

**October 2001**

# **MEDICARE SUBVENTION DEMONSTRATION**

## **DOD Costs and Medicare Spending**

**G A O****Accountability \* Integrity \* Reliability**

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## Abbreviations

BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare and Medicaid Services
DEERS	Defense Enrollment Eligibility Reporting System
DOD	Department of Defense
DSH	disproportionate share hospital
GME	graduate medical education
HCC	Hierarchical Coexisting Conditions
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IME	indirect medical education
LOE	level of effort
MTF	military treatment facility
NMOP	national mail order pharmacy



United States General Accounting Office  
Washington, DC 20548

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## Congressional Committees

The Balanced Budget Act of 1997<sup>1</sup> (BBA) authorized the Department of Defense (DOD) to conduct the Medicare subvention demonstration for a 3-year period. Under this demonstration, DOD formed Medicare managed care organizations—collectively called TRICARE Senior Prime—at six sites that provided enrolled older military retirees<sup>2</sup> the full range of Medicare-covered services as well as additional DOD-covered services, notably prescription drugs. The Medicare program was to pay DOD for Medicare-covered care of the enrolled military retirees if DOD continued to spend on all aged military retirees (Senior Prime enrollees and nonenrollees) at least as much as it had historically.

At the outset, subvention was expected to be beneficial for older military retirees, the Medicare program, and DOD. After they turn 65, military retirees remain eligible for hospital and physician care at military treatment facilities (MTF), but only when space and medical staff are available, because active duty personnel and other beneficiaries under age 65 have priority.<sup>3</sup> This “space-available” care is not provided on a regular and continuous basis, which older retirees often consider important. Enrollment in Senior Prime gave enrollees higher priority for MTF care than nonenrolled older military retirees. Subvention was also expected to be beneficial for Medicare because, under the BBA, Medicare would pay DOD a discounted capitation rate—a fixed monthly payment for enrollees that would be less than that paid to private plans serving other Medicare beneficiaries. Subvention gave DOD the opportunity to test its ability to deliver care to seniors efficiently, thereby providing expanded training opportunities for its physicians and contributing to military readiness.

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<sup>1</sup>P.L. 105-33, sec. 4015.

<sup>2</sup>In this report “older military retirees” and “older retirees” refer to military retirees, their spouses, and dependents who are aged 65 or older and are eligible for Medicare.

<sup>3</sup>The context for space-available care changed with the passage of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106-398, sec. 712). This legislation established a new program, known as TRICARE For Life, which started October 1, 2001. Under this program, TRICARE is a secondary payer to Medicare, paying nearly all beneficiary cost-sharing for Medicare-covered services obtained from civilian providers.

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DOD could also gain by earning additional funds from Medicare to maintain and improve military health care.

The BBA directed us to evaluate the demonstration's implementation, including its effects on DOD costs and Medicare spending. Specifically, this report (1) examines the costs to DOD of Senior Prime enrollees, (2) compares Medicare's capitated rate to what Medicare would have spent on Senior Prime enrollees without the demonstration, and (3) determines the impact of the BBA's payment rules for the demonstration on Medicare's payments to DOD.<sup>4</sup>

To address these issues, we analyzed DOD and Medicare data; interviewed health care, budgeting, and program evaluation officials at DOD; and spoke with Medicare officials.

Our analyses are based on 1999 data, the demonstration's first full year of operation. DOD costs and Medicare spending may differ in subsequent years. See appendixes I and II, which describe our methods. We did not independently verify DOD and Medicare data on enrollment, cost, and utilization, and did not validate DOD's method of allocating costs to Senior Prime enrollees. We conducted our study from January 1999 through September 2001, in accordance with generally accepted government auditing standards.

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## Results in Brief

Under the subvention demonstration, Senior Prime enrollees' care in 1999 cost DOD far more than the Medicare capitation rate that was established for the demonstration. This mostly resulted from enrollees' heavy use of medical services, although DOD's coverage of prescription drugs—not included in the Medicare benefit package—also contributed to its high costs of care. Health conditions did not drive these high costs, since enrollees typically were not sicker than comparable Medicare beneficiaries.

Without the demonstration, Medicare's spending in 1999 for retirees who enrolled in Senior Prime would have been, on average, 55 percent of the Senior Prime capitation rate. One reason for this was that Senior Prime enrollees were somewhat healthier than other Medicare beneficiaries with the same demographic traits. The key factor, however, was that Medicare

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<sup>4</sup>A list of related GAO products is included at the end of this report.

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would have paid for only part of the enrolled retirees' care. MTFs would have provided much of their care, which would not have been reflected in Medicare's spending on their behalf.

The BBA payment rules resulted in no Medicare payment to DOD in 1999. This was because they were designed to prevent the government from paying twice for the same care—once through DOD's appropriations and again through Medicare. The rules also required that the payment be adjusted to account for Senior Prime enrollees' health status. Together, these two requirements resulted in Medicare paying DOD nothing for care provided in 1999. Even without these two features of the payment rules Medicare still would have paid DOD less than the monthly Senior Prime capitation rate of \$320 per person. This is because the BBA capped the Medicare payment for all enrollees at \$60 million for 1999—an amount that would have averaged \$196 per month for each enrollee.

DOD and CMS reviewed a draft of this report and found its contents to be generally accurate and appropriate. The agencies provided some updated information and technical comments, which we incorporated as appropriate.

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## Background

The military health system has three missions: (1) maintaining the health of active-duty service members; (2) maintaining readiness—the capability to treat wartime casualties; and (3) providing care to the dependents of active-duty personnel, retirees and their families, and survivors of military personnel. In fiscal year 1999, DOD's annual appropriations included about \$16 billion for health care, of which over \$1 billion funded the care of seniors.

In the mid-1990s, DOD implemented the TRICARE framework for military health care in response to rapidly rising costs and beneficiary concerns about access to military care. Its goals were to improve beneficiary access and quality while containing costs. TRICARE provides care through over 600 MTFs and a network of civilian providers managed by outside contractors. TRICARE offers three options: TRICARE Prime, a managed care option; TRICARE Extra, a preferred provider option; and TRICARE Standard, a fee-for-service option. TRICARE covers inpatient services, outpatient services such as physician visits and lab tests, and skilled nursing facility and other post-acute care. TRICARE also covers

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prescription drugs, which are available at MTFs, through DOD's national mail order pharmacy (NMOP), and at civilian pharmacies.<sup>5</sup>

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## Medicare

Medicare is a federally financed health insurance program that covers health care expenses of the elderly, some people with disabilities, and people with end-stage kidney disease. Military retirees aged 65 or older are eligible for Medicare on the same basis as civilian retirees. Medicare enrollees receive part A benefits and are eligible for optional part B benefits if they pay a monthly premium.<sup>6</sup>

Under traditional Medicare, beneficiaries choose their own providers, and Medicare reimburses those providers on a fee-for-service basis. Beneficiaries who receive care through traditional Medicare are responsible for paying a share of the costs for services. Most beneficiaries have supplemental coverage that pays for many of the costs not covered by Medicare. Major sources of this coverage include employer-sponsored health insurance, "Medigap" policies sold by private insurers to individuals, and state Medicaid programs.

Beneficiaries have an alternative to traditional Medicare, the Medicare+Choice option. Medicare+Choice allows beneficiaries to enroll in private managed care plans<sup>7</sup> and other types of health plans.<sup>8</sup> Managed care plans provide all traditional Medicare benefits and typically offer additional benefits, such as prescription drug coverage. Plan members generally pay less out-of-pocket than under traditional Medicare. When choosing a plan, beneficiaries must weigh these benefits against other features of managed care. For example, beneficiaries enrolled in Medicare

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<sup>5</sup>A small copayment is required for prescriptions filled by mail order or at civilian pharmacies, but not for prescriptions filled at MTFs.

<sup>6</sup>Medicare part A covers inpatient hospital care, skilled nursing facility care, home health care following an inpatient or skilled nursing facility stay, and hospice care. Medicare part B covers physician care, other outpatient services, and home health services not covered by part A for beneficiaries choosing to pay a monthly premium. In 1999 part A covered about 39 million enrollees and part B covered 37 million enrollees.

<sup>7</sup>In this report, "managed care plans" refers to capitated plans, which receive a fixed monthly payment for each Medicare beneficiary they serve—regardless of the actual costs incurred in providing care to the beneficiary.

<sup>8</sup>In 1999, about 16 percent of Medicare beneficiaries were members of a Medicare+Choice plan.

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managed care plans generally must use the physicians in a plan's network and often must obtain plan approval before they can see a specialist.

Older military retirees who enroll in Medicare+Choice plans may choose to supplement the care they receive through the plan with space-available care provided by MTFs in their areas. The space-available care they receive saves the plan money if it otherwise would have provided the care. Similarly, MTF care provided to older retirees who are in traditional Medicare reduces Medicare spending.

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## DOD Health Care for Medicare-Eligible Military Retirees

Today, there are about 1.5 million retired military personnel, dependents, and survivors aged 65 or older residing in the United States who are eligible for certain military health care services. About 600,000 of these seniors live within about 40 miles of an MTF. Retirees have access to all MTF and network services through TRICARE until they turn age 65 and become eligible for Medicare. Subsequently, they can only use military health care on a space-available basis, that is, when MTFs have unused capacity after caring for younger beneficiaries.<sup>9</sup> In the 1990s, downsizing and changes in access policies led to reduced space-available care throughout the military health system. Some retirees aged 65 or older rely heavily on military facilities for their health care, but most do not, and over 60 percent do not use military health care facilities at all.

Sweeping changes in retiree benefits and military health care are occurring in 2001 as a result of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. This legislation gave older retirees two major benefits:

- **Pharmacy benefit.** Beginning April 1, 2001, military retirees from the uniformed services aged 65 or older have access to prescription drugs through TRICARE's NMOP and at civilian pharmacies, as well as through pharmacies at MTFs.<sup>10</sup>
- **TRICARE eligibility.** On October 1, 2001, older retirees enrolled in Medicare part B became eligible for TRICARE coverage—commonly

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<sup>9</sup>In addition, retirees aged 65 or older have historically been able to get prescriptions filled at MTF pharmacies without charge.

<sup>10</sup>Beneficiaries who turned age 65 prior to April 1, 2001, automatically qualify for this benefit. Those who turned age 65 on or after that date must be enrolled in Medicare part B to obtain the pharmacy benefit.

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termed TRICARE For Life. As a result, TRICARE is now a secondary payer for these retirees' Medicare-covered services—paying most of the required cost-sharing. In addition, older retirees can enroll in TRICARE Plus—a program that provides MTF primary care.<sup>11</sup>

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## The Medicare Subvention Demonstration

The Medicare subvention demonstration permitted DOD to create managed care organizations that participate in the Medicare+Choice program and enroll older retirees. Medicare may pay DOD for enrollees' care, but only after DOD has spent an amount equal to what it has spent historically on care for all older retirees. Under the demonstration, enrolled retirees receive their Medicare-covered benefits and additional TRICARE benefits (notably prescription drugs) through TRICARE Senior Prime, the DOD-run managed care organizations set up by the demonstration. To be eligible for Senior Prime, retirees must reside in one of the six geographic areas covered by the demonstration, be enrolled in both Medicare part A and part B, and be eligible for military health care benefits. They also must have either (1) used a military treatment facility before July 1, 1997, or (2) turned age 65 on or after July 1, 1997.

Senior Prime is based on TRICARE Prime, DOD's managed care program for active-duty personnel, family members, and retirees under age 65. Although DOD could charge enrollees a premium for Senior Prime, as any Medicare+Choice organization can, it has chosen not to do so. Services can be provided, at Senior Prime's option, at an MTF or by a civilian network provider. Copayments differ by where the service was provided. For example, inpatient care is free at the MTF, but a copayment is charged for care at a civilian hospital.

Senior Prime gives its members priority for treatment at MTFs over other older military retirees (that is, nonenrollees). Like enrollees in private Medicare managed care plans, Senior Prime enrollees agree that the plan will be the sole source of their Medicare benefits. Enrollees who use civilian providers without authorization are responsible for the full charge.

Senior Prime began delivering care at its first site in September 1998 and was delivering care at all sites by January 1999. Sites differ in the numbers of older retirees in their area and enrollment (see table 1), as well as by

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<sup>11</sup>The number of enrollees is limited at each site according to capacity and may not be available at all sites.

geographic region, size of military health facility, and managed care penetration in the local Medicare market.

**Table 1: Enrollment at the Subvention Demonstration Sites Varied Widely**

Site	Eligible military retirees <sup>a</sup>	Enrollment <sup>b</sup>	Percentage of eligible military retirees enrolled
Colorado Springs (Colo.)	14,988	4,121	27%
Dover (Del.)	3,894	1,062	27%
Keesler (Miss.)	8,309	3,507	42%
Madigan (Wash.)	21,072	4,674	22%
San Antonio <sup>c</sup>			
San Antonio Area (Tex.)	36,507	12,451	34%
Texoma Area (Tex./Okla.)	7,693	2,541	33%
San Diego (Calif.)	34,485	4,751	14%
<b>Total</b>	<b>126,948</b>	<b>33,107</b>	<b>26%</b>

<sup>a</sup>Data are as of December 31, 2000, for all sites except Dover (as of June 30, 1998).

<sup>b</sup>Data are as of December 31, 2000.

<sup>c</sup>The BBA specifies six test sites. Although DOD has designated San Antonio as a single site, for the purpose of analysis we treat the San Antonio area and the Texoma area, which are roughly 300 miles apart, as separate sites.

Source: TRICARE Senior Prime Plan Operations Report (Washington, D.C.: DOD, Dec. 31, 2000). The number of eligible retirees (by site and total) is drawn from DOD's Defense Enrollment Eligibility Reporting System (DEERS).

The demonstration sites were not representative of all military health care service areas. This was because sites' ability to support the demonstration was a factor in site selection. Military health care resources were greater in demonstration areas than in other military health care service areas. At the start of the demonstration, about 80 percent of older retirees in the demonstration areas lived near a military medical center—a teaching hospital with multiple specialty clinics—whereas in service areas that were not in the demonstration, only 30 percent of older retirees were served by a nearby medical center.

The BBA authorized the demonstration for a 3-year period beginning on January 1, 1998, and ending on December 31, 2000. The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 extended the demonstration for another year—through 2001. DOD has announced that Senior Prime will end on December 31, 2001, because the new TRICARE

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For Life program will provide expanded health care coverage to older military retirees.

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## Medicare Payments to DOD for TRICARE Senior Prime

In establishing the demonstration, the BBA also established rules for Medicare to follow in paying DOD. The monthly Senior Prime capitation rate was set at 95 percent of the Medicare+Choice capitation rate, consistent with a belief that DOD could provide care at lower cost than the private sector. The rate was further adjusted by excluding the part of the Medicare+Choice rate that reflects graduate medical education (GME) and disproportionate share hospital (DSH) payments,<sup>12</sup> as well as a percentage of payments made for hospitals' capital costs. The GME and capital costs exclusions took into account the fact that GME and capital costs in the military health system are funded by DOD appropriations, and the DSH exclusion recognizes that DOD medical facilities do not treat the low-income patients for whom DSH payments compensate hospitals. The law directed the Health Care Financing Administration (HCFA)<sup>13</sup> and DOD to determine the amount of the capital adjustment, and the two agencies agreed to exclude two-thirds of the capital costs reflected in the Medicare+Choice rate.

The total amount that Medicare could pay DOD for the demonstration was capped at \$50 million in 1998, \$60 million in 1999, and \$65 million in 2000. The BBA also required that participating MTFs maintain their "level of effort" (LOE). That is, they had to spend as much on care for older retirees as they did prior to the demonstration before Medicare could make any payment. This provision ensured that the government would not pay for the same care twice—through both the DOD appropriations and Medicare. (Appendix III explains how LOE works in practice and how Medicare's final payment to DOD is determined.)

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<sup>12</sup>GME payments cover Medicare's share of teaching hospitals' expenses incurred in training medical interns and residents. DSH payments assist hospitals that treat a disproportionate number of uninsured and indigent patients.

<sup>13</sup>On June 14, 2001, the Secretary of Health and Human Services announced that the name of HCFA had been changed to the Centers for Medicare and Medicaid Services (CMS). In this report, we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

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## DOD's Costs Per Person Outstripped Medicare's Capitation Rate for Senior Prime

DOD's costs of providing care to Senior Prime enrollees were considerably higher in 1999 than what Medicare could pay Senior Prime or any other managed care organization. This difference was not because Senior Prime enrollees were sicker than other Medicare beneficiaries. Instead, it was mostly due to Senior Prime enrollees' heavy use of services. A smaller part of the difference reflected DOD's coverage of prescription drugs.

Contrary to initial expectations, DOD was unable to provide care to enrollees within the capitated rate. In 1999 DOD's monthly costs for Senior Prime members were \$586 per person.<sup>14</sup> Senior Prime's monthly capitated rate was \$320 per person—a difference of \$266. (See fig. 1.) Even if DOD had been paid the full Medicare+Choice rate, the monthly difference would still have been over \$200 per person.<sup>15</sup>

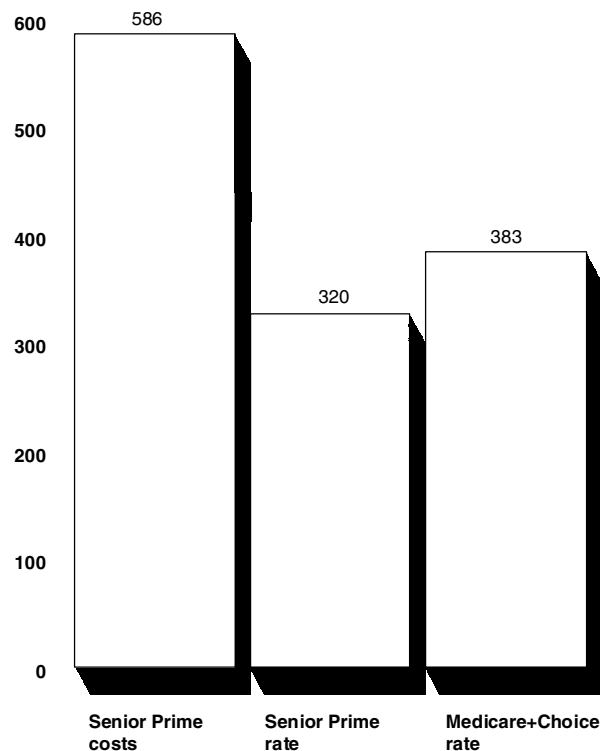
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<sup>14</sup>This amount includes overhead costs and prescription drug expenses. See app. I.

<sup>15</sup>The Senior Prime capitated rate was \$63 lower than the Medicare+Choice rate because the BBA set it at 95 percent of the Medicare+Choice rate, less some adjustments.

**Figure 1: Senior Prime Costs, Senior Prime Rate, and Medicare+Choice Rate, 1999**

700 Dollars per person per month



Source: GAO analysis of Medicare data and DOD data from SRA International, Inc., *Medicare Subvention Demonstration CY 1999 Reconciliation Processing*, San Antonio, Texas: March 2001.

Although part of the difference was due to DOD's coverage of prescription drugs, the main reason for the difference was Senior Prime enrollees' higher utilization. Compared to similar Medicare fee-for-service beneficiaries, enrollees were hospitalized 41 percent more often and had 58 percent more outpatient visits.<sup>16</sup> (See table 2.) If Senior Prime had matched Medicare fee-for-service utilization, its monthly costs would have dropped by more than \$150 per person. The higher utilization probably had several sources, including lower cost-sharing by Senior Prime

<sup>16</sup>See *Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs* (GAO-02-68, October 31, 2001).

enrollees and weak incentives to limit inappropriate utilization. However, their separate impacts cannot be quantified.

**Table 2: Utilization Was Higher in 1999 for Senior Prime Enrollees Than for Comparable Medicare Fee-for-Service Beneficiaries**

	Utilization of Senior Prime enrollees	Utilization of comparable Medicare fee-for-service beneficiaries <sup>a</sup>
Inpatient stays per 1,000 persons	367	261
Outpatient visits per person	16.7	10.6

<sup>a</sup>Fee-for-service utilization assuming Senior Prime health status and demographics. See app. I.

Source: GAO analysis of DOD and Medicare data.

Officials at several demonstration sites stated that Senior Prime enrollees had high utilization because they were less healthy than other patient groups. Although some sites had sicker enrollees than others, overall the demonstration’s enrollees were not in poorer health than comparable Medicare beneficiaries. In fact, they were somewhat healthier.<sup>17</sup>

In contrast to the high utilization of services by Senior Prime enrollees, Senior Prime’s drug coverage played a small role. Prescription drugs for enrollees—not included in the Medicare benefit package—cost DOD on average \$55 per month per enrollee.

**The Capitated Rate Exceeded What Medicare Would Have Spent on Senior Prime Enrollees Without the Demonstration**

Without the demonstration, Medicare in 1999 would have spent 55 percent of the Senior Prime capitation rate on retirees enrolled in Senior Prime. In part, this was because Senior Prime enrollees were somewhat healthier—and therefore somewhat less costly—than other Medicare beneficiaries with the same demographic characteristics. However, the primary reason was that Medicare would have paid for only part of their care. Much of their care would have been provided by MTFs and would have been free to Medicare.

We estimate that, without the demonstration, Medicare would have spent on the average enrollee \$144 per month less than the Senior Prime rate. Most of this difference reflects the care that fee-for-service beneficiaries

<sup>17</sup>See app. I.

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would have received from MTFs—care that was free to Medicare. Enrollees who before they enrolled in Senior Prime had been fee-for-service beneficiaries would have cost Medicare \$91 per month—\$229 less than the Senior Prime rate. By contrast, enrollees who were former health maintenance organizations (HMO) beneficiaries would have cost Medicare, on average, the full Medicare+Choice capitation rate—\$63 per month more than the Senior Prime rate.

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## BBA Payment Rules Resulted in No Medicare Payment to DOD

The BBA payment rules for the demonstration limited what Medicare could pay DOD for care rendered to Senior Prime enrollees, reflecting the fact that DOD had an additional source of funds for retiree health care—its appropriations. Contrary to expectations, however, these rules resulted in Medicare owing DOD nothing for the care provided to enrollees during 1999.

The BBA set a ceiling on Medicare's payment to DOD, consistent with the expectation that the payment might be sizable. In 1999 Medicare's payment to DOD was capped at \$60 million for enrollee care. Because DOD allowed 30,228 retirees to enroll and provided them over 305,000 months of care in 1999, the most that DOD could have been paid was \$196 per enrollee per month, or 61 percent of the Senior Prime capitation rate which was \$320 per month. Any Medicare payment would have supplemented DOD's appropriated funds.

The BBA payment rules resulted in Medicare actually paying DOD nothing for care provided to Senior Prime enrollees during 1999. Under these rules, DOD was required to spend as much as it had historically spent on all seniors in the demonstration areas before it could be paid by Medicare. Otherwise, the government would have paid twice for the same care—both through Medicare and the DOD appropriations. The rules also required that the payment be adjusted upward or downward according to whether Senior Prime enrollees were sicker or healthier than comparable Medicare beneficiaries.<sup>18</sup> Together, these two requirements resulted in Medicare owing DOD nothing.

DOD expenditures on care for all retirees (enrolled and not enrolled) in the demonstration areas exceeded its level of effort requirement by \$79 million. These additional expenditures, which reflect DOD's high

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<sup>18</sup>See app. III.

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utilization and high costs, were paid with appropriated health care funds. Using these funds for Senior Prime meant that less was available for other purposes.

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## Concluding Observations

Under the demonstration, Senior Prime enrollees' utilization of care was substantially higher than that of comparable Medicare beneficiaries. As a result, DOD's costs were so high that the full Senior Prime capitation rate could not have covered its costs.

Without the demonstration, Medicare would have spent less than the Senior Prime capitation rate on enrollees. This would have occurred because military retirees who used fee-for-service providers would have obtained much of their care for free from MTFs and therefore would have cost Medicare substantially less than the capitation rate.

The BBA rules prevented the government from paying twice for the same care and protected the Medicare program from a large increase in its spending for Senior Prime enrollees. However, DOD incurred greater costs for seniors due to the demonstration and covered these costs by redirecting funds from other uses.

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## Agency Comments

DOD and CMS reviewed a draft of this report. DOD said that the report adequately described the financial complexities it faced in implementing, administering, and managing the Medicare subvention demonstration. However, DOD found that the report addressed neither the details of the agreement with CMS concerning LOE nor the annual reconciliation process that determined the amount of Medicare's final payment for Senior Prime care. According to DOD, these features resulted in an extremely complicated payment mechanism that was difficult for DOD managers to understand and execute. In response to our reference to the high cost of DOD's care, DOD stated that a contributing factor to the high cost of care was the design of the health care benefit provided by Senior Prime. The agency cited an estimate by an actuarial consulting firm that the Senior Prime benefit was worth \$105 more per member per month than the typical Medicare+Choice plan. It stated that the burden of providing this benefit and the requirement to maintain fiscal year 1996 Indirect Medical Education (IME)<sup>19</sup> rules made it difficult for DOD to attain

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<sup>19</sup>IME is a component of Medicare payments to hospitals for training physicians. Changes since 1997 in the rules governing IME reduced Medicare payments to hospitals.

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its LOE target. In response to our discussion of the effect of risk adjustment on the final Medicare payment, DOD noted that the latest risk adjustment calculation shows that the Senior Prime enrollee population is healthier than the fee-for-service Medicare populations in the demonstration areas. As a result, DOD received no payment from CMS for Senior Prime care provided in 1999. Regarding our concluding observation that DOD incurred greater costs to support Senior Prime and had to cover the shortfall, the agency observed that the report does not state whether the federal government as a whole spent more or less as a result of the demonstration. Finally, DOD suggested that the Hierarchical Coexisting Conditions (HCC) method<sup>20</sup> for determining beneficiaries' costliness may have resulted in risk scores that overstated the health of the enrollees, due to the HCC method's use of ambulatory data, which in DOD's case may be incomplete and may also contain data coding errors.

In an earlier report,<sup>21</sup> we described in detail the LOE mechanism and the annual reconciliation process that determines Medicare's final payment. We also noted in that report that the payment mechanism created uncertainty for DOD managers. Concerning the burden placed on DOD in meeting the LOE requirement, we observe that the Senior Prime benefit included both Medicare-covered services and non-Medicare-covered services. The LOE requirement applied only to Medicare-covered services, for which DOD incurred high costs. We agree that maintaining the fiscal year 1996 IME rules made it more difficult for DOD to meet its LOE requirement, but the effect was very small. Regarding the 1999 final payment by Medicare to DOD, the estimate in our draft report was based on preliminary information from CMS and DOD. We have incorporated into the published report information from the final accounting recently completed by the agencies that shows that there was no payment by Medicare for DOD's 1999 Senior Prime care. Although the issue of whether the federal government as a whole spent more or less as a result of the demonstration is outside of the scope of this report, our analyses indicate that the demonstration's impact on total federal costs for the demonstration population was negligible. We share DOD's concern about the completeness and reliability of ambulatory care data, but doubt that these data weaknesses had any substantial effect on the risk adjustment calculation. We performed the risk adjustment calculation using a method

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<sup>20</sup>See app. I for a description of this method.

<sup>21</sup>*Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns* (GAO/HEHS-99-39, May 28, 1999).

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based only on inpatient data and obtained a result comparable to that obtained using the HCC method.

CMS found the conclusions of the report to be appropriate. The agency noted that our findings pertained to the initial phase of the demonstration. CMS observed that start-up conditions in the first year of a demonstration may affect the findings. The agency therefore recommended that we include a statement noting that our results are from the initial phase of the demonstration. We make a statement to this effect in the beginning of the report. In addition, CMS noted that there were considerable problems encountered with the DOD cost and use data. We were aware of the limitations of DOD data during our analysis and have described them in appendix I.

CMS also suggested technical changes to the report, which we incorporated where appropriate. DOD's and CMS's comments appear in appendixes IV and V, respectively.

We are sending copies of this report to the Secretary of Defense and the Administrator of the Centers for Medicare and Medicaid Services. We will make copies available to others upon request.

If you or your staffs have questions about this report, please contact me at (202) 512-7114. Other GAO contacts and staff acknowledgments are listed in appendix VI.

A handwritten signature in black ink that reads "William J. Scanlon". The signature is fluid and cursive, with the first name "William" and last name "Scanlon" clearly legible.

William J. Scanlon  
Director, Health Care Issues

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# Appendix I: DOD Cost Analysis

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This appendix summarizes the methods and data underlying our analysis of Senior Prime financial issues. Specifically, we analyzed the effect of the Medicare subvention demonstration on DOD's total costs for enrolled and nonenrolled retirees at the demonstration sites. In addition, we analyzed DOD's costs per Senior Prime enrollee because, under the demonstration's rules, the size of these costs has implications for the size of the payment that DOD receives.

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## DOD Total Costs

The total costs of the demonstration to DOD—its actual costs of caring for enrollees and nonenrollees in the demonstration areas—have four components:

- **MTF care.** Most hospital stays and outpatient visits by Senior Prime enrollees occurred in MTFs. We based our MTF cost calculations on DOD's allocation of the costs for an entire facility to the enrolled retirees. This allocation of MTF costs is necessary because DOD's cost accounting systems do not record or generate cost data for each MTF patient. For the demonstration MTFs, DOD extracted the facility costs from its accounting system for MTF costs (the Medical Expense and Performance Reporting System). Using an elaborate set of cost-allocation rules it had developed,<sup>1</sup> DOD split an MTF's costs of caring for all users—whether in Prime, Senior Prime, or space-available care—between Senior Prime enrollees and all other users.
- **Civilian network care.** Senior Prime also paid for enrollees' admissions to civilian hospitals and visits to civilian physicians in the Senior Prime network. These network providers submitted claims to TRICARE, which DOD summed to obtain network costs of inpatient care and of outpatient care for enrollees.
- **Pharmacy.** For enrollee prescriptions filled at civilian pharmacies, DOD's costs were recorded like other network claims. For prescriptions filled at MTF pharmacies, DOD reported its costs based on data from local MTF pharmacy information systems. For enrollees' prescriptions from DOD's national mail order pharmacy system, DOD extracted cost information from NMOP's separate information system.

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<sup>1</sup>This set of rules is known as DOD's Medicare Patient Level Cost Allocation algorithm. See *Methodology for Allocating Expenses to Encounters in Military Treatment Facilities for the Medicare Demonstration Projects*, Director, Health Services Analysis and Measurement, Health Services Operations and Readiness, Office of the Assistant Secretary of Defense (Health Affairs), January 1998.

- **Administrative overhead.** We used DOD's figures for Senior Prime's administrative costs associated with its managed care support contractors. DOD officials told us that DOD does not have a central system for collecting and reporting the administrative costs of MTF care. As a result, our estimate somewhat understates Senior Prime's total overhead costs.

We calculated total costs to DOD of the demonstration for enrollees, nonenrollees, and all older retirees. For enrollees, we calculated DOD's total costs by summing the MTF, network, pharmacy, and overhead costs reported by DOD for 1999. For nonenrollees, we used the total cost estimates reported by DOD for 1999.<sup>2</sup> To determine DOD's total costs for all older retirees, we summed the total costs of enrollees and nonenrollees at the demonstration sites. To calculate the change in total cost for older retirees (enrolled and nonenrolled) due to the demonstration, we compared DOD's 1999 health care costs for older retirees in the demonstration areas to its historical LOE.

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## DOD Per-Enrollee Costs

We analyzed DOD's per-enrollee costs because they affect the size of Medicare's final payment to DOD even though they are not an explicit factor in the calculation of this payment.<sup>3</sup>

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## DOD Costs Compared to Senior Prime Capitation Rate

We calculated monthly costs per Senior Prime enrollee for 1999 as total Senior Prime costs—MTF, civilian network, pharmacy, and administrative overhead—divided by total member months in 1999. Total monthly costs per enrollee for Senior Prime were \$586. This represents the cost to DOD of providing the combined Medicare and TRICARE Prime benefit package to Senior Prime enrollees. In contrast, under the demonstration's payment rules, in 1999 DOD was credited for Senior Prime enrollment at a Medicare capitation rate of \$320 per month per enrollee.<sup>4</sup> We found that DOD's costs

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<sup>2</sup>Our enrollee and nonenrollee cost estimates are based on data in SRA International, Inc., *Medicare Subvention Demonstration CY 1999 Reconciliation Processing*, San Antonio, Texas: March 2001.

<sup>3</sup>Under the demonstration's payment rules, DOD's final payment could have equaled the 1999 payment cap of \$60 million if DOD's per-enrollee costs had been lower—for example, if they had exceeded the monthly Senior Prime capitation rate by no more than 19.5 percent—and if DOD had spent the money saved on increased care for nonenrollees.

<sup>4</sup>This represents the risk-adjusted capitation rate that resulted from the annual end-of-year reconciliation that determines the final payment from Medicare to DOD. The unadjusted capitation rate would have been \$337.

for delivering the Senior Prime benefit package (which includes prescription drug coverage) to enrollees were over 80 percent higher than the Senior Prime capitation rate.

DOD's higher costs partly reflected Senior Prime's coverage of prescription drugs, but even net of drug expenses Senior Prime's costs still were high. Table 3 presents Senior Prime costs in three ways: the first (total costs) is comprehensive and measures DOD's costs of providing the Senior Prime benefit package; the second measures DOD's costs of providing the Medicare benefit package, which does not include prescription drug coverage;<sup>5</sup> and the third (in effect, medical claims) measures DOD's costs of providing the Medicare benefit package, net of the overhead costs associated with DOD's managed care support contractors for Senior Prime.

**Table 3: Senior Prime Per-Enrollee Costs Exceed Its 1999 Capitation Rate**

	DOD's Senior Prime per-enrollee costs		Medicare capitation rate for Senior Prime	
	Monthly	Annual	Monthly	Annual
<b>Total</b>	<b>\$586</b>	<b>\$7,027</b>	<b>\$320</b>	<b>\$3,840</b>
Less prescription drugs	\$531	\$6,367		
Less prescription drugs and network overhead	\$483	\$5,804		

Source: GAO analysis of DOD data.

Even if one of the less comprehensive measures is selected, DOD's costs for Senior Prime enrollees were much higher than the Senior Prime capitation rate. For example, the difference between the narrowest view of Senior Prime costs (net of drugs and overhead) and the capitation rate is \$1,964 annually.

Health Status of Senior Prime Enrollees

We examined the relative health status of enrollees because people with higher medical care costs are usually less healthy. Our analysis showed that Senior Prime enrollees were healthier on average than their fee-for-service counterparts. We used the HCC method to determine the costliness of each beneficiary, based on that person's clinical diagnoses

<sup>5</sup>This second measure does not, however, adjust for the cost of certain Senior Prime preventive care visits that are not part of the Medicare benefit.

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and demographic traits, relative to the average Medicare fee-for-service beneficiary in the United States.<sup>6</sup> Beneficiaries with lower scores are healthier than beneficiaries with higher scores, and the average Medicare fee-for-service beneficiary in the United States has an HCC score of 1.00. In 1999, Senior Prime enrollees had an average HCC score of 0.94 while Medicare fee-for-service beneficiaries in the demonstration areas had an average HCC score of 1.19.<sup>7</sup>

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### Comparing Senior Prime Utilization and Medicare Fee-for-Service Utilization

We analyzed enrollees' relative utilization of services because people who use more services generally have higher costs. In 1999, Senior Prime enrollees averaged 0.367 inpatient stays per person and 16.7 outpatient visits per person. To control for differences by age, sex, and health status, we estimated a statistical model of inpatient utilization for Medicare fee-for-service beneficiaries in the demonstration areas. Using the coefficients from this model, we projected the inpatient utilization for fee-for-service beneficiaries with the same demographic and health traits as Senior Prime enrollees. We also estimated a similar model for outpatient utilization, which we used to project outpatient utilization for fee-for-service beneficiaries with the same characteristics as Senior Prime enrollees.

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<sup>6</sup>See Arlene S. Ash and others, "Using Diagnoses to Describe Populations and Predict Costs," *Health Care Financing Review*, Spring 2000, 21:3.

<sup>7</sup>We used the Medicare 20-percent sample of fee-for-service beneficiaries residing in the official demonstration areas. We excluded Medicare+Choice members, military retirees, persons with end-stage renal disease, Medicaid beneficiaries, persons with disabilities (under age 65), and people who lost Medicare part A or part B entitlement for reasons other than death.

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Our analysis showed that Medicare fee-for-service beneficiaries similar to the Senior Prime enrollees would have averaged 0.261 inpatient stays per person and 10.6 outpatient visits per person in 1999.<sup>8</sup> Consequently, we found that Senior Prime enrollees were hospitalized 41 percent more often than similar Medicare fee-for-service beneficiaries and had 58 percent more physician and other outpatient visits than similar Medicare fee-for-service beneficiaries.

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<sup>8</sup>To the extent possible, we counted Medicare and Senior Prime outpatient visits the same way. For example, we excluded telephone consultations from our count of Senior Prime outpatient visits. However, we were unable to exclude certain Senior Prime preventive care visits that are not part of the Medicare benefit.

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# Appendix II: Medicare Spending Analysis

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This appendix summarizes the data and methods used in our analysis of Medicare spending during the demonstration. We estimated what Medicare would have spent without the demonstration for beneficiaries who—before they enrolled in Senior Prime—were covered by Medicare fee-for-service. We did this by projecting historical spending patterns of this population into the demonstration period. We also calculated what Medicare would have spent on Senior Prime enrollees who were previously members of managed care plans.

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## Database Construction

We constructed a database of monthly spending for Medicare beneficiaries spanning January 1994 through December 1999. It included variables that made it possible to aggregate the data for each month by demonstration site, age, and sex, or any combination of these characteristics. We also included data on (1) older military retirees at the eight control sites used in the RAND evaluation of the demonstration<sup>1</sup> and (2) a sample of nondual eligibles—Medicare beneficiaries not eligible for military health care—at both the demonstration and RAND control sites.

Constructing the database involved four major steps:

1. **Identifying the Populations.** To identify the population of Medicare-eligible military retirees, we obtained quarterly files<sup>2</sup> from DOD for the period 1994 through 1999 that included all military retirees and their dependents aged 65 or older who were eligible for military health care. We matched a master list of these individuals to Medicare's Enrollment Data Base to produce a national file of all Medicare-eligible military retirees. This file was used to create separate lists for the demonstration and RAND control sites using Medicare data on beneficiaries' current and previous residences.

To select comparison samples of Medicare beneficiaries not eligible for military health care, we created a master list of all nondual eligibles for each site. To do this, we matched a list of zip codes for the demonstration and RAND control sites to Medicare's annual master

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<sup>1</sup>DOD and HCFA contracted with the RAND Corporation to evaluate the demonstration. DOD, HCFA, and RAND jointly selected the eight control sites used in RAND's evaluation. See Donna O. Farley and others, *The First Year of the Medicare-DoD Subvention Demonstration: Evaluation Report for FY 1999*, RAND Corporation, Contract Number MR-1271.0-HCFA, December 2000.

<sup>2</sup>The source files are from DEERS.

lists of beneficiary characteristics and excluded the dual eligibles. Finally, we selected a random sample of 30,000 beneficiaries for each site.<sup>3</sup>

2. **Determining Monthly Medicare Payments for Several Populations.** We used the list of older retirees and the sample of nondual eligibles at both the demonstration and RAND control sites to extract all Medicare fee-for-service claims for these individuals in the years spanning 1993 through 1999.<sup>4</sup> The payment amount of each claim was prorated among the months spanning the beginning and end dates of the period during which the service was provided. The prorated claims were then summed by month for each beneficiary.

From the same lists of beneficiaries we also identified all former Medicare HMO enrollees.<sup>5</sup> For each year spanning 1994 through 1999, we used HCFA's HMO rate calculation methodology to calculate the capitation rate for every month during which a beneficiary was enrolled in a Medicare HMO. These data were then merged with the monthly fee-for-service payments to create a file of all Medicare payments by month.

3. **Creating Variables That Describe Beneficiaries' Characteristics.** We created a separate file of monthly beneficiary characteristics from Medicare and DOD data. These included age, sex, Medicare part A and part B enrollment status, eligibility for DOD health care, and residence at a demonstration or RAND control site. For Senior Prime enrollees we also added variables indicating their monthly enrollment status, their Senior Prime capitation rate, and the final Medicare payments to DOD per enrollee for 1998 and 1999.
4. **Creating the Master File and Time-Series Variables.** We created the master file by merging the monthly beneficiary characteristics file with the monthly Medicare payments file. We used the master file to

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<sup>3</sup>For Holloman Air Force Base in New Mexico we included all beneficiaries not eligible for military health care because there were fewer than 30,000 beneficiaries at this location.

<sup>4</sup>Claims for 1993 were included so that a complete history of prior-year spending could be constructed for 1994 through 1999.

<sup>5</sup>As of 1999, Medicare HMOs have been part of Medicare+Choice and are referred to as Medicare+Choice organizations.

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create two time-series variables—average real<sup>6</sup> monthly Medicare payments and the number of beneficiaries. For demonstration sites, these segments included all enrollees, enrollees who were fee-for-service beneficiaries before the demonstration, nonenrollees, and nondual eligibles. For the RAND control sites, these segments included all older retirees and nondual eligibles.

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## Modeling Methodology

We used a standard statistical method (ordinary least-squares regression) to estimate forecasting equations of average monthly real Medicare spending for the population segments included in the database. A common feature of time-series data is that each period's value is likely to be correlated with previous periods' values. We therefore used a standard correction in our estimates to counteract the forecasting error that would otherwise be introduced.<sup>7</sup>

We assessed the forecasting accuracy of several alternative forecasting equations. To do this, we estimated an equation for a shortened version of the average spending series that omitted the 12 months preceding the demonstration. This equation was then used to forecast the spending variable for the omitted months. Finally, the actual spending during those months was compared to the forecast. The equation with the best forecasting accuracy has two independent variables—a time trend and average monthly real Medicare payments for nondual eligibles.

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## Forecasting Accuracy

We used this equation to estimate spending during the predemonstration period for 1999 Senior Prime enrollees and nonenrollees. We tested the forecasting accuracy of the equation using data from the RAND control sites. In this case, the forecast period was the demonstration period itself (September 1998 through December 1999). The resulting forecast error was 1.9 percent, indicating that the equation produces reasonable forecasts for a comparable set of sites.

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## Spending for Former Fee-for-Service Beneficiaries

We used the forecasting equation to project the 1999 monthly average Medicare spending for enrollees who were former fee-for-service beneficiaries. We defined this population as enrollees who were not HMO

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<sup>6</sup>“Real” indicates that payments are deflated by the consumer price index for medical care.

<sup>7</sup>This is known as a first-order autoregression correction.

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enrollees at any time during the 6-month period preceding their enrollment in Senior Prime.

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# Appendix III: The Level of Effort Requirement and Medicare's Final Payment to DOD

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The BBA required DOD to maintain its level of effort (LOE) in providing care to older military retirees. That is, DOD must spend as much on care for older retirees as it did historically before it could receive any payment from Medicare. This provision ensured that the government would not pay for the same care twice—through both the DOD appropriations and Medicare.

In establishing the LOE requirement, DOD and HCFA defined LOE as the amount DOD spent on space-available care for retirees 65 and over in 1996—the most recent year for which complete data were available. To receive Medicare payments, DOD must exceed the 1996 LOE, which was approximately \$172 million for all the demonstration sites combined. The LOE threshold remained constant throughout the demonstration with no adjustment for inflation.

In measuring DOD's spending for the LOE test, care provided to Senior Prime enrollees and to nonenrolled retirees are valued differently. According to rules that DOD and HCFA agreed to, for each month a retiree is enrolled, DOD is credited with the Senior Prime capitation rate regardless of the services the retiree received. In 1999 this rule magnified the effect of the LOE requirement because the Senior Prime rate was much less than what enrollees' care cost DOD. The capitation rates are adjusted if there is "compelling" evidence that enrollees are healthier or sicker than their fee-for-service Medicare counterparts.<sup>1</sup> Nonenrollees' care is credited at DOD's estimated cost of the actual Medicare-covered services they receive. In each year Senior Prime enrollees' care must account for a minimum percentage of LOE—30 percent in 1998, 35 percent in 1999, and 47.5 percent in 2000. In principle, the entire LOE could be met by care provided to enrollees; there is no required minimum amount for space-available care provided to nonenrollees.

If DOD meets its LOE and enrolled care requirements it receives a Medicare payment equal to the difference between the amount credited for care provided to all older retirees and the LOE requirement. If this amount

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<sup>1</sup>The HCC method is used to adjust payments for beneficiaries' care based on their clinical diagnoses and demographic traits, relative to the average Medicare fee-for-service beneficiary. HCFA and DOD agreed that if the difference between the adjusted and unadjusted payments equaled or exceeded 2.5 percent of the unadjusted payments, then there is compelling evidence that enrollees' health status differs from that of their Medicare counterparts.

is less than the spending cap specified in the BBA—\$60 million for 1999—then DOD gets the full amount; otherwise it gets the cap.

The payment rules resulted in Medicare owing DOD nothing for care provided in 1999. Table 4 shows how this amount was calculated. DOD was credited \$98 million for care provided to enrollees. This included an adjustment for the health status of enrollees, who were found to be significantly healthier than Medicare fee-for-service beneficiaries with the same demographic characteristics. DOD was also credited \$72 million for care provided to nonenrollees, so the total credited amount of care provided to older retirees was \$170 million. This amount was then compared to the LOE requirement of \$172 million. Since DOD fell short of this target, the final payment from Medicare was zero.

**Table 4: Calculation of Medicare's Final 1999 Payment to DOD**

<b>Credits for providing care to older retirees in the demonstration areas</b>	\$72 million <sup>a</sup>	Credit for providing care to nonenrollees (credited at DOD's cost)
	\$98 million <sup>a</sup>	Credit for providing care to enrollees: \$320 Senior Prime capitation rate × 305,456 member months
	\$170 million <sup>a</sup>	Total credit for providing care to older retirees in the demonstration areas
<b>Deduction for amount of care provided historically through DOD's appropriations</b>	– \$172 million <sup>a</sup>	LOE requirement
		<b>\$0<sup>b</sup> Medicare payment to DOD</b>

<sup>a</sup>Dollars rounded to the nearest million.

<sup>b</sup>Since DOD fell short of the LOE target by \$2 million, the final payment from Medicare was zero.

# Appendix IV: Comments From the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

OCT 4 2001

Mr. William J. Scanlon  
Director, Health Care Issues  
U.S. General Accounting Office  
Washington, D.C. 20548

Dear Mr. Scanlon:

This is the Department of Defense response to the General Accounting Office (GAO) draft report GAO-01-1105, "MEDICARE SUBVENTION DEMONSTRATION: DoD Costs and Medicare Spending," dated September 4, 2001 (GAO Code 290027). Overall the Department of Defense finds the report to be accurate and thorough. It adequately describes the financial complexities the Department has encountered in implementing, administering, and managing the Medicare Subvention Demonstration.

The draft report does not address the specific intricacies of the "Level of Effort" (LOE) Agreement negotiated with the Centers for Medicare and Medicaid Services (formerly, Health Care Financing Administration) or the annual reconciliation of TRICARE Senior Prime costs and Medicare payments. These two features made for an extremely complicated payment mechanism that was very difficult for managers to comprehend and execute. The enclosed comments provide an explanation regarding LOE and resulting increased costs experienced by the Department of Defense in providing care for the demonstration enrollees.

The Department appreciates the opportunity to comment on the draft report and we have prepared the most thorough and comprehensive response possible given the brief time allotted for review. I trust these comments will strengthen the GAO final report.

Please feel free to address any questions to my project officers on this matter, Dr. Richard Guerin, Director, Health Program Analysis and Evaluation (functional) at (703) 681-3636 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Sincerely,

J. Jarrett Clinton, MD, MPH  
Acting Assistant Secretary

Enclosure:  
As stated

**GAO DRAFT REPORT – DATED SEPTEMBER 4, 2001  
(GAO CODE 290027)**

**“MEDICARE SUBVENTION DEMONSTRATION: DoD Costs and Medicare Spending”**

**DEPARTMENT OF DEFENSE COMMENTS**

The draft report contains no recommendations, however, the Department would like to offer several comments and observations regarding the report and the financial impact experienced by the Department of Defense in supporting the Medicare Subvention Demonstration.

Overall Comments:

- Page 3, “Results in Brief” and Pages 12-13, “DoD’s Cost Per Person Outstripped Medicare’s Capitation Rate for Senior Prime.” The General Accounting Office (GAO) refers, on these pages, to the high cost of care and the beneficiary’s high use of services. A contributing factor to the Department of Defense’s high cost of care is the design of the health care benefit. The actuarial firm of Reden and Anders has estimated the actuarial value of the benefit design, in terms of its copayment structure and additional benefits, at \$105 more per member per month compared to the typical Medicare Plus Choice Health Plan. The Level-of-Effort (LOE) process failed to recognize this burden. In addition, the requirement to maintain FY 1996 Indirect Medical Education (IME) rules was costly. The reduction in bed size at our teaching facilities caused the amount taken out for IME to increase, creating even greater difficulty in attaining the LOE.
- Page 4, Paragraph 1, “Results Brief”; Page 17, “BBA Payment Rules Had a Large Impact on Medicare’s Actual Payments to DoD;” and Page 35, Paragraph 2, “The Level of Effort Requirement and Medicare’s Final Payment to DoD.” In these sections, the GAO addresses risk and payments. The risk adjustment issue remains undetermined. The latest estimate shows that the Department of Defense will receive no payments from the Center for Medicare and Medicaid Services in calendar year 1999. The risk adjustment effort is still unsettled due to discrepancies in working-aged fields in the data files. This risk adjustment calculation indicates, for the demonstration as a whole, that the enrollee population is healthier than the fee-for-service Medicare populations in the counties where the demonstration is occurring. As a result, when corrected for working-aged factors, it is probable that the difference between the adjusted and unadjusted payment will exceed 2.5 percent of unadjusted payments and reduce capitated payments for enrollees by more than 2.5 percent. Subsequently, this would have increased the funding requirement for the Defense Health Program.
- Page 18, Paragraph 3, “Concluding Observations.” While the report indicates that the Department of Defense incurred greater costs to support the program and had to cover these shortfalls, the report does not state whether the government (i.e., Medicare and DoD) spent more or less as a result of the demonstration.

- Page 27, Paragraph 1, “Health Status of Senior Prime Enrollees”. The narrative describes the Hierarchical Coexisting Condition (HCC) method to determine costliness of each beneficiary. The lower the score, generally the healthier the beneficiary. Senior Prime enrollees had a lower score than Medicare fee-for-service beneficiaries in the demonstration area. Data completeness and data coding within the Department, particularly for ambulatory care, may have contributed to inaccurate scoring of the HCC. Since HCC relies, in part, on ambulatory data, it is possible these data issues biased risk scores to be lower than the true health status of the enrolled population.

# Appendix V: Comments From the Centers for Medicare and Medicaid Services



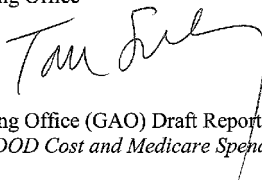
DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

**DATE:** OCT - 2 2001

**TO:** William J. Scanlon  
Director, Health Care Issues  
General Accounting Office

**FROM:** Thomas A. Scully   
Administrator

**SUBJECT:** General Accounting Office (GAO) Draft Report – *Medicare Subvention Demonstration: DOD Cost and Medicare Spending* (GAO-01-1105)

We appreciate the opportunity to review and comment on the above-referenced subject report. The report presents the analysis of cost incurred by the Department of Defense (DOD) and Medicare in a clear and understandable manner. The conclusions reached are appropriate.

Although we have no comments on the report's conclusions, we suggest the report include a section on "limitations of the study." We note there are often start-up conditions in demonstrations that may affect any initial findings. Additionally, there were considerable problems encountered with DOD cost and use data. This section, which could be included in the Appendix, should state that the results are from the initial phase of the demonstration.

We look forward to working with GAO on this and other issues.

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS).  
We are exercising fiscal restraint by exhausting our stock of stationery.

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# Appendix VI: GAO Contacts and Staff Acknowledgments

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## GAO Contacts

Phyllis Thorburn, (202) 512-7012  
Jonathan Ratner, (202) 512-7107

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## Staff Acknowledgments

Contributors to this report were Eric Wedum, Martha Wood, Dae Park, Jessica Farb, Robert DeRoy, Wayne Turowski, and Judy Chesley.

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# Related GAO Products

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*Medicare Subvention Demonstration: Greater Access Improved Enrollee Satisfaction but Raised DOD Costs* ([GAO-02-68](#), October 31, 2001).

*Medicare Subvention Demonstration: DOD's Pilot Appealed to Seniors, Underscored Management Complexities* ([GAO-01-671](#), June 14, 2001).

*Medicare Subvention Demonstration: Enrollment in DOD Pilot Reflects Retiree Experiences and Local Markets* ([GAO/HEHS-00-35](#), Jan. 31, 2000).

*Medicare Subvention Demonstration: DOD Start-up Overcame Obstacles, Yields Lessons, and Raises Issues* ([GAO/GGD/HEHS-99-161](#), Sept. 28, 1999).

*Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns* ([GAO/HEHS-99-39](#), May 28, 1999).

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U.S. General Accounting Office, 441 G. Street NW, Room 7149,  
Washington, D.C. 20548