going on across the Nation, and I would like to salute you for it.

Dr. KIZER. Thank you.

Senator CHAFEE. One question I have for Dr. Berenson is about the military retirees under 65 qualifying for Medicare based on disability. As you know, they can qualify for that. But, apparently, those are excluded from this demonstration. Is there some reason for that?

Dr. BERENSON. I think——

Admiral CARRATO. Would you like me to answer that? As you mentioned, those who are eligible for Medicare who are under 65 by reason of disability, they are eligible for both Medicare benefits and they are eligible for the Champus benefits. So, they are entitled to enroll in our Tricare Prime program, and are enrolled. So our feeling is, they are already covered under the Tricare program, and that was the reason that we did not include them in the demonstration program.

Senator CHAFEE. Would they be eligible for the Tricare program if it was not some service-connected disability?

Admiral CARRATO. If they are eligible for Medicare by reason of disability and under the age of 65, they are eligible for the Tricare program.

Senator CHAFEE. I see.

Admiral CARRATO. So it is a disability determination made by HHS.

Senator CHAFEE. All right. Fine. Thank you. Thank you, Mr. Chairman.

Congratulations, again, Dr. Kizer, for what you have done there. That is a remarkable statistic, I think, that you have closed 28,000 beds. That is the way things are going in this country.

Dr. KIZER. Thank you, sir.

The CHAIRMAN. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. I apologize for being late for a committee meeting that I obviously care enormously about, but I was testifying before the International Trade Commission, doing my best to represent the Ranking Member of this committee, and others.

Dr. Kizer, I want to ask you a question that has to do with veterans' income. There is a sense in all of this conversation that, when we talk about subvention, that the words for the "higher income veteran" tend to creep in quite a lot. I would like to point out that we are talking about folks that have an average income of about $22,000 a year.

Twenty-two thousand dollars a year, if you have a family and obligations, is not generally what I would call Moynihan-type wealth. [Laughter.] So what is your view about doing this kind of thing, ensuring access to VA health care, as a system from this group of what I would refer to as more moderate-income veterans as opposed to what I call "high income veterans?" I mean, do you back up my point on this?

Dr. KIZER. Absolutely. The terminology is one that is rooted in history. We have tried in recent years to use the term "higher income," which I think is a better descriptor. I do not think that $22,000 would qualify as high income, really, anyplace.

Certainly, the overwhelming majority of individuals that we are talking about, even in what might be the higher, higher income, are those that would be in the $30,000, $40,000 a year range. So, clearly, higher, I think, is a better descriptor than high.

Senator ROCKEFELLER. Thank you.

I would like to ask Dr. Berenson if the administration is committed to the enactment of a VA subvention project this year.

Dr. BERENSON. Absolutely. We are approximately a week away from having a memorandum of agreement signed by relevant officials, the secretaries of both departments.

Senator ROCKEFELLER. I was hoping you were going to announce that it was signed yesterday.

Dr. BERENSON. Well, in fact, that is what we were hoping. But, in fact, we are still working through the level of effort agreement because we learned in the DoD subvention that that gets tricky, and you want to have those rules worked out ahead of time and not after the fact.

So, that is really the one item that we are still working through. We have agreed on the concept of how it would work and the advantage to veterans to participate. We are committed to it, and you will hear from us very soon that the agreement has been signed.

Senator ROCKEFELLER. The DoD had overcome a certain series of hurdles and obstacles in getting its subvention project not just talked about, but up and running. That was true especially in calculating the amount that DoD had been paying in caring for the dual eligibles the so-called level of effort matter.

Can you assure this committee that HCFA will do whatever it takes to overcome similar hurdles with the VA?

Dr. BERENSON. Yes. I mean, absolutely. We have learned a lot, again, with the help of the GAO, about what we need to do up front to make sure that we have a determination.

We are working with the VA to establish the rules up front that will determine the level of effort, and we will assure the committee that that will be determined and that we will have some caps on the trust fund to protect the taxpayers.

Senator ROCKEFELLER. Can I ask why you believe, Dr. Berenson, that Medicare subvention is good for the Veterans Administration and for national public policy?

Dr. BERENSON. Well, it adds choice for veterans, permits them to actually get services, in many cases, at the facilities where they have been getting services in the past, if the space were available. Choice is consistent with what we are doing with the whole Medicare+Choice program, and adding that kind of opportunity makes sense.

I guess the other major part is, the commitment that the VA has made under Dr. Kizer to actually move towards a coordinated care system where veterans can be assured a certain level of quality gives us confidence.

I should also say, as part of the agreement, the Medicare+Choice requirements related to quality improvement projects and reporting outcomes, quality outcomes, et cetera, will all be required, so we have confidence, again, that this will be in the interest of veterans.

Senator ROCKEFELLER. Thank you.

Dr. Kizer, in my remaining time, another one of the kind of cliches that goes about, is one of the reasons that the VA wants to do it, or people like me want to do all of this, is that it will help Medicare subsidize the Veterans Administration. Yet, there is substantial evidence to indicate that quite the reverse is currently true. Could you elaborate on that?

Dr. KIZER. Yes, sir. I think that clearly it is not the intent of this proposal that Medicare subsidize VA.

Indeed, we have become concerned over the last few years, from experience in both Florida, Southern California, and now more of a national picture is emerging, that there has been some cost shifting, if you will, from the Medicare+Choice HMOs to VA, and that many patients who ostensibly would be covered by those plans are being sent, for whatever reason, to the VA for their treatment and we are not able to get reimbursement for that. In essence, the taxpayer is paying twice in those cases.

Senator ROCKEFELLER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

Gentlemen, we appreciate your being here today. We apologize once more for the delay at the beginning. We look forward to working with you as we proceed.

It is now my pleasure to welcome our second panel. Dr. William Scanlon, who is Director of Health, Financing and Systems Issues at the Government Accounting Office; Stephen Backhus, who is the Director of the Veterans' Affairs and Military Health Care Issues of the General Accounting Office.

We also have with us today James Woys, chief operating officer from Foundation Health Federal Services, the largest contractor providing managed care to military retirees.

Finally, we have Jo Ann Webb, who is program director for Health Policy Analysis from the Paralyzed Veterans of America, an organization that is known for its expertise in veterans' health care policy issues.

Again, let me welcome you. Your full statements will be included as if read. We ask you to limit your statements here to 5 minutes.

Dr. Scanlon, will you start, please?

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC; ACCOMPANIED BY STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman and members of the committee.

We are pleased to be here today as you review the Medicare subvention demonstration from the Department of Defense, as well as the subvention demonstration proposals for the Department of Veterans Affairs.

With me today is Stephen Backhus, who is the Director of GAO's Veterans' Affairs and Military Health Care Issue area. Members of that group, along with members of the Health Financing and Public Health group, which has responsibility for work on Medicare, are conducting the evaluation of subvention that the Congress requested in the Balanced Budget Act.

The stated goal of subvention is to implement an alternative for delivering accessible and quality care to Medicare-eligible military retirees and certain Medicare-eligible veterans without increasing the costs to DoD, VA, or to Medicare. It would also allow DoD and VA to benefit from augmented appropriated funds with Medicare payments and to use excess capacity where it exists.

Medicare may gain if it pays DoD and the VA less than it would pay private providers. These outcomes, however, are not guaranteed. The Balanced Budget Act, accordingly, structured DoD's subvention as a 3-year demonstration, and directed GAO to evaluate its performance. We will be providing you with interim reports during the course of the demonstration.

We would like to focus today on the lessons that have emerged from the implementation of the DoD subvention demonstration and their implications for a possible VA demonstration. DoD subvention did get off to a slow start and missed the BBA target for initiating service delivery of January 1, 1998. However, as noted, it is now operational in all six sites.

The delay should not have been surprising. Not only did the negotiation of the memorandum of agreement between Medicare and DoD and the selection of sites take longer than expected, but so did the preparation of the sites to become Medicare managed care organizations.

DoD officials at all sites emphasized to us that this task was far more complex than originally perceived. It took longer, despite HCFA's efforts, to facilitate and accelerate the process.

While service delivery is under way at all sites, operational issues remain that may affect the success or replicability of a demonstration. Some relate to how Medicare payments to DoD are structured, and others to DoD's capacity to operate as a managed care organization.

In the BBA, Congress specified, as we have heard, that DoD should not, in essence, be paid twice for care to Medicare-eligible retirees. These retirees were already receiving some care funded by DoD's appropriation, and since that appropriation was not adjusted because of the subvention, those funds previously spent on retirees, known as level of effort, were to be deducted from the Medicare payments.

The inability of DoD's accounting and management information systems to identify the costs of services delivered to individuals has made that calculation of historical level of effort problematic.

We will be issuing a report to you later this month on this subject, and DoD and HCFA, as you have heard, have indicated that they will review the calculations of level of effort to ensure that they are as accurate as possible for the demonstration.

The Medicare payment mechanism and subvention is also complicated by uncertainty over how many retirees will be enrolled over the course of the year, and whether they will be sicker or healthier than average.

To ensure Medicare ultimately pays the right amount, there is a system of monthly interim payments and a year-end reconciliation to see if Medicare owes more, or if DoD must refund some of those payments.

This system creates uncertainty for DoD about what resources it will have available, leading DoD to limit the Medicare funds it has distributed to sites. Site managers then are handicapped in making decisions about expanding capacity to serve subvention enrollees, since they are not assured of what additional resources they will have available.

Operating a Medicare managed care organization is a new endeavor for DoD, creating certain challenges and raising some questions. Some are operational, involving the ability to undertake tasks, such as developing a provider network, marketing to eligibles, enrolling applicants, purchasing care, and conducting quality assurance activities.

DoD has had a significant advantage in initiating these tasks because it could rely heavily on some of the Tricare Prime HMOs that had considerable experience with these activities to serve as contractors.

Operating as a managed care organization also involves learning to operate efficiently, balancing service delivery and cost consciousness. However, in the DoD setting, factors undermine this incentive to be cost conscious.

Most importantly, as long as facilities are still providing some space-available care, they have a safety valve. If resources become too strained, they can reduce the amount of space-available care. This gives facilities the flexibility to cover costs that are higher

than expected, but the down side is that they have less incentive to be efficient.

DoD's early experience with subvention does offer some insights for the potential Medicare/VA subvention demonstration. The complexity of establishing a Medicare managed care organization strongly suggests that sufficient lead time be given to implement a VA demonstration.

With Tricare Senior Prime taking 13 to 17 months to become operational, it would be reasonable to allow 12 to 18 months to start the VA demonstration, especially since VA, unlike DoD, does not have the established relationships with HMOs that can take on important tasks.

Second, simplifying the payment rules to provide increased certainty about Medicare payments to VA would facilitate effective management and operation of subvention.

Third, DoD's data systems proved to be problematic in calculating level of effort and may hinder the site's ability to managed care delivery. Data systems will also be critical to the VA, and a review of the VA data systems with an eye to the needs of a subvention demonstration would be very beneficial.

There are issues that are more unique to the VA as well. In particular, VA needs to determine how to make subvention attractive to sufficient numbers of eligible veterans who already have access to a broad range of VA services. VA also needs to be able to take steps to serve subvention enrollees without unduly crowding out other higher priority veterans.

In conclusion, we would note that subvention holds significant potential for giving military retirees and veterans an additional option for health care coverage, for giving DoD and VA additional funds, and for possibly saving Medicare money. The uncertainty of achieving these outcomes underscores the value of introducing subvention as a demonstration, as the BBA did for the Department of Defense.

If a similar VA demonstration is authorized, VA could increase its chances of successfully achieving subvention's goals by taking advantage of DoD's experiences.

Thank you very much, Mr. Chairman. I would be happy to answer any questions you or members of the committee may have.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. Thank you, Dr. Scanlon.

Mr. Backhus?

Mr. BACKHUS. Sir, I am here to assist in answering any questions.

The CHAIRMAN. All right.

Ms. Webb, please?

STATEMENT OF JO ANN K. WEBB, PROGRAM DIRECTOR, HEALTH POLICY ANALYSIS, PARALYZED VETERANS OF AMERICA, WASHINGTON, DC

Ms. WEBB. Thank you, Mr. Chairman. My role here today is to reflect the broader interests of the four million plus what we term as disenfranchised Medicare-eligible veterans who, because of the

limited VA appropriation and their higher income, cannot receive health care services from the VA.

I would like to add a quote from Senator Specter, and also from Senator Jeffords, on the issue of fundamental fairness for VA's participation in this program. "The rapidly changing health care landscape has forced change on all health care systems.

VA, unlike the private sector, cannot issue stock, borrow funds, or merge with other systems to finance change. It must look to increased appropriations—that is a possibility, but highly unlikely—or tap into other revenue streams, such as Medicare."

Given that managed care is a permanent and growing part of the health care delivery system, it is essential that VA be able to play as a full partner in this highly competitive marketplace. VA is not a novice in the contracting world.

As has been laid out before, VA has over 10 years of experience in shared services and a broad base of comparative data with best pricing and contractual arrangements. Also, in the last 2 years, it has been able to retain third party collections. All of these programs have laid the groundwork for VA's participation in Medicare subvention. Past attempts to legislative subvention have included a fee-for-service component, which is very important.

We feel very strongly that this should be part of any legislation considered for the following three reasons. Veteran beneficiaries should be allowed to participate in Medicare on an equal footing with all other Medicare beneficiaries. That is, the opportunity to choose either fee-for-service or managed care.

Inclusion of a fee-for-service option not only allows choice for veterans, but also is an important opportunity to amass comparative data onto which fully you can develop program evaluation.

The fee-for-service component will also provide insight into the motivation of veterans who seek out care and test the assumptions that VA care is of higher quality and cost effective.

It will also provide important answers to questions of VA's ability to successfully compete when veterans actually have a choice.

That concludes my remarks. I would ask that my statement be entered in its entirety, and I would be happy to respond to your questions.

The CHAIRMAN. Without objection, it is so ordered. Thank you, Ms. Webb.

[The prepared statement of Ms. Webb appears in the appendix.]

The CHAIRMAN. Now, Mr. Woys?

STATEMENT OF JAMES E. WOYS, CHIEF OPERATING OFFICER, FOUNDATION HEALTH FEDERAL SERVICES, RANCHO CORDOVA, CA

Mr. WOYS. Mr. Chairman, distinguished members of the committee, thank you for the opportunity to address you on the status of the Tricare Senior Prime program from the perspective of a Tricare managed care support contractor.

My company, Foundation Health Federal Services, is the current managed care support contractor for five Tricare regions in the State of Alaska, covering over 1.6 million Tricare-eligible beneficiaries, and 5 of the 8 military treatment facility sites selected for the 1998 Medicare subvention demonstration project.

More commonly referred to as Tricare Senior Prime, the program was successfully launched in 1998, and today there are over 18,000 Senior Prime members linked to the military treatment facilities in foundation of service regions.

In my opinion, the Tricare Senior Prime program is clearly an operational success. The Tricare Senior Prime program has increased quality and access to our valued beneficiaries over 65 years of age in the following ways: (1) it has provided over-65 beneficiaries with full health coverage, including pharmacy; (2) provides aging and privileges for many prime members facing disenrollment for military health coverage upon turning the age of 65; (3) provides better benefits than either Medicare or Tricare; (4) provides assured access to high-quality care; (5) advances DoD's readiness mission; (6) enhanced and strengthened the working relationship among government agencies and private contractors.

There are lessons that we learned in this process that can be used to improve the effectiveness and efficiency of starting new sites in the event Tricare Senior Prime becomes an expanded program offering or provided in the VA environment.

These include: (1) we must be able to phase in implementation over time and it is important to properly manage the preparation, education, and enrollment of new members in an orderly way; (2) we must use existing expertise of lead agents in MTF command who have previously implemented this program; (3) we must anticipate resource requirements as a result of potential large beneficiary interest in the program; (4) we must protect the continuity of care for new members; (5) we must reduce the beneficiary confusion through clearly written materials and effectively communicated messages to beneficiaries.

Participation in a demonstration project has met most enrollment expectations, particularly in urban areas where greater numbers of eligibles reside. The success achieved in enrolling beneficiaries in the demonstration is attributable to a collaborative effort between the lead agents, military treatment facilities and foundation, and explaining the program benefits and providing enrollment assistance to beneficiaries.

Although the Tricare Senior Prime demonstration began delivering health care services only 8 months ago at Madigan Army Medical Center in Takoma, the foundation is closely monitoring the beneficiaries satisfaction with the program. Beneficiary visits to our Tricare service centers, written correspondence, and toll-free telephone calls are overwhelmingly favorable.

Another measure of beneficiary satisfaction is determined by evaluating reasons given for disenrolling from the program. Less than 4 percent of the over 18,000 beneficiaries have disenrolled, and more than 99 percent of those disenrolled were due to reasons other than dissatisfaction. Only 9 members of the over 18,000 beneficiaries indicated dissatisfaction with the program and disenrolled.

The foundation is also responsible for the timely, accurate, and consistent process of payment of claims submitted by either Tricare Senior Prime enrollees or civilian health care providers.

Since most health care services performed under the auspices of this demonstration are rendered within the military facilities, the

volume of claims processed and paid by foundation is relatively small.

Foundation supports the lead agents by managing grievance review activities for issues involving network providers. Through joint efforts, foundation and lead agents develop, recommend, and direct corrective action plans to improve overall delivery of care.

During the first 6 months of the program, grievance activity averaged less than 1 per 1,000 members. In comparison, a sample of commercial population reflected an average of 2.5 cases per 1,000 members.

From our recent experience, it is clear that there is a growing support and satisfaction for the Tricare Senior program. This demonstration project, which addresses the health benefit needs of our senior service member population, has exceeded its original intent to show how DoD and HCFA, with the support of the managed care support contractors, can join together to keep the promise to these deserving men and women.

We strongly believe that continuing the program will lead to successful fulfillment of your goal to provide health care for Tricare's over-65 beneficiaries.

Thank you, Mr. Chairman, for the opportunity to express my views. I would be happy to answer any questions.

[The prepared statement of Mr. Woys appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Woys.

Dr. Scanlon, and Mr. Backhus, too, in your testimony you highlight some key challenges that the DoD has faced in implementing a subvention demonstration. Could you elaborate on these and discuss how the lessons learned from the DoD demonstration could apply to veterans?

Dr. SCANLON. I think probably the largest two challenges that were faced were, one, the uniqueness of subvention, not wanting to pay twice for the same services, created the challenge of identifying what prior service level of effort had been. That was complicated by the data systems that were available to do that.

We recognize that, in the past, identification of services at the individual level may not have been critical, but in the subvention context it becomes a critical issue and, therefore, the data system became significantly challenged.

The second issue, is that the Defense Department was being asked essentially to operate a health maintenance organization, which was an entirely new endeavor, complicated by the fact that there are unique requirements for Medicare managed care organizations. It was occurring at a time when Medicare managed care organization requirements were changing, since we were introducing the Medicare+Choice regulations.

HCFA did all, we believe, that it could in terms of trying to facilitate the process whereby both DoD would learn about these requirements, and it would be certified that they had complied. But, at the same time, it was still a considerable task.

We think now, for the longer term, the issue of operating a managed care organization, operating an HMO, which is something in which there needs to be strong incentives for cost containment, is something that will be a challenge for DoD for the future.

The CHAIRMAN. Mr. Backhus?

Mr. BACKHUS. That summarizes as well as I could ever state. Thank you.

The CHAIRMAN. All right. Let me ask you, Ms. Webb. It is my understanding that recently your organization co-authored a report to OMB, along with three other major veteran organizations. That report highlighted serious delays in treatment, claims processing, and procurement of services as a result of underfunding.

Now, testimony earlier this morning outlined infrastructure, manpower, and systems requirements that are necessary to meet Medicare standards and manage a demonstration. These requirements would be at a cost to the VA, just as they are to all Medicare providers.

Concern has been expressed about the veterans, as I say, currently in the VA health system and the impact a demonstration may have in pulling valuable resources away from these priority veterans in order to implement a demonstration. What is your opinion on this?

Ms. WEBB. Well, sir, I think there is a risk. However, I think the larger issue is that VA must have the opportunity to compete in this marketplace. If subvention legislation goes through, the risk is just as great for a capitated system as it would be for a fee-for-service system.

The major issue with the VA, is its appropriation. I think that is what we pointed out in that document, that the underfunding over periods of years and flat-line budgets have really affected its ability to supplement the needs of the infrastructure.

The CHAIRMAN. All right. Let me turn to you, Mr. Woys. Could you please describe the operational and administrative challenges you have faced in implementing the DoD demonstration, including beneficiary response to the demonstration? Could you identify how these challenges have varied across sites as a result of differences in managed care penetration and physician practice patterns?

Mr. WOYS. Sure. I think the biggest challenge that we had in helping assist our partner, DoD, in implementing the subvention program was the start and stop. We never could get really going on the program.

I think it is important to note that, as we move forward into doing future implementations, that we give the proper lead time to implement the program. It is so important that you have all of the systems in place prior to the implementation of a program this important for our seniors.

It did vary oversights, based upon the penetration within managed care, and also varied because of the size of the facility that we were helping assist in the implementation of the program.

In places like San Diego, or in Takoma where Madigan is at, or even in San Antonio, the facilities are fairly well equipped and can deliver the majority of all of the services of large medical centers.

So our support in delivering and helping them implement a delivery system outside of the military treatment facility was fairly simple: they gave us what type of provider, what kind of specialties they could not do within their facility, and we obtained contracts in the civilian environment for that.

In more rural areas, in Fort Sill and Sheppard Air Force Base in Lawton, and Wichita Falls, less capability of the MTF, more re-

quirements for us to go out and find providers to help supplement to give a full range of care for our beneficiaries.

That was a little more challenging, especially when we started trying to, again, contract for providers at Medicare rates, which, in some of the rural areas, are harder to get. But we were successful over time. That is why I think we need the appropriate lead times available to implement the program.

The CHAIRMAN. Thank you.

Senator Moynihan?

Senator MOYNIHAN. Thank you, Mr. Chairman. This has been illuminating and helpful testimony. We much appreciate it, always, from the General Accounting Office. I would like to press two questions, and nothing more than that.

In the course of this decade and in dealing with health care in its many manifestations, we keep coming upon this phenomenon of the introduction of pricing, the rationalization of a system. We had testimony in 1994 in which a Jesuit, actually, from Fordham said, what you are seeing is the commodification of medicine, which was a new idea, from a guild to a marketplace.

But, Ms. Webb, you used the phrase in some context here, that it helped to compete in this marketplace, which is a common usage now. This is taking place in the context of a very large methodological change in medicine. I do not know if that is a good term.

But Dr. Kizer described, since 1994, in the last five years, half of the acute care hospital beds had been closed, a third of inpatient admissions had dropped, and the outpatient had increased by 35 percent.

I was wondering if you could tell me something that just interested me. We have not really found a way to get hold of it. How much do pharmaceuticals account for the drop in acute care medical facilities? Mr. Woys mentioned pharmaceuticals as part of what you provide.

That one little pill, Zantac, has emptied out a third of the beds in most hospitals. Our hospitals' adventures in administration dates back to the Civil War in the United States. In looking after a person, all you could do was keep them in a bed with clean bandages. Of your outlays, what goes for pharmaceuticals today?

Mr. WOYS. In our Tricare business, it is hard to determine exactly how much is pharmaceutical, since I pay whatever does not get paid within the military treatment facility. If they cannot deliver that pharmaceutical in the military treatment facility, then they go to the civilian network which I provide.

But as far as my outlays go for pharmacy, it has gone from somewhere in the 10 percent range in my total outlays to closer to 20, 25 percent of my total outlay. So, pharmaceutical expenses are increasing rapidly. There are lots of reasons for that, such as new drugs. I think they become a bigger and bigger piece of the pie.

Senator MOYNIHAN. And there is a correlation—I do not assert this, I am asking—between the dropping off of acute care medical facilities, not the paralyzed veterans, obviously, but people do not stay in the hospital. They do not even enter the hospital, but they get care in the context of the hospital.

Dr. SCANLON. Our acute care trends have stayed almost fairly normal, fairly straight, so they have not increased at the rate that

you would see other health care costs growing. Outpatient care, of course, has grown substantially over time, and so has pharmaceuticals.

Senator MOYNIHAN. That, almost by definition, involves pharmaceuticals.

Mr. WOYS. Yes. I believe so.

Senator MOYNIHAN. Mr. Backhus?

Mr. BACKHUS. Thank you. Senator, I know I have some information on the Department of Defense, in particular. Their pharmaceuticals represent about $1 billion out of a $16 billion budget.

However, that cost trend is increasing rather dramatically, as it is in other health programs. So, while there is a positive benefit clearly associated with the new medications in terms of keeping people out of the hospitals, on the other hand, that increases the pharmaceutical prices.

Senator MOYNIHAN. We always turn to the GAO for more data. Can I ask, Mr. Chairman, that Dr. Scanlon and Mr. Backhus give us some numbers in that regard and kind of relate them to Mr. Woys' experience?

Dr. SCANLON. Senator, we would be happy to. I also would note that we are working on a request that we received from several members of the House to look at the question of the substitution of pharmaceuticals for other health care services.

While we know that there are some spectacular examples of how a single drug dramatically changes the treatment of an illness and reduces the use of other services, there are also many improvements in drugs that allow, sort of, for illnesses that we could not have treated in the past to be treated. We end up, from that perspective, adding to cost. But, on net, we are very happy with the fact that we are dealing with, and treating effectively, many more illnesses.

Senator MOYNIHAN. We can start out with penicillin, can we not?

Dr. SCANLON. We can.

Senator MOYNIHAN. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Moynihan.

Senator Jeffords?

Senator JEFFORDS. Thank you. I am interested in your comments on the importance of having a fee-for-service option in a demonstration project. As you know, this is a central part of our discussion on the architecture of the demonstration program. We are talking about veterans here.

Could you please expand on the importance of a fee-for-service alternative?

Ms. WEBB. Thank you, Senator Jeffords. The issue here is one of parity for veterans, when you consider the larger Medicare population, that current Medicare-eligible beneficiaries are able to choose. They can either go to managed care, Medicare+Choice, if they want to, or they can stay under a fee-for-service system. I think it is important that veterans be treated on that same level playing field.

I think another area, by adding this component to the legislation, would really offer you comparative data to understand why people would come to the VA. I think that, as was brought out earlier in

the hearing, veterans live everywhere. A managed care option may work in a suburban area, but it may not work in a rural area. I think that the ability to test that option deserves consideration.

Senator JEFFORDS. Thank you. Dr. Scanlon, is $50 million enough to allow full demonstration at 10 sites and maximize our learning about Medicare subvention for veterans? Should the cap be raised to $100 million per year—I am sure you would like the money—or increase progressively over the years the demonstration project?

Dr. SCANLON. At this point, we have not reviewed the cap and the potential capacity of sites in enough detail to really give you an informed answer. We would be happy to look into this some more and provide you some information on that.

Mr. BACKHUS. Can I add to that?

Senator JEFFORDS. Mr. Backhus?

Mr. BACKHUS. Sir, thank you. The Department of Defense subvention demonstration has a cap of a maximum of $65 million. In the first year, they will begin at $50 million. With that, they have estimated that they can enroll nearly 30,000 people. That is a sizable population, I think.

Obviously, they would have an answer to this question, too. But it seems to me like that is a sufficient size to be able to test whether this program will be cost effective, improve the access, and maintain the quality.

Senator JEFFORDS. Mr. Chairman, do we have the right to submit questions to this panel?

The CHAIRMAN. Yes. We will keep the record open until 7:00 this evening for further questions. I would ask that you respond in writing.

Senator JEFFORDS. Thank you.

The CHAIRMAN. Are you finished?

Senator JEFFORDS. Yes, I am.

The CHAIRMAN. Thank you, Senator Jeffords.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman. An exclusive right for the Senator from Vermont, as he always deserves.

The CHAIRMAN. No, no.

Senator ROCKEFELLER. No, no. I am just teasing, Mr. Chairman.

One of the reasons, Dr. Scanlon, that I think it is so incredibly important that both managed care and fee for service be studied, is that there is an incredible difference built in already between DoD and VA which works sharply to the disadvantage of the Veterans Administration in all of this with respect to managed care.

The difference is this. DoD is basically trying to keep people who are already using their system. The VA is trying to attract people who are not already using their system. Managed care, by its definition, if that is all we test and we do not test fee for service at the same time, that puts VA at an enormous disadvantage and probably a clinically not very useful study.

For example, I think it is about 15 percent of all Medicare patients generally in the country are in managed care. The Medicare Commission said that will go to 50 or 75 percent by the year 2020. Well, I am not necessarily going to be around by then, but I will

bet half of Pat Moynihan's dollars that that figure will never arrive.

Senator MOYNIHAN. I am going to suggest that perhaps you and I could just pool our resources and split. [Laughter.]

The CHAIRMAN. Can I join you? [Laughter.]

Senator ROCKEFELLER. The point, of course, is why would a VA veteran give up Medicare, which they would have to do in order to join a plan? Why would they do that? They do not have to do that under fee for service. They would have to do that under managed care. So why on earth would we conduct an experiment in which you were not looking at both fee for service and managed care? Otherwise, I think one is weighted totally against the Veterans Administration.

Dr. SCANLON. Senator, we can see the true value in looking at both. When we expressed concerns in our testimony, it was about the issue of trying to implement both on a very tight time frame. Following what Dr. Berenson indicated, there is a whole set of rules for fee-for-service Medicare, and then there is a whole set of rules for Medicare+Choice.

Recognition of those differences and recognition that the VA would have to both learn them and adapt their systems to be able to deal with them is important to the implementation of the demonstration.

Now, having a sort of a fee for service and a managed care component creates different issues with respect to measuring the cost impacts. We recognize that.

But it really does provide, as you have indicated, a test of both models, and also, as has been indicated, an increased choice for veterans, that they very well may be much more attracted to the fee-for-service option than they are to the managed care option.

Mr. BACKHUS. May I?

Senator ROCKEFELLER. Please.

Mr. BACKHUS. I think your point about what incentive veterans have is a good one. Presently, although I know there is much debate about the budget and whether the VA budget is sufficient for this fiscal year or not, they have decided, as a matter of policy, the VA has, to try to enroll all eligible seven-priority veterans, which means everyone who is interested.

If these veterans can already access the VA system for all the comprehensive benefits that they think they need, one would have to ask, what is the incentive for them to give up their Medicare benefits to enroll in a system that they are already eligible for? So, there is an attractiveness, I think, to that fee for service.

Senator ROCKEFELLER. I would than ask both of you, even if it takes longer for VA—and it will take longer because it is more complicated for HCFA. But HCFA deals with complicated things all the time. That is all they do, is deal with complicated things.

Let us suppose it takes a little bit more time for a fee-for-service component under VA subvention to get started. So what? The point is, what we are really looking at here is, what is the right thing to do in terms of administering the Medicare benefit?

If it takes a little bit longer to help VA get set up, then so be it. But both have to be done to give the veteran a fair shot. We are

talking, after all, I think, about 23 or 24 million veterans not now able to use the VA system. That is a lot of people.

Mr. BACKHUS. The extent to which the VA system is able to produce the data to carry out both of these aspects of a demonstration, I think, is the major challenge. Whether it is a little bit more time to develop or a lot more time to develop, I think, is the uncertainty that I have and the reservations I have about doing both simultaneously.

Senator ROCKEFELLER. Thank you, gentlemen.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

Let me thank the panel. I think the discussion this morning has been very helpful to the committee in an effort to better understand what has happened under the subvention of the Defense Department, and, of course, what are the issues as we proceed with veterans. But it has been very helpful to have you all here today. Thank you very much.

The committee is in recess.

[Whereupon, at 11:59 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ROBERT A. BERENSON, M.D.

Good morning, Chairman Roth, Senator Moynihan and members of the Committee, thank you for inviting us to discuss our demonstration for Medicare subvention involving Medicare-eligible military retirees and their families and our proposed demonstration for Medicare subvention involving our nation's veterans. I also want to thank the General Accounting Office for its valuable evaluation of the Department of Defense demonstration project, which raises issues that we are working with the DoD to address and provides us information to better plan for the Veterans Affairs subvention demonstration.

In recent weeks we have been reminded once again of the contributions America's military retirees and veterans have made to our country. We are committed to working with the DoD and VA to see if there is a way to improve their access to care while protecting the Medicare Trust Funds. The Clinton Administration strongly supports these demonstrations, which will provide needed information regarding the effects of subvention and its potential to benefit all parties involved. I want to update you on the status of these demonstrations and to explain the need to limit the Veterans Affairs demonstration project to coordinated care.

The term "subvention" refers to Medicare paying for care provided at military, veterans or other federal facilities to Medicare beneficiaries. Medicare is precluded by statute from doing this. The Balanced Budget Act of 1997 authorized a 3-year, demonstration for military retirees and an implementation plan for a similar veterans demonstration. Enrollment in the DoD demonstration began in August 1998, and we expect to have a signed Memorandum of Agreement with the Department of Veterans Affairs on the VA demonstration in about a week. These demonstrations provide the opportunity to assess how a coordinated approach to subvention might improve efficiency, access, and quality of care for Medicare-eligible military retirees and veterans in a select number of sites. In implementing the DoD demonstration and drafting the memorandum of agreement with the VA, we focused on two imperatives: protecting beneficiaries and protecting the Medicare Trust Funds.

DOD SUBVENTION DEMONSTRATION

The DoD demonstration creates a DoD-run HMO, TRICARE Senior Prime, in six sites around the country for military retirees and their dependents who are eligible for the Medicare program. It also creates the option for a second program called Medicare Partners, which would allow regular Medicare+Choice health plans to contract with military treatment facilities to provide specialty care for military retirees who are enrolled in Medicare+Choice plans. The six sites participating in the demonstration are:

- Dover Air Force Base, Dover, DE.
- Fort Carson and the Air Force Academy, Colorado Springs, Colorado;
- Keesler Air Force Base, Biloxi, Mississippi;
- Madigan Army Medical Center, Fort Lewis, Washington;
- Naval Medical Center San Diego, San Diego, California; and
- Wilford Hall Medical Center and Brooke Army Medical Center, San Antonio, Texas, Sheppard Air Force Base, Wichita Falls, Texas, and Fort Sill, Lawton, Oklahoma;

The TRICARE Senior Prime Option provides a full range of Medicare benefits to enrollees. Covered services include the standard Medicare benefits, including skilled nursing facilities and home health care, as well as other TRICARE benefits such as pharmaceutical coverage. The demonstration sites must meet all conditions of

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participation required of Medicare+Choice plans except those waived in the memorandum of agreement related to fiscal soundness and licensure for physicians in the State where they are practicing (due to the nature of military assignments).

DoD is obligated to spend as much for the care of those in the demonstration areas as it already spends on them, known as its "level of effort." Medicare pays for care only after the DoD has met its agreed upon historic level of effort. Once the level of effort is met, Medicare will pay 95 percent of the county-based rate it pays for beneficiaries in Medicare+Choice plans, minus the cost of medical education, disproportionate share payments, and a portion of hospital capital payments, which DoD funds separately.

Enrollment is voluntary and enrollees agree to receive all covered services through TRICARE. Services from civilian providers who furnish services not available at military facilities require a copayment. The DoD is not charging a premium for the first year of the demonstration. Prior to this demonstration, dually eligible beneficiaries could only be treated at DoD facilities on a "space available" basis. Medicare payments to DoD are capped at $50 million in the first year, $60 million in the second year, and $65 million in the third year..

GAO Concerns

The GAO report raises two important concerns about the DoD subvention demonstration:

- DoD's estimates of its level of effort may be over or underestimated; and
- Data problems and payment issues could make the demonstration difficult to manage at both the national and local levels.

We are working with the DoD to address these concerns, and the DoD has been extremely helpful in this regard. In reviewing the level of effort methodology and baseline data, we determined that we should devote additional staff and resources to reviewing the DoD's data and methodology, and are therefore hiring an outside contractor to help us in this effort.

DoD Subvention Evaluation Plan We have contracted with RAND, Inc., to evaluate the DoD demonstration, and they have submitted a detailed plan for their evaluation. It includes assessments of:

- impact on the costs to both the Medicare Trust Funds and DoD;
- whether there is improved access to care;
- any change in quality of care provided to the demonstration population; and
- any impact on the local health care providers and other Medicare beneficiaries in the surrounding community.

There will be interim reports in July of 1999, March of 2000, and March of 2001. And RAND will issue a final report in December of 2001. This evaluation is one of two independent evaluations required in the legislation authorizing the demonstration. The law also directs the HHS Inspector General to obtain an evaluation, which will be conducted by the GAO. RAND is coordinating with the GAO to insure that their independent efforts are complementary.

VA DEMONSTRATION

We are also working toward implementation of a Veterans Affairs subvention demonstration, in which Medicare will pay for care in the VA health care system for Medicare beneficiaries who are also eligible for VA health care benefits. We believe this could provide more access to VA services for veterans, savings to the Medicare Trust Funds, and administrative efficiencies to both programs.

The memorandum of agreement between HCFA and the VA is modeled on the DoD demonstration and, like the DoD demonstration, relies upon a coordinated care model. Medicare will reimburse the VA for health services provided through an HMO-like organization run by the VA to Medicare beneficiaries who are Priority 7 veterans (generally those without a service-connected disability who are above the VA income threshold).

Beneficiaries who enroll in the demonstration will be able to use their Medicare benefits to obtain Medicare coordinated care services at VA facilities and other sites under contract to the VA. The VA organization will provide the complete range of Medicare benefits, and adhere to the conditions of participation and quality standards required of Medicare+Choice plans. As with the DoD, the VA will receive Medicare payments only after it surpasses its current level of effort for dual-eligible beneficiaries in demonstration site facilities. After the VA meets its level of effort, Medicare will reimburse the VA at the rate of 95 percent of county-based Medicare+Choice capitation rates, excluding the cost of medical education, disproportionate share payments, and a portion of hospital capital payments. As we are able, we will risk adjust payments so they take into account enrollee health status.

We have taken care in designing this demonstration to protect the Medicare Trust Funds. If Medicare costs are more than they would have been without the demonstration, Medicare and the VA have agreed to take any necessary corrective action. For example, the VA may refund Medicare, we may suspend or terminate the demonstration, or we may adjust payments. To further insulate Medicare from financial risk, a "cap" of $50 million a year will be placed on the total Medicare reimbursement to VA. Furthermore, the VA has agreed to open its facilities to audits by HCFA and the HHS Inspector General.

We have addressed issues the GAO identified in its evaluation of the DoD demonstration in our planning of the VA demonstration. For example, as with the DoD subvention demonstration we plan to base the level of effort calculation on actual expenditures the VA made during a specified base period. We are working with the VA to make sure we have the information we need to make accurate and reliable payments based upon a valid baseline.

Thus, we strongly believe that we have taken all possible steps to protect beneficiaries, the Trust Funds, and the VA from any potential adverse outcomes. And, as with the DoD demonstration, we will solicit a rigorous evaluation by an independent evaluator. Over the 3 years of the demonstration, the independent evaluator will monitor performance and collect data on:

- impact on the costs to either the Medicare Trust Funds or VA;
- whether there is improved access to health care;
- any change in quality of care provided to the demonstration population; and
- any effect on local health care providers and other Medicare beneficiaries in the surrounding community.

Focusing on Coordinated Care

The DoD demonstration is limited to coordinated care by statute and, for good reasons, we have limited the proposed VA demonstration to coordinated care. This will:

- promote higher quality through better coordinated care;
- protect the Medicare Trust Funds
- limit the administrative burden; and
- provide consistency between the two demonstrations.

Under a coordinated care model, enrollees would obtain all services from or through the VA. This will ensure that all needed care is received from the appropriate providers who have access to patient records and other needed patient information. We believe it will help ensure that beneficiaries receive high quality, coordinated care. It will help the VA better anticipate costs and payment amounts, resulting in better planning and improved access to care. It also means the demonstration will more likely remain within the spending caps established in the memorandum of agreement, thereby minimizing the likelihood that participation will be curtailed later in the demonstration. And a coordinated care model also will better protect the Medicare Trust Funds by removing many of the unknowns and risks inherent in a fee-for-service model.

Focusing on one model will also minimize the demonstration's administrative burden to the VA and to HCFA. In addition, our memorandum of agreement with the VA is similar to the one we have with the DoD and, as proposed, our role is similar in both demonstrations. Therefore, we can leverage the staff, resources, and lessons learned between the two demonstrations, something that can only be achieved with some level of consistency between the two programs.

I would like to alert the Committee that it does take a long time to implement a demonstration of this complexity, even when only one service-delivery model is used. With the DoD demonstration receiving high-priority implementation treatment from both HCFA and DoD, it took between 13 and 17 months to deliver services in sites after passage of authorizing legislation.

CONCLUSION

Subvention has the potential to benefit all parties involved—the DoD, VA, Medicare and, most importantly, beneficiaries eligible for both Medicare and military or veterans' health care benefits. They should enjoy enhanced choice and improved service, which is the true "bottom line" in this effort. The President strongly supports these demonstrations, and we are committed to meeting the challenges they present and learning as much as we can about what would be necessary to expand such programs. We look forward to working with this Committee, the DoD, and the VA as we continue to seek to improve health care services available to our nation's Medicare-eligible veterans and military retirees. It is critical that we limit the risk to VA and the Trust Funds, and ensure top quality care to veterans. In this regard,

we recommend limiting the demonstration to coordinated care only, and to understand the importance of allowing for about a 1-year implementation period.

PREPARED STATEMENT OF REAR ADMIRAL THOMAS F. CARRATO, USPHS

Mr. Chairman, distinguished members of the Committee, thank you for the opportunity to appear before your Committee today to discuss our progress in implementing the TRICARE Senior (Medicare Subvention) demonstration program, authorized by the Balanced Budget Act of 1997. This demonstration program allows dual Military Health System (MHS) and Medicare eligible beneficiaries in select sites to participate in the TRICARE program.

The Department of Defense operates one of the nation's largest health care systems. Nearly 8.3 million individuals are eligible to receive care through the MHS. Since the end of the Cold War, the United States military has dealt with new challenges to its organization and mission. Fewer men and women are on active duty. Along with fewer combat forces, there have been reductions in support forces, including physicians and other medical professionals. In fact, the number of doctors, nurses and medical technicians in military service has declined as much as 50 percent in some locations.

The Base Realignment and Closure Commission (BRAC) recommended closing a number of installations that were no longer needed for a smaller military force. As a result of this and other downsizing efforts, 35 percent of the DoD Medical Treatment Facilities (MTFs) that existed in the United States in 1987 closed by the end of 1997. In contrast, the total number of people seeking health care through the MHS has decreased by only nine percent. However, there has been a dramatic shift in the makeup of our beneficiary population: the number of active duty members and dependents who are eligible for care has decreased by 27 percent, whereas retirees and their family members now make up over 50 percent of our beneficiaries.

As hospitals closed, health care became less accessible, with appointments at military hospitals and clinics more difficult to obtain. Simply stated, the demand for health care began to exceed the system's capacity to deliver it. The desire to improve access was a significant factor in the development of TRICARE, along with the continued rise of health care costs and the continuing requirement to maintain a trained and ready medical corps to support our troops, in peace or in combat.

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE brings together the health care resources of the Armed Forces and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support military operations.

TRICARE offers expanded access to care, a choice of health care options, consistent high-quality health care benefits, and reduced costs for beneficiaries. TRICARE features a triple-option benefit, TRICARE Prime, TRICARE Extra, and TRICARE Standard.

- **TRICARE Prime** is modeled after civilian HMOs, it requires enrollment by persons who wish to use it, and requires enrollees to pay small co-payments when they get care. Among the many features of TRICARE Prime is guaranteed access to care in a timely manner at MTFs or the civilian provider network. Priority for treatment in MTFs is given to participants enrolled in TRICARE Prime. Another key feature of TRICARE Prime is that all who enroll are assigned a Primary Care Manager (PCM). A PCM is a health care professional or medical team who patients will see first for their health care needs. The PCM is supported by military and civilian medical specialists to whom patients are referred to if they need specialty care.

- **TRICARE Extra** is an enhanced version of TRICARE Standard, offering the advantage of an integrated network of health care providers under a preferred provider concept. Participating providers agree to charge lower fees for military beneficiaries. The beneficiaries themselves get a discount on the cost-shares they are required to pay for the care they get from the network provider.

- **TRICARE Standard** is the old CHAMPUS fee-for-service option, renamed. Standard provides beneficiaries with the greatest freedom in selecting civilian TRICARE authorized providers, but has the highest cost of the three options.

Despite the successful implementation of TRICARE, TRICARE will always be incomplete until we have the capability to enroll retirees over the age of 65. Within the continental United States, our retired beneficiaries, their families and survivors are eligible to receive health care benefits under the Medicare system when they become 65 years of age. They continue to be eligible for care in the MHS on a space-available basis, but because they are not statutorily eligible for CHAMPUS, are not eligible to participate in the TRICARE program. Medicare reimbursement to DoD may be the key to alleviating the access-to-military care problem for our Medicare-eligible population.

Access to military health care is a benefit these people have earned based on their years of service to and sacrifice for their country. DoD feels a sincere and enduring responsibility for the health of our retired beneficiaries, and will do all it can to meet its moral commitment to provide health care for our military retirees and their families. At the same time, they understand the reality of fewer hospitals, fewer physicians, and less money. We are committed to finding the best alternatives for ensuring our older retirees and their families comprehensive health care delivery.

Our highest priority for keeping our commitment is TRICARE Senior. DoD worked closely with the Congress to achieve the Balanced Budget Act of 1997 provision authorizing a three-year demonstration of Medicare subvention. The goal of the

demonstration, TRICARE Senior, is to test cost-effective alternatives for delivering accessible and quality care to dual-eligible beneficiaries that does not increase costs to the Medicare Trust Funds.

The TRICARE Senior demonstration was authorized in section 4015 of the Balanced Budget Act of 1997, under which the Medicare program treats the MHS similarly to a risk-type HMO for dual-eligible Medicare/DoD beneficiaries. The legislation also authorized Medicare HMOs to make payments to DoD for care provided by MTFs participating in the demonstration to HMO enrollees. This part of the demonstration, called Medicare Partners, will allow DoD to enter into contracts with Medicare HMOs to provide specialty and inpatient care to dual-eligible beneficiaries. The demonstration includes two components: under the first component, TRICARE Senior Prime, DoD sites may qualify asMedicare+Choice health plans, and receive capitated payments from the Medicare Trust Funds for beneficiaries enrolling in TRICARE. Under the second component, Medicare Partners, DoD will enter into agreements with Medicare + Choice Organizations and receive direct payments from the organizations for inpatient and physician specialty care services provided to dual-eligibles enrolled in the Medicare + Choice Organization's plan. Currently, only the TRICARE Senior Prime program is operational at six selected demonstration sites.

Eligibility for participation in TRICARE Senior Prime consists of people who (during the demonstration):

- Are age 65 or older and live within the geographic area where enrollment in TRICARE Senior Prime is offered;
- Are covered through Medicare's aged program by Medicare Part A and Medicare Part B and are eligible for care from DoD as described in section 1074(b) or 1076(b) of title 10 United States Code. The program excludes Medicare beneficiaries who are disabled or eligible for End Stage Renal Disease benefits prior to enrollment; and,
- Are a dual-eligible beneficiary who used a military treatment facility prior to July 1, 1997 or became dual-eligible on or after July 1, 1997.

The provisions of the demonstration and conditions of participation are co-monitored by organization elements within the Health Care Financing Administration and the TRICARE Management Activity. As the demonstration sites were selected, a Memorandum of Agreement (MOA) addressing the provisions for the demonstration and the applicable conditions of participation was written and signed by the Secretary of Defense and the Secretary of Health and Human Services. This MOA was signed 5 months after the passage of the BBA, at which time DoD began a nine-month process of qualifying sites as Medicare+Choice plans. The first site began health care delivery 8 months after the MOA was signed and 13 months after the BBA was signed, and the last demonstration site began health care delivery 17 months after the BBA was signed.

The provisions and conditions for participation as Medicare Managed Care organizations required the selected sites to meet the requirements for certification and award as a Medicare+Choice Organization under the requirements of Section 1876 and

Part C of title XVIII of the Social Security Act. DoD met all requirements, other than a few specifically waived by HCFA in recognition of the unique aspects of dealing with Federal health care program, including:

- allowing DoD to use its 40-mile catchment area (rather than Medicare's 30-minute, 30-mile service area criteria);
- allowing DoD providers licensed in other States to practice in the demonstration locations; and,
- stipulating that DoD meets the fiscal solvency requirements.

Meeting the statutory requirements for approval as Medicare+Choice plans was a major undertaking for DoD. Qualification of the sites required DoD and HCFA to devote extensive resources over a nine-month period, even though the application approval process was expedited significantly by HCFA in order to accommodate the demonstration time frames.

The six participating sites are: 1) Madigan Army Medical Center, Fort Lewis, WA. 2) Wilford Hall and Brooke Army Medical Centers, San Antonio, TX; Fort Sill, Lawton, OK; and Sheppard AFB, Wichita Falls, TX; 3) Naval Medical Center San Diego, San Diego, CA; (4) Keesler AFB, Biloxi, MS; (5) Fort Carson and the Air Force Academy, Colorado Springs, CO; and (6) Dover AFB, Dover, DE.

- HCFA conducted its site review of Madigan Army Medical Center June 2-4, 1998. Madigan received its certification as a Medicare + Choice Organization demonstration in July 1998, and began health care delivery in September 1998. Madigan currently has 3,634 enrolled beneficiaries in its program.

- HCFA conducted its site review of Wilford Hall and Brooke Army Medical Centers June 24-26, 1998. Both Wilford Hall and Brooke received their certification as Medicare + Choice Organizations in August 1998, and began health care delivery in October 1998. Combined, both facilities have 10,413 enrolled beneficiaries in the program.

- HCFA conducted its site review of Fort Sill and Sheppard AFB as service area expansions of San Antonio September 1-2, 1998. Both Fort Sill and Sheppard AFB received their certification as expansions to the San Antonio site in September 1998, and began health care delivery in December 1998. Combined, both facilities have 1,844 enrolled beneficiaries in the program.

- HCFA conducted its site review of the Naval Medical Center San Diego July 14-16, 1998. NMC San Diego received its certification as a Medicare + Choice Organization demonstration in September 1998, and began health care delivery in November 1998. NMC San Diego currently has 2,897 enrolled beneficiaries in its program.

- HCFA conducted its site review of Keesler AFB August 25-27, 1998. Keesler AFB received its certification as a Medicare + Choice Organization demonstration in November 1998, and began health care delivery in December 1998. Keesler AFB currently has 2,687 enrolled beneficiaries in its program.

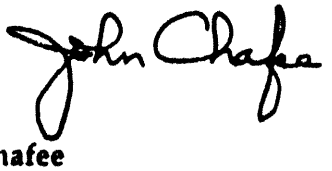
- HCFA conducted its site review of Fort Carson and the Air Force Academy September 9-11, 1998. Both received their certification as Medicare + Choice Organizations in November 1998, and began health care delivery in January 1999. Combined, both facilities have 2,895 enrolled beneficiaries in the program.

- HCFA conducted its site review of Dover AFB September 28-30, 1998. Dover AFB received certification as a Medicare + Choice Organization demonstration in November 1998, and began health care delivery in January 1999. Dover AFB currently has 678 enrolled beneficiaries in its program.

Since January 1999, all sites are providing health care delivery under the TRICARE Senior Prime demonstration program. All sites are currently reviewing their ability to implement the second component of the TRICARE Senior demonstration, Medicare Partners.

I am very pleased with the excellent progress that we have made in implementing this important program. Success in this endeavor will be critical in enabling DoD to keep its health care commitments to its senior beneficiaries, to whom we owe so much.

Thank you.



Statement by Senator John H. Chafee

Senate Finance Committee
Hearing on Medicare Subvention Demonstration Project
Tuesday, May 4, 1999, 10:00 a.m.

I would like to thank the Chairman for holding this hearing today and I look forward to hearing the testimony of our distinguished guests. Like many of my colleagues, I supported the idea of a Medicare subvention demonstration, and I am interested to learn the preliminary results of this test and to hear discussion of a similar demonstration for veterans.

Military retirees, like all Medicare beneficiaries, deserve the best possible health care and deserve a choice of where they can receive that care. Many of these retirees would like to continue receiving their medical care at military treatment facilities. If this demonstration shows that care at these facilities is as effective and cost efficient, or more so, than health care provided by civilian providers, it seems a logical step for Medicare to reimburse DOD for that care as it would any provider.

Before considering any Medicare issue, it is crucial to have as much information as possible about the impact of the issue on Medicare beneficiaries and on the Medicare Trust Fund. This demonstration will provide many of the answers to these questions and I look forward to learning from this project whether Medicare subvention is in the best interests of military retirees as well as the rest of the Medicare beneficiary population.

Statement by Senator James M. Jeffords
Committee on Finance
Hearing on Medicare Subvention
May 4, 1999

Mr. Chairman,

I commend you for holding this hearing today on the issue of Medicare subvention and specifically on my legislation to extent Medicare subvention to the Veterans Health Administration. As you have mentioned, the Senate unanimously endorsed this proposal on February 24, 1999, and I am anxious to see this committee move forward in keeping with that support.

As a veteran myself, I believe this is an important tool for the VA in its push to maintain high quality veterans health care in the face of inadequate budgets over the past few years. While I was pleased that our efforts to increase the overall funding level for veterans health care were successful, as Dr. Kizer knows, next year's budget agreement level still falls short of the amount needed to keep pace with inflation. Medicare subvention has long been sought after by veterans who want to get their Medicare-covered services at the VA. It also makes good sense as a way of augmenting a quality health care system in which the Federal Government has invested a lot, and which veterans depend on to fulfill our promises to them. To ensure the future of the Veterans health care system, we must continue to seek new and creative ways to increase the number of Veterans served at VA hospitals. My bill does that.

I am glad to hear the lessons learned from the Department of Defense experience with its subvention pilot program. We will take them carefully into account in planning the VA subvention program. But I urge my colleagues to remember that the DoD and the VA are very different systems, and face different challenges. As they have done before, I am sure Secretary West and Dr. Kizer will say that the Veterans Health Administration is eager to get going on this pilot program. I trust that this endorsement will help speed passage of my legislation.

During your visit to Vermont two weeks ago, Dr. Kizer, we discussed this issue, and I appreciate your working with me on issues at the White River Junction VA Medical Center. As you know, White River Junction is very interested in participating in a pilot subvention program.

Mr. Chairman, veterans want this legislation. The VA wants this legislation. The US Senate wants this legislation. Seems like pretty good momentum to me! I trust this committee can keep this ball rolling, moving forward with the information we have gather today with an eye to enactment of my legislation in the very near future.

STATEMENT
OF
KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
REGARDING VA MEDICARE SUBVENTION
BEFORE
THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

MAY 4, 1999

Mr. Chairman and members of the Committee, thank you for the opportunity to testify on behalf of a Medicare Subvention pilot for the Department of Veterans Affairs. VA has sought authorization for Medicare reimbursement for a number of years because we believe this would be beneficial to both the veterans who would like to use their Medicare benefits through the VA healthcare plan and, importantly, to Medicare and the Medicare Trust Fund.

Medicare Subvention is an issue of equity for those Medicare-eligible veterans who can use their Medicare benefits anywhere they choose, except at VA healthcare facilities. In VA's view, this represents significant potential savings since VA has agreed to provide Medicare-covered services at a discount. We recognize, however, that the Health Care Financing Administration (HCFA) views this as a test to see if the savings can be realized.

I am pleased that VA and the Department of Health and Human Services have been able to work together to successfully reach the agreement contained in a Memorandum of Agreement (MOA) between our two Departments, which we expect to forward to Congress in about a week. This MOA establishes the foundation for a VA Medicare Subvention pilot and will serve as an

implementation plan as we move forward in this effort. This agreement addresses concerns that have been expressed in the past about the financial risk of increased cost to the Medicare Trust Fund and VA's capability to successfully meet Medicare requirements and operate as a Medicare provider. When I discuss the MOA in more detail, I will cover the safeguards that have been included to protect the Trust Fund.

First, however, I would like to address concerns about VA's ability to be a Medicare provider, by describing the fundamental transformation that the VA healthcare system has undergone in the last four years. I know that some of you are already aware of this transformation. However, for those who may not be as familiar with the VA healthcare system, I hope this gives you a new perspective on VA.

In 1994, when I was asked to take my current position as Under Secretary for Health, VA was a hospital centered healthcare system that had not kept pace with the changes in healthcare that were occurring in all of American healthcare. VA recognized that it had become an outdated, unresponsive, and inefficient healthcare system that could better serve its patients. To address these issues, the veterans healthcare system initiated a systemic and systematic effort to fundamentally re-invent itself. In the process, the Veterans Health Administration (VHA) has become the largest fully integrated healthcare system in the nation, delivering a full continuum of services. The effort has involved reengineering VHA's operational structure, streamlining its processes, implementing "best practices", improving information management, reforming eligibility rules, expanding contracting authority, and changing the culture of VA healthcare. I can tell you today, without reservation, that no other healthcare system in the U.S. can match either the extent or rapidity of change that has occurred in the veterans healthcare system since our reinvention effort was launched in late 1995.

To illustrate the nature of VHA's transformation, let me cite a number of facts and figures that attest to the nature of the improvement that has occurred:

- VA's now approximately 1,100 sites of care delivery have been organized into 22 Veterans Integrated Service Networks (VISNs) and these networks are now the system's basic operating unit.
- Beginning with about 10 percent of VA patients enrolled in primary care in 1994, universal primary care has been implemented, as well as universal telephone triage of "call centers." In a recent survey, almost 90 percent of patients could identify their primary caregiver.
- Since September 1994, 54 percent (28,195) of all acute care hospital beds have been closed.
- Compared to FY 1994, annual inpatient admissions in FY 1998 decreased 32 percent (288,398 fewer admissions), while ambulatory care visits increased by 35 percent (10.3 million increase for a total of 35.8 million outpatient visits in FY 1998).
- From October 1994 through September 1998, bed days of care per 1,000 patients decreased 62 percent - from 3,530 to 1,333.
- Cumulative levels of staffing have decreased 12 percent (25,073) since 1994, even though we provided hands-on care to 520,000 (22 percent) more patients in 1998 than in 1994.
- Ambulatory surgeries have increased from 35 percent of all surgeries performed in FY 1995 to about 75 percent of all surgeries now. Associated with this has been increased surgical productivity and reduced mortality.
- A new capitation-based resource allocation methodology (the "Veterans Equitable Resource Allocation" system) has been implemented and validated. This has brought much needed financial discipline to the system.
- Customer service standards have been implemented, customer satisfaction surveys are being routinely performed, and management is being held accountable for improving service satisfaction. Statistically significant improvements have been documented. In FY 1998, 65

percent of all patients, including psychiatric patients, reported the quality of their care as very good or excellent.

- A pharmacy benefits management program implemented in FY 1995, which includes a national formulary, has produced an estimated $347 million in annual savings simply on the purchase of pharmaceuticals.
- Other elements of a Commercial Practices Initiative are yielding tens of millions of dollars of savings in the acquisition of medical and surgical supplies, prosthetics, equipment and maintenance, renal dialysis, and support services. (Indeed, a number of GAO reports have documented VA's marked savings in this regard compared to Medicare.)
- Over 270 new community-based outpatient clinics (CBOCs) have been sited, or are in the process of being sited, from savings achieved in other areas. Many of these are by contract with private providers.
- Major initiatives have been launched to increase care management, end of life care, pain management, use of clinical guidelines, and home care.
- A multi-dimensional, process-and outcome-focused quality of care accountability framework has been implemented to ensure the consistency and predictability of high quality healthcare being delivered everywhere in the VA system, and VHA has been designated as a national laboratory for healthcare quality management by the National Partnership for Reinventing Government.
- Universal pre-admission screening and admission and discharge planning have been implemented, along with many other "infrastructure" and processes changes, such as a universal semi-smart identification and access card.
- Significant improvements in the quality of care have been demonstrated, and in a number of areas, VA's performance is significantly better than that of the private sector.

I am proud of these accomplishments and anticipate that VA will continue to make significant gains as its transformation matures. I believe these changes demonstrate that the infrastructure and processes are in place to enable VA to successfully meet all Medicare requirements. Training and education will be required at our pilot sites so that our healthcare providers and administrators become fully knowledgeable about the myriad Medicare requirements. However, the success that VA health plan managers have demonstrated in meeting the challenges of the past four years shows that they are up to the Medicare challenge. Implementation of the demonstration will require us to address a number of administrative issues with HCFA. HCFA's knowledge in this area will be helpful in addressing the issues and setting an implementation timeline.

VA already offers the full range of services that must be offered under any Medicare program. The services are available either directly at VA facilities or through contractual arrangements. VA's contracting authority permits us to provide any services that are required and not readily accessible. VA has experience in billing third-party insurance companies. Through internal reviews we have become aware of some shortcomings in our documentation and coding, not unlike what many private plans have found, and we have taken steps to address these concerns. Necessary changes will be implemented by September 1999. We are able to generate the Medicare required UB92's and HCFA 1500's, and implementation of our Decision Support System in all our facilities gives us an enhanced capability to track costs.

On the clinical side, we have universal primary care, and we practice coordinated care across the entire continuum of healthcare services. I believe that in the coordination of care, we must manage care, not costs. It is becoming increasingly clear that the greatest failure of managed care has been that it has focused on managing cost, without actually improving care. Too often, managed care companies have addressed only the symptoms of the ills that afflict private healthcare; they have not addressed the basic pathology of fragmented, provider-focused and user-unfriendly services, and redundant and excess capacity. So far, managed care has not done enough to make care more

coordinated, more convenient and more coherent (i.e., to manage care so that is actually improves outcomes). If we focus on managing care to produce higher quality, then costs will decrease, for I believe that higher quality care actually costs less.

The importance of coordinating a patient's entire care is one reason that I advocate a Medicare+Choice model for the VA Medicare Subvention pilot. Only through this model can we be sure that we have a well-managed, well-coordinated approach to our veterans' healthcare needs, rather than the fragmented "body-part" approach that characterized VA care in the past. VA's current use of coordinated care puts us in an excellent position to successfully operate a Medicare+Choice plan. In addition, VA's high proportion of elderly mirrors the population that would enroll in a VA Medicare+Choice plan.

The Medicare Subvention pilot which VA and HCFA are proposing would be for dual-eligible veterans who are classified as Priority 7 — that is, those veterans with higher incomes who have no service-connected disability or a service-connected disability that does not entitle the veteran to compensation. If VA is unable to treat all eligible veterans because of resource constraints, Priority 7 veterans would be the first to be cut off from care. Although we have been able to offer healthcare services to this group of veterans in FY99, this is subject to an annual determination. The authorization for these veterans to bring their Medicare benefits to VA would assure them access on a continuing basis and improve equity of access during the duration of the demonstration. In many cases, Medicare subvention would allow VA to treat veterans who otherwise would be getting either fragmented care or no healthcare at all.

Historically, the Priority 7 veterans have made up a relatively small proportion of those who use the veterans healthcare system – about 3 or 4 percent. Although the numbers have increased in recent years and continue to increase under our current enrollment process, the proportion of users is still slightly below 10 percent. Costs associated with the care of this group of veterans have been less than that of the higher priority groups since they tend to use fewer and less costly services. Nevertheless, both VA and HCFA realize

that appropriated dollars have been spent to provide care for this population. For this reason, the Memorandum of Agreement contains a provision to establish a Level of Effort (LOE) which represents what VA has spent in the past to deliver Medicare-covered services to these veterans. Payment from the Medicare Trust Fund will be made only after the LOE is reached. Although it is difficult to make precise LOE calculations, the estimates will be based on the cost data that are available. Because of the relatively small numbers of Priority 7 users in the past, VA does not anticipate that the LOE will represent a substantial amount at any one pilot site.

Our proposal includes only a Medicare+Choice pilot. This is the direction that the VA healthcare plan has been heading over the past three years and one which offers the best opportunity to provide comprehensive, coordinated care for our enrollees. This is also the mode of healthcare delivery which Medicare beneficiaries have increasingly chosen. The adoption of this approach does not preclude establishing a pilot in a rural area, although there may be some additional challenges associated with this, e.g. possible higher expenses associated with more contractual services and lower capitated rates. I believe a rural site should be given consideration as it could provide some valuable insights for both VA and HCFA. Adding a fee-for-service demonstration would limit VA's ability to coordinate all care that veterans receive. A fee-for-service demonstration entails additional data requirements. Implementing both a fee-for-service and coordinated care demonstration would introduce greater administrative complexities and resource requirements.

Several things should be said about the various concerns that have been raised in regard to risk to the Medicare Trust Fund as a result of the pilot. First, this is a limited pilot. The MOA is proposing that the demonstration be limited to eight sites or two Veterans Integrated Service Networks (VISNs). In addition, the cap on the reimbursement from the Trust Fund is only $50 million annually. This does not mean that the risk to the Trust Fund is $50 million, as this represents compensation for services that VA is providing and that Medicare would have to

reimburse any other Medicare provider to provide healthcare services to these same veterans.

Moreover, there are provisions in the MOA that provide additional protections to the Trust Fund. In addition to the "cap" on Medicare payments, there is the level of effort calculation, an annual reconciliation with the LOE, an end of year reconciliation to assure accurate payments and data calculations, and a mechanism to make adjustments or even end the pilot if ongoing analyses and evaluations identify unacceptable costs to either VA or to the Trust Fund. Beyond these safeguards, the payment, which VA has agreed to accept, represents a discount to the Trust Fund compared to private sector rates. The rate is based on 95 percent of Medicare normal payments to the private sector, along with exclusion of DME, IME, DSH, and two-thirds of capital. Compared to the annual national Medicare Trust Fund expenditures, I believe the VA Medicare Subvention proposal does not represent a threat to the Trust Fund, but offers an opportunity to realize savings. I am confident that both VA and Medicare will gain from this pilot experience.

In conclusion, I want to assure the Committee of the importance that the Secretary and I place on this Medicare Subvention initiative. VA will devote its energy and resources to ensuring that the pilot is a success – for both VA and Medicare - and that every veteran who comes to VA will receive quality healthcare. I am confident that both VA and HCFA have the desire, resourcefulness and expertise to work together as partners to achieve the objectives that are embodied in the Memorandum of Agreement and in the VA Medicare Subvention pilot.

Medicare - Subvention

STATEMENT FOR THE RECORD
SENATOR MURKOWSKI
SENATE FINANCE COMMITTEE
MAY 4, 1999

Mr. Chairman:

Thank you for holding this hearing on this important issue. I have the honor of serving under your chairmanship, Senator Roth, and the chairmanship of our first witness, Senator Specter, on the Veterans Affairs Committee.

Today, I believe it's important for us to remember what we are trying to accomplish here. The task before this committee is to make sure Medicare is run in an efficient manner. But all of us must also consider the plight of military retirees and veterans.

Believe me as the former Chairman and member of the Veterans Affairs Committee for 18 years, I know the difficulty in juggling the demands and needs of our veterans and what is feasible.

The debate on Medicare Subvention has continued for years. Will Subvention put additional pressure on the Medicare Trust Fund or will Subvention save Medicare money? I don't know. But unless we test the program, we will only continue to talk about helping veterans and saving Medicare rather than taking action.

I am proud to say that I am a co-sponsor of S. 445, the "Veterans Equal Access to Medicare Act" which was introduced by Senator Jeffords. This legislation will help Congress understand the effects of Medicare Subvention for the VA on the Medicare Trust Fund.

We must give Medicare Subvention a chance. Already, Congress has authorized a pilot within Tricare for military retirees. It only makes since that we also test it within the VA for all veterans. Senator Jeffords legislation, which was included in S. 4, does this.

The proposal would test Subvention throughout the VA system, including an

atypical site, such as Alaska. This proposal is a legitimate test. The VA would closely monitor the maintenance of efforts at the sites and the cost to the Medicare Trust Fund. The VA would benefit since they would receive funding for care given to Medicare eligible veterans. Finally, veterans would benefit since more veterans could get care within the VA.

I want to thank Senator Jeffords, Senator Specter, and Senator Rockefeller for their leadership in this area, and I look forward to hearing the testimony of today's witnesses.

Thank you Mr. Chairman.

STATEMENT
Senator John D. Rockefeller IV

Committee on Finance
Hearing on Medicare Subvention
May 4, 1999

As a member of the Finance Committee and Ranking Minority Member of the Senate Committee on Veterans' Affairs, I am enormously pleased that we are focusing on the existing DOD Medicare reimbursement project, as well as the potential for a similar project within the Department of Veterans Affairs. I thank the Chairman, Senator Roth, and the Ranking Minority Member, Senator Moynihan, for the opportunity to review these related issues.

Some of us on this Committee have worked over the years to enact a project to allow VA to bill Medicare for health care services provided to certain dual beneficiaries. Known as VA Medicare subvention, this is a concept that has also been supported by veterans service organizations and by virtually every advisory body that has ever studied the VA health care system. Although subvention has not been authorized for VA yet, it is currently being tested in six sites within the DOD health care system. I am eager to hear about how it is working and hope that we will come away from this hearing with some concrete and valuable lessons for the VA.

In the past, many VA hospitals and clinics have been forced to turn away middle income, Medicare-eligible veterans who sought VA care. These hospitals simply did not have the resources to care for them. Now, due to changes in the law, all enrolled veterans will have access to a comprehensive, uniform benefit package. Yet, resources for veterans' health care have not increased, and, in fact, have remain flatlined over the last years.

Traveling through the State of West Virginia and talking to veterans at the VA hospitals in Clarksburg, Huntington, Martinsburg, and Beckley, the subject of Medicare subvention repeatedly comes up. Veterans there and throughout the country perceive an injustice -- they have "paid for" their Medicare coverage and want the choice about where they are to receive their health care.

The four VA hospitals in my home state are already caring for a large portion of Medicare-eligible veterans who have other choices but choose the VA hospital in their area. In fact, they spent nearly $5 million caring for Medicare-eligible veterans last year. Enactment of a VA demonstration project would encourage other eligible veterans who have not previously received care from VA to do so. All the while, Medicare would be presented with cost-savings opportunities.

For veterans, approval of a veterans subvention project would also mean the infusion of new revenue into their health care system and, thus, greater access to care. For the Health Care Financing Administration (HCFA), a VA subvention demonstration project will provide the opportunity to assess the effects of coordination on improving efficiency, access, and

quality of care for dual-eligible beneficiaries in a selected number of sites. Finally, Congress would receive the results of this feasibility study, which, once and for all, would give us the necessary data to make rational policy decisions in the future about Medicare and VA's involvement, as we are currently doing for the DOD project.

All subvention test projects are designed to be budget neutral. The VA would be required to maintain its current level of services to Medicare-eligible veterans already being served, and would effectively be limited to reimbursement for additional care provided to new users. Payments from Medicare would be at a reduced rate and would exclude Disproportionate Share Hospital adjustments, Graduate Medical Education payments, and a large percentage of capital-related costs. In effect, the VA would be providing health care to Medicare-eligible veterans at a deeply discounted rate. The Department of Health and Human Services and VA would have the ability to adjust payment rates, or to shrink or terminate the program if Medicare's costs increase. In the event that these safeguards included in the proposal fail -- an event which the VA has declared unlikely -- this proposal caps all Medicare payments to the VA at $50 million per year.

A HCFA representative testified before the last Congress and stated that this proposal will provide quality service to certain dual-eligible beneficiaries and, "at the same time, preserve and protect the Medicare Trust Fund for all Americans." I believe this, and I am thrilled to see HCFA and VA finalizing the details of an updated subvention agreement.

I have seen a draft of the agreement and note many similarities with Senator Jeffords' bill, S. 445 -- the Veterans' Equal Access to Medicare Act -- of which I am an original cosponsor. There is one important difference, however. S. 445 would test two models of Medicare reimbursement -- a risk-contract HMO and fee-for-service. The VA health care system is a system that has traditionally cared for an older and sicker population. I believe this makes it the perfect venue to test both approaches to financing. We will be able to make some assessments about how managed care works for an older and chronically ill group. I also believe that our former servicemembers deserve maximum choice when deciding where they want to receive their health care. I am hopeful that we can overcome these differences, and look forward to enactment of VA subvention legislation.

I can't overstate the fact that a VA subvention proposal is enormously important to our veterans and the health care system they depend upon. And regardless of any policy change resulting from the Bipartisan Commission on the Future of Medicare or other recommendations, an excellent opportunity will remain for VA to test the idea of Medicare subvention.

Truly, this VA/Medicare proposal is a way to provide quality health care to veterans who are also eligible for Medicare, while at the same time preserving and protecting the Medicare Trust Fund. With a signed Memorandum of Agreement between VA and HCFA, VA will be ready to move ahead with this demonstration project. Finally, the Department of Defense Medicare Subvention test program -- TRICARE Senior Prime -- is progressing, and

we will hear about that today. Let us not delay VA any longer in establishing its own subvention program.

Again, I thank the Chairman and Ranking Member for the opportunity to hear from these witnesses about VA and DOD subvention. At the end of the hearing, I hope we will have a solid record with which to fully justify a VA subvention project. Veterans deserve the opportunity to come to VA facilities for their care and to bring their Medicare coverage with them. I hope my colleagues here on the Finance Committee will choose to make this long sought-after proposal a reality.

PREPARED STATEMENT OF WILLIAM J. SCANLON, PH.D. AND STEPHEN P. BACKHUS

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you review the Medicare subvention demonstration for the Department of Defense (DOD), as well as subvention demonstration proposals for the Department of Veterans Affairs (VA). The stated goal of subvention is to implement an alternative for delivering accessible and quality care to Medicare-eligible military retirees and certain Medicare-eligible veterans, without increasing the cost to DOD or VA, or to Medicare. In principle, Medicare-eligible military retirees who enrolled in the subvention program would get higher priority at military facilities than before, permitting them to get Medicare-covered care from DOD--a new alternative to retirees' current Medicare options. Similarly, proposals have surfaced to allow certain Medicare-eligible veterans to use their Medicare benefits at VA facilities. Subvention could allow DOD and VA to augment appropriated funds with Medicare payments and to use excess capacity where it exists. Medicare might gain because under subvention it would pay DOD and VA less than the rate paid to private Medicare providers and managed care plans.

The 3-year DOD demonstration involves about 30,000 enrolled retirees and limits Medicare payments to DOD to at most $65 million a year. A nationwide DOD subvention program could potentially provide military health care to at least 600,000 retirees and might generate, by one estimate, as much as $2 billion a year in Medicare payments to DOD. In VA, the potential may be even greater.

These outcomes are not, however, guaranteed, so the Balanced Budget Act of 1997 (BBA) authorized a large-scale, three-year demonstration of DOD subvention and directed GAO to evaluate the demonstration's results. The BBA posed 15 evaluation questions about the demonstration, including its effects on cost to DOD and Medicare as well as on access and quality of care. We are currently surveying approximately 20,000 military retirees, dependents, and survivors so we can profile the characteristics of those who enrolled and did not enroll, their access to health care, and their satisfaction with it. We are also analyzing the costs to DOD and to Medicare--compared with what the costs would have been without the demonstration--for the 125,000 people eligible for the demonstration. A team visited all the demonstration sites to evaluate implementation and progress. We will be providing you with interim reports on aspects of the demonstration. Our final results will not, however, be available until several months after the demonstration ends in December 2000.

Our testimony today focuses on the lessons from the experience to date of the DOD demonstration and its implications for a possible VA demonstration. Specifically, we report on the early phases of implementing the DOD demonstration, issues raised by that experience for DOD subvention, and lessons from the DOD demonstration for a possible VA demonstration.

In summary, subvention holds the potential to benefit military retirees and veterans, DOD and VA, and Medicare. Although it got off to a slow start, DOD has initiated its subvention demonstration and is now serving Medicare-eligible military retirees at six

sites. Several key operational issues remain. These include development of more understandable payment rules, viable for the longer term, and development of data to manage the demonstration and support its evaluation. Most important, the demonstration's final results, in terms of access to health care, quality of patient care, and costs to DOD, Medicare, and retirees, will not be known until the evaluation is completed, several months after the end of the demonstration in December 2000.

DOD's early experience with subvention does offer insights if proposals are acted on to permit Medicare subvention for VA. In particular, it would need to consider, in collaboration with HCFA, how to determine its baseline costs and payment rules, as well as the need for good data for implementation, management, and controlling costs. Moreover, VA would need to make its regular enrollment of veterans who wish to use VA health care services interface smoothly with subvention demonstration enrollment. VA would also need to be concerned about potential crowding-out of other, currently higher-priority veterans by subvention enrollees. Our early work on DOD subvention suggests that VA would have a greater chance of success if it has sufficient time to plan and establish the demonstration, and if the value and feasibility of implementing fee-for-service and managed care subvention models simultaneously were reconsidered.

BACKGROUND

Medicare

Most military retirees age 65 and over are eligible for Medicare, a federally financed health insurance program for the elderly, some disabled persons, and people with end-stage kidney disease. Medicare covers about 39 million beneficiaries and spends about $212 billion a year. Its benefits include hospital, physician, and other services such as home health and limited skilled nursing facility care. The Health Care Financing Administration (HCFA) administers Medicare and regulates participating providers and health plans.

Original, or traditional, Medicare reimburses private providers on a fee-for-service basis and allows Medicare beneficiaries to choose their own providers without restriction. A newer option within Medicare[1] allows beneficiaries to choose among private, managed care health plans. Currently, 17 percent of beneficiaries use Medicare managed care. In original Medicare, beneficiaries must pay a share of the costs for various services. Most Medicare managed care plans have only modest beneficiary cost-sharing and many offer extra benefits, such as prescription drugs.

DOD Health Care

DOD received an appropriation for military health care of almost $16 billion in fiscal year 1999. Of that, an estimated $1.2 billion is spent on the 1.3 million Medicare-eligible military retirees. Under its TRICARE program, DOD provides health benefits to active

[1] The BBA expanded this option to include plans in addition to health maintenance organizations and labeled it "Medicare+Choice."

duty military, retirees, and their dependents, but most retirees 65-and-over lose their eligibility for comprehensive, DOD-sponsored health coverage. DOD delivers most of the health care needed by active duty personnel and military retirees[2] through its military hospitals and clinics. DOD gives priority for care to active duty personnel and their dependents, and to certain retirees under 65. Retirees who turn 65 and become eligible for Medicare can get military care if space is available (called "space-available care")--that is, after other DOD beneficiaries are treated.[3] Some military facilities have little or no space-available care.

Since the early 1990s, DOD health care has shifted toward managed care. DOD established its own managed care plan, TRICARE Prime, which uses military providers, supplemented by a network of civilian providers. However, it is not available to retirees aged 65 and over.[4] TRICARE Prime covers services of military physicians as well as civilian network providers by drawing on DOD's appropriated funds and premiums and copayments charged to some enrollees. In TRICARE Prime, DOD generally organizes the delivery of care on managed care principles--for example, an emphasis on a primary care manager for each enrollee. DOD has gained considerable experience with managed care, but it relies heavily on contractors to conduct marketing, build a network of providers, and perform other critical functions.

The DOD Subvention Demonstration

The BBA established a 3-year demonstration of Medicare subvention, to start on January 1, 1998, and end on December 31, 2000. Within the BBA's guidelines, DOD and HCFA negotiated a Memorandum of Agreement (MOA). The MOA stated the ways in which HCFA would treat DOD like any other Medicare health plan and the ways in which HCFA would treat it differently. The MOA also spelled out the benefit package and the rules for Medicare's payments to DOD. After DOD and HCFA signed the MOA, they selected six demonstration sites. They would be able to serve about 30,000 of the 125,000 people eligible for both Medicare and military health benefits in these areas.

The subvention demonstration made DOD responsible for creating a DOD-run Medicare managed care organization for elderly retirees. This pilot health plan, which DOD named Senior Prime, is built on DOD's existing managed care model. By enrolling in Senior Prime, Medicare-eligible military retirees obtain priority for services at military facilities—an advantage, compared to nonenrollees. Senior Prime's benefit package is "Medicare-plus"--the full Medicare benefits package supplemented by some other benefits, notably prescription drugs.

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[2] We use "retirees" to refer to military retirees, their dependents, and their survivors.

[3] A partial, unofficial exception to this rule occurs at teaching hospitals, where aged retirees with serious, persisting conditions are treated on an ongoing basis, in large measure so that medical residents can be given the clinical experience required.

[4] Active duty members of the armed forces receive their health care through TRICARE Prime. Dependents of active duty military can choose among three DOD-run health plans that include TRICARE Prime. Retirees under 65 can pay a premium and "buy in" to TRICARE Prime.

The BBA provides the basic rules by which, under the demonstration, Medicare pays DOD. First, Medicare is to pay DOD for each enrollee the Medicare managed care rate, less several adjustments and a 5-percent discount. Second, in order to receive Medicare payments, DOD must at least match its baseline costs, or "level of effort" (LOE)--that is, devote at least the same resources as it did in the recent past to providing care to 65-and-over retirees. The MOA translated these guidelines into a complex payment system. For example, it allows any demonstration site to earn monthly interim payments if its Senior Prime enrollment exceeds a threshold derived from baseline LOE. But at the end of the year, DOD can only retain a portion of these payments if that year's costs for the six sites together exceed baseline LOE.[5]

VA Health Care

VA provides a comprehensive array of health services to veterans with service-connected disabilities or low incomes. Since 1986, VA has also offered health care to higher-income veterans, who must however make copayments for services. Overall, VA serves over 13 percent of the total veteran population of 25 million, with the remaining veterans receiving their health care through private or employer health plans or other public programs. Many of the veterans whom VA serves also get part of their care from other sources, such as DOD, Medicaid, and private insurance. The administration has requested $17.3 billion for VA medical care in fiscal year 2000. To make up the differences between appropriated funds and projected costs, VA estimates that, by fiscal year 2002, it can derive almost 8 percent of the medical care budget from nonappropriated sources, including Medicare reimbursement.

Since the early 1990s, VA has shifted its focus from inpatient to outpatient care. At the same time, it implemented managed care principles, emphasizing primary care. In 1995, VA accelerated this transformation by realigning its medical centers and outpatient clinics into 22 service delivery networks and empowering these networks to restructure the delivery of health services.

In 1996, the Congress passed the Veterans' Health Care Eligibility Reform Act that established, for the first time, a system to enroll or register veterans. Enrollment is in effect a registration system for veterans who want to receive care. The law establishes seven priority groups, with Priority Group 1 the highest and Priority Group 7 the lowest. Priority Group 7 includes veterans whose incomes and assets exceed a specified level and (a) do not have a service-connected disability or (b) do not qualify for VA payments for those disabilities. Priority Group 7 veterans must agree to make copayments for health services.

Each year, VA determines, on the basis of available resources, which priority groups of enrolled veterans will be eligible for VA care in the coming year. Currently, VA serves all seven priority categories, but in the future that will not necessarily be true. Enrolled veterans in any one of the priority groups are eligible for the VA Uniform Benefits

[5] These issues are discussed in greater detail in a forthcoming report on the DOD demonstration of Medicare subvention.

Package. This is a broad package that covers inpatient and outpatient care; rehabilitative care and services; preventive services; respite and hospice care; and pharmaceuticals, durable medical equipment, and prosthetics.

Enrolled veterans remain free to get some or all of their care from other private or public sources, including Medicare. VA, on the other hand, is committed to serving all enrolled veterans.

Possible VA Subvention Demonstration

The structure of any VA subvention demonstration would depend upon the principles and directions that the Congress incorporates in authorizing legislation. We have found certain common elements in all demonstration proposals we reviewed. A VA subvention demonstration would serve certain higher-income[6], Medicare-eligible veterans (effectively, Priority Group 7 veterans):

- for a limited time period, such as 3 years;
- in a limited number of locations; and
- in compliance with Medicare rules that HCFA applies to the private sector, although HCFA could waive rules that were inappropriate or irrelevant to VA.

Regarding Medicare payments to VA,

- HCFA would pay VA at a lower rate than it currently pays to private Medicare providers or health plans;
- HCFA would pay VA for care of veterans in the demonstration only after VA exceeds its historic spending, or level of effort, for higher-income veterans; and
- HCFA payments to VA would be limited to a predetermined annual amount, such as $50 million.

Several current proposals also

- direct VA to establish at least one demonstration site near a closed military base;
- direct VA to establish at least one demonstration site that serves a predominantly rural area; and
- direct VA to maintain reserves against the risk that appropriated funds would be needed to pay for the care of veterans enrolled in the subvention demonstration.

Some proposals authorize VA to establish both fee-for-service and managed care subvention sites, while at least one only authorizes managed care.

[6] Those who exceed VA's income thresholds. For example, the current threshold for a single veteran without dependents is $22,350.

DOD DEMONSTRATION LAUNCHED AFTER DELAY, BUT KEY ISSUES REMAIN

In implementing the subvention demonstration, DOD and HCFA completed numerous and substantial tasks. DOD sites had to gain familiarity with HCFA regulations and processes, prepare HCFA applications, prepare for and host a HCFA site visit to assess compliance with managed care plan requirements, develop and implement an enrollment process, market the program to potential enrollees, establish a provider network (for care that cannot be provided at the MTFs), assign Primary Care Managers to all enrollees, conduct orientation sessions for new enrollees, and begin service. The national HCFA and DOD offices developed a Memorandum of Agreement, spelling out program guidelines in broad terms. They also developed payment mechanisms, and translated the BBA requirement that DOD maintain its historical level of effort (LOE) in serving dual eligibles into a reimbursement formula. HCFA accelerated review procedures and assigned additional staff so that timelines could be met. But these accomplishments were not without difficulties, and several issues remain that are likely to impact the demonstration's results. These include the extent to which payment rules can be made more understandable and workable, and the extent to which DOD can operate successfully and efficiently as a managed care organization serving seniors.

Implementation Delayed by Several Factors

In view of the steep learning curve that DOD faced--it started without any Medicare experience--it is not surprising that the demonstration did not start on time. The BBA was enacted in August 1997 and authorized a demonstration beginning in January 1998. The first site started providing service in September 1998 and all sites were providing service by January 1999. Officials at all DOD sites emphasized to us that the process of establishing a Medicare managed care organization at their facility was far more complex than they had expected. They noted several issues that caused difficulty during this accelerated startup phase, including the following:

- Delayed notification to sites of their selection for the demonstration.
- Difficulties in learning and adapting to HCFA rules, procedures, and terms for managed care organizations. For example, DOD had to significantly rework grievance and appeals procedures to comply with HCFA requirements.
- Difficulties due to shifts in Medicare requirements. All sites started planning as HCFA was developing the new Medicare managed care regulations to replace the rules for the former HMO risk contract program. Consequently, the sites had to adapt to changed rules when they were published.

Capacity and Enrollment

Sites vary significantly in their capacity for caring for Medicare-eligible retirees, how close enrollment is to capacity, and what fraction of eligibles has enrolled. This variation suggests that potential demand for a subvention program is uncertain. Retirees' enrollment decisions reflect several factors, some that DOD may be able to influence but others--such as the extent of managed care presence in an area--outside its control.

In establishing their enrollment capacity--which effectively became an enrollment target--some sites were more conservative than others. Sites' assessment of their resources focused on the availability of primary care managers--physicians and other clinicians who both provide primary care and serve as gatekeepers to specialist care. Additionally, the national TRICARE office developed a model to show how many enrollees a site would need to meet its LOE threshold and start receiving increased resources from subvention, and these results were made available to sites. Capacity varied from San Antonio, the largest site with four hospitals and a capacity of 12,700, to Dover, which provides only outpatient care in its military health facility and set its capacity at 1,500.

Many DOD officials and other observers expected that sites would be deluged with applications and would rapidly reach capacity, but this did not happen. One site is currently at capacity, but only after several months. Other sites have enrolled between 44 percent and 91 percent of capacity as of the end of April 1999.

As table 1 shows, there is a four-fold difference in sites' enrollment as a percentage of eligibles in their catchment areas--from 8 percent (San Diego) to 35 percent (Keesler). Several factors may explain this variation:

1. Enrollment in other Medicare managed care plans varies widely, from one site with a low percentage of eligible enrollees (San Diego)--where nearly 50 percent of dual eligibles are in private Medicare managed care plans--to two sites with higher percentages of enrollees (Keesler and Dover)--where no one is in managed care because no plans are available.

2. The availability of military care varies. Several sites emphasized in their marketing that retirees who did not enroll could not count on receiving space-available care. This information might spur retirees who prefer military care to enroll in Senior Prime. At other sites, space-available care was less of an issue. At these sites, prospective enrollees who believe that they can continue to receive space-available care may not see an advantage in enrollment but rather a disadvantage--especially because enrolling in Senior Prime locks them out of other Medicare-paid care.

3. Sites may differ in the amount of space-available care they have given in the past and in beneficiaries' satisfaction with that care. These factors could also affect the decision to enroll.

4. Some retirees expressed reluctance to enroll because the demonstration is due to end in December 2000. They also noted that they did not get information about how, after the demonstration ends, enrollees would transition back to space-available care, traditional fee-for-service Medicare, or a Medicare managed care organization.

Table 1. TRICARE SENIOR PRIME ENROLLMENT

	Enrolled *	Capacity**	Enrolled As % Capacity	Total Eligible	Enrolled As % Eligibility
Madigan Army Medical Center, WA	3,296	3,300	99.9%	21,709	15.2%
San Antonio, TX	11,534	12,700	90.8%	41,215	28.0%
Naval Medical Center, San Diego, CA	2,767	4,000	69.2%	35,619	7.8%
Keesler Medical Center, MS	2,563	3,100	82.7%	7,361	34.8%
Colorado Springs, CO	2,744	3,200	85.8%	13,689	20.0%
Dover, DE	661	1,500	44.1%	3,905	16.9%
Total	23,565	27,800	84.8%	123,498	19.1%

Note: Status as of April 26, 1999

* Includes only persons who were 65 years old at the beginning of the demonstration

** Capacity at the beginning of the demonstration. Does not include capacity for those who turned 65 after the demonstration started.

Managed Care Issues

The subvention demonstration for age 65-and-over military retirees is a new endeavor that highlights challenges for DOD to operate as a Medicare managed care organization. The first is operational--putting in place procedures, organization, and staff to deliver a managed care product to these seniors. The second is economic and organizational--creating the business culture that reconciles delivering services to this illness-prone population with cost-consciousness.

DOD's reliance on contractors (like Foundation Health and Humana) has both enabled it to accomplish key managed care tasks and brought risks with it. DOD overcame obstacles in launching TRICARE Senior Prime as a managed care organization.

Specifically, to establish and run a managed care plan requires infrastructure--the ability to market the plan, enroll members, and recruit, manage, and pay a provider network. In building Senior Prime organizations at the six sites, DOD has benefited from its TRICARE Prime experience, and from its contractors who help with or perform many of these tasks.[7] Sites with well-established TRICARE Prime organizations that had worked with the same contractor for several years seemed to us to have a sizeable advantage in establishing Senior Prime. It is not yet known what effect DOD's extensive use of contractors will have on DOD costs for Senior Prime. But an expanded, permanent subvention program would require establishing and monitoring contractors at many new sites. That would make contractor quality, relationships, and costs a pivotal and uncertain feature of a potential DOD subvention program.

Cost-consciousness matters greatly to managed care plans, especially because they do not use much cost-sharing by enrollees to curb excess use of services. Managed care plans have an incentive to control costs because they are paid a fixed rate per member per month. If the plan cannot provide all services within that amount, it will not survive. However, in the DOD setting, several factors undermine this incentive to be cost-conscious. First, as long as facilities are still providing some space-available care, they have a safety valve: if resources become too strained, they can reduce the amount of space-available care--spreading a fixed appropriation over fewer patients. This gives facilities considerable flexibility to cover costs that are higher than expected, but the downside is that they have less incentive to be efficient. Second, military treatment facility commanders do not have as much control over their budgets as their civilian counterparts. Many decisions about budgets and personnel are made independently of the local facility, and it can be difficult, for example, to get more military primary care doctors or to set up a new program with large up-front costs, even if these would promote longer-term efficiency.

Payment Issues

DOD and HCFA have devised payment rules to meet the statutory requirement that Medicare should pay DOD only after its spending on retirees' care reaches predemonstration levels--that is, after it has met its baseline, or LOE. These rules have added to the difficulty and the complexity of the demonstration. Furthermore, they have resulted in Medicare payments to DOD not being immediately distributed to the sites. As a result, DOD site managers tend to view DOD appropriations as the sole funding source for all Senior Prime care delivered at military health facilities; the managers are likely to consider Medicare subvention payments as irrelevant to their plans for dealing with capacity bottlenecks or other resource needs in TRICARE Senior Prime.

[7] The DOD sites relied on the TRICARE contractors for handling enrollment, claims processing, and network management. They have also, to varying degrees, assisted with the application, site visit, quality assurance, and utilization review areas.

The demonstration's payment system requires extensive cost and workload data--data that are often problematic and difficult to retrieve and audit. It also involves a complicated sequence of triggers and adjustments for interim and final payments from Medicare to DOD.

Interim payments are made to DOD for care delivered at each site that is above a monthly LOE threshold. A reconciliation after the end of the year to determine final Medicare payments can result in DOD returning a portion of those interim payments if the LOE for all sites for the entire year is not reached. DOD would also return Medicare payments if data showed that the demonstration population was in better health than that allowed for in the Medicare payment rates, or if payments exceed the statutory cap ($50 million in the first year, $60 million in the second, and $65 million in the third).[8]

Because of the potential for adjustments after the close of the year, the payment rules create some uncertainty for DOD. DOD cannot be certain that it will retain all--or even part--of the monthly interim payments at the end of the year. DOD has been slow to distribute interim payments to the sites, in part because some of the money may have to be returned to HCFA. This creates great uncertainty for DOD sites and means that care under subvention is currently paid for with DOD's appropriated funds. The demonstration's payment method differs significantly from the Medicare managed care payment system, in which payments are made at the beginning of the month to cover care delivered during the month.

Based on experience to date with the demonstration, any payment approach for subvention must be even-handed (that is, it should favor neither HCFA nor DOD); straightforward and readily understandable; and prospective (DOD and its sites should receive payment in advance of delivering care to enrollees). The demonstration's payment mechanism, which relies on LOE, is functional in the short term--although the calculation of LOE has weaknesses.[9] However, this payment mechanism may not be appropriate over the longer term for an extended or expanded subvention program. Moreover, a credible long-term payment system should start with a zero-based budgeting approach: first, determining the cost to DOD of providing TRICARE Senior Prime care to dual eligibles and then deciding how much care will be provided from DOD's appropriations and how much from Medicare reimbursement.

PROPOSED VA DEMONSTRATION CAN BENEFIT FROM DOD EXPERIENCE

One of the key issues for VA under the proposed demonstration would be how to market subvention and persuade veterans in subvention sites to enroll in the demonstration. This issue is complicated by VA's own enrollment process and the broad benefits package it offers to all priority groups. VA is committed, as a matter of policy, to serving all enrolled veterans in 1999 and has indicated a desire to do so next year. As a result, it has

[8] The enrollment targets for each site reflect the statutory caps. Consequently, rebates (from DOD to Medicare) as a result of payments exceeding the cap are unlikely.

[9] Our first interim report on the demonstration will discuss the payment rules and LOE.

relatively few options if veterans in a subvention demonstration consume so many resources that they crowd out–or at least put pressure on VA's capacity for serving– other veterans. Two models are possible for the demonstration–fee for service and managed care. Although fee for service is, in principle, easier to implement and operate, VA's past difficulties with billing third-party payers raise concern. Proposals for a VA demonstration could be strengthened by taking account of DOD's difficulties in establishing a subvention demonstration. In particular, DOD experience shows that implementation is difficult and that enough time should be allowed to undertake the numerous operational steps needed to get a demonstration started. Furthermore, payment rules need to be as simple as possible, and data systems are key to managing and evaluating a subvention demonstration.

Veteran Enrollment in Demonstration

For VA, an important issue is why veterans would want to enroll in a subvention plan that would not give them significantly more services than they can currently receive from VA. Priority Group 7 veterans–the only ones eligible for subvention–can now get all services in VA's broad Uniform Benefits Package. Veterans who are eligible for Medicare can also get care from non-VA providers–either under fee-for-service or through a managed care plan. If it needed to make subvention benefits more attractive, VA could either reduce co-payments or increase benefits.

However, VA officials tell us that, due to resource constraints, VA may not serve Priority Group 7 veterans in the future. If this happens, these veterans could only get VA services through a subvention demonstration and hence would probably be more likely to enroll. (To make this exception possible, legislation would be required, as eligibility for VA enrollment is uniform nationally.) Alternatively, some VA officials have suggested to us that, to give Priority Group 7 veterans a reason to enroll, it may be necessary to exclude them from VA services--except through the demonstration.

The greatest risk in a VA subvention program is that subvention enrollees could consume so many services that VA patients in higher priority groups would be "crowded out." However, VA, according to its policy, cannot deny care to an enrolled veteran (that is, one who is registered with VA), even if it does not have sufficient capacity. In the short term, waiting times for appointments would probably increase, or care could be limited to certain facilities, which might be inconvenient for some veterans. VA could also reduce the benefits package, although that would require a change in regulations. In the longer term, some veterans could be denied all VA care if VA excludes one or more priority groups. This would be particularly serious for veterans who lack other insurance.

Managed Care and Fee-for-Service Models

Current proposals for a VA subvention demonstration permit both managed care and fee-for-service sites. Of the two, fee-for service appears to be easier to implement, because it only requires submitting claims for covered services to HCFA for payment. However, in the past, VA has had difficulty in collecting from insurance companies because its bills

have not had enough detail (for example, diagnosis, service, procedure, and individually identified provider).[19] While VA is moving toward a billing system that will more closely approximate private-sector counterparts, its success remains to be seen.

Managed care, by definition, places VA at financial risk, and it is also, as DOD's experience demonstrates, difficult to implement. On the other hand, managed care is highly compatible with the direction in which VA is currently moving. Moreover, VA does not have the experience that DOD gained from TRICARE, and it does not have broad-based managed care contractors that appear to have greatly facilitated implementing and managing the DOD demonstration.

If a VA subvention demonstration were to include both managed care and fee-for service sites, a phased implementation, with one type of delivery system being successfully implemented before the other started, would allow both HCFA and VA to focus their resources. The requirements for Medicare fee-for-service and managed care differ considerably. As a result, implementing both types of sites simultaneously may place significant strains on both HCFA and VA staffs, particularly at the national level.

Lessons From DOD Subvention Demonstration

We see three main lessons for VA in DOD's experience in establishing its subvention demonstration.

- Officials at every DOD site told us that establishing a Medicare managed care organization was more difficult and required more effort than they had expected. Months into the implementation, they continue to encounter new issues. Even though the sites took 13-17 months after the legislation was passed to establish Senior Prime, hindsight suggest that the goals to get it running earlier were unrealistic. If a VA demonstration is authorized, it should have 12-18 months to implement its plans for the demonstration; both VA headquarters and the sites will need that much time.

- The complexity of the LOE definition and Medicare payment rules, as well as ambiguity about what sites could earn and whether earnings would be distributed to the sites, were issues for DOD. These factors caused many site managers and physicians to largely disregard the potential changes in available financial resources and focus their attention primarily on implementation and patient care issues. As a result, the demonstration may not produce the cost savings and efficiencies that are expected from managed care. VA and HCFA have tentatively agreed to rules that are consistent with the DOD rules and still contain many of the elements that have made it difficult for DOD to manage the demonstration. In particular, payments would be retrospective and an annual reconciliation process could lead to VA returning money to HCFA.

[19] See VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult (GAO/HEHS-98-4, Oct. 17, 1997).

- DOD's experience shows that data systems are a point of vulnerability for a successful and credible program. The extent to which data quality would pose an obstacle to a VA demonstration depends in part on how the payment rules are specified. Good data, consistent across sites, would also be needed to manage and evaluate the demonstration. Data quality problems would probably vary by site, with some sites having better data than others. The types of data systems needed would depend in part on the subvention model that is selected. For example, in a fee-for-service model, billing systems are critical.

In addition, both DOD and VA will need to develop a strategy to inform and assist beneficiaries with their options in the post-demonstration period. Further, as Medicare enrollment in managed care plans is shifting to an annual open season, it would be desirable to coordinate enrollment in and termination of the demonstration with Medicare's open season.

CONCLUDING OBSERVATIONS

Subvention holds significant potential for giving military retirees and veterans an additional option for health care coverage, for giving DOD and VA additional funds, and for saving Medicare money. However, at this point—with little systematic data yet available--these outcomes are uncertain. This uncertainty underlines the value of demonstrations of subvention, such as the one that the BBA established for DOD. If a VA demonstration were authorized, VA would clearly need sufficient time to plan and initiate it. VA could also increase its chance of successfully establishing the demonstration if it took advantage of DOD's experience.

Mr. Chairman, this concludes our prepared statement. We will be happy to answer any questions that you or Members of the Committee may have.

UNITED STATES SENATE
COMMITTEE ON FINANCE
Medicare Subvention in the Department of Veterans Affairs
HEARING
MAY 4, 1999

STATEMENT OF SENATOR ARLEN SPECTER
Chairman, Committee on Veterans' Affairs
and
Chairman, Committee on Appropriations Subcommittee on Labor, Health and Human Services

On behalf of the members of the Committee on Veterans Affairs, which I am privileged to chair, I want to thank you, Mr. Chairman, for agreeing to hold this hearing of the Committee on Finance to discuss the merits of participation of the Department of Veterans Affairs (VA) in a Medicare "subvention" program. I particularly want to acknowledge my fellow Veterans Affairs Committee members, Senators Murkowski, Rockefeller, and Graham, who joined me in cosponsoring Senator Jeffords' important legislation to authorize a key demonstration of whether two Federal leviathans can work together for the common good.

At the outset I want to say that, as a Congress, we have had this proposal of a VA-Medicare partnership, in effect, under advisement, for over two years, so this is not really a new concept for the Committee on Finance. Also, already in the law from your work in 1997 is a Medicare demonstration program for the Defense Department that holds major promise as the means to expand health care options for aging military retirees. I understand that one of your purposes today, in fact, is to

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assess how well the Defense Department is achieving your goals in its Medicare experiment.

Mr. Chairman, aging is a powerful demographic variable in the veteran population. Right now, 7.7 million World War II veterans and 4.5 million Korean War veterans -- all largely eligible for Medicare benefits -- will be requiring extensive heath care assistance as they age. Some already go to VA for care; most are involved in Medicare. A minority uses both benefits to one degree or another. I believe that we ought to make it possible for some of these veterans, those who would not ordinarily see VA as an option based on their incomes, to invoke their Medicare eligibility in a VA setting.

Mr. Chairman, the Commonwealth of Pennsylvania, which I represent, has the distinction of leading the nation as home to the oldest state cohort of the American veteran population. So, it's important to me, both as Chairman of the Veterans' Affairs Committee and of the Appropriations Subcommittee on Labor, Health and Human Services, and as an advocate for the older veterans of my state, that we do everything that we can to make health care available and accessible for older Americans. Obviously, older Americans are depending more and more on Medicare, and as members of the Finance Committee with such an outstanding record of bringing affordable health care to the nation, you know as well as I that we need to reform the Medicare system to ensure that it remains viable, too. In the particular matter now before the Committee on Finance, we can target a new health care accessibility option for Medicare eligible veterans. I believe that Senator Jeffords' proposal, S.445, which he, I and twenty-six other colleagues have

cosponsored, including my Veterans Affairs Committee colleagues Murkowski, Graham and Rockefeller, provides an effective means to test the concept of greater partnership between a national coordinated care service -- the Department of Veterans Affairs, and a massive public health care financing system -- Medicare. Surely, with the proposed 10 demonstration sites we can show the Congress and the country that Government can work together to save taxpayer funds, promote better utilization of the government's capital assets, and provide a *new and accessible health care option* for an aging population of veterans.

Mr. Chairman, I am very confident that a VA demonstration will help establish whether and to what degree the Department of Veterans Affairs can aid in meeting some of the rising needs for care of a small but important proportion of the Medicare population, while helping conserve and sustain the Medicare Hospital Insurance Trust Fund. VA Secretary West and Under Secretary Kizer have assured me that VA can do this job, expand choice for beneficiaries, save the Trust Fund a significant outlay, and help fill out any underutilized VA programs. Further, this bill contains a number of safeguards to assure us that this demonstration will be completed correctly, without even the possibility of any party to the demonstration being able to "game" the system for a financial or parochial advantage.

The Department of Veterans' Affairs (VA) is enthusiastic about our legislation, and has urged it be enacted. I understand that VA Under Secretary Kizer is here this morning as well to offer direct testimony to the Committee, so I am sure you will hear this message again. I invite you to sharply question Dr. Kizer to allow him to articulate his reasoning that you should support this proposal.

What the VA is seeking is to bring some new veterans into the VA system, those who currently receive their care outside its confines, and be reimbursed for their care at a rate below that paid to private providers He needs to give you a full, complete and rational justification for this proposal. While I am convinced, along with Members of the Senate Veterans Affairs Committee, of the merit of this demonstration, I know that you as Finance Committee members want to learn more about this idea from someone who is eminently qualified to offer a convincing justification, and that certainly would be Under Secretary Kizer.

Mr. Chairman, our veterans groups have long pushed for providing veterans with additional choice in obtaining their Medicare services at VA facilities. In fact, this idea of veterans using their Medicare eligibility can be traced to the 1990-91 *VA Commission on the Future Structure of Veterans Health Care*, the so-called VA "Mission Commission." So we are not at a new place today, Mr. Chairman. You will recall that a similar version of this important legislation was approved by your Committee and the full Senate in 1997 as part of our *Balanced Budget Act*, but the subvention measure was stricken from the final version of that legislation in conference with the House. Last year, the full House approved a similar VA Medicare subvention bill, but the House's action occurred too late in the 105th Congress to enable the Senate to act on it. So, this is an old idea, which was originally recommended by a federal advisory committee, endorsed by veterans, supported by the Administration, cosponsored by 28 members of the Senate, and approved by four relevant committees and both Houses of Congress at different periods. Yet still, Medicare subvention remains an elusive goal. My hope is that we have reached the point at long last that, on this matter, we can now conclude that

Medicare subvention is an old idea whose time has finally come. This option will benefit the veteran, the VA system and the Medicare Trust Fund. In my view, how can we *not* now approve it?

Mr. Chairman, this legislation would authorize the VA to establish demonstration projects at up to 10 sites around the country. The VA would bill for Medicare-covered services provided to eligible veterans at these sites. The bill dictates that of the 10 sites to be selected for this demonstration, at least one be located in an area near a closed military base, and one must serve a predominantly rural veteran population. Participation would be voluntary, and a preference would be given to military retirees in areas near closed military bases. Demonstration participants would be required to make the same Medicare co-payments in the demonstration that they would normally make in a regular Medicare program.

Under the terms of this bill, Medicare reimbursement to the VA would be at 95 percent of the current average Medicare reimbursement rate in the area of the demonstration, and limited grossly to $50 million per year. Some of this funding support from Medicare would be refunded if the VA treats fewer Medicare-eligible veterans than in a preceding baseline period. Also, veterans who are 65 at the time of enactment must be enrolled in Medicare Part B to be eligible for participation. The General Accounting Office would monitor the operation of the demonstration and report to Congress any unanticipated increases in costs to Medicare or other operational problems. If the demonstration project increases Medicare's costs, the VA would reimburse Medicare for these increased costs and take action to reduce the rate of Medicare reimbursement, suspend demonstration activities, or terminate

the project altogether. The VA and HHS Secretaries would be required to closely monitor all these activities and make a series of reports to Congress with policy recommendations.

As Members of the Committee will recall, the Balanced Budget Act specifies that appropriated funding for the provision of health care services by VA will be flat over the next four fiscal years. As a Congress, we have recognized that this flat line decision for VA health care has had some unintended consequences, and with our recent approval of a Budget Resolution for Fiscal Year 2000, we are beginning to take corrective action with a $1.66 billion supplement. Approval of our subvention legislation would further our resolve to ensure that the VA system, along with the Medicare system, remain viable into the future. This legislation provides a new revenue stream, but it will also benefit Medicare. In a nut shell, under this legislation Medicare would pay discounted rates for care for its veteran beneficiaries, and VA would receive a vitally needed new source of funding.

To reiterate, Medicare subvention is supported unanimously by the members of the Veterans Affairs Committee. It is supported by the Administration. Veterans' service organizations have urged enactment. And, as I previously noted, the Senate approved this legislation in 1997 as part of the Senate-approved Balanced Budget Act.

So, Mr. Chairman, this is the question that is before the Committee on Finance: will you recommend to the full Senate the legislation that establishes a demonstration of this innovative partnership between VA and Medicare that my colleagues and I have advanced? I think that I leave little doubt of my recommendation, which is to proceed forthwith. I believe that a high degree of expectation is building in the veteran population that indeed, this is the year that we will act. I hope and trust that all members of the Committee on Finance agree with these views. Let's do what we can to expand health care choices for our veterans.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

THE HONORABLE JO ANN K. WEBB

PROGRAM DIRECTOR, HEALTH POLICY ANALYSIS

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE FINANCE COMMITTEE

CONCERNING

VA PARTICIPATION IN THE

MEDICARE SUBVENTION PILOT PROGRAM

MAY 4, 1999

Mr. Chairman, thank you for inviting me to discuss the participation of the Department of Veterans Affairs (VA) in a Medicare Care subvention pilot program in cooperation with the Health Care Financing Administration of the Department of Health and Human Services. My name is Jo Ann Webb, I am the Program Director for Health Policy Analysis at Paralyzed Veterans of America. I have been involved in the VA Medicare subvention issue for the last six years, as a former Assistant Secretary for Policy at the Department of Veterans Affairs, as subcommittee counsel to the House Veterans Affairs'

Committee, and presently as a principal author of the *Independent Budget* and staff member of the Paralyzed Veterans of America.

PVA is a congressionally chartered veterans service organization, representing over 18,000 members with spinal cord injury or dysfunction, whose mission is to be the leading advocate for quality health care for our members; promote research and education addressing spinal cord injury and dysfunction; ensure the availability of benefits earned through honorable military service; and to maximize the civil rights, opportunities, and independence of our members. As a veterans advocacy group, PVA stands ready to support the veteran community of more than 25 million men and women to ensure that each eligible veteran and his or her dependents receive the benefits earned through service to this country.

My testimony today is an attempt to reflect PVA's broader role and interest in preserving quality VA health care, not only for the veterans who are statutorily eligible for services, but also for the more than 4 million disenfranchised Medicare-eligible veterans age 65 and over, who, because of the limited Medical Care Appropriation and their higher income level, are not eligible to receive health care services from the VA.

As you are aware, the delivery of health care has changed dramatically over the last five years. The intense pressure to control costs coupled with the rapid spread of managed care has had an impact on every health delivery system in this country, including VA. As a hospital-based system with an aging infrastructure and patient population, the VA has

not faired well under the constraints of a global budget capped by the limitations of the Balanced Budget Act of 1997. Meanwhile, the rapidly changing health care landscape of the last few years has made management of VA health care extremely challenging. Its leadership has worked tirelessly, if not always successfully, to move the delivery of health care away from an institutionally based medical model to a more streamlined ambulatory care system. The greatest stumbling block to completion of this necessary revampment has been adequate resources. It should be noted that change, especially dramatic change, such as system transformation, does not come without costs and committed investment. VA, unlike the private sector, cannot issue stock, borrow funds, or merge with other systems to find needed capital to finance what it needs to become to adequately serve and attract new veteran workload. It must rely on prudent management and legislative fixes.

P.L. 104-262 granted VA the authority to retain collections from third party payers. Although VA collection efforts have met with mixed success, this legislation has forced VA away from the outdated practice of averaging costs to the development of reasonable charges for services rendered to veterans – a universal billing practice demanded by all insurers and health plans. It is my understanding that VA will implement its reasonable charges billing system on September 1st of this year.

VA has more than ten years of experience with shared services and has worked in partnership with the Department of Defense (DoD) and with local communities nationwide on a multitude of contractual arrangements for shared services. Monies

obtained from sharing agreements have been used to augment and enhance services for veterans, while providing cost-effective care for DoD beneficiaries. Community arrangements have also created numerous opportunities to control costs through the shared purchase of expensive medical equipment and the development of other shared service arrangements. P.L. 104-262, enhanced VA's sharing authority. Together, these programs have laid the groundwork for VA's potential participation in Medicare subvention - an important aspect of VA's long term strategy to maintain a comprehensive and high quality health care system.

Given that managed care is now a permanent and growing part of the health delivery landscape, it is essential that VA be able to play in that marketplace. Speaking for PVA and others in the veteran community, there is qualified support for VA's participation in the Medicare Subvention pilot. An important term of participation is that Medicare-eligible veterans must be offered the same participation opportunities as other Medicare beneficiaries, especially, the option to chose to come to the VA under a fee-for-service Medicare pilot, as well as the managed care pilot.

Previous attempts to legislate VA Medicare subvention have included a fee-for-service component. It is fitting that present efforts also include this important provision. Medicare-eligible veterans who are not currently receiving services in the VA must be allowed the opportunity to overcome past VA disenfranchisement by participating on an equal footing with current Medicare beneficiaries, choosing either managed care or continued participation in a fee-for-service arrangement. As you are aware, the Medicare

program allows beneficiaries the freedom to choose their service arrangement. Veterans must be permitted the same choice options. Just as current users of VA health care bring their third party reimbursement to the VA, Medicare-eligible veterans should be allowed to freely participate in the Medicare program, which they paid into throughout their years of employment.

PVA appreciates the constraints and potential problems that VA would face under a fee-for-service Medicare pilot option. However, it is the position of this organization that these barriers to participation are no greater and, in fact, are very similar to those posed under a managed care option.

The inclusion of a fee-for-service option, would, as previously stated, offer choice and equal participation for a universe of more than 4 million Medicare-eligible veterans who have been disenfranchised from the VA solely by their income and the inadequacy of VA appropriations. In addition, the fee-for-service option would also enable VA to develop comparative data on the two options.

For either or both options to function successfully, Congress must require VA to institute data systems to track the costs and services provided to each eligible participant. This type of accounting is the accepted standard for successful health plans; no less should be expected of the VA. One of VA's greatest failings has been its inability to develop accurate cost data. This problem has been historically evidenced in its Medical Care Cost Recovery Program. VA's system of averaging costs has frustrated not only insurers and

health plans, but has, in some cases, discouraged eligible veterans from using the system. Fear of being billed for non-service connected care, which is routinely covered in the community setting, is a strong deterrent to a veteran living on a fixed income.

We view the current DoD TRICARE Senior Prime program as a first step in the realization of VA's potential successful partnerships. VA participation in Medicare subvention appears to be the next logical step in the provision of comprehensive, seamless care to veterans.

We understand that VA is very eager to be part of a Medicare subvention pilot and is willing to participate in a managed care subvention no matter what the initial cost to the Department. It is for this very reason that we feel a fee-for-service component should be added to the pilot. Understanding that the operation of the pilot must be cost neutral to the Medicare Trust Fund, VA would be compelled to demonstrate that it can market, track, and operate a high quality system that will attract new users over its current level of effort. Recent articles on Medicare + Choice point to an undercurrent of dissatisfaction among providers and consumers in managed care communities. A VA fee-for-service model will allow for a useful comparison of what veteran consumers want and will use.

We recognize that at the end of the three-year pilot Health Care Financing Administration (HCFA), VA, or both could view this effort as not worth sustaining. We hope that the Committee will see fit to allow a comparison that will give not only Medicare-eligible

veterans, but also the VA, a level playing field in the highly competitive health care marketplace.

I remember answering a constituent's letter on Medicare subvention. A higher income veteran who had previously been able to receive VA care and had received excellent care for a hip replacement found himself locked out of the VA for a needed second surgery. His plea was that he understood the VA's resource constraints and did not want anything he was not entitled to have. He just did not understand why he could not choose to bring his Medicare dollars to the VA. He felt that he would get better care and, most importantly, that he would be with his buddies. Mr. Chairman, these are the veterans who want and deserve a fee-for-service option.

We hope the Committee will approve a VA Medicare Subvention program, and make certain that this program includes a fee-for-service component.

I would be happy to respond to your questions.

REPONSES TO QUESTIONS SUBMITTED BY SENATOR JEFFORDS

Benefits of a fee-for-service option:

You have indicated that a fee-for-service option is important to maintaining quality in access to Medicare-covered services for veterans. What indications do you have that this type of choice makes a difference to veterans? In what ways might the information we gather from a fee-for-service differ from the coordinated care sites? How would this be valuable in evaluating what a permanent subvention program should look like?

One of the most important aspects of veteran participation in the proposed Medicare subvention pilot program is that veterans must be offered the same terms of participation as all other Medicare beneficiaries, namely, the option to choose to receive their Medicare benefits either through managed care or the fee-for-service option. Previous attempts to legislate VA Medicare subvention have included a fee-for-service component. Medicare-eligible veterans who are not currently receiving services from the VA must be allowed the opportunity to overcome past budgetary disenfranchisement and participate in a program that they have supported through payroll contributions since its creation in 1965.

Approximately 14 percent of the total Medicare population is enrolled in managed care. However, there is great variability in the level of satisfaction among enrollees. A study by Passman, Garcia, Campbell, and Winter, which appeared in the December 1997 issue of the *Journal of General Internal Medicine*, suggests that dual eligible veterans enrolled in Medicare-financed HMOs opted to use VA services, especially for chronic conditions, instead of obtaining services from their Medicare HMO. The end result of such utilization patterns was duplicate federal spending by the Health Care Financing Administration (HCFA) and the VA, with the potential for the payment of excess premiums to HMOs (article included as attachment A).

A limited unpublished survey conducted by the Health Policy Department of PVA revealed that veterans, especially veterans with chronic and catastrophic conditions, exhibited dissatisfaction with their health plans by procuring services through multiple health plans for which they were eligible. As pointed out by Passman et al., veterans will shop for the best deal for their condition, especially if it lowers their out of pocket costs.

Inclusion of a fee-for-service option to the Medicare subvention pilot will allow the evaluation of a number of factors, such as a direct cost comparison between the two programs – managed care and fee-for-service. It will measure the importance of choice to veteran enrollees and provide data on the utilization of various services by the two different classes of enrollees. A two-option pilot will also allow for a program evaluation of marketing efforts, ease of program administration, service quality and accessibility, and the impact of the pilot on higher priority veterans.

In addition, a two-option pilot will measure the impact of health care delivery on a Medicare-eligible population with unique characteristics. The veteran population is

considered to be older, sicker, and a bigger consumer of health care services than the general population. Under a two-option pilot, it will be possible to measure the direct impact of a locked versus unlocked VA plan, access to specialists, delivery issues in a rural versus urban setting, and ability to manage enrolled patients who may be highly mobile part of the year (such as snow bird veterans).

If VA is to compete as an equal player in the health care arena, it must be able to market itself as full partner in Medicare. This can only be accomplished through a two-option Medicare subvention pilot program. A three-year pilot should be able to provide Congress, HCFA, VA, and the veteran community with the data necessary to fairly evaluate the future of VA with regard to Medicare subvention.

JGIM

BRIEF REPORTS

Elderly Veterans Receiving Care at a Veterans Affairs Medical Center While Enrolled in Medicare-Financed HMOs

Is the Taxpayer Paying Twice?

Leigh J. Passman, MD, PhD, Rosa Elena Garcia, MPH, Lynn Campbell, BS, Eric Winter, RN, PHN

Elderly veterans who visit our Veterans Affairs (VA) Medical Center primary care clinic often mention they are enrolled in HMOs. Approximately 20% of patients hospitalized at our facility report health insurance coverage. Of 1,000 hospitalizations during a 6-month period in which veterans reported insurance coverage, 337 involved elderly veterans. Of these 337 hospitalizations, 313 (93%) were for 174 veterans who stated they were enrolled in a Medicare-financed HMO. The VA's Medical Care Cost Recovery Program deemed only 46 (13.1%) of the hospitalizations billable and received reimbursement for 20 (5%). Thus, the VA is providing costly services already paid for by the Health Care Financing Administration under prepaid capitation contracts, and recovers minimal reimbursement from the HMOs.

KEY WORDS: veterans; elderly; Medicare; HMOs; health care financing.

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Enrollment of Medicare beneficiaries in HMOs under capitated risk contracts has been touted as one approach to constrain the growth in Medicare expenditures.[1] Enrollment of Medicare beneficiaries in HMOs has accelerated in recent years: 9% or 3.8 million aged Americans are now enrolled in HMOs under Medicare risk contracts.[2,3]

Physicians from Department of Veterans Affairs (VA) Medical Centers in California, Florida, Kansas, New Mexico, and other states have noted an increase in the number of elderly veteran patients who seek care at VA facilities while enrolled in HMOs (personal communications at the 1996 SGIM national meeting). Two studies at individual VA facilities found that HMO enrollment ranged from 10% among veterans of all ages,[4] to about 25% among elderly veterans.[5]

We quantified the extent to which elderly veterans hospitalized at one Southern California VA Medical Center reported HMO enrollment. We then determined the reimbursement that the VA's Medical Care Cost Recovery (MCCR) Program received from HMOs for the inpatient care provided to these HMO enrollees.

METHODS

Patients hospitalized at this VA facility are routinely asked about health insurance or health plan coverage at the time of admission; this information is forwarded to the MCCR Program staff to facilitate billing of third-party payers. We reviewed medical, surgical, and neurology hospitalizations in which a discharge occurred during the 6-month period between December 1993 and May 1994, and focused on those hospitalizations in which an elderly veteran (defined as age 65 or older) reported such coverage. For those who specified HMO coverage, we obtained further demographic and clinical data from the VA's inpatient treatment file.

Historically, the MCCR Program staff has concentrated its billing and collection efforts on care for conditions that are not connected to the veteran's military service. HMOs generally contest payment for elective or nonemergent care not previously authorized, so MCCR Program staff often do not pursue HMO reimbursement for such care. We reviewed billing and collections for those hospitalizations in which reimbursement was sought from the HMO.

RESULTS

Veterans and Their Hospitalizations

Veterans of all ages disclosed insurance or health plan coverage in 1,000 (20.8%) of 4,879 hospitalizations. Elderly veterans reported such coverage in 337 (17.9%) of their

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the VA will be providing medical services to an increasing number of veterans enrolled in Medicare-financed HMOs. Whereas capitating Medicare expenditures was expected to contain (or at least enhance the predictability of) future Medicare outlays, out-of-plan utilization that occurs at federally financed VA facilities means the federal government pays twice. Although the VA has the authority to bill and collect from third-party payers, actual collections from HMOs are small in relation to the costs incurred by the VA and those averted by the HMO.

In addition to the financial implications, our findings raise other important questions. Many hospitalizations appear to be for exacerbations of chronic conditions. Do elderly HMO enrollees experience or perceive barriers to timely HMO care? Are the copayments that HMOs charge for office visits and medications an incentive for veterans to seek VA care? How is the continuity and quality of HMO care affected when enrollees obtain some care at VA facilities?

Our study has several limitations. First, HMO enrollment was self-reported; confirmation was pursued only for those cases in which MCCR Program staff expected to bill the HMO. Some patients may have been mistaken about coverage or whether it was still in force. Others, however, most likely forgot or concealed HMO enrollment. We suspect our figures understate VA utilization by HMO enrollees.

Second, our study examined only those veterans over age 65; we ignored the one in six Medicare-eligible VA users who are disabled veterans under age 65.[7] Though relatively few disabled Medicare beneficiaries have enrolled in HMOs, it is possible that some hospitalized disabled veterans not included in our sample were HMO enrollees.

Third, this study examined a 6-month period during fiscal year 1994. Since 1994, HMO enrollment of Medicare beneficiaries in California has increased 46.4%[8]; thus, the numbers presented here most likely understate the current reality. Finally, this study made no effort to examine ambulatory care or prescription medications provided to veterans enrolled in HMOs, which certainly account for substantial added costs to the VA.

Further research needs to be done to quantify the magnitude of VA utilization by Medicare-eligible veterans enrolled in HMOs nationwide; to understand the reasons veterans who enroll in Medicare-financed HMOs still go to VA facilities; to estimate the duplicate federal spending by the Health Care Financing Administration and the VA and potential excess premiums paid to HMOs; and to explore whether better coordination of these overlapping benefits could improve care and avoid duplicate federal expenditures.

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Statement By

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Foundation Health Federal Services, Inc.

Before The

Senate

Finance Committee

TRICARE Senior Prime Program

May 4, 1999

Introduction

Mr. Chairman, Distinguished Members of the Committee, thank you for the opportunity to address you on the status of the TRICARE Senior Prime Program from the perspective of a Department of Defense (DoD) TRICARE Managed Care Support contractor.

My Company, Foundation Health Federal Services, Inc. (FHFS) is the current Managed Care Support Contractor for five TRICARE regions and the State of Alaska covering over 1.6 million TRICARE eligible beneficiaries. FHFS contracts cover the following DoD geographical areas:

Region 6	:	Texas (excluding El Paso), Oklahoma, Arkansas, and Louisiana (excluding New Orleans)
Region 9	:	Southern California and Yuma, Arizona
Region 10	:	Northern California
Region 11	:	Washington, Oregon, and Northern Idaho
Region 12	:	Hawaii and Alaska

In addition, FHFS provides healthcare services directly to the Department of Veterans Affairs (VA) through seven Community Based Outpatient Clinics (CBOCs).

FHFS' parent company, Foundation Health Systems, Inc. (FHS), is the nation's fourth-largest publicly traded managed health care company. Its mission is to enhance the quality of life for its customers by offering products distinguished by their quality, service and affordability.

FHFS is also the current Managed Care Support Contractor for five of the eight Military Treatment Facility sites selected for the 1998 Medicare Subvention Demonstration Project. More commonly referred to as TRICARE Senior Prime, the program was successfully launched with close coordination among DoD, HCFA and FHFS in the following four states:

Washington	Madigan AMC	09/01/98
Texas	Wilford Hall, Brooke AMC	10/01/98
California	NMC San Diego	11/01/98
Oklahoma	Fort Sill, Sheppard AFB	12/01/98

FHFS brought the considerable Medicare Risk experience of its sister companies, HealthNet and Foundation Health Systems, to the demonstration team effort which enabled DoD and FHFS to work more efficiently in preparation for HCFA site visits and approvals. There are over 18,000 Senior Prime members today linked to the Military Treatment Facilities in FHFS service regions.

In my opinion, the TRICARE and TRICARE Senior Prime programs are a success. The TRICARE Program has lowered cost, both for the taxpayer and the beneficiary, increased beneficiary choice and access to care and, most importantly, increased the overall quality of care delivered to the beneficiary population. Similarly, the TRICARE Senior Prime program has increased quality and access to beneficiaries over 65 years of age (Over 65) in the following ways:

- Provides Over 65 beneficiaries full health coverage as Prime enrollees in their MTF with access to their military physician, thereby keeping the promise of health benefits.
- Provides aging-in privileges for many Prime members who were facing disenrollment from TRICARE health coverage upon turning 65 years of age.
- Provides better benefits than either Medicare or TRICARE.
- Provides assured access to the MTF vs. in the past when access was conditional upon "space available" (Space A) in the military hospital or clinics.
- The program advances the readiness mission support through the requirements for enhanced medical care in this population.
- Implementation and operation of TRICARE Senior Prime has enhanced and strengthened working relationships among Lead Agents, MTF Commands, Managed Care Support contractors and the TRICARE Management Activity (TMA).

To achieve this success required a strong partnership with the DoD leadership, TRICARE Management Activity, Lead Agents and MTF Commands and the Health Care Financing Administration. TRICARE Senior Prime is much bigger than the Managed Care Support contractors or any one agency. It is the vehicle to deliver the health care benefit promised to our Over 65 beneficiaries. It encompasses both the direct care and civilian delivery systems and provides quality, accessible health care regardless of location.

It is absolutely critical that the Managed Care Support contractors and DoD and HCFA work in cooperation with each other to maximize quality and access. FHFS has been fortunate to have very strong leadership at our Lead Agents who are responsible for the care delivered in their regions. We have developed close partnerships with our regional Lead Agents that allow us to solve issues at the regional level and work towards our common goal: providing quality, cost-effective care that is accessible by all of beneficiaries. These relationships have clearly demonstrated how a military/civilian partnership relationship enhances program goals and enabled the start-up of an entirely new, challenging demonstration program which required looking at new ways of doing things. In starting up five TRICARE Senior Prime sites, the DoD and FHFS team essentially established five new Medicare Managed Care Organizations (Plans) under HCFA's authority, compliant with all requirements of any commercial Medicare Plan in the country. There are lessons that were learned in this process that can be used to improve the effectiveness and efficiency of starting new sites if TRICARE Senior Prime becomes a national program and if it is provided in the VA environment.

Lessons Learned

1. Phasing the implementation over time is important to properly manage the preparation, education and enrollment of new members in an orderly way.
2. Use the expertise of Lead Agents and MTF commands who have successfully prepared and implemented these programs in coordination with HCFA and the MCS contractors.
3. Anticipating resource requirements and predicting enrollment is difficult; must prepare for high enrollment levels and be ready to make adjustments
4. Important that transition protects continuity of care issues for new members, adding staff where necessary in support functions and phasing in transfers from civilian providers.
5. Reduce beneficiary confusion through clearly written materials and effectively communicated messages to beneficiaries, managed centrally with the input of all MTFs and Lead Agents.
6. Important that Lead Agents have a direct working relationship with HCFA regional offices in start-up phase.

Civilian Provider Networks

One of the contractor's most important functions is to establish a quality, comprehensive network and properly educate the provider community on TRICARE Senior Prime benefits, policies, and billing procedures. Successful delivery of health care to the beneficiary and timely, accurate claims processing starts with appropriate delivery of the TRICARE Senior Prime benefit and accurate filing of the claim for services by the provider. History has told us that insufficient provider education and communication greatly increases our service and claims processing problems. The contractor must continuously communicate with their network on reinforcing and reeducating on the TRICARE Senior Prime Program. Below is a discussion of Foundation's contracted network and the process we employ to ensure adequacy and program knowledge.

Each Foundation Health Federal Services TRICARE Senior Prime demonstration region has a robust network which offers a full complement of quality providers who are accessible to beneficiaries throughout demonstration areas. Each region is analyzed on a monthly basis by service area to ensure adequacy.

In order to ensure that our TRICARE Senior Prime physicians are appropriate in number, we use required adequacy standards of DoD and HCFA. Targets are developed if requirements are less than contracted, or if there is a fluctuation in physician capacity. In order to ensure these providers have capacity to see patients, Foundation's Provider Relations Staff call at least 75-80% of the contracted PCM's in each service area approximately every three to four months to determine if the provider has an open practice status. The results are housed and maintained in a central provider file, which is used by Health Care Finders, and for the directory process.

In addition to this quarterly update, Provider Relation Representatives are also required to perform monthly site visits. These site visits focus on all Primary Care Managers as well as high volume specialty providers. This monthly tool includes a section specifically for access standards, patient capacity and open practice status. All site visits are forwarded to the Regional TRICARE Provider Relations Manager for utilization in determining access and capacity for each network service area. Providers who indicate a closed practice are monitored against enrollment reports to determine if patient ratios have exceeded providers available capacity. Providers who have chosen to close their practice

for capacity and other reasons are noted so additional providers can be targeted for inclusion in the network to ensure availability.

Foundation Provider Services also places a large emphasis on access standards through our Provider Workshops, Provider Manuals, Provider Bulletins, and Quarterly Provider Newsletters. The TRICARE Senior Prime standard for appointment and wait times are a contractual requirement in ALL Provider Agreements. Physicians are reminded of their contractual obligations through the above listed correspondence, site visits and Provider Surveys. It is here that emphasis on education of the TRICARE Senior Prime Program is placed, including claims processing issues.

All information obtained through Surveys, Workshop Evaluations, Beneficiary Complaints, Health Care Finder input, and Site Visits are compiled monthly and reported through Provider Services Monthly meetings with the Provider Relations Representatives. Any issues that are identified with providers who are not complying to standards are given a thirty day corrective action with a follow-up meeting scheduled with the provider.

Adequacy, access and capacity are continually reviewed from feedback from enrollment experience, Health Care Finders, beneficiary complaints, MTF meetings, Lead Agent interaction, Case Managers, Credentialing and Program Integrity.

Foundation Health Federal Services is always looking at ways to improve the monitoring process for provider accessibility. One method currently being evaluated is the possibility of using FHFS' web site as a mechanism to attain feedback from the beneficiaries who are having a problem with provider access.

Enrollment in TRICARE Senior Prime

Enrollment in TRICARE Senior Prime required enrollees to meet both HCFA and TRICARE eligibility standards, which limited a category of beneficiaries from gaining enrollment due to failure to obtain and retain Medicare Part B coverage. In spite of this limitation, participation in the demonstration project has met most enrollment expectations, particularly in the urban areas where greater numbers of eligibles reside. The success achieved in enrolling beneficiaries in the demonstration is attributable to a collaborative effort between the Lead Agencies, Military Treatment Facilities and FHFS in explaining the program benefits and providing assistance to beneficiaries in completing the requisite

paperwork. The chart below identifies enrollment capacities, actual enrollment, and wait list size, if any, as of December 31, 1998 and March 31, 1999 at each demonstration site within FHFS' Managed Care Support contracts.

			As of 12/31/98		As of 03/31/99	
MTF	Date of Health Care Delivery	Enrollment Capacity	Members	Wait List	Members	Wait List
Madigan	09/01/98	3,300	3,454	786	3,580	780
Wilford Hall	10/01/98	5,000	5,065	70	5,64	321
BAMC	10/01/98	5,000	4,336	-	4,916	-
NMC San Diego	11/01/98	4,000	2,297	-	2,788	-
Sheppard AFB	12/01/98	1,300	629	-	714	-
Ft. Sill	12/01/98	1,400	935	-	1,079	-
Total		**20,000**	**16,716**	**856**	**18,341**	**1,101**

Enrollment continues to increase as is evident from the near 10% gain in total enrollment between December 31, 1998 and March 31, 1999; additionally, the wait list at Wilford Hall more than quadrupled during this three month period. Subsequent to the March 31, 1999 enrollment report being produced, BAMC reached capacity in mid-April. Beneficiaries that age-in continue to be permitted to enroll at any site regardless of current enrollment.

Beneficiary Satisfaction

Although the TRICARE Senior Prime demonstration began delivering health care services only eight months ago at Madigan, FHFS is closely monitoring beneficiary satisfaction with the program. Beneficiary visits to the TRICARE Service Centers, written correspondence and toll-free telephone calls are overwhelmingly favorable. Another measure of beneficiary satisfaction is determined by evaluating reasons given for disenrolling from the program. FHFS has recorded information pertaining to 550 disenrollment requests received through March 31, 1999, which is presented below.

Reason For Disenrollment	Number	Percentage
Return to previous plan/coverage	153	28%
Beneficiary deceased	149	27%
No specific reason given	123	22%
Enrolled in another health plan	42	8%
Various reasons given	42	8%
Relocating away from service area	22	4%
Changed mind regarding TSP	10	2%
Dissatisfied with some aspect of TSP	9	1%
	550	100%

Over 92% of beneficiaries that have elected to disenroll from the program have either changed health care coverage, become deceased, specified no particular reason for withdrawal or offered miscellaneous reasons for their departure. The nine (9) beneficiaries that indicated dissatisfaction with the program represent .0005% of all enrollees. Beneficiary satisfaction will continue to be closely monitored by FHFS to determine program features or performance that warrants modification or improvement.

Claims Processing for TRICARE Senior Prime

FHFS is responsible for the timely, accurate and consistent processing and payment of claims submitted by either TRICARE Senior Prime enrollees or civilian health care providers. Since most health care services performed under the auspices of this demonstration are rendered within the MTF, the volume of claims processed and paid by FHFS is relatively small.

FHFS utilizes the services of two subcontractors to process and pay TRICARE Senior Prime claims. Wisconsin Physicians Service (WPS) processes claims for beneficiaries enrolled at Madigan, Wilford Hall, BAMC, Sheppard AFB and Ft. Sill. Palmetto Government Business Administrators (PGBA) processes claims on behalf of beneficiaries enrolled at the NMC San Diego. Rules governing the payment of claims for services performed under this demonstration embrace both TRICARE and Medicare regulations.

The charts below identify the volume of claims processed during the first three quarters for TRICARE Senior Prime and performance related to claims timeliness and aging.

Claims Processed

Quarter	Region 11	Region 6	Regs 9/10/HI	Total
Jul-Sep 1998	6	0	0	6
Oct-Dec 1998	176	586	34	796
Jan-Mar 1998	501	2111	256	2868

Claims Processing Timeliness
(75% Processed Within 21 Days)

Quarter	Region 11	Region 6	Regs 9/10/HI	Total
Jul-Sep 1998	100%	N/A	N/A	100%
Oct-Dec 1998	80.1%	97.3%	94.1%	93.3%
Jan-Mar 1998	77.2%	87.1%	96.1%	86.2%

Claims Aging
(2.5 Days Receipts or Less in Inventory Over 30 Days)

Quarter	Region 11	Region 6	Regs 9/10/HI	Total
Jul-Sep 1998	N/A	N/A	N/A	N/A
Oct-Dec 1998	0.76	0.22	0.00	0.33
Jan-Mar 1998	0.00	0.11	0.00	0.08

Claims Aging
(.06 Days Receipts or Less in Inventory Over 60 Days)

Quarter	Region 11	Region 6	Regs 9/10/HI	Total
Jul-Sep 1998	N/A	N/A	N/A	N/A
Oct-Dec 1998	0.00	0.00	0.00	0.00
Jan-Mar 1998	0.00	0.03	0.00	0.03

FHFS expects that the volume of claims presented for processing and payment under TRICARE Senior Prime will continue to remain small. Consequently, processing performance is expected to comply with both claims timeliness and claims aging contract requirements.

The Role of the TRICARE MCS Contractor on the Quality of Care in TRICARE Senior Prime

The TRICARE MCS contract has introduced several important managed care techniques to a health care benefit plan and a beneficiary population, which never had these program enhancements. The Quality Management (QM) plan currently being implemented by FHFS in its TRICARE Contracts (which includes five regions) has several program components, which mirror Commercial, Medicare and Medicaid quality management programs. Among the QM activities TRICARE MCS offers are Credentialing, Quality of Care Studies and Provider profiling.

Before TRICARE MCS was introduced throughout the country, providers could be reimbursed for rendering services to eligible beneficiaries if they met the administrative requirements of being a "CHAMPUS authorized provider". This required little more than submitting a copy of a medical license and a signature. By contrast, to become a network provider in TRICARE, providers must undergo rigorous credentialing, similar to other managed care organizations. Providers included in our network have satisfactorily demonstrated eligibility and the appropriate specialty. A partial list of credentialing requirements includes verification of professional school graduation (i.e. medical school), completion of internship, residency and fellowship, medical specialty board certification status, review of malpractice history and current coverage, review of a confidential questionnaire which addresses among other things mental and physical health, and affiliation with accredited and MCS contractor affiliated hospitals and institutions.

The process of scrutinizing our provider network allows us to facilitate the delivery of necessary care. Once a provider has been credentialed, we include him in our provider directories as a reference for our TRICARE Senior Prime members and our Health Care Finders (HCF). The HCF coordinates medical review activities with the MTF to ensure optimal use of the MTF services and to refer those services available solely through our credentialed network. The referral process into our credentialed network provides the first and best opportunity for our beneficiaries to obtain optimal health care outcomes outside the MTFs. In the past, the absence of a provider network credentialing and referral process prevented the organized and efficient delivery of care seen today in managed care programs.

Prior to TRICARE MCS, there was virtually no ongoing measurement and analysis of the quality of care rendered to CHAMPUS/TRICARE beneficiaries. Under TRICARE Senior Prime, we submit a Quality Management plan to HCFA for its review and approval. The QM plan is designed to incorporate HCFA's Quality Improvement System of Managed Care standards. Among the activities outlined in the QM plan are prospective and retrospective reviews; these typically focus on clinical areas that may be considered high volume, potential high risk, or problem-prone conditions due to the clinical circumstance of the population. These studies are developed, overseen and analyzed with the active involvement of our FHFS management, Lead Agent and Military Treatment Facility professionals and civilian network providers. Some of the clinical areas of study include breast cancer, hysterectomy, acute myocardial infarction, asthma, depression, immunization, depression and cholesterol screening. As a result of our analyses of the information we gather, we expect to identify opportunities to improve the care delivered by our network to our beneficiaries or validate conformance to national standards in delivering care.

FHFS supports the Lead Agents by managing grievance review activities for issues involving network providers. Through joint efforts, FHFS and Lead Agents develop, recommend, and direct corrective action plans to improve overall delivery of care. Any areas of concern are identified and analyzed to determine educational needs and monitoring of practices. During the first six months of the program, grievance activity averaged 0.8 per 1000 members. In comparison, a sample of a commercial population reflected an average rate of 2.5 cases per 1000 members.

Analysis of provider practices through quality improvement activities, grievance review, potential quality issue reporting and tracking trends provides us with opportunities to improve the care delivered by our network to our beneficiaries and to validate conformance to national standards of delivering care. The introduction of these activities to TRICARE Senior Prime population is a substantial enhancement to the quality of the health benefit plan these beneficiaries now receive.

To further support Lead Agents, FHFS identifies specialty services that are frequently referred outside of the MTF and the provider network. The findings are communicated to Lead Agents for possible enhancements to the network or MTF services. Examples of services commonly referred to non-network providers are durable medical

equipment, skilled nursing facilities, podiatry, cardiology, ophthalmology and chiropractic services.

Provider profiling is an activity of the managed care process, which allows continual evaluation of care by the network providers to whom we refer large numbers of beneficiaries. FHFS actively accumulates and integrates various outcome measures to assess the continuing appropriateness of provider network affiliation. We recredential our network providers every two years and use that opportunity to review their experience with us during that time.

Through a multi-disciplinary and collaborative process, we assimilate any quality issues identified in the providers care, complaints or grievances from any of their patients, any pattern of aberrant utilization practices and deficiencies in meeting accessibility or other service standards. The recredentialing process is the one time every two years that each network provider is individually reviewed to reaffirm conformance to our program standards. Provider profiling also occurs at a "higher" level, aggregating providers in larger specialty specific or regional groups to obtain other inferences and opportunities to understand and improve care for our beneficiaries.

Impact of Medicare + Choice (M+C)

On January 1, all TRICARE Senior Prime demonstration sites officially became Medicare + Choice (M+C) organizations, as did every other Medicare Risk contractor in good standing across the nation. Implementation of the M+C program has had a significant affect not only on TRICARE Senior Prime, but on the Medicare managed care industry as a whole.

The M+C program was established by the Balanced Budget Act (BBA) of 1997, the same legislation that enabled the Medicare Subvention Demonstration. In the June 26, 1998 Federal Register, which contained the interim final rules for M+C implementation, HCFA noted: "The introduction of the M+C program represents what is arguably the most significant change in the Medicare program since its inception in 1965."

M+C significantly increases the number of health care delivery options available to beneficiaries (including medical savings accounts, private fee-for-service plans, and provider sponsored organizations), and enhances certain benefits that M+C organizations

must provide (for example, direct beneficiary access to women's health care specialists). Increased beneficiary protection is also an important M+C theme. For health plans and providers, there is likewise significant M+C impact over a wide range of areas, including eligibility and enrollment, benefits and beneficiary protections, quality assurance and improvement, payments to M+C organizations, premiums, appeals and grievances, rules for participating providers, and contracting rules.

The nature and sheer scope of the nationwide M+C implementation effort impacts TRICARE Senior Prime in another way as well. With so many new or significantly revised provisions (the M+C program requires its own dedicated section in the Code of Federal Regulations), HCFA has been developing much of the needed M+C regulatory guidance in the course of business, utilizing expedient vehicles like Operational Policy Letters (OPLs) and Program Memoranda. The burden for obtaining and operationalizing these publications falls to each M+C organization. For TRICARE Senior Prime, the accountability rests with the Lead Agent, since Lead Agents directly contracted with HCFA as the M+C organization. At the same time, authority to change or add provisions to MCS contracts belongs solely with the contracting officer at TMA. Therefore the Lead Agent cannot unilaterally direct contract changes. This makes keeping pace with the continuing development of M+C rules and requirements a distinct challenge. Once again, the high level of communication and coordination among Lead Agents, MTFs, TMA, and MCS contractors has proven crucial to dealing with this issue, and to the overall success of TRICARE Senior Prime.

TRICARE Senior Prime has implemented, or is in the process of implementing, all required M+C changes. Some of the more notable areas of change are highlighted below.

Eligibility and Enrollment

- Revised timeframes and requirements for enrollment in M+C plans
- Revised eligibility criteria, including rules for hospice beneficiaries and residency within the service area
- Significant changes in membership effective dates

Beneficiary Rights and Protections

- Expanded requirements addressing beneficiary cultural, literacy, and disability issues
- Increased beneficiary financial protection

Benefits, Access, and Continuity of Care

- Increased preventive care benefits, including direct access to screening mammography and influenza vaccinations,
- Direct access to women's health care specialists for routine and preventive care
- Renal dialysis when the beneficiary is temporarily out of the service area
- Initial health assessment for all new enrollees
- Written treatment plans for beneficiaries with complex or serious medical conditions

Relationships with Providers

- Increased level of provider protection, including notice and appeal rights
- Significant requirements for expressly written M+C provisions in contracts between providers and M+C organizations, particularly regarding beneficiary protection
- Expanded rules for credentialing

Quality Management

- Implementation of HCFA's Quality Improvement System for Managed Care (QISMC), a comprehensive framework for quality assessment and quality improvement that touches all aspects of the M+C program

Challenges and Conclusion

From our recent experience, it is clear there is growing support and satisfaction for the TRICARE Senior Program. This demonstration project which addresses the health benefit needs of our senior service member population has succeeded in its original intent to show how DoD and HCFA, with the support of the MCS contractors, can join together to "Keep the Promise" to these deserving men and women. There are still challenges ahead to identifying the most appropriate settings for TRICARE Senior Prime to succeed. We strongly believe that continuing the program will lead to the successful fulfillment of your goal to provide for TRICARE's Over 65 beneficiaries.

The TRICARE Senior Prime program, as designed, creates a benefit much more advantageous to both the beneficiary and the Government. It was designed to increase quality and access while reducing costs. Quality health care is cost-effective health care. Many of its elements are to provide additional quality measures and oversight that did not exist under the Standard CHAMPUS program at less cost to the beneficiary and the taxpayer.

In conclusion, TRICARE and TRICARE Senior Prime are well underway to meeting the goals and expectations of the government and the beneficiary population. Maturing of these programs needs to occur so that TRICARE can become a stable and reliable product for all beneficiaries. Our experience shows that with time, operations stabilize and beneficiary and provider satisfaction increases. This program is not without challenges, but with strong leadership in DoD and support from Congress to streamline the benefit, TRICARE can and will be the model health care program in the U.S.

Thank you again Mr. Chairman for the opportunity to express my views of the TRICARE Senior Prime Program.

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