Army-Baylor Graduate Program in Health Care Administration

Graduate Management Project

Preparing for the Implementation of the TRICARE Senior Demonstration Project at the TRICARE Region 11 Lead Agency and Madigan Army Medical Center: A Case Study

Presented to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree of

Master of Health Administration

By

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Tacoma, Washington

March, 1997

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. AGENCY USE ONLY *(Leave blank)*	2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
	MARCH 1997	FINAL REPORT (08-96 TO 07-97)

4. TITLE AND SUBTITLE
PREPARING FOR THE IMPLEMENTATION OF THE MEDICARE SENIOR SENIOR DEMONSTRATION PROJECT AT THE TRICARE REGION 11 LEAD AGENCY AND MADIGAN ARMY MEDICAL CENTER: A CASE STUDY

5. FUNDING NUMBERS

6. AUTHOR(S)
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TACOMA, WA 98431

8. PERFORMING ORGANIZATION REPORT NUMBER
7B-97

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)
U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
BLDG 2841 MCCS HRA U.S. ARMY BAYLOR PROGRAM IN HCA
3151 SCOTT ROAD
FORT SAM HOUSTON, TX 78234-6135

19. SPONSORING / MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION / AVAILABILITY STATEMENT
APPROVED FOR PUBLIC RELEASE: DISTRIBUTION IS UNLIMITED

12b. DISTRIBUTION CODE

13. ABSTRACT *(Maximum 200 words)*

This study provides an analysis of the activities undertaken by the TRICARE Region 11 Lead Agency and Madigan Army Medical Center (MAMC) staff in planning and preparing for the implementation of a TRICARE Senior Demonstration of Military Managed Care. The study utilizes a survey instrument and identifies management's perceptions about the relative importance of TRICARE Senior Demonstration implementation issues, time and coordination requirements for managing the issues, learning requirements during the implementation process, and management's perception about the potential threats to the ultimate success of the demonstration. Survey results are compared and contrasted among seven different demographic sub-groups. Managements perceptions of the most important issues can provide an invaluable source of information for management staff of other Lead Agencies and Medical Treatment Facilities that will likely implement this program in the future. The discussion of the major issues, the discussion of potential threats, and the comparison of results among demographic sub-groups contained in this study can further help define management priorities when implementing a similar program in the future.

14. SUBJECT TERMS
TRICARE SENIOR DEMONSTRATION, MEDICARE, TRICARE, MEDICARE SUBVENTION,

15. NUMBER OF PAGES
186

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
N/A	N/A	N/A	

ACKNOWLEDGEMENTS

My sincere thanks go out to COL William Cahill, USA, Deputy Commander for Administration/Chief of Staff, Madigan Army Medical Center; and COL Van (Rick) Booth, USA, Deputy Chief of Staff, Northwest Regional Medical Command, both of whom provided input and guidance on all aspects of this project. Thanks also to Mr. Michael Petty from Region 11 Lead Agency, who continuously sent me the latest and most updated information on my topic as it became available, and informed me of the time and place of all upcoming teleconferences on my topic. Additional thanks go to MAJ Mary Whitfield, USAF, from Region 11 Lead Agency, who provided guidance in my survey and project design. Thanks to MAJ Steve Carpenter, my fellow Baylor resident, for his guidance and support throughout the residency year. Finally, I want to thank Celia Boyce, secretary to the Deputy Commander for Administration (DCA) at Madigan, for her assistance in the distribution and collection of the survey instrument used in this project.

12. Please rate the following **potential threats** to the successful implementation of the TRICARE Senior Option Medicare Subvention Simulation Project, with 1 a very low threat and 5 being a very high threat.

ABILITY TO PROVIDE ALL MEDICARE SERVICES - Madigan staff (mean = 4.47, st. dev. = .78) feel that the our ability (or inability) to provide all Medicare services poses a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.73, st. dev. = 1.39)
F(1,59) = 6.658, p<.012

INADEQUATE INFORMATION SYSTEMS CAPABILITIES - People working in administrative positions (mean = 3.96, st. dev. = 1.10) feel that inadequate information systems pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in clinical positions (mean = 2.98, st. dev. = 1.14)
F(1,60) = 6.591, p<.013

INADEQUATE MARKETING CAPABILITIES - Lead Agency staff (mean = 4.27, st. dev. = .80) feel that inadequate marketing capabilities pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.47, st. dev. = 1.07)
F(1,59) = 7.011, p<.010

INADEQUATE STAFFING LEVELS - Madigan staff (mean = 4.13, st. dev. = .93) feel that inadequate staffing levels pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.47, st. dev. = 1.41)
F(1,59) = 16.072, p<.000

INADEQUATE TRAINING - Physicians (mean = 3.25, st. dev. = 1.23) feel that inadequate training poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.98, st. dev. = 1.01)
F(1,60) = 5.936, p<.018

INADEQUATE UTILIZATION MANAGEMENT - Physicians (mean = 2.75, st. dev. = 1.29) feel that inadequate utilization management poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.47, st. dev. = 1.22)
F(1,60) = 4.368, p<.041

ABSTRACT

This study provides an analysis of the activities undertaken by Region 11 Lead Agency and Madigan Army Medical Center (MAMC) staff in planning and preparing for the implementation of a TRICARE Senior Demonstration of Military Managed Care. The study utilizes a survey instrument and identifies management's perceptions about the relative importance of TRICARE Senior Demonstration implementation issues, time and coordination requirements for managing the issues, learning requirements during the process of demonstration implementation, and management's perception about the potential threats to the ultimate success of the TRICARE Senior Demonstration. Survey results of the Region 11 Lead Agency management are compared and contrasted with survey results of MAMC management to identify significant differences in issue perception at a regional level versus an MTF level. Additionally, results are compared and contrasted among the following demographic sub-groups:

1. Healthcare Administrators (HCAs) vs. non-HCAs
2. Healthcare Administrators (HCAs) vs. Physicians
3. Physicians vs. non-Physicians
4. Nurses vs. non-Nurses
5. Clinical positions vs. Administrative positions
6. New employees vs. other employees

The Lead Agency management staff and MAMC management staff have performed extensive work in preparing for the TRICARE Senior demonstration. Their perceptions of the most important issues can provide a source of invaluable information for management staff of other Lead Agencies and MTFs that will likely implement some form of Medicare subvention in the future. The discussion of the major issues, the

discussion of the potential threats, and the comparison of results among demographic sub-groups contained in this study can further help define management priorities when implementing a similar program in the future.

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CHAPTER I

INTRODUCTION

The Department of Defense (DoD) will conduct a demonstration in which selected Military Treatment Facilities (MTFs) will operate similarly to Medicare at-risk Health Maintenance Organizations (HMOs). While this effort will not include actual Medicare reimbursement, it will attempt to simulate what would happen if DoD maintained its current level of effort and there were actual Medicare reimbursement. The goal of this demonstration is to test a cost-alternative for delivering accessible and quality care to dual-eligible beneficiaries that would not increase the total federal cost for either agency (OCHAMPUS 1997). Before revealing specifics of this demonstration, it is important to first understand the history of both the Medicare program, the Military Health Services System (MHSS), and the events that culminated in this simulation demonstration.

a. Conditions which Prompted the Study.

Medicare. Beginning in 1915, various efforts to establish government health insurance programs have been initiated every few years. From the 1930's on, there was broad agreement on the real need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. Efforts to include a health insurance program in the original 1935 Social Security Act were dropped by President Roosevelt because he feared strong physician opposition would jeopardize the entire program (Brecher 1995). Various national health insurance plans, financed by payroll taxes, were proposed in Congress starting in the 1940's; however, none was ever brought

to a vote (Social Security Bulletin 1993). Post World War II efforts to add national health insurance to the nation's social security system by President Truman led to a large-scale, well-funded campaign against it by the American Medical Association and various business organizations. The victory of a Republican in the 1952 presidential election led to an 8-year period of little action or prospect for change in federal health care policy. (Brecher 1995).

The presidential election of 1960 saw a revival of interest in federal efforts. This time the Democrats, supported by labor organizations, advocated hospital insurance for the elderly only, rather than immediate enactment of a universal system. The Democratic presidential candidate won, but the legislation that emerged from Congress reflected major compromises with more conservative legislative leaders. The Kerr-Mills act of 1961 established a program to pay for the medical expenses of the poor elderly that was closely linked to joint state-federal welfare programs rather than a broader program linked to federal Social Security (Brecher 1995).

The landslide victory of the Democrats in the 1964 national elections made possible the passage of broader legislation (Brecher 1995). A more comprehensive improvement in the provision of medical care, especially for the elderly, became a major congressional priority (Social Security Bulletin 1993). After various considerations and approaches, and after lengthy national debate, Congress passed legislation in 1965, which established the Medicare and Medicaid programs as Title XVIII and Title XIX of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly, while Medicaid was established in response to the widely perceived

inadequacy of the "welfare medical care" under public assistance (Social Security Bulletin 1993).

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as Medicare. When first established in 1966, Medicare covered most persons age 65 and over. Since then, legislation has added other groups: (1) persons who are entitled to disability benefits for 24 months or more (1972); (2) persons with end-stage renal disease (ESRD) requiring dialysis or kidney transplant (1972); and (3) certain otherwise non-covered persons who elect to "buy into" Medicare (1973) (Waid 1996).

Medicare consists of two parts: hospital insurance (HI), also known as Part A; and supplementary medical insurance (SMI), also known as Part B. Part A covers inpatient hospital care, skilled nursing facility (SNF) care, home health agency (HHA) care, and hospice care. Part B covers primarily physician services (in both hospital and non-hospital settings). It also covers certain other non-physician services including clinical laboratory tests, durable medical equipment, flu vaccinations, drugs which cannot be self-administered, most supplies, diagnostic tests, ambulance services, some therapy services, certain other health care services, and blood which is not supplied by Part A (Waid 1996).

When Medicare began on July 1, 1966, there were 19.1 million persons enrolled in the program. By the end of 1966, 3.7 million persons had received as least some health care services covered by Medicare. In 1995, more than 37 million persons were enrolled in one or both parts of the Medicare program. About 83 percent of (84 percent

of the aged) of all Medicare "enrollees" used some HI and/or SMI service in fiscal year (FY) 1995 (Waid 1996).

From the mid-1970's to 1992, federal efforts focused on controlling the rising cost of Medicare and Medicaid rather than expanding their scope. This shift was first evident in 1972 with the creation of utilization review organizations. The federal Health Maintenance Organization Act of 1973 sought to promote these organizations because they also were viewed as cost-saving delivery mechanisms (Brecher 1995).

Medicare Managed Care. The triumph of conservative Republicans in the 1980 national elections and the reelection of President Reagan in 1984, gave greater energy to efforts to curb spending under Medicare and Medicaid as well as virtually all other forms of domestic federal policy (Brecher 1995).

In 1982, with the passage of the Tax Equity and Fiscal Responsibility Act (TEFRA), Congress mandated the provision of managed care plan options to Medicare beneficiaries. The statute allows Medicare beneficiaries to enroll in risk or cost contract Health Maintenance Organizations (HMOs), or Competitive Medical Plans (CMPs) which offer a limited benefit plan. Risk plans contract with Medicare's administrative agency, the Health Care Financing Administration (HCFA) to provide Medicare benefits. In exchange for their participation, the plans receive a capitated payment to cover the cost of care to beneficiaries. The structure provides incentives for plans to keep utilization of services to a minimum (Edson 1996).

The Adjusted Average Per Capita Costs (AAPCC) is calculated as the basis for the capitation of an enrolled beneficiary. It is calculated by HCFA by: (1) projecting the

United States per capita costs (USPCC) for services rendered to Medicare beneficiaries; (2) adjusting the USPCC to county level historical cost data (with the exception of end-stage renal disease whose costs are calculated on a state level); (3) converting costs to a fee-for-service basis by removing Medicare HMO beneficiaries; and (4) recalculating the county per capita cost adjusting for demographic variables (age, gender, institutional status, and Medicaid status). Medicare then pays 95 percent of the AAPCC rate to the Medicare HMO for each beneficiary enrolled by county of residence (HCFA 1995).

To obtain a TEFRA Medicare contract, a plan must be either a federally qualified HMO or designated by the HCFA as a CMP. The HMO or CMP must meet TEFRA requirements in a range of issues including membership, medical services, enrollment, marketing, administrative ability and quality assurance. The Omnibus Budget Reconciliation Acts (OBRA) of 1985, 1987 and 1990 further defined the rules and regulations governing Medicare HMO's (Zarabozo and LeMasurier 1995).

Since 1993, the number of Medicare and Medicaid beneficiaries enrolled in managed care plans has experienced unprecedented growth. As a result, HCFA is currently the largest purchaser of managed care in the country, accounting for 15.5 million Americans. The Clinton Administration has worked to expand choices for Medicare beneficiaries and ensure that all beneficiaries enrolled in managed care receive quality care. As part of his seven-year balanced budget proposal, President Clinton would further expand the availability of managed care to Medicare beneficiaries by increasing the number of Medicare options available (HCFA 1996).

As of February 1, 1996, almost 4 million Medicare beneficiaries were enrolled in managed care plans, accounting for more than 10 percent of the total Medicare population. That represents a 67 percent increase in managed care enrollment since 1993. Currently 81.6 percent of Medicare beneficiaries in managed care plans are in risk plans. Since January 1, 1993, enrollment in risk plans has grown 105 percent. As of February 1, 1996, risk plans made up 194 of the 278 managed care plans participating in Medicare (HCFA 1996).

Military Health Services System (MHSS) Managed Health Care. 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 services and support to members of the armed forces, their family members and others entitled to DoD medical care (TRICARE Final Rule 1995). The idea of military medical care for the families of active duty members of the uniform services dates back to the late 1700s. In 1884, Congress directed that "medical officers of the Army and contract surgeons shall whenever possible attend the families of the officers and soldiers free of charge" (OCHAMPUS Fact Sheet 1, 1995).

There was very little change until World War II. Most draftees in that war were young men who had wives of child-bearing age. The military medical care system, which was on a wartime footing, could not handle the large number of births, nor care for the very young children. In 1943, Congress authorized the Emergency Maternal and Infant Care Program (EMIC). EMIC provided for maternity care and the care of infants up to one year of age for wives and children of service members in the lower four pay grades.

It was administered by the "Children's Bureau" through state health departments (OCHAMPUS Fact Sheet 1, 1995).

The Korean conflict again strained the capabilities of the military health system. In 1956, the Dependents Medical Care Act was signed into law, effective December 7, 1956. The 1966 amendments to this act created the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The CHAMPUS program was effective October 1, 1966. Retirees, their family members, and certain surviving family members were brought into the program on January 1, 1967 (OCHAMPUS Fact Sheet 1, 1995).

The CHAMPUS program is a federal medical benefit program that cost shares charges for medically necessary services and supplies required in the diagnosis or treatment of and illness or injury. Funding and benefits for this program are provided by Congress. Medicare eligible military beneficiaries, who lose CHAMPUS eligibility when they attain Medicare eligibility, are also eligible for care in the direct system on a space-available basis, and can be reimbursed for civilian care under the Medicare program. The majority of care for military beneficiaries is provided within catchment areas of MTFs, a catchment area being roughly defined as the area within a 40-mile radius around an MTF (TRICARE Final Rule 1995).

Recently DoD has embarked on a new program, called TRICARE, which will improve the quality, cost and accessibility of services for its beneficiaries. Because of the size and complexity of the MHSS, TRICARE implementation is being phased in over a period of several years. The principal mechanisms for the implementation of TRICARE

are the designation of the commanders of selected MTFs as Lead Agents for 12 TRICARE regions across the country, operational enhancements to the MHSS, and the procurement of managed care contracts for the provision of civilian health care services within those regions. Under the TRICARE health care enrollment structure, all health beneficiaries become participants in TRICARE and are classified into one of four categories:

1. Active duty members, all of whom are automatically enrolled in TRICARE Prime, an HMO-type option;
2. TRICARE Prime enrollees, who (except for active duty members) must be CHAMPUS eligible;
3. TRICARE Standard and TRICARE Extra participants, which includes all CHAMPUS-eligible DoD beneficiaries who do not enroll in TRICARE Prime; or
4. Medicare-eligible beneficiaries and other non-CHAMPUS-eligible DoD beneficiaries, who, although not eligible for TRICARE Prime, may participate in many features of TRICARE. These other features are outlined in the TRICARE Final Rule and Section 32, part 199 of the Code of Federal Regulations (32 CFR Part 199) (TRICARE Final Rule 1995).

Medicare Subvention. Medicare-eligible beneficiaries lose their CHAMPUS eligibility when they attain Medicare eligibility, and only CHAMPUS eligible individuals are eligible for the TRICARE Prime program. Medicare-eligible beneficiaries are still eligible for space-available care at MTFs, but as more beneficiaries enroll in TRICARE

Prime, there is less space-available within MTFs. Military retirees feel they are effectively being "locked out" of the MHSS (TROA 1996).

Effective lobbying efforts of the Military Coalition, a collection of 23 military organizations, resulted in various legislative initiatives in 1995 and 1996 to provide a solution to this problem. Senator Phil Gramm (R-TX) introduced Senate Bill 1487 on December 20, 1995. This bill proposed establishment of a demonstration project to provide that the Department of Defense receive Medicare reimbursement for health care provided to certain Medicare-eligible military beneficiaries. This bill was cited as the 'Uniformed Services Medicare Subvention Demonstration Project Act' (S. 1487 1995).

Representative Joel Hefley (R-CO) introduced House Resolution (H.R.) 580 on January 19, 1996. This bill proposed amending title XVIII of the Social Security Act and title 10, United States Code, to allow the Secretary of Health and Human Services to reimburse the Military Health Services System for care provided to Medicare-eligible military retirees and their spouses in the MHSS (H.R. 580 1996).

These initial legislative proposals were reworked by various legislative committees. New, more specifically defined legislation was reintroduced on March 21, 1996. Senator Robert Dole introduced Senate Bill 1639, Representative Hefley introduced H.R. 3142, and Representative J.C. Watts (R-OK) introduced H.R. 3151. There were now two legislative forms of a Medicare Subvention demonstration project proposed by congress. The Gramm (S.1487 1995)/Hefley (H.R.3142 1996) and the Dole (S.1639 1996) /Watts(H.R.3151 1996) bills were very similar pieces of legislation. However, it was now up to the Department of Defense and the Department of Health and

Human Services to prepare a Memorandum of Agreement in a timely manner so final legislation could be prepared and enacted as part of the Fiscal Year 1997 Defense Authorization Act.

Both versions of proposed legislation required that a Medicare Subvention Demonstration Project be enacted in two of DoD's 12 regions and evaluated by an independent evaluator. The regions chosen by DoD were regions 6 and 11. Region 6 includes Arkansas, Oklahoma, parts of Louisiana, and most of Texas, and is home to approximately 11.5% of the nation's 1996 Medicare-eligible military retirees and their spouses. Thirteen medical centers and hospitals are located within Region 6. The Lead Agency in Region 6 is located at Wilford Hall Air Force Medical Center, located at Lackland Air Force Base (AFB) in San Antonio, TX. Region 11 includes Washington, Oregon and a small portion of Idaho near Spokane, Washington, and is home to approximately 4.2% of the nation's Medicare-eligible military retirees and their spouses. Four medical centers and hospitals are located within Region 11. The Lead Agency in Region 11 is located at Madigan Army Medical Center, which is located near Tacoma, Washington (733 Update Report 1996). These regions were chosen because they were the first regions where the TRICARE program was implemented. The TRICARE program is a requirement for the demonstration, since it limits its coverage to TRICARE Prime (U.S. Medicine 1996).

The Department of Defense contracted with United HealthCare to evaluate the feasibility of the Medicare Subvention Demonstration Project and prepare a modeling and impact study. This study documented the advantages DoD possesses as it prepares to

emulate civilian Medicare-risk HMOs, and scrutinized an array of potential obstacles to program success. This study, prepared on July 26, 1996, called the "DoD Medicare Modeling and Impact Study," highlighted numerous weaknesses DoD would have to overcome to successfully implement Medicare Subvention. Their final conclusion indicated "that the demonstration is probably not financially feasible in Seattle and only marginally feasible in San Antonio (United Health Care 1996).

A Memorandum of Agreement titled "Medicare Demonstration of Military Managed Care" was signed on September 6, 1996 by William Perry, Secretary of Defense; Donna Shalala, Secretary of Health and Human Services; Steven Joseph, Assistant Secretary of Defense (Health Affairs); and Bruce Vladeck, Administrator, Health Care Financing Administration (Joseph, Perry, Shalala and Vladeck 1996). On September 10, 1996, President Clinton announced the "Medicare Demonstration of Military Managed Care." Pending final legislation from Congress, the demonstration was scheduled for implementation on January 1, 1997, or shortly thereafter (News Release 1996).

Republican congressional leaders met September 27 with chairmen of every committee having jurisdiction over the military or Medicare and agreed to support a subvention test. Three days later, however, when proponents tried to insert the plan into the omnibus appropriations bill, Representative William Thomas (R-CA) blocked the move. Thomas chairs the House Ways and Means subcommittee on health, which has oversight responsibility for Medicare (Philpott 1996). Thomas was likely influenced by a Congressional Budget Office memorandum dated September 19,1996, which stated the

demonstration project would increase Medicare costs by $80 million over four years (F-D-C Reports 1996).

The Memorandum of Agreement was to be conducted under the authority of new legislation reflecting the terms of the agreement (Joseph, Perry, Shalala and Vladeck 1996). Dr. Joseph, however, was emphatic that the MHSS would not suspend efforts, but push as far as possible without the legislative support for the demonstration. According to Mr. John Casciotti, the DoD Health Affairs legal advisor, Health Affairs and the MHSS could perform the demonstration without legislation. Dual eligible beneficiaries can be enrolled in TRICARE as part of the Medicare Demonstration of Military Managed Care. Dr. Martin, the Principal Deputy Assistant Secretary of Defense (Health Affairs) pointed out that the signed agreement between HCFA and DoD already shows that the MHSS can operate as a Medicare Health Maintenance Organization (Broyles 1996). Additionally, Representative Hefley stated that he will reintroduce Medicare subvention in Congress again in 1997 (Philpott 1996).

The MHSS redirected their Medicare Subvention plan, and developed a "Medicare Simulation" demonstration. Under this program, the DoD will conduct a demonstration in which selected MTFs will operate similarly to Medicare at-risk Health Maintenance Organizations. While this effort will not include actual Medicare reimbursement, it will attempt to simulate what would happen if DoD maintained its current level of effort and there were actual Medicare reimbursement. The goal of this demonstration is to test a cost-alternative for delivering accessible and quality care to

dual-eligible beneficiaries that would not increase the total federal cost for either agency (OCHAMPUS 6010.49-M 1997).

This program will be titled the TRICARE Senior Program, and will be expanded to include six different geographic areas in Regions 3, 4, 6, 9, and 11. The TRICARE program is operational in all of these geographic areas. The areas include:

1) San Antonio Area
    a) Wilford Hall Medical Center, Lackland Air Force Base, TX
    b) Brooke Army Medical Center, Fort Sam Houston, TX
2) Madigan Army Medical Center, Tacoma, WA
3) Reynolds Army Community Hospital, Fort Sill, Lawton, OK
4) Keesler Air Force Base, Biloxi, MS
5) Eisenhower Army Medical Center, Fort Gordon, GA
6) San Diego Naval Medical Center, San Diego, CA

The Army Medical Department Plan for the Medicare Simulation further details the reasoning for proceeding with this simulation. This document states that the purpose for the simulation project is to implement an internal test of a managed care program to include DoD Medicare eligible beneficiaries. The project will not involve an exchange of funds between DoD and HCFA for health care services provided to these beneficiaries, but the project will enable DoD to validate the feasibility of proceeding with current efforts to obtain approval for a Medicare Subvention program. The simulation will also serve to strengthen and expand current Executive Branch, Congressional and beneficiary

advocacy group support for Medicare Subvention (Army Medical Department Plan 1996).

This Army Medical Department Plan has identified 11 objectives of this program as follows:

1) To provide enhanced priority access to quality health care for involved beneficiaries.
2) To ensure direct care system staff, including primary care managers (PCMs) and others who will be involved in the simulation, understand managed care conceptually and specific TRICARE and Medicare requirements.
3) To create and ensure a seamless interface between direct care staff and associated contractors to promote program success.
4) To ensure the simulation marketing (enrollment/information/education) program supports beneficiary and provider satisfaction.
5) To coordinate simulation program activities with Air Force and Navy counterparts, to ensure program success.
6) To provide all primary care, preventive services and most specialty care/ services to dual-eligibles enrolled in the TRICARE Senior Program.
7) To establish and implement a utilization management program capable of supporting a capitated Medicare reimbursement system.
8) To provide accurate and timely tracking of all health care costs for Medical eligible space-available users and costs both within and outside of the direct care system for TRICARE Senior Program enrollees.

9) To work with other DoD entities to support timely fielding of information systems equipment, timely and adequate staff training and the integrity and quality of data and reports.

10) To support development of an information management system designed to address the implicit infrastructure requirements for an integrated health care delivery system.

11) To ensure program integrity to accommodate DoD demonstration evaluation efforts and programs.

The simulation conducted in Army MTFs will be evaluated by US Army Medical Command, Army , the Office of The Surgeon General and the Office of the Assistant Secretary of Defense for Health Affairs. DoD will solicit the participation of HCFA in the evaluation process to ensure the fundamental provisions contained in the DoD/DHHS MOA are maintained. The evaluation will focus on determining if subvention is a cost effective alternative for delivering accessible and quality health care to dual-eligible beneficiaries and their families. The evaluation will also examine the impact of the simulation on medical services for active duty, active duty family members, TRICARE eligible retirees and their family members (Army Medical Department Plan 1996).

b. Problem Statement

A TRICARE Senior Demonstration will begin in 1997 at Madigan Army Medical Center. Experience and historical data to aid in implementing this complex process are not available at either the regional or the facility level, nor have the impact of

implementation on employees, beneficiaries, and the community at both the regional level and medical treatment facility level been measured and evaluated.

c. Literature Review

DoD's Reasons for Wanting Medicare Subvention

Increased Access for Retirees. As discussed earlier, space-available care for retirees at military MTFs is disappearing as enrollment of other beneficiaries in TRICARE Prime increases. Retirees feel they have been promised healthcare for life by the military, and demand access to military MTFs. Prior to 1956, the statutory authority to provide health care to retirees and dependents was not clear. The Dependents' Medical Care Act of 1956 described and defined retiree/dependent eligibility for health care at military facilities as being on a space available basis. Authority was also provided to care for retirees and their dependents at these facilities (without entitlement) on a space available basis. The legislation also authorized the imposition of charges for outpatient care for such dependents as determined by the Secretary of Defense (Burelli 1991).

Although no authority for entitlements was extended to retirees and their dependents, the availability was almost assured given the small number of such beneficiaries. Therefore, while not legally authorized, for many people the "promise" of "free" health care "for life" was functionally true. This "promise" was and continues to be a useful tool for recruiting and retention purposes (Burelli 1991).

Retiree groups, such as The Retired Officers Association, feel that "the government has an obligation to fulfill the long-standing health care commitments that

have been made to service members to help persuade them to accept the demands and sacrifices inherent in arduous careers in uniformed service"(TROA 1996). Dr. Stephen Joseph, Assistant Secretary of Defense (Health Affairs), testified before Congress in 1995 that DoD has an "implied moral commitment" to provide health care to all eligible beneficiaries (TROA 1996). Dr. Joseph called the demonstration project "a giant step in the right direction for us (DoD) to be able to care for our older beneficiaries (News Release 1996).

Cost Savings. Proponents believe Medicare subvention can save HCFA money. Some of the earliest data on HMOs come from the massive RAND Health Insurance Experiment, launched in 1971. Although HMOs represented only a tiny segment of the health care market at the time, they were beginning to attract notice, and so one large, well-established HMO was included in the study. The major finding – that large, staff-model HMOs are able to control costs and still provide care as good at those in the fee-for-service system – still stands (RAND 1995).

For example, health expenditures in California, the state with the largest enrolled managed care population (85 percent of the state's insured population), have grown at a dramatically slower rate than those in the country at large. This is not only true with overall costs, but with every major category of health care spending. For example, spending on hospital services has grown by 27 percent in the last decade, exactly half of the national average of 54 percent. Money paid to physicians increased by 58 percent in California, while national spending on doctors went up 82 percent. Spending on

pharmaceuticals went up 41 percent in California compared to 65 percent across the country (RAND 1995).

Finally, DoD's "Section 733 Study of the Military Medical Care System," released in May, 1994, found that military care is actually up to 24 percent less expensive than civilian care. Proponents of Medicare subvention argue that if the military managed care environment can provide care at a better cost than a civilian care and increase access for retirees, then why would HCFA not fully embrace Medicare Subvention?

Quality and Satisfaction. Medicare Subvention proponents point to additional indicators of quality and satisfaction in managed care plans to support the demonstration project. A Health Insurance Reform Project at George Washington University found that although growth in Medicare managed care plans has not kept pace with the private sector, seniors who are already enrolled in managed care plans are happy with them. A recent American Viewpoint survey shows only 2 percent of Blue Cross and Blue Shield Medicare HMO members switch back to fee-for-service, even though they have the option of switching every month. Moreover, the survey demonstrates that even Medicare beneficiaries with chronic and serious medical conditions, such as cancer, kidney disease and pulmonary disease, prefer HMOs over traditional Medicare. The poll found, by a three-to-one margin, seniors cite 1) HMOs reduced paperwork, 2) lower out-of-pocket costs and 3) expanded benefits, as tremendous advantages over the traditional Medicare program (Etheredge 1996).

A survey conducted in February, 1996, for the Physician Payment Review Commission, which advises Congress on Medicare payment issues, found that Medicare

managed care enrollees find healthcare accessible and are relatively satisfied with their plans. The survey also found that only 8 percent of Medicare managed care enrollees reported trouble seeing physicians, 96 percent of enrollees were able to see the same physician for most scheduled visits and 43 percent rated their plans' overall healthcare coverage as "excellent," while only 4 percent said it was either "fair" or "poor" (Gardner 1996).

While satisfaction issues are important, they are simply a perception of quality. HCFA contracted with the RAND corporation to evaluate Medicare HMO's effect on quality of care for the elderly. The RAND research team found that "although some patients were being discharged before they were stable, the majority received good care and came to no harm as a consequence of shorter hospitalizations." RAND concluded that "cost-cutting is not necessarily the enemy of quality. It is possible to have both, provided that the adverse effects of the cost-savings are identified early and ways are found to ameliorate them" (RAND 1995).

David Chellappa, MD, corporate medical director at Anthem Blue Cross and Blue Shield of Indiana, Kentucky, and Cincinnati, clearly illustrated the belief that coordination improves the quality of care when he stated that "the major focus of managed care is on addressing the patient's total health care needs, which is especially challenging in the senior population. Old-fashioned, fee-for-service Medicare concentrated on episodic illness—treating each illness or injury as a separate, unrelated event. But managed care has changed that. Physicians are now rewarded for anticipating

and preventing future problems, and making sure that all prescriptions and other services are coordinated in a sensible way" (Etheredge 1996).

Health services research supports these doctor's observations. A recent article in the American Journal of Public Health, for example, found that seniors enrolled in Medicare HMOs had cancer diagnosed at an earlier stage than seniors in the traditional program. The authors wrote, "The earlier detection of certain cancers among HMO enrollees may result from coverage of screening services and, perhaps, promotion by HMOs of such services" (Etheredge 1996).

Equity for Military Retirees. Retiree groups are outraged at their treatment by the government. The Retired Officer's Association (TROA) claims that "DoD is almost the only very large employer that does not provide heavily subsidized supplemental health care benefits to its retired Medicare-eligible employees. As the largest single employer in America, DoD can't be compared to the small and medium-sized firms that often scrimp on health care costs. Compared to the top five corporations in America – General Motors, Ford, Exxon, IBM and General Electric – DoD gives its retirees short medical shrift, indeed. All of these firms pay nearly all of their retirees' Medicare supplemental premiums, cap retirees' out-of-pocket medical expenses at modest levels, or both. All of them provide highly subsidized prescription drug coverage, four provide dental coverage, and three provide vision coverage" (TROA 1996).

TROA also asks "how can the government possibly claim that it cannot afford to provide these subsidized benefits to retired uniformed service members when it provides the identical coverage without a complaint to other retired government employees?"

(through the Federal Employees Health Benefits Plan (FEHBP))." Finally, TROA asks "if these same benefits are funded for every retired Federal civilian, every retired congressional staffer, and every retired Member of Congress, how can anyone convincingly assert that there is no room left at the health care table for the retired service member who contributed decades of service and sacrifice to preserve the collective national well-being?" (TROA 1996).

Other Demonstration Projects. Proponents of Medicare Subvention emphasize that a demonstration project with an independent evaluation will help both HCFA and DoD realize potential benefits and drawbacks of subvention. HCFA has admittedly experienced problems with the current Medicare HMO payment methodologies. Last year, HCFA announced "Medicare Choices," a demonstration project designed to expand the types of managed care plans available to Medicare beneficiaries and to test different payment methodologies. HCFA invited a wide variety of managed care organizations to participate in this demonstration, including Preferred Provider Organizations (PPOs), HMOs and integrated delivery systems. HCFA targeted eight geographic areas for the demonstration (Vladeck 1995).

Of particular interest in these demonstration projects will be the outcome of innovative payment arrangements between Medicare and the networks. If these projects prove successful, it may create unprecedented opportunities for provider networks other than HMOs to serve the growing Medicare population (Hash 1996). Proponents of Medicare Subvention point out that since Medicare is experimenting with various Managed Care Programs and payment methodologies, then why not provide a Medicare

Subvention demonstration? Only a demonstration project, evaluated by an independent source, can help both HCFA and DoD realize the potential benefits and drawbacks of implementing subvention across the entire MHSS. Evaluation by HCFA or DoD would be inherently biased, with a HCFA evaluation attempting to protect the Medicare trust fund, and a DoD evaluation attempting to protect its current size, end-strength and very survival.

Strengths and Opportunities of Medicare Subvention. Medicare Subvention proponents point to the "Department of Defense Medicare Modeling and Impact Study," prepared by United HealthCare, for additional reasons to support Medicare Subvention. United HealthCare prepared a Strengths, Weaknesses, Opportunities and Threats (S.W.O.T.) analysis of the Demonstration Project. This analysis provided a synopsis of the issues facing the DoD as it prepared to implement the program. The analysis identified **strengths** in the following areas:

1. Market Clout: DoD has substantial leverage (money, large potential markets, etc.) with health care service providers in the Demonstration areas.
2. Each health services region has a highly developed infrastructure for delivering health care.
3. Experience: DoD health care system has extensive experience with serving the military retiree population.
4. Potential Turn Keys (referring to the ability to make use of the existing resources to come up with a new product):

i. There have been effective managed care initiatives with the DoD health care system reform process. The Demonstration Project will be able to benefit from lessons of past initiatives;

ii. DoD has a nation-wide health care delivery network. There is a huge potential for DoD to enjoy economies of scale once the Demonstration Project is successfully experimented;

iii. Functional administrative units are already in place. The existing staff will be able to bring their experiences from managing other types of managed care initiatives into the Demonstration Project; and

iv. There is strong support from DoD's administration for Management Information System development initiatives. MIS support for routine operations and strategic management is essential to the success of the Demonstration project.

5. The Demonstration Project involves three phases. The scope and complexity of the Project grow gradually. This will help bring about a smooth transition at each phase of the project.

6. DoD's health care system has and will continue to have a loyal and well-entrenched customer base. This gives the Demonstration Project competitive advantages in almost every aspect of management of the future military HMO.

7. DoD's health care system has a reputation for good customer service. This image will benefit the marketing of the new product. The experience in

customer service can be incorporated into the operation of such services for the Demonstration Project.

Additionally, United HealthCare identified the following **opportunities** for DoD in Medicare Subvention:

1. To meet the actual and perceived commitment of access to high quality Health care for the Medicare-eligibles who have served our country, while saving tax-payers money.
2. To use proven experience from managed care to contain overall costs.
3. The mechanisms identified in the Demonstration Project could potentially be used to improve TRICARE
4. To gain additional funding and savings:
    i. Well-defined policies and procedures, if globally used, could generate savings in administration costs; and
    ii. There is additional funding available from HCFA
5. The Demonstration Project will offer DoD opportunities to streamline operations to provide health care services and reduce the amount of contracted services.
6. The flexibility of HCFA approval process and privileges to waive some regulation items, as compared to a commercial risk contract provider, can result in competitive advantages and decrease administrative burdens to meet HCFA regulations.

7. Positive feedback could enhance readiness:

   i. There is a positive feedback loop as follows:

      - savings bring about better outcomes
      - better outcomes ensure the maintenance of clinical skills which are essential for positioning DoD health care system for readiness;

   ii. A fully integrated and continuum-based approach to health care management will undoubtedly increase readiness;

   iii. The positive feedback will encourage the administration to acquire skills to reallocate the provision of services away from the traditional acute and tertiary setting (United HealthCare 1996).

Weakness and threats of the S.W.O.T. analysis are addressed in Appendix A.

HCFAs Concern with Medicare Subvention.

Problems with Financing Medicare. Medicare's hospital insurance (Part A) is financed through a payroll tax of 2.9 percent, divided equally between employers and workers. In recent years, payroll tax revenues exceeded insurance payments, and the surplus was accumulated in a trust fund to help pay for future costs. In 1995, the trust fund amounted to about $134 billion, which is invested in interest-bearing U.S. Treasury securities (Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund 1995). The problem is that the program's outlays are expected to rise more

rapidly than future payroll tax revenues. As a result, the trust fund will be drawn down until it runs out, which is projected to occur in 2002. Unless Congress curtails benefits, raises revenues, or cuts its payments to hospitals, the hospital insurance plan will become insolvent.

In 1994, the average Medicare cost per enrollee of the hospital trust fund was about $2900, while the average payroll tax revenue per beneficiary was about $2,600. That $300 shortfall is projected to grow wider mainly because health care costs are expected to continue climbing more rapidly than the wages subject to the payroll tax. As the gap grows, the trust fund will be depleted (Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund 1995).

Medicare's hospital insurance payments will increase not only because health care costs in general are rising faster than inflation, but because greater numbers of Americans will become eligible for coverage. The number of Medicare beneficiaries is expected to increase about 2 percent per year for the next fifteen years, with the number of elderly growing from 33 million in 1995 to 35 million in 2000, and eventually to 40 million in 2010. Further, Americans over eighty-five are the fastest-growing population group and also consume the most medical care per capita, exacerbating the pressure on the hospital insurance trust fund (Senate Special Committee on Aging, et al. 1991).

The increase in the elderly population will rapidly accelerate when the baby boomers begin to turn sixty-five in 2010. By 2030, Medicare will become responsible for covering nearly 20 percent of the population, compared to today's 12.8 percent. Demographers project that in just thirty-five years, the population of Americans aged

sixty-five and older will be roughly double today's 33 million (U.S. Department of Commerce 1994). By the middle of next century, the ratio of workers contributing payroll taxes to Medicare beneficiaries will have declined from today's four-to-one to two-to-one (Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund 1995).

Bringing Managed Care to Medicare. Both Democrats and Republicans have advocated encouraging more beneficiaries to join HMOs and Preferred Provider Organizations (PPOs). The idea is to discourage visits to high-cost doctors and to shift from fee-for-service payments to a capitated system that rewards physicians for keeping beneficiaries from becoming sick. HCFA officials remain uncertain, however, that managed care, in any of its forms, will contain health care cost increases. HCFA is concerned that improvements in cost and quality are not fully realized in Medicare Managed Care.

Cost Issues. The elderly who have joined HMOs are healthier than the average Medicare beneficiary and are less likely to use covered health services. Medicare pays HMOs based on the average cost of beneficiaries according to their age, sex, and place of residency, but those factors alone have overstated the cost of HMO enrollees to Medicare. Medicare, therefore, has ended up paying nearly 6 percent more for beneficiaries who enrolled in HMOs than it would have spent if the participants had remained with the standard benefit package (Brown et. al. 1993). HMOs have learned how to make money in the Medicare market, at the expense of the American taxpayer. In counties where HCFA has set its monthly capitation rates high, competition among

HMOs for Medicare enrollees is stiff. They have learned how to take care of this population for significantly less than that payment, and they need not share that savings with the federal government. HCFA's capitation formula is viewed by nearly everyone as seriously flawed (Gesensway 1995).

The Government Accounting Office (GAO), in a report titled "Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem," pointed out that Medicare has not yet harnessed the cost-saving potential of its managed care option. According to the report, Medicare has paid HMOs more for serving Medicare beneficiaries than it would have spent, on average, had those same beneficiaries received care in the fee-for-service sector. Specifically, because HMO payment rates are fixed, Medicare cannot lower rates through competition among HMOs or negotiate a share in any savings that HMOs achieve through greater efficiency. Also, HMO payment rates are not adequately "risk adjusted" to reflect cost differences deriving from the healthier enrolled HMO population. Finally, HMO payment rates are based on county fee-for-service rates, which can vary considerably because of utilization differences. As a result, Medicare's low rates deter HMO participation in some areas, while its high rates cause overpayments in other areas (GAO 1995).

Certain groups warn that managed care will only be selected by the healthy. The young and elderly will enjoy the expanded benefits of managed care, while older and sicker beneficiaries will remain in fee-for-service medicine. In reviewing Medicare Risk Programs, Mathematica Policy Research concluded that "...beneficiaries with chronic health problems are less likely than those in good health to change doctors or give up

their freedom to use the primary care physicians, specialists, and hospitals of their choice" (Mathematica Policy Research 1993).

Some efforts to engage in favorable selection run counter to law. In March of 1995, the Inspector General of the Department of Health and Human Services reported that more than 40% of Medicare HMO enrollees were asked about their health prior to joining the HMO. This practice is not permitted under current law. The report also indicated that a small, but significant percentage of those seeking to join HMOs were given a pre-enrollment physical. This is also a clear violation of current law (Department of Health and Human Services 1995).

The problem of favorable selection will spiral and further drive up the AAPCC, thus increasing capitated payments and Medicare's losses. As a 1994 General Accounting Office (GAO) Report explained, "... as more healthy beneficiaries join HMOs, the Medicare fee-for-service population on average becomes sicker, driving up Medicare's average cost of treating fee-for-service payments. When this average cost rises, so does the capitation rate HCFA pays to risk contract HMOs" (GAO 1994). Favorable selection in the Medicare HMO program enriches the managed care plans and frustrates Medicare's efforts to use managed care to save money.

Selection problems will continue unless Medicare devises a payment formula which properly factors in the health status of enrollees. In fact, HCFA Administrator Bruce Vladeck has indicated that, "no operational risk adjuster will contain sufficient information to eliminate favorable selection entirely. So long as the HMO has more information on individual beneficiaries than can be captured by the risk adjuster, the

HMO will have an opportunity to create favorable selection" (Vladeck 1995). Although the GAO has engaged in extensive review of this subject, there is no indication they have developed a new payment methodology that eliminates the problem of favorable selection.

In reviewing the experience of plans participating in the HMO Risk program, Mathematica Policy Research pointed out the paradox facing HCFA. Plans making money will stay in the pool and cost HCFA millions. Those losing money will simply drop out. More specifically, if enrollees are healthier on average than other beneficiaries (that is, if the HMOs experience 'favorable selection'), the HMO will save more than the intended five percent and will increase costs to HCFA. If enrollees are sicker on average than other beneficiaries (that is, if the HMOs experience 'adverse selection,') HCFA will save money, but the HMOs will lose money and simply drop out of the program (Mathematica Policy Research 1993).

Quality Issues. In addition to the numerous cost issues creating problems for Medicare, HCFA is also concerned about the quality of care provided in Medicare HMO's. A recently released four year observational study of 2235 chronically ill patients found that for elderly patients (those aged 65 and older) treated under Medicare, declines in physical health were more common in HMOs than in FFS plans (54% vs. 28%; $p<.001$) (Ware et. al. 1996).

Previous studies have found no differences in health outcomes between FFS and HMO plans, but these studies followed patients for only one year. The Ware study supports the conclusion that these studies were too brief to draw conclusions about health

outcomes. His study also found no statistically significant differences after one year, but the 4-year statistical models reported in his study explained twice as much of the variance in patient outcomes as did the same models in analysis of one and two year outcomes. Thus, follow-up periods longer than one year may be required to detect differences in outcomes for groups differing in chronic condition, age, income, and across different health care systems (Ware et. al. 1996).

At the American Medical Association Conference in San Francisco in October, 1996, Mr. Ware, a researcher at the New England Medical Center, who also teaches at Harvard and Tufts University, said that medical researchers "have not been looking at the sick, the elderly and the poor. This is the group for whom health care matters the most. These are vulnerable patients for whom less care is not going to produce a better state of health" (Olmos 1996). Ware cautioned that the study results were not an "indictment" of managed care but rather that the results conflict with the idea that what works well for younger, healthier, more well-to-do patients will work just as well for the elderly, poor and chronically ill (Olmos 1996).

HCFA is responding to the issue of quality by requiring managed care plans contracting with Medicare to undertake their first widespread quality reporting effort beginning January 1, 1997. "HCFA will require the plans to furnish the Medicare-relevant portions of version 3.0 of the Health Plan Employer Data and Information Set (HEDIS)," said Bruce Fried, director of the HCFA office of Managed care. HEDIS is a program of self-reported quality measures created by the National Committee for Quality Assurance. Fried and other HCFA officials met in Baltimore on September 6, 1996 with

representatives from more than 100 managed care plans, consumer groups and trade associations to detail their plans (Weissenstein 1996).

Specific Concerns with Medicare Subvention. Although the Memorandum of Agreement between HCFA and DoD has specified a Medicare reimbursement rate lower than the 95% of AAPCC that Medicare pays to Medicare HMO's, the Congressional Budget Office, in a memorandum dated September 19,1996, stated that the Medicare Subvention Demonstration would increase Medicare costs by $80 million dollars over four years (F-D-C Reports 1996).

Representative Bill Thomas (R-CA), Chairman of the health panel of the Ways and Means Committee, wants tighter test controls and greater proof of savings before implementing a Medicare demonstration project. "I'm not going to agree to something unless I have a comfort level that it's not costing (Medicare) more money. I don't have (that) comfort level," said Thomas (Philpott 1996)

Representative Pete Stark (D-CA), an Air Force veteran, portrays the pentagon as an insatiable budget beast now determined to feed off Medicare. He stated that "the Defense Department has enough cash to solve its own health care crisis." He noted that $9 billion was added this year to the 1997 Clinton defense budget, and wondered why DoD could not simply spend some of this additional money to take care of retirees (Philpot 1996).

These financial concerns have created problems with passing Medicare subvention legislation, but even if legislation were enacted, HCFA has numerous other issues of concerns, which are outlined in the "Department of Defense Medicare Modeling

and Impact Study" prepared by United HealthCare. United HealthCare prepared a Strengths, Weaknesses, Opportunities and Threats (S.W.O.T.) analysis of the Demonstration Project. This analysis provided a synopsis of the issues facing the DoD as it prepared to implement the program. The analysis identified only 8 strengths as compared to 37 weaknesses, and 7 opportunities as compared to 13 threats to the demonstration project. The entire S.W.O.T. analysis is presented in Appendix A.

The study further elaborated on the weakness with a GAP analysis. This analysis summarized the GAPs between a commercial risk HMO's business requirements and DoD's current capabilities to manage a Medicare risk contract for its retiree population. The study identified 85 "GAPS" that needed to be resolved before DoD could adequately manage a Medicare risk contract for its retiree population (Appendix B). Some of these "GAPS" were resolved in the Memorandum of Agreement between DoD and HCFA, but the majority of these GAPs remain unresolved.

These "GAPS" were grouped into the following 10 major areas:

1. Demographics
2. Service Area
3. Benefit Level and Competitive Analysis
4. Provider Network
5. Actuarial Analysis
6. Administration, Staffing and Costs
7. Operations
    i. Appeals
    ii. Grievances
    iii. Enrollment Requirements
    iv. Disenrollment Requirements: Voluntary and Involuntary
    v. Billing Requirements and Procedures
    vi. Claims Requirements and Procedures
    vii. Reconciliation Requirements and Procedures
8. Health Services and Delivery
9. Quality Assurance and Utilization Management
10. Management Information Systems

These "GAPS" raise serious doubts about DoD's capability to effectively manage a Medicare risk contract for its retiree population (United HealthCare 1996).

d. Purpose

The purpose of this case study is to analyze the activities undertaken by Region 11 Lead Agency and Madigan Army Medical Center (MAMC) in planning and preparing for the implementation of a TRICARE Senior Demonstration of Military Managed Care. The study utilizes a survey instrument to identify management's perceptions about the relative importance of TRICARE Senior Demonstration implementation issues, time and coordination requirements for managing demonstration implementation issues, learning requirements during the process of demonstration implementation, and management's perception about the potential threats to the ultimate success of the TRICARE Senior Demonstration. Survey results of the Region 11 Lead Agency management will be compared and contrasted with survey results of Madigan Army Medical Center's management to identify significant differences in issue perception at a regional level versus an MTF level. Additionally, results will be compared and contrasted among demographic sub-groups as follows:

1. Healthcare Administrators (HCAs) vs. Non-HCAs
2. Healthcare Administrators (HCAs) vs. Physicians
3. Physicians vs. Non-Physicians
4. Nurses vs. Non-Nurses
5. People currently in Clinical Positions vs. People in Administrative Positions
6. New Employees (less than six months in current position) vs. other employees

These results will help identify significant differences in issue perception between these sub-groups.

CHAPTER II

METHODS AND PROCEDURES

This project is a case study. The case study was conducted through a survey of Region 11 Lead Agency management staff and Madigan Army Medical Center's management staff. The case study focuses primarily on planning and preparing for implementing the TRICARE Senior Demonstration, rather than the actual implementation of the demonstration, since the completion date of the study coincided with the actual implementation of the demonstration. Local marketing of this program will begin April 1, 1997, with enrollment of beneficiaries beginning May 1, 1997, and actual healthcare delivery beginning June 1, 1997. Evaluation of TRICARE Senior Demonstration implementation activities are beyond the scope of this study because the implementation of the demonstration coincides with the completion due date of this Graduate Management Project.

The initial draft of the survey (Appendix C) was developed using the top issues from the GAP analysis performed by United HealthCare. This GAP analysis raised serious doubts about DoD's capability to effectively manage a Medicare risk contract for its retiree population. The survey instrument identified management's perception about the importance of each issue to the organization, to their individual positions, time management requirements for each issue, and coordination requirements for managing each issue. The survey also asked management to indicate their perceptions about the learning required to manage TRICARE Senior Demonstration issues, since Region 11 and MAMC management staff are not experienced at operating a Medicare risk HMO.

Finally, the survey helped determine management's perception about the potential threats to the ultimate success of the TRICARE Senior Demonstration.

The draft survey was pre-tested using a group of five volunteers. The average time for completing the survey by these volunteers was 16 minutes, and this information was included in the survey cover letter. The pre-tested volunteers were interviewed about the survey content to evaluate the validity of the survey. The volunteers were all very involved with the TRICARE Senior Demonstration, and were in good agreement with the surveyor about the intent of the survey items. They provided helpful comments about the layout of the survey, and their comments were incorporated into the final survey. A final survey instrument was developed and distributed on November 15, 1996 (Appendix D).

Region 11 Lead Agency and MAMC employees in key leadership positions were surveyed. Since almost all personnel at the Region 11 Lead Agency were involved in planning for the TRICARE Senior Demonstration, almost every staff member was targeted. At MAMC, all senior management was targeted, from the Commander to department heads, division chiefs and any other staff involved in implementing the TRICARE Senior Demonstration. A total of 124 personnel were surveyed. Appendix E provides a complete list of all personnel surveyed by name, rank, department/division and service.

The surveys were distributed via the CC-Mail electronic mail system. This made for an easy distribution to many people. The cover letter for the survey was signed by the Deputy Commander for Administration/Chief of Staff of MAMC, and respondents were

asked to either return the survey by CC-Mail or print the survey and return it by hand. Respondents were asked to return the surveys not later than November 27, 1996. By December 4, many of the surveys had not yet been received, so the survey was redistributed, and recipients were reminded to return the surveys if they had not already returned them. A new due date of December 13, 1996, was established. All survey responses were grouped for analysis, and the identity of each respondent remained confidential. The survey allowed respondents to add up to three issues of importance for each question. 18 respondents added a total of 50 comments. This allowed for another measure of validity. Providing respondents the opportunity to add comments to the survey strengthened its validity by assuring that issues were not omitted that respondents perceived as critical. Of the 18 respondents adding comments, only 5 added more than three total comments on their entire survey. Since only 8 percent of the respondents added more than three comments, the validity of the survey instrument was strengthened.

Of the 124 surveys distributed, 100 were sent to MAMC staff, 23 were sent to Lead Agency staff and 1 was sent to the Commanding General of MAMC, who is also the Lead Agent for Region 11. 15 surveys were returned by Lead Agency staff, for a return rate of 65.21%. 46 surveys were returned by MAMC staff, for a return rate of 46%. The Commanding General, representing both MAMC and the Lead Agency, also returned his survey, bringing the total amount of surveys returned to 62, or an overall return rate of 50%. The range of responses to survey items was at least 1 to 5 for all except 3 survey items. Descriptive statistics were computed, and the means of items were

inserted into missing data fields. This method allows a complete data set to be constructed without changing the original computed means.

Demographic data obtained with each survey included where the individual works (i.e. Lead Agency, Madigan), the primary workplace of the individual (e.g. Surgery, Pharmacy, Resource Management), and the primary job of each individual (i.e. physician in clinical position, physician in administrative position, nurse in clinical position, nurse in administrative position, health care administrator, other occupation in clinical position, other occupation in administrative position). Survey results were tabulated by groups of participants (i.e. Lead Agency staff, Madigan staff, health care providers, non-health care providers, etc.). Chronbach's Alpha was computed as a reliability measure. Survey items in questions 1 through 4 were not included in this analysis because these questions contained demographic data only. Chronbach's Alpha for all survey items in question 5 through question 11 (n=84), and all survey respondents (n=62) was computed at .9491, indicating strong reliability of the survey instrument. Survey responses for survey question 12 were then removed from the analysis, because the question contains different sub-items than questions 5 through 11. Chronbach's Alpha for survey items in questions 5 through 11 (n=70) for all survey respondents (n=62) was computed at .9498, indicating an even stronger reliability of the survey instrument.

The survey responses were then grouped by sub-items (e.g. all first sub-items under each question, all second sub-items under each question, etc. for all questions except the last question, which has different sub-items. Chronbach's Alpha was computed among these sub-items as a measure of internal consistency. All sub-items

displayed a significant positive item-to-item correlation and whole-part correlation, thereby indicating strong content and construct validity. Table 2-1 contains further details about Chronbach's Alpha computations among sub-items. These results demonstrated that each survey sub-item is a significant contributor to the overall survey score, and none of the survey items is a negative contributor.

Table 2-1. Chronbach's Alpha computations among survey sub-items.

Survey Sub-Group	**Survey items**	**Respondents**	**Chronbach's Alpha**
Claims/Billing Issues	7	62	.8114
Contracting Issues	7	62	.7834
Enrollment/Disenrollment	7	62	.7629
Meeting HCFA Standards	7	62	.8550
MIS Issues	7	62	.8064
Marketing Issues	7	62	.7907
Quality Assurance/Quality Management	7	62	.8565
Staffing Issues	7	62	.7867
Training Issues	7	62	.7968
Utilization Management Issues	7	62	.7852

Means, standard deviations and other descriptive statistics were calculated for all survey questions and survey sub-items for all survey responses. Appendix F provides tables showing the survey item responses (means, standard deviations, variances, ranges) for each question rank ordered according to their mean scores by total survey respondents. Appendix G provides tables showing the survey item responses (means, standard deviations, variances, ranges) for each survey sub-item. Appendix G does not

include survey sub-items from question 12 because that question contains different sub-items than questions 5 through 11.

A one-way Analysis of Variance for mean differences was conducted in an attempt to determine significant differences in perceptions of staff demographic sub-groups as follows:

1. Region 11 Lead Agency staff vs. MAMC staff
2. Healthcare Administrators (HCAs) vs. Non-HCAs
3. Healthcare Administrators (HCAs) vs. Physicians
4. Physicians vs. Non-Physicians
5. Nurses vs. Non-Nurses
6. People currently in Clinical Positions vs. People in Administrative Positions
7. New employees (less than six months in current position) vs. other employees

The full sample size (n=62) was utilized in five of these subgroup comparisons (HCAs vs. Non-HCAs, Physicians vs. Non-Physicians, Nurses vs. Non-Nurses, Clinical vs. Administrative and New Employees vs. other Employees). A smaller sample size (n=61) was utilized in the Lead Agency vs. Madigan comparison. The Commanding General of MAMC is also the Region 11 Lead Agent, so he was excluded from this comparison. An even smaller sample size (n=39) was utilized in comparing HCAs vs. Physicians. This sample represented 20 HCAs and 19 Physicians.

CHAPTER III

RESULTS

Appendix F provides tables showing the survey item responses (means, standard deviations, variances, ranges) for each question rank ordered according to their mean scores by total survey respondents. Appendix G provides tables showing the survey item responses (means, standard deviations, variances, ranges) for each survey sub-item. Appendix G does not include survey sub-items from question 12 because that question contains different sub-items than questions 5 through 11.

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5. Nurses vs. Non-Nurses
6. People currently in Clinical Positions vs. People in Administrative Positions
7. New employees (less than six months in current position) vs. other employees

Appendix H provides a description of significant differences of the seven comparison groups. There were 64 significant differences between the means of the comparison groups as follows:

1. Lead Agency vs. Madigan Staff - 16 significant differences
   - 4 in Staffing Issues
   - 3 in Contracting
   - 3 in Enrollment/Disenrollment
   - 2 in Information Systems
   - 2 in Marketing/Beneficiary Education
   - 2 in other areas

2. Healthcare Administrators vs. Non-HCAs - 17 significant differences
   - 3 in Quality Assurance/Quality Management
   - 2 in Contracting Issues
   - 2 in Enrollment/Disenrollment
   - 2 in Marketing/Beneficiary Education
   - 2 in Staffing Issues
   - 6 in other areas

3. Healthcare Administrators vs. Physicians - 13 significant differences
   - 3 in Enrollment/Disenrollment
   - 2 in Quality Assurance/Quality Management
   - 2 in Staffing Issues
   - 6 in other areas

4. Physicians vs. Non-Physicians - 5 significant differences
   - 3 in Utilization Management
   - 2 in Training of MAMC Staff

5. Nurses vs. Non-Nurses - 5 significant differences
   - 2 in Meeting HCFA Standards and Requirements
   - 3 others

6. Clinical Positions vs. Administrative Positions - 4 significant differences

7. New Employees vs. Other Employees - 4 significant differences

Appendix I describes the same 64 significant differences, but breaks the differences out by the sub-item issues within the questions. Differences were grouped as follows:

1. Claims Processing/Billing Issues	2 total significant differences
2. Contracting Issues	6 total significant differences
3. Enrollment/Disenrollment Issues	10 total significant differences
4. Management Information Systems Issues	4 total significant differences
5. Marketing/Beneficiary Education	6 total significant differences
6. Meeting HCFA Standards and Requirements	4 total significant differences
7. Quality Assurance/Quality Management	6 total significant differences
8. Staffing Issues	10 total significant differences
9. Training of MAMC Staff	5 total significant differences
10. Utilization Management Issues	6 total significant differences
11. Other Issues	5 total significant differences

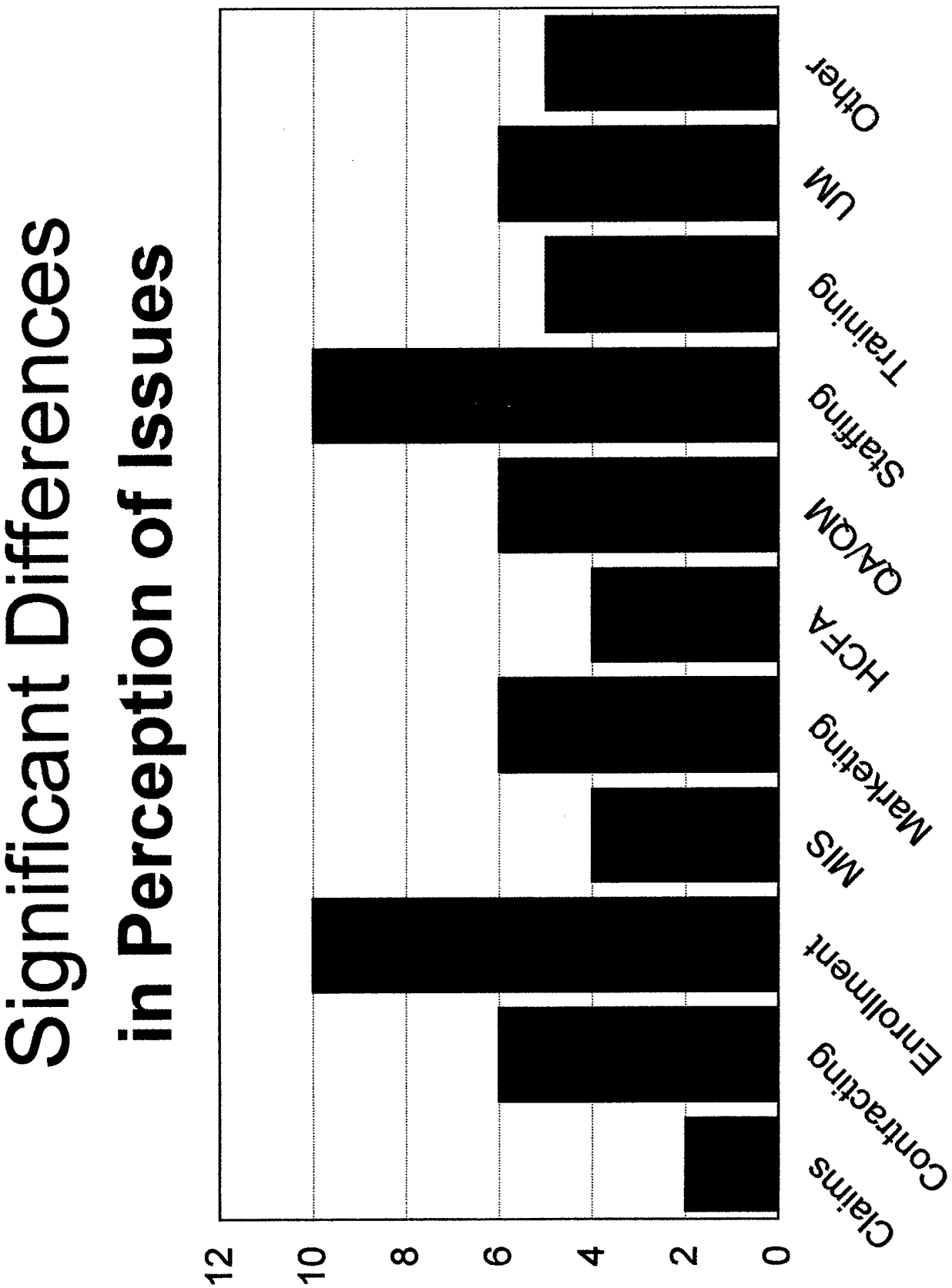
Appendix J describes the same 64 significant differences but breaks the differences out by question number as follows:

Rate issues according to ...

Question 5 - "importance to your organization"	5 significant differences
Question 6 - "importance to your position"	12 significant differences
Question 7 - "amount of time required"	13 significant differences
Question 8 - "lead time (prior planning) required"	6 significant differences
Question 9 - "internal coordination required"	8 significant differences
Question 10 - "external coordination required"	7 significant differences
Question 11 - "amount of new learning required"	3 significant differences
Question 12 - "potential threats"	10 significant differences

Table 3-1 graphically depicts the significant differences in appendix I, while Table 3-2 graphically depicts the significant differences in appendix J.

Table 3-1


Significant Differences
in Perception of Issues
12
10
8
6
4
2
0
Claims
Contracting
Enrollment
MIS
Marketing
HCFA
QA/QM
Staffing
Training
UM
Other

Significant Differences
in Perception by Question

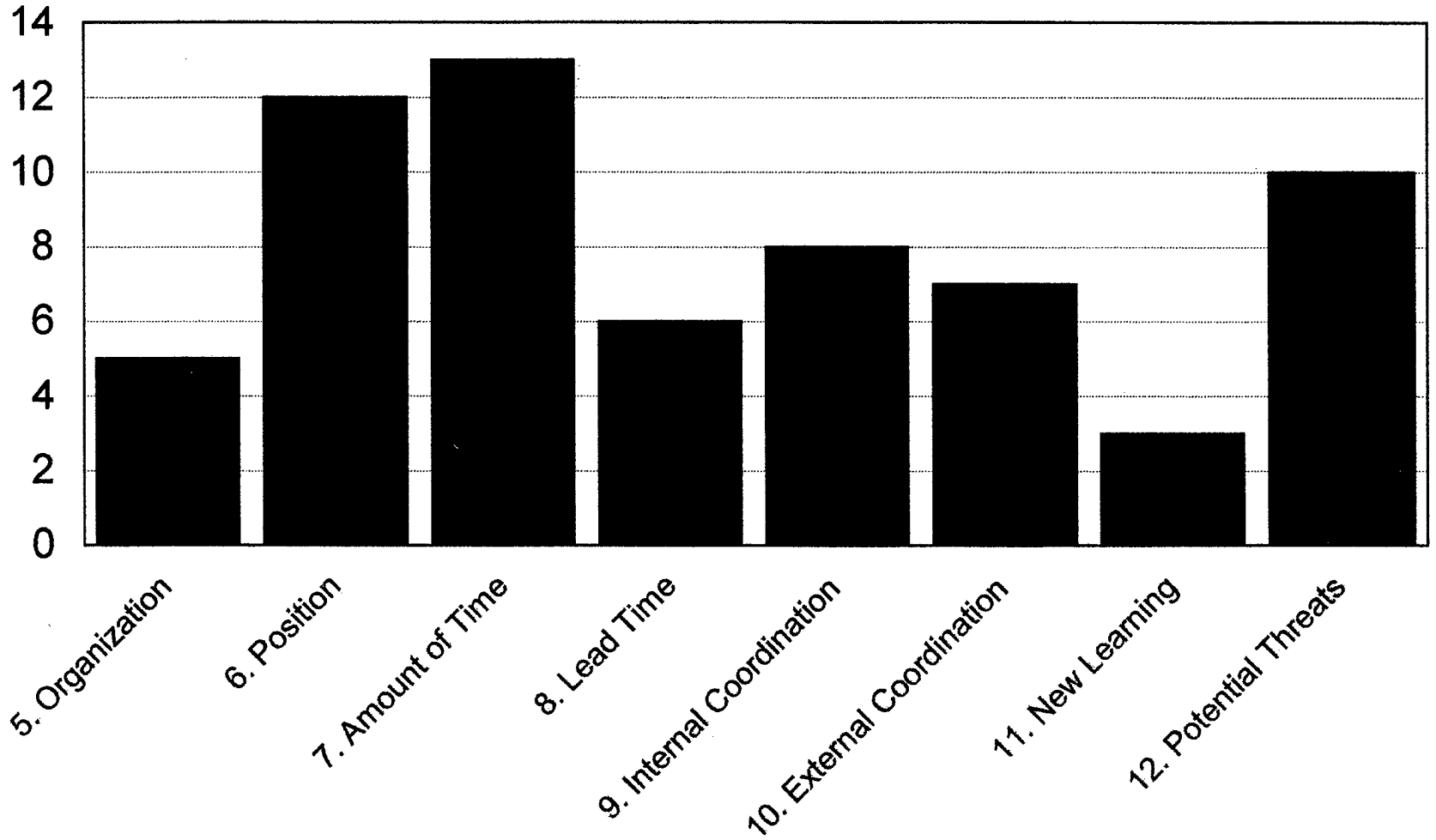


Table 3-2

The ten major issues were compared, and findings indicated that Management Information Systems Issues and Marketing/Beneficiary Education Issues were considered significantly more important than other issues, while Claims Processing Issues and Quality Assurance/Quality Management Issues were considered significantly less important than other issues. Table 3-3 indicates average score and ranges of issues.

Table 3-3. Comparison of Issues

Issue	Overall Mean Score	Range of Mean Scores
Management Information Systems	4.00	4.57-3.52
Marketing/Beneficiary Education	3.90	4.37-3.21
Contracting	3.73	4.15-3.03
Staffing	3.690	4.47-2.86
Enrollment	3.687	4.21-2.95
Utilization Management	3.67	4.25-3.17
Training of MAMC Staff	3.660	4.27-2.59
Meeting HCFA Requirements	3.659	4.07-3.23
Claims Processing/Billing	3.22	3.87-2.46
Quality Assurance/Quality Management	3.16	3.87-2.68

Table 3-4 graphically depicts these results for the top two issues (Management Information Systems and Marketing/Beneficiary Education) and the bottom two issues (Claims Processing/Billing and Quality Assurance/Quality Management) for questions 5 through 11. Question 12 is not included because the question contains different issues than the other questions.

MEDICARE ISSUES

Most and Least Important

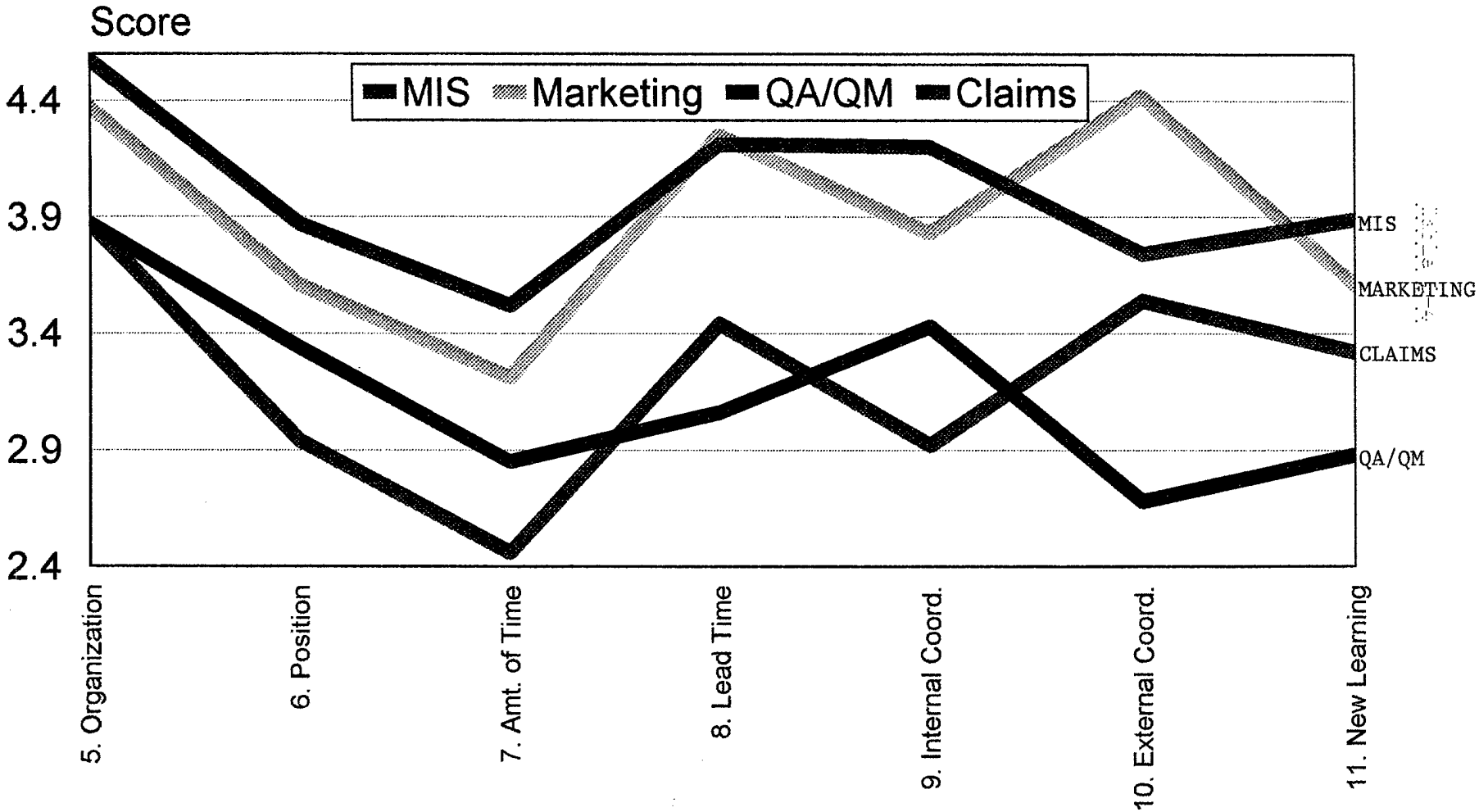


Table 3-4

CHAPTER IV

DISCUSSION

Comparison and discussion of the ten major issues can provide excellent guidance for other medical centers and regional lead agencies having to implement a similar program in the future. This chapter will discuss each issue in the order of importance listed in Table 3-3.

Management Information Systems. The results of the survey indicate that Management Information Systems (MIS) are perhaps the most crucial issue facing those individuals involved with implementation of the TRICARE Senior Demonstration. The SWOT Analysis by United Health Care (see Appendix A) indicated that MIS support for routine operations and strategic management is essential to the success of the Demonstration project. Although the United Health Care study identified DoD's strong support for Management Information System development initiatives as a strength, a significant number of the weaknesses were identified pertaining to MIS issues. Additionally, the GAP analysis (Appendix B) dedicates an entire section to the Management Information Systems issues that must be overcome to ensure successful implementation of the demonstration.

Survey respondents felt that MIS issues were the most important issues to the organization and would require the greatest amount of internal coordination. Additionally, MIS issues were identified as being the second only to staffing issues in importance to respondents' individual positions and amount of time required. MIS issues were also ranked second in lead time (prior planning) required , and second in the

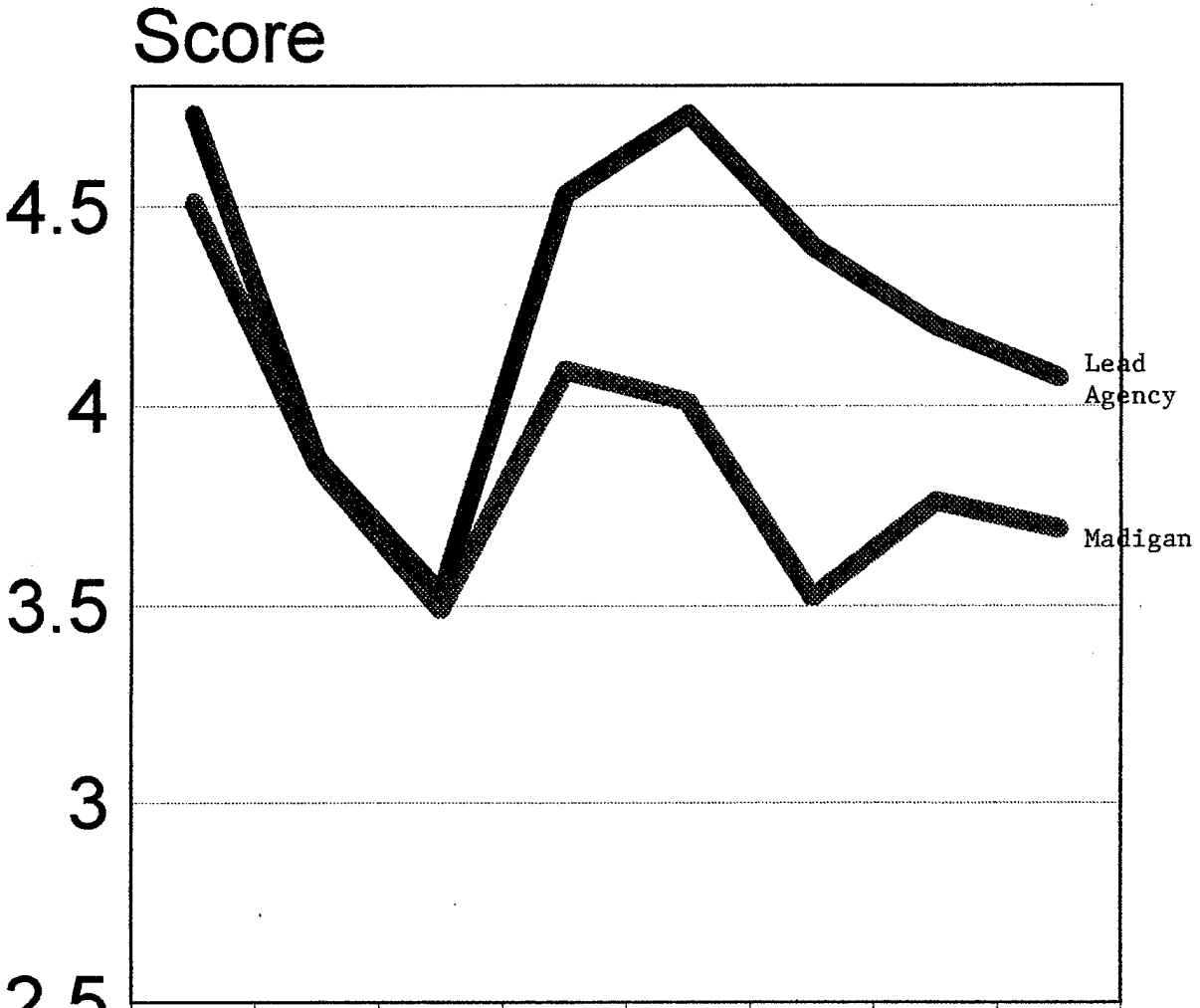
amount of new learning required. This means that out of the eight questions asked, MIS issues were ranked first or second in six of the eight questions.

In comparing staff demographic sub-groups, relatively few significant differences were identified in perception of the importance of MIS issues. Only four significant differences were identified overall. This constitutes fewer differences than any other issue with the exception of claims processing/billing. These results indicate that all demographic groups were in general agreement in their perceptions of the importance of MIS issues. Table 4-1 graphically compares Region 11 Lead Agency responses to Madigan responses in MIS issues, and indicates that Lead Agent staff identified MIS issues as more important than Madigan staff in all eight questions. Two of these differences (questions 9 and 10, dealing with internal and external coordination) were statistically significant differences. One other noteworthy difference identified was that people working in administrative positions felt that inadequate information systems pose a greater potential threat to the successful implementation of the demonstration than those people working in clinical positions. This would indicate that although those people in clinical positions feel that MIS issues are very important, they do not think that inadequate handling of these issues pose a threat to the success of the demonstration.

Table 4-1

Lead Agency vs. Madigan

Information Systems Issues



	5	6	7	8	9	10	11	12
Lead Agency	4.73	3.87	3.53	4.53	4.73	4.4	4.2	4.07
Madigan	4.51	3.85	3.49	4.09	4.01	3.52	3.76	3.69

Lead Agency Madigan

Marketing/Beneficiary Education. The results of the survey indicate that Marketing/Beneficiary Education issues are second only to MIS issues in importance. The United Health Care SWOT analysis does not discuss many specifics in relation to Marketing/Beneficiary Education, but it does indicate that if the program fails to provide adequate customer service, it could lead to public backlash and congressional pressure to cancel the project. Public backlash is something the MHSS wants to avoid, and that is one of the primary reasons that this issue is considered so important by the survey respondents.

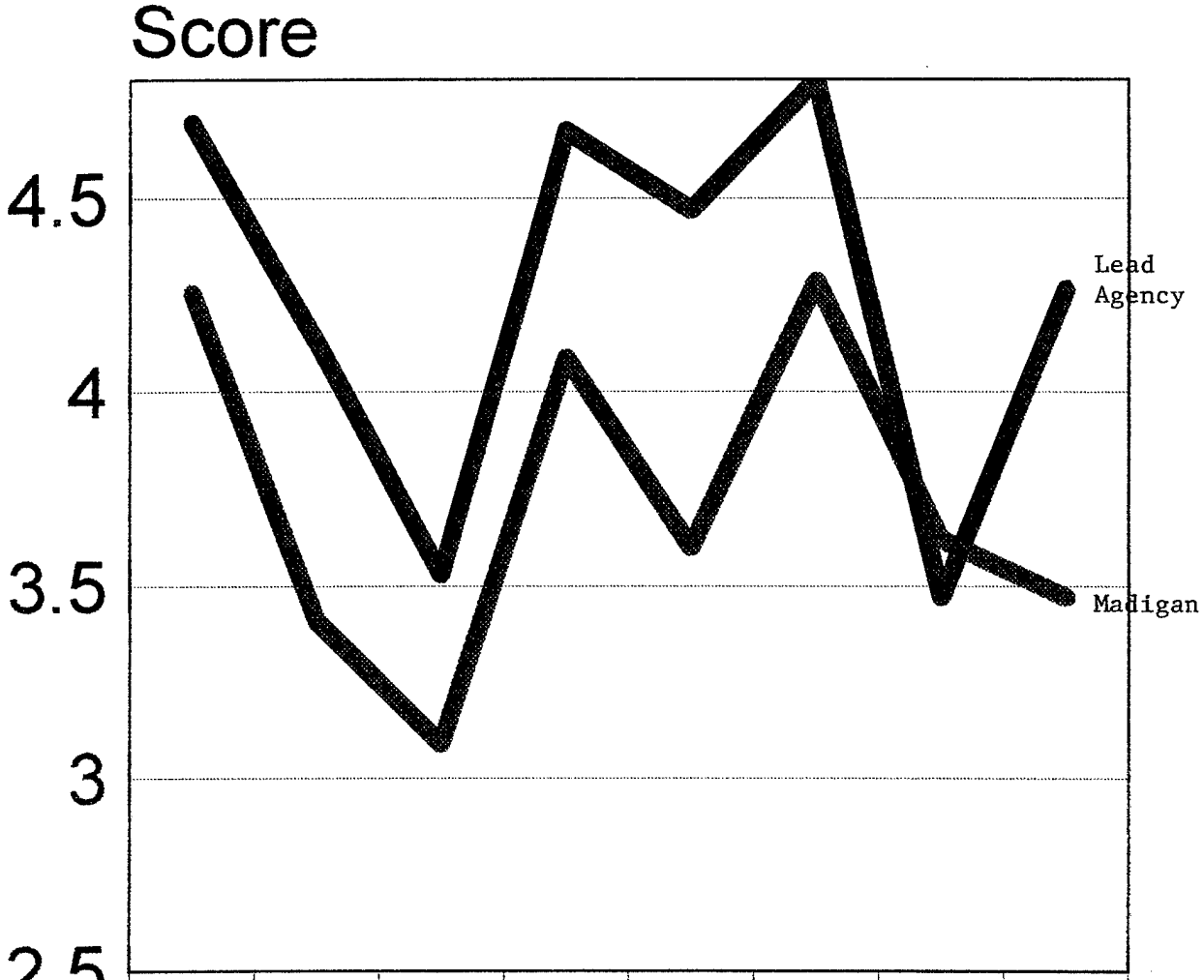
Survey respondents felt that Marketing issues would require the greatest amount of lead time (prior planning) and require the greatest amount of coordination with entities outside the medical center (external coordination). Additionally, Marketing issues were rated as the third most important issue to the organization, but inadequate marketing was only ranked tenth of the fourteen potential threats to the success of the demonstration.

In comparing staff demographic sub-groups, six significant differences were identified concerning Marketing issues. Table 4-2 graphically compares Region 11 Lead Agency responses to Madigan responses, and indicates that Lead Agent staff identified Marketing/Beneficiary Education issues as more important than Madigan staff in seven of the eight questions. Two of these differences (question 9- internal coordination, and question 12 - potential threats) were statistically significant. Lead Agency staff felt that Marketing/Beneficiary Education issues require more internal coordination, and

Table 4-2

Lead Agency vs. Madigan

Marketing/Beneficiary Education Issues



	5	6	7	8	9	10	11	12
Lead Agent	4.69	4.13	3.53	4.67	4.47	4.8	3.47	4.27
Madigan	4.26	3.41	3.09	4.09	3.6	4.29	3.62	3.47

inadequate Marketing/Beneficiary Education can pose a much greater threat to the success of the demonstration.

Table 4-3 graphically compares Health Care Administrators (HCAs) to non-HCA responses, and indicates that HCAs identified Marketing/Beneficiary Education issues as more important than non-HCAs in seven of the eight questions. Two of these differences (question 9- internal coordination, and question 10 - external coordination) were statistically significant. HCAs felt that Marketing/Beneficiary Education issues require much greater internal and external coordination than non-HCAs.

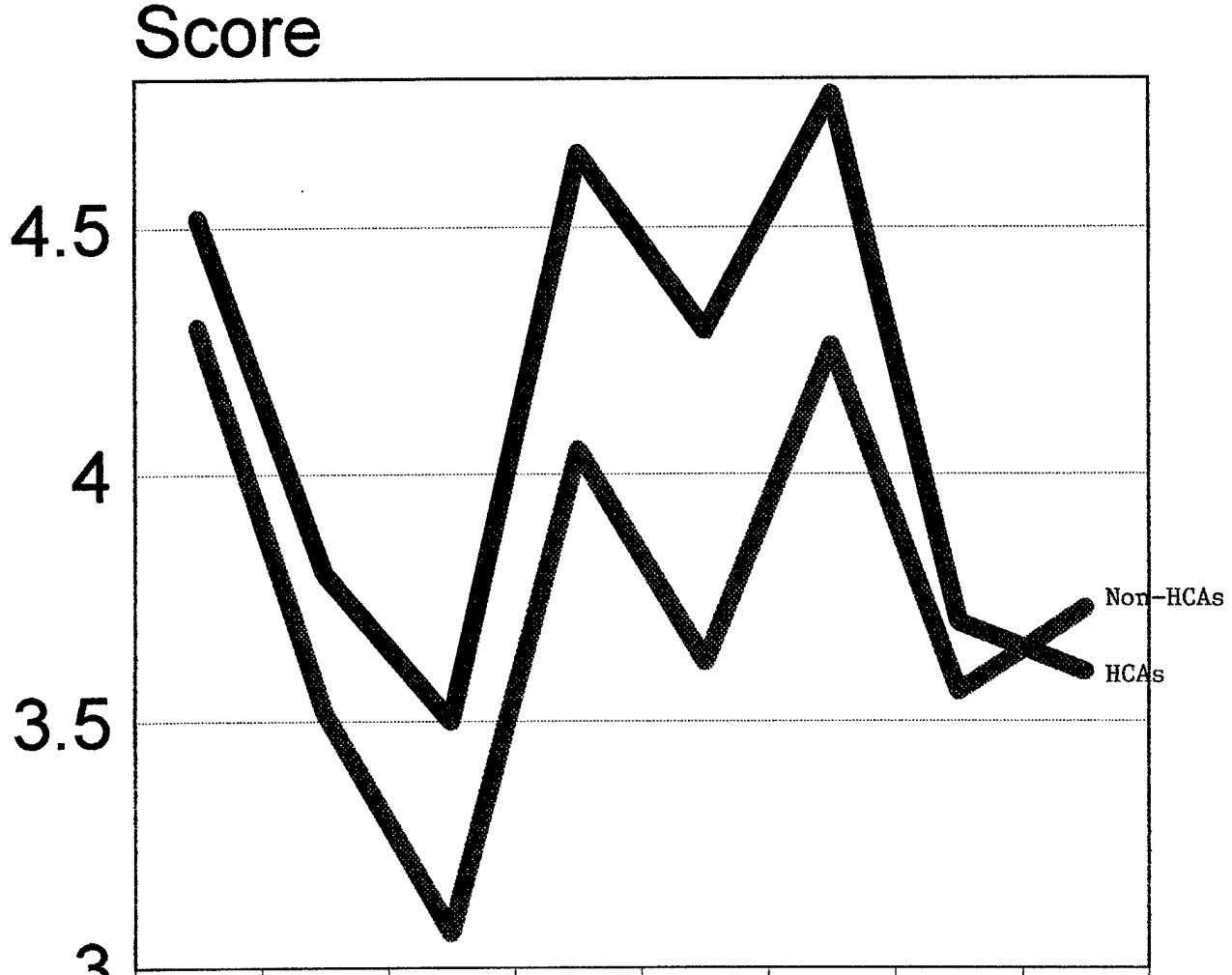
Contracting. The survey results ranked Contracting issues as the third most important set of issues. Contracting issues ranked second only to Marketing/Beneficiary Education issues in external coordination required and third in Lead Time (Prior Planning) behind Marketing/Beneficiary Education and MIS issues.

In comparison of staff demographic sub-groups, six significant differences were identified concerning Contracting issues. Three of these six differences involved the comparison of Lead Agency staff versus Madigan staff. Table 4-4 graphically compares Lead Agency staff responses to Madigan staff responses, and indicates that Lead Agency staff identified Contracting issues as more important than Madigan staff in all eight questions. Three of these differences (question 7 - time required, question 9 - internal coordination, and question 10 - external coordination) were statistically significant. These differences can be explained by the amount of contracting involved in the TRICARE program. The TRICARE Senior Demonstration requires significant modifications to the existing TRICARE contract with Foundation Health Federal

Table 4-3

Healthcare Administrators (HCAs) vs. Non-HCAs

Marketing/Beneficiary Education Issues



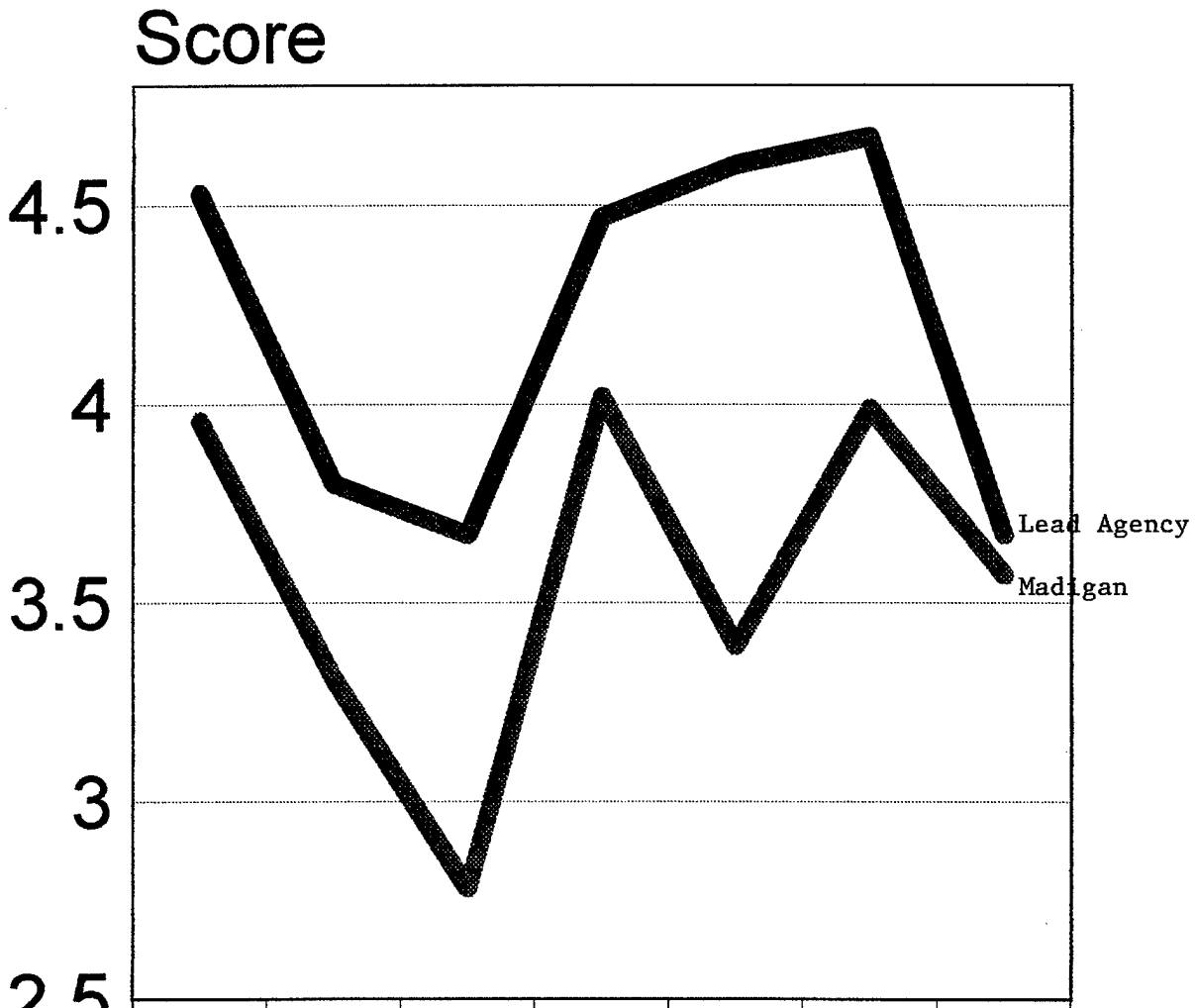
	5	6	7	8	9	10	11	12
HCAs	4.52	3.8	3.5	4.65	4.29	4.77	3.7	3.6
Non-HCAs	4.3	3.52	3.07	4.05	3.62	4.26	3.56	3.73

HCAs Non-HCAs

Table 4-4

Lead Agency vs. Madigan

Contracting Issues



	5	6	7	8	9	10	11
Lead Agency	4.53	3.8	3.67	4.47	4.6	4.67	3.67
Madigan	3.96	3.31	2.78	4.02	3.39	3.99	3.57

Lead Agency Madigan

Services, Inc. These contract modifications will be performed by the contracting division at the Lead Agency. Additionally, Lead Agency staff perform contractor performance evaluation and assessment. These Lead Agency duties account for a significantly greater perception of the importance of contracting issues in the TRICARE Senior Demonstration.

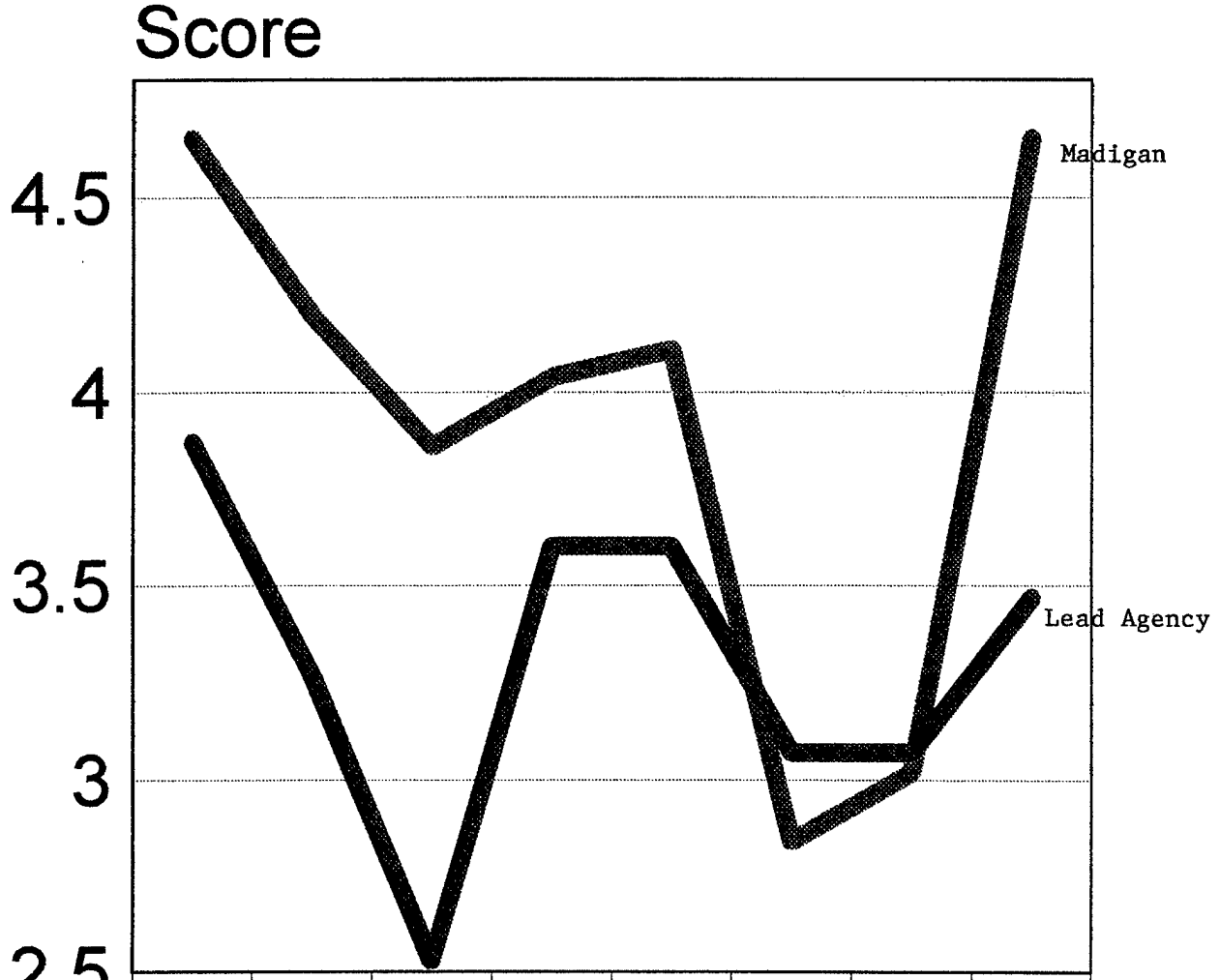
Staffing. The survey results rank Staffing issues as the fourth most important set of issues. Survey respondents felt that staffing issues were the most important issues to their individual positions and would require the greatest amount of time in preparing for implementation of the demonstration. Additionally, respondents indicated that staffing issues were second only to MIS issues in importance to their organization. Staffing issues were ranked among the least important issues in external coordination and amount of new learning required, indicating that Madigan and the Lead Agency are already very familiar in coping with staffing issues. Finally, inappropriate staffing levels were ranked as the fourth greatest potential threat to the success of the TRICARE Senior Demonstration.

In comparing demographic sub-groups, ten significant differences were identified concerning staffing issues. This represents the greatest amount of disparity (tied with enrollment/disenrollment issues) in perceptions among demographic sub-groups as to the importance of Staffing issues. Table 4-5 graphically compares Lead Agency staff responses to Madigan staff responses, and indicates that Madigan staff identified Staffing issues as more important than Lead Agency staff in six of the eight questions. Of these differences, four were statistically significant. Madigan Staff felt that Staffing issues

Table 4-5

Lead Agency vs. Madigan

Staffing Issues



	5	6	7	8	9	10	11	12
Lead Agency	3.87	3.27	2.53	3.6	3.6	3.07	3.07	3.47
Madigan	4.65	4.2	3.86	4.04	4.11	2.84	3.02	4.65

are more important to their organization, to their positions, require more time and pose a greater threat to the success of the demonstration. Perhaps most noteworthy is the high significance of the differences. Madigan staff felt that staffing issues were very much more important than Lead Agent staff.

The other important difference in perceptions involved HCAs versus non-HCAs and HCAs versus Physicians. These differences almost parallel each other, and clearly demonstrate that Physicians and other non-HCAs feel much stronger about the importance of staffing issues than HCAs. Tables 4-6 and 4-7 graphically compares HCAs to non-HCAs and HCAs to Physicians.

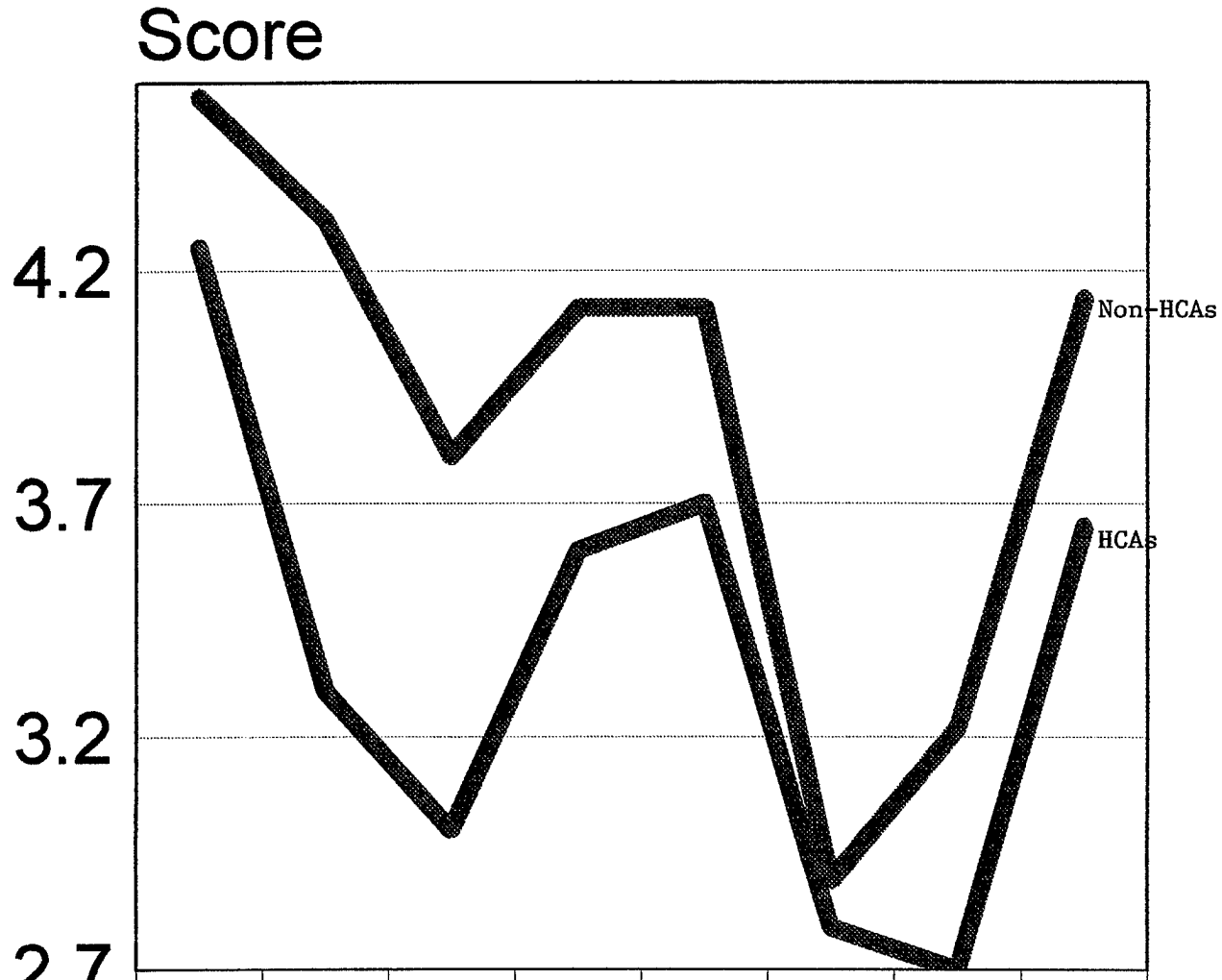
The survey respondents from the Lead Agency were primarily administrators, while most of the Madigan staff respondents were non-administrators. Therefore, the HCA vs. non-HCA perception difference appears to be the primary factor behind the Lead Agency/MAMC differences. Staffing shortages are a chronic problem at Madigan and throughout the entire MHSS, and whenever new programs are implemented that require increased capacity, those people in clinical areas are extremely concerned about having adequate staffing to handle the increased capacity. These concerns help account for the differences in perception of the importance of staffing issues between HCAs and non-HCAs.

Enrollment/Disenrollment. The survey results indicate that enrollment issues are nearly equal to staffing issues in overall importance and in the amount of disparity in perceptions among demographic sub-groups. Survey respondents felt that enrollment /disenrollment issues required the third greatest amount of external coordination after

Table 4-6

Healthcare Administrators (HCAs) vs. Non-HCAs

Staffing Issues



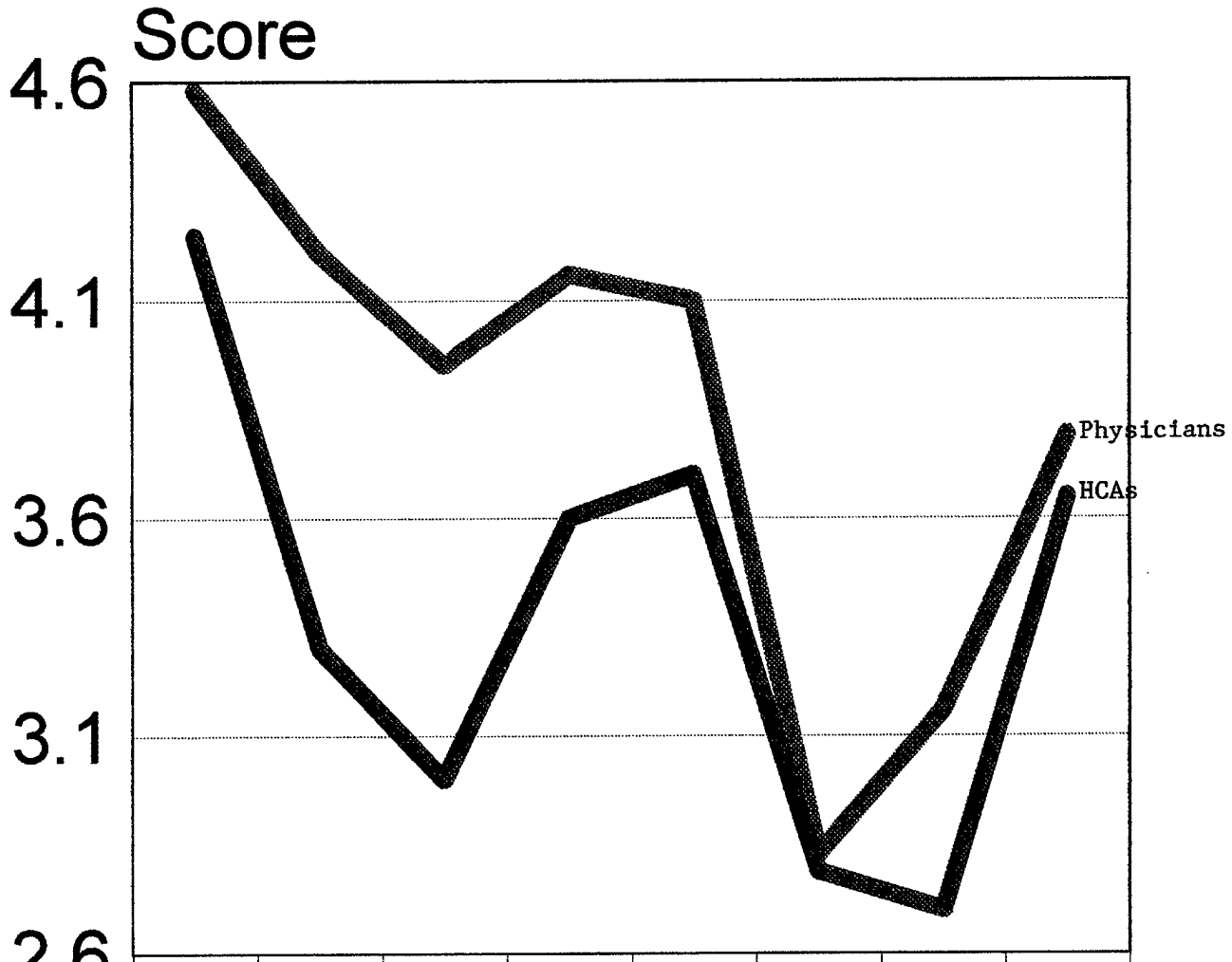
	5	6	7	8	9	10	11	12
HCAs	4.25	3.3	3	3.6	3.7	2.79	2.7	3.65
Non-HCAs	4.57	4.31	3.8	4.12	4.12	2.89	3.22	4.14

HCAs Non-HCAs

Table 4-7

Healthcare Administrators (HCAs) vs. Physicians

Staffing Issues



	5	6	7	8	9	10	11	12
HCAs	4.25	3.3	3	3.6	3.7	2.79	2.7	3.65
Physicians	4.58	4.21	3.95	4.16	4.1	2.83	3.16	3.79

HCAs Physicians

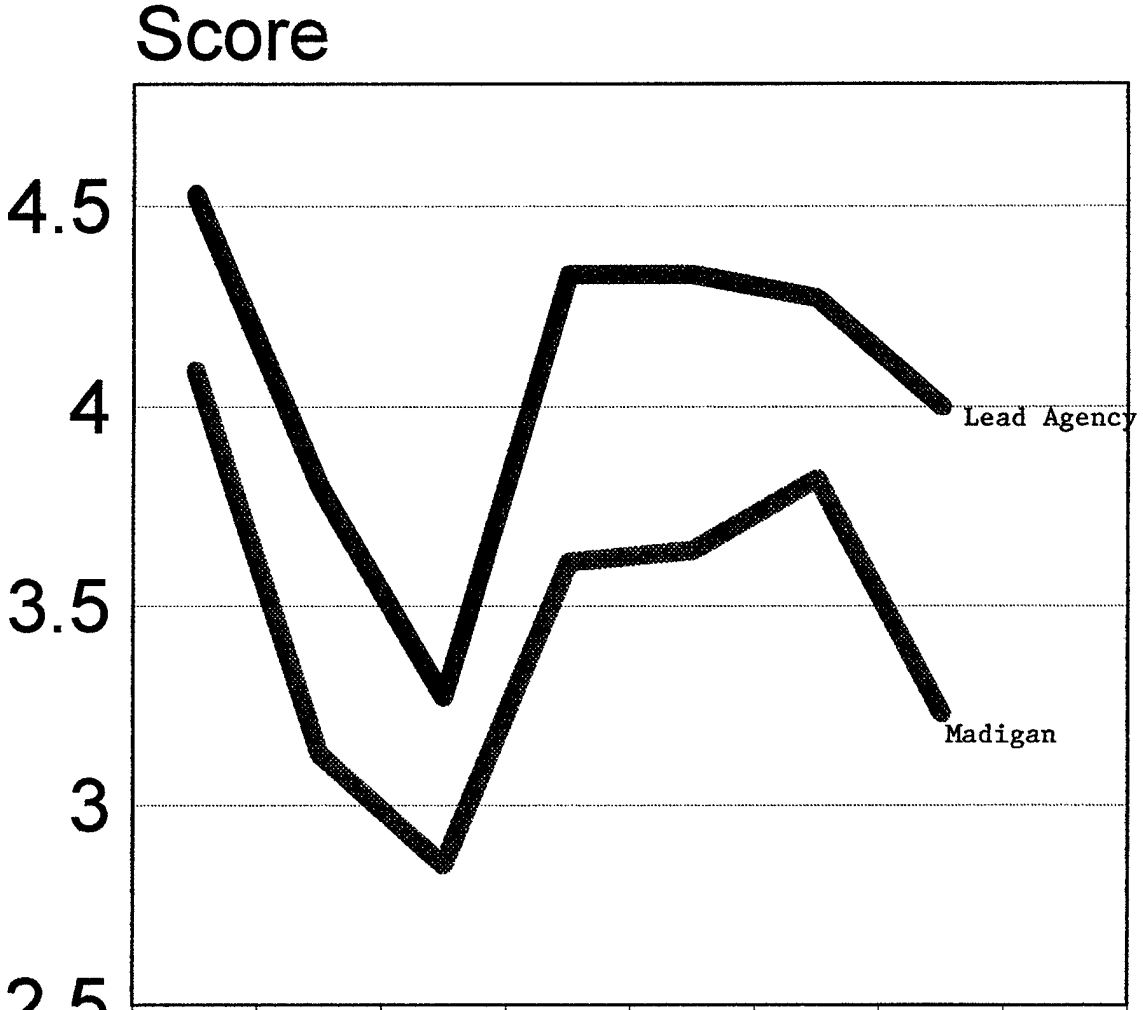
Marketing/Beneficiary Education and Contracting issues. This is explained by the fact staff members must coordinate with patients during the enrollment and disenrollment process. Enrollment/Disenrollment issues ranked near the bottom in importance to individuals positions. This finding can be explained by the fact that very few staff members are actually involved in the enrollment/disenrollment process. In TRICARE, enrollment and disenrollment are performed by the TRICARE contractor, so while most staff members recognize it as an important issue, it is a relatively low priority to most staff members individual positions.

In comparing demographic sub-groups, ten significant differences were identified concerning enrollment/disenrollment issues. This represents the greatest amount of disparity (tied with staffing issues) in perceptions among demographic sub-groups. Table 4-8 graphically compares Lead Agency staff responses to Madigan staff responses, and indicates that Lead Agency staff identified Enrollment/Disenrollment issues as more important than Madigan staff in all eight questions. Of these differences, three were statistically significantly. Lead Agency staff felt that Enrollment/Disenrollment issues require much greater lead time (prior planning), much more new learning and greater internal coordination than Madigan staff. These differences can be explained by the fact that the Lead Agency staff is much more involved with tracking enrollment and disenrollment in the TRICARE program than Madigan staff, so they perceive this issue as being much more important.

Table 4-8

Lead Agency vs. Madigan

Enrollment/Disenrollment Issues



	5	6	7	8	9	10	11	
Lead Agency	4.53	3.8	3.27	4.33	4.33	4.27	4	
Madigan	4.09	3.13	2.85	3.61	3.64	3.82	3.23	

The other important difference in perceptions involved HCAs versus non-HCAs and HCAs versus Physicians. These differences almost parallel each other, and clearly demonstrate that HCAs feel much stronger about the importance of Enrollment/ Disenrollment issues than Physicians and other non-HCAs. Tables 4-9 and 4-10 graphically compare HCAs to non-HCAs and HCAs to Physicians. HCAs differed from Physicians and other non-HCAs in their perceptions about the amount of lead time (prior planning), and the amount of internal and external coordination required in dealing with Enrollment/ Disenrollment issues. HCAs felt much greater lead time and coordination were required in enrollment issues. This can be explained by the fact that administrators are primarily involved with the Enrollment/Disenrollment process and are more aware of the number of issues involved in the Enrollment/Disenrollment process. They therefore perceive a greater importance of Enrollment/Disenrollment issues in the demonstration.

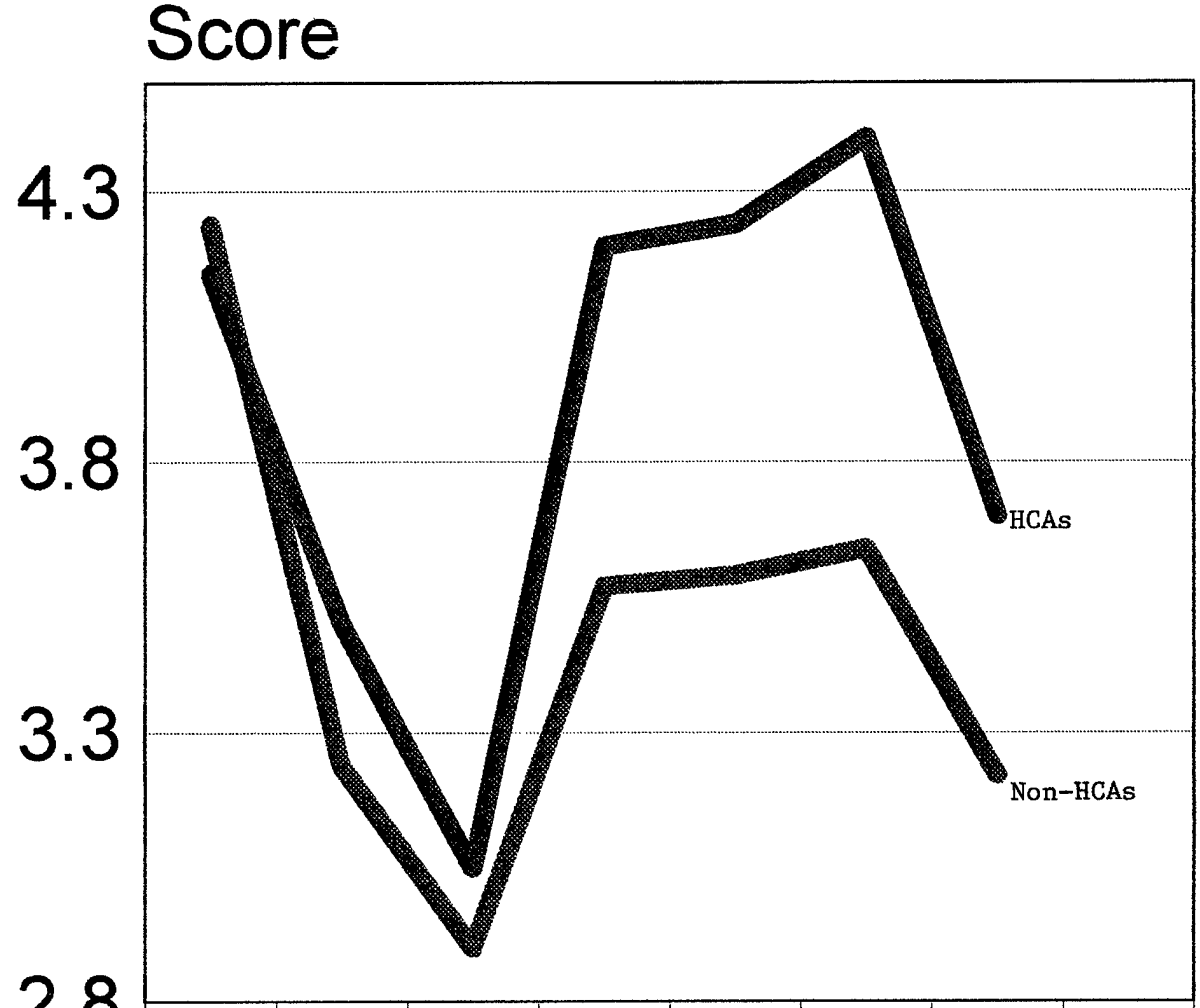
Utilization Management. The survey results rank Utilization Management (UM) as an important issue in a number of areas. Respondents felt UM issues would require the third greatest amount of time (after staffing issues and MIS issues), and would require the third greatest amount of internal coordination (after MIS issues and Training of MAMC staff). Overall, though, UM issues fell toward the middle on all questions. Inadequate UM ranked rather low as a potential threat to the success of the demonstration, ranking twelfth out of fourteen potential threats.

In comparing demographic sub-groups, six significant differences were identified concerning Utilization Management issues. Three of these six differences involved the

Table 4-9

Healthcare Administrators (HCAs) vs. Non-HCAs

Enrollment/Disenrollment Issues



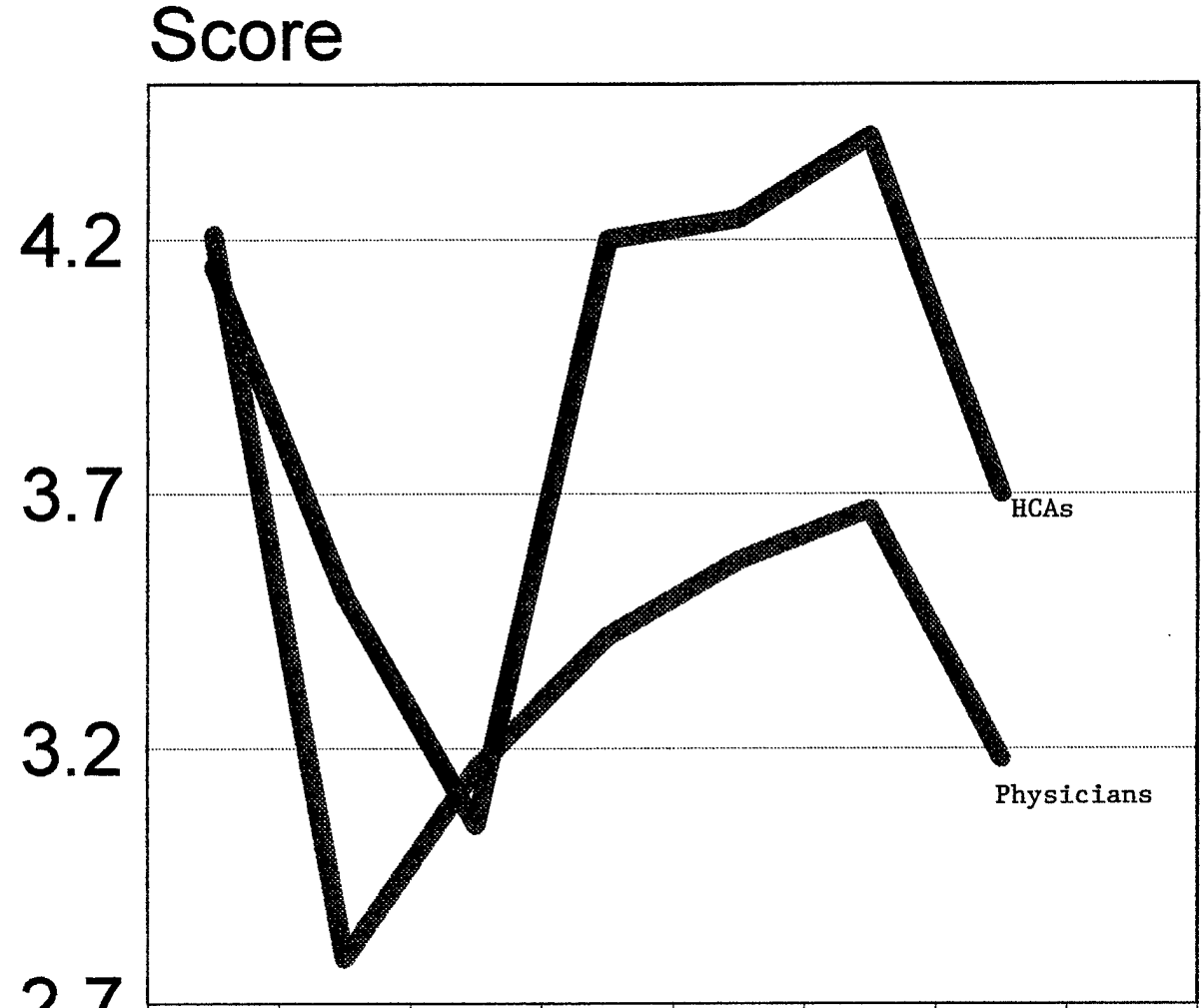
	5	6	7	8	9	10	11	12
HCAs	4.15	3.5	3.05	4.2	4.24	4.4	3.7	
Non-HCAs	4.24	3.24	2.9	3.57	3.59	3.64	3.22	

HCAs Non-HCAs

Table 4-10

Healthcare Administrators (HCAs) vs. Physicians

Enrollment/Disenrollment Issues



	5	6	7	8	9	10	11	12
HCAs	4.15	3.5	3.05	4.2	4.24	4.4	3.7	
Physicians	4.21	2.79	3.16	3.42	3.57	3.67	3.18	

HCAs Physicians

comparison of Physicians to non-Physicians. Table 4-11 graphically compares Physician responses to non-Physicians, and indicates that non-Physicians identified UM issues as more important than Physicians in seven of eight questions. Three of these differences (question 8 - lead time (prior planning), question 10 - external coordination, and question 12- potential threats) were statistically significant. Based on these results, it appears that Physicians do not place as much importance on Utilization Management issues as non-Physicians. It is interesting to note, however, that the one area in which Physicians ranked UM issues higher than non-Physicians was importance to their position. This would indicate that although physicians do not feel strongly about UM, they know that this issue does affect their jobs.

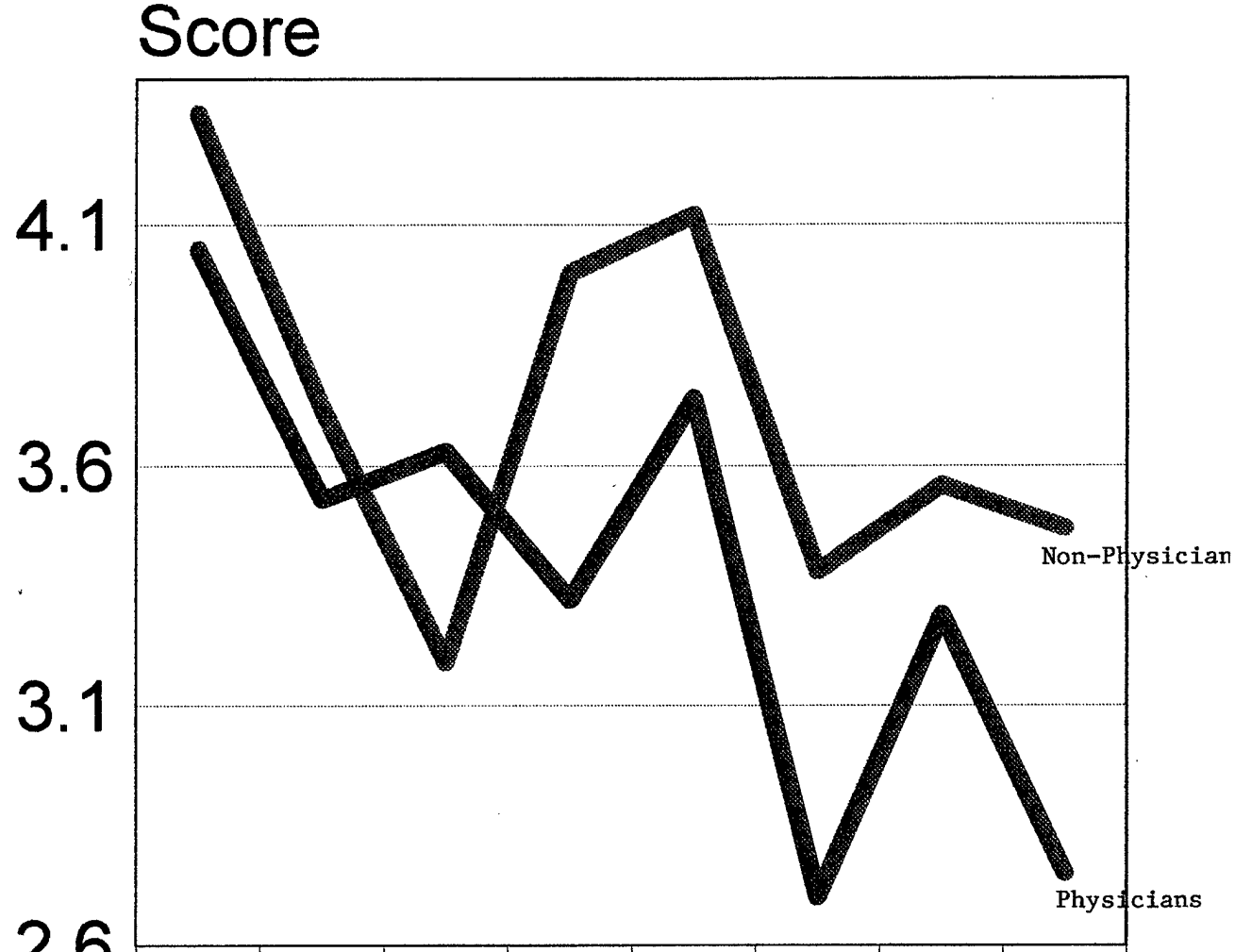
Training of MAMC Staff. The survey results rank training of MAMC staff as an important issue in a number of areas. Respondents felt training was second only to MIS in amount of internal coordination required. Additionally, respondents felt training was the third most important issue in importance to their position (after staffing and MIS issues) and would require the third greatest amount of new learning (after meeting HCFA standards and MIS issues). Respondents ranked training as the least important issue in the amount of external coordination required.

In comparing demographic sub-groups, five significant differences were identified concerning training issues. Physicians felt similar to non-physicians on most issues, but significantly differed from non-physicians on two questions. Physicians perceived that training of MAMC staff would require much greater time, and felt that inadequate

Table 4-11

Physicians vs. Non-Physicians

Utilization Management Issues



	5	6	7	8	9	10	11	12
Physicians	4.05	3.53	3.63	3.32	3.74	2.7	3.29	2.75
Non-Phys	4.33	3.72	3.19	4	4.12	3.38	3.56	3.47

Physicians Non-Phys

training would pose a much greater threat to successful implementation of the demonstration. Table 4-12 graphically compares physician responses to non-physicians and highlights these differences. These differences can be explained by the fact that physicians will be most directly affected by this training, so they are more concerned about this issue, and perceive it to be more important in some areas.

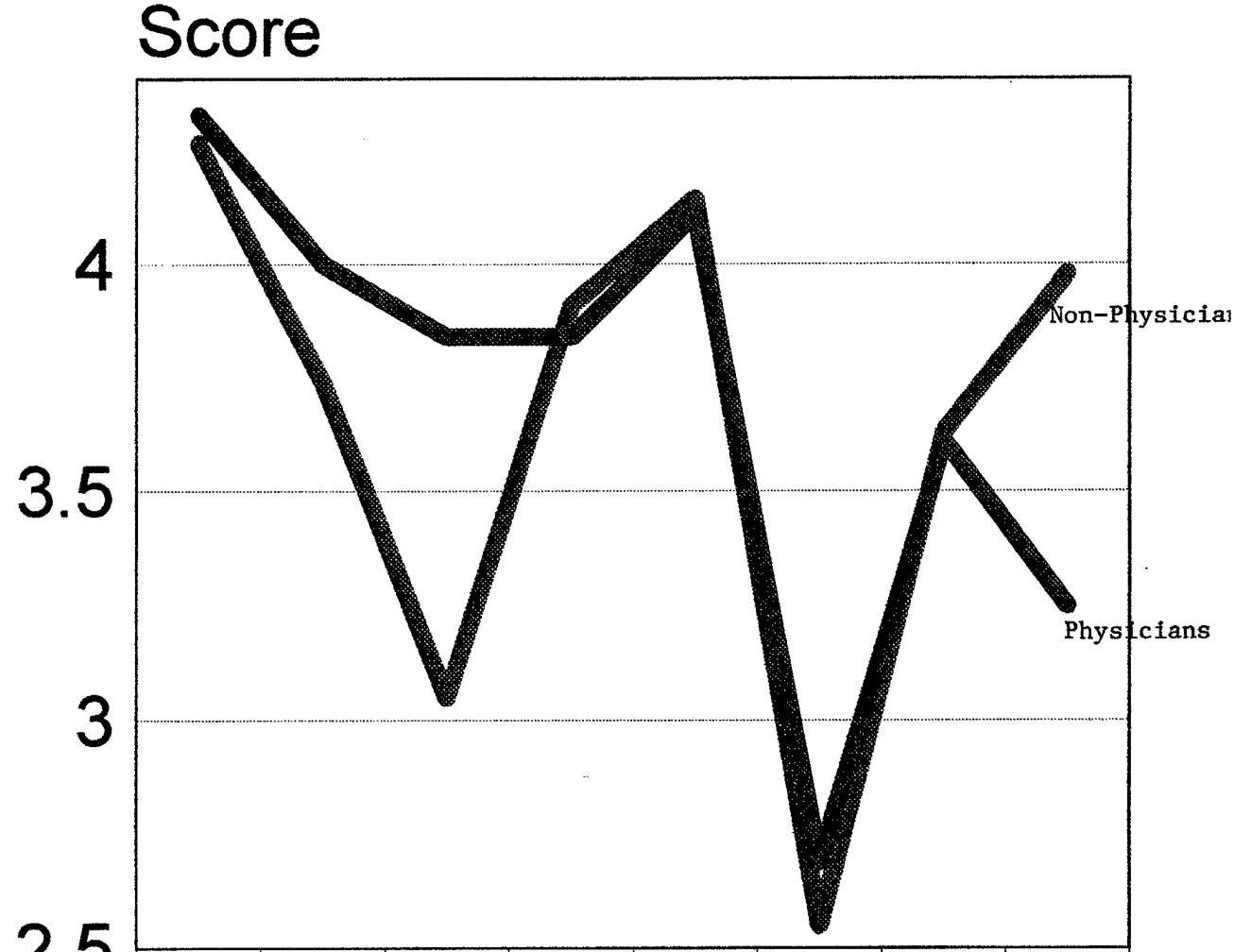
Meeting HCFA Standards/Requirements. United Health Care performed the DoD Medicare Modeling and Impact Study under the assumption that the MHSS and Region 11 would receive legislation and have to meet all HCFA standards/requirements to be eligible for reimbursement. United Health Care was therefore very concerned with this issue, and considered inability to meet all non-waived HCFA requirements as the top threat to the success of the demonstration. United Health Care also dedicated a significant portion of their GAP analysis describing GAPs that exist between HCFAs requirements for a Medicare HMO and the MHSS system. If subvention legislation had passed, this issue would likely have been a much more important issue, but in a simulation situation, without HCFA reimbursement, meeting the HCFA standards did not rank very high.

The results varied widely for this issue. Respondents ranked it as the least important issue to the organization, yet ranked it as the issue which would require the most amount of new learning, and ranked the ability to provide all Medicare services as the second greatest threat to the potential success of the demonstration. Perhaps this variation can be explained by the fact that when the surveys were distributed, legislation had only recently failed to pass, and the importance of meeting HCFA requirements in

Table 4-12

Physicians vs. Non-Physicians

Training of MAMC Staff



	5	6	7	8	9	10	11	12
Physicians	4.32	4	3.84	3.84	4.11	2.69	3.61	3.25
Non-Phys	4.26	3.74	3.05	3.91	4.14	2.55	3.63	3.98

Medicare "simulation", which later became the TRICARE Senior Demonstration, was not fully understood. One of the goals of the TRICARE Senior Demonstration is to make the MHSS appear as much like a Medicare HMO as possible, so respondents ranking "inability to provide all Medicare services" as a high threat demonstrates that respondents did at least have some understanding of the importance of this issue.

In comparing demographic sub-groups, only four significant differences were identified concerning meeting HCFA standards/requirements. Two of these differences involved the comparison of Nurses to non-Nurses and are depicted graphically in Table 4-13. Nurses felt meeting HCFA standards and requirements was much more important to their positions and required much more time than non-Nurses. It is interesting to note that an issue with such variation in respondents perceptions would produce very little difference between demographic sub-groups.

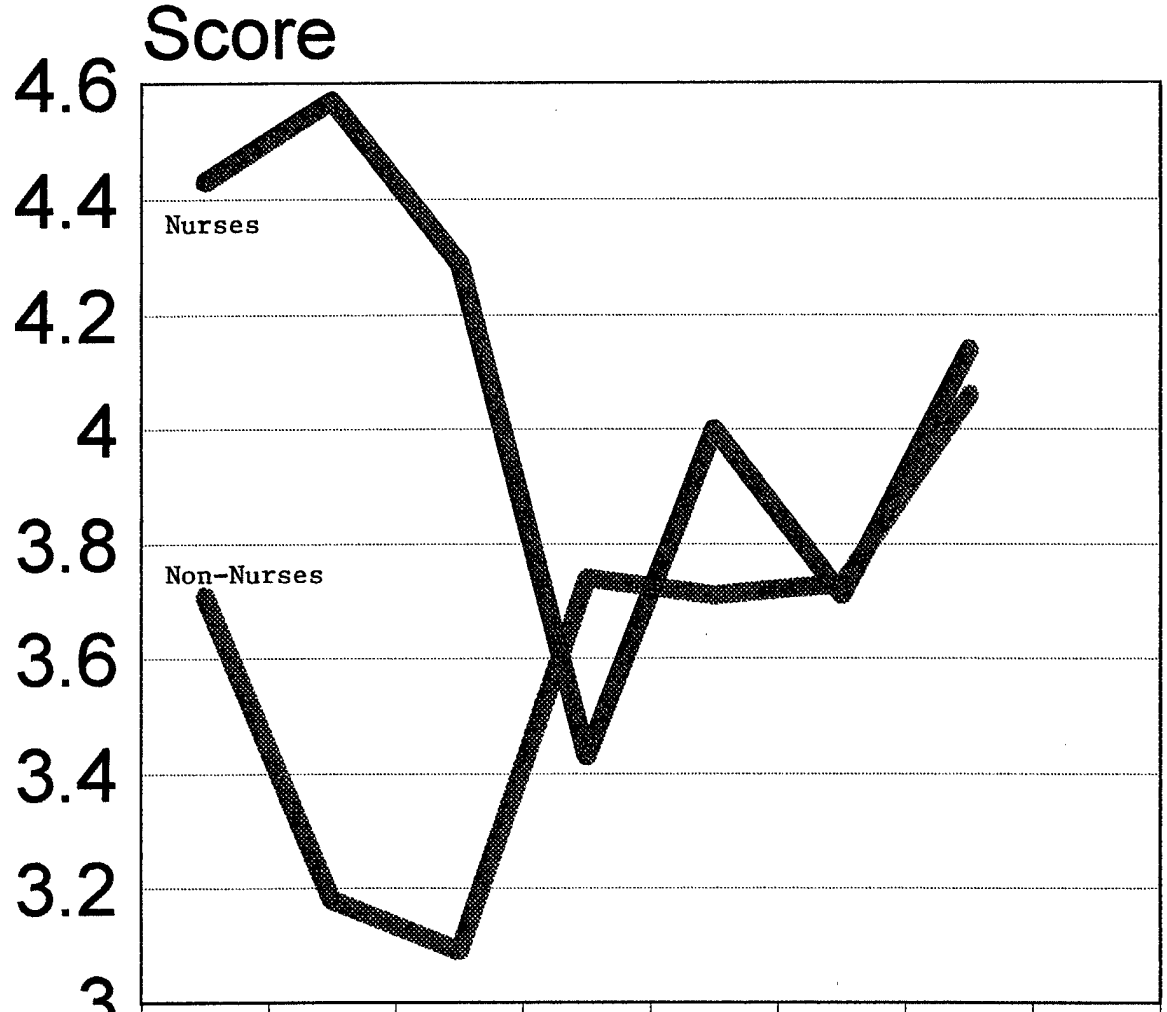
Claims Processing/Billing. As with the "meeting HCFA standards" issue, this issue would likely have had much more significance had Medicare subvention legislation actually passed. However, the TRICARE Senior Demonstration does not include actual HCFA reimbursement, so claims processing and billing becomes a very low priority. It was ranked at or near the bottom on all questions except question 10 (external coordination), where it was ranked sixth out of ten issues.

In comparison of demographic sub-groups, only two significant differences were identified. This is the least number of significant differences of any issue. This demonstrates that respondents were in agreement as to the importance (or lack of importance) of this issue.

Table 4-13

Nurses vs. Non-Nurses

Meeting HCFA Standards and Requirements



	5	6	7	8	9	10	11	12
Nurses	4.43	4.57	4.29	3.43	4	3.71	4.14	
Non-Nurses	3.71	3.18	3.09	3.74	3.71	3.73	4.06	

Quality Assurance/Quality Management. This issue ranked as the least important issue overall. This indicates that respondents feel that a high Quality of Care is provided at Madigan and within Region 11, and do not feel this will not be impacted by the TRICARE Senior Demonstration. This issue was ranked near the bottom in all areas, and was felt to be the lowest potential threat to the success of the demonstration.

In comparing demographic sub-groups, six significant differences were identified considering Quality Assurance/Quality Management. Table 4-14 graphically compares HCAs to non-HCAs, and indicates that non-HCAs identified QA/QM issues as equally or more important than HCAs on all eight questions. These results demonstrate that although all demographic groups consider QA/QM issues as a relatively low priority, HCAs tend to view these issues as an even lower priority than non-HCAs.

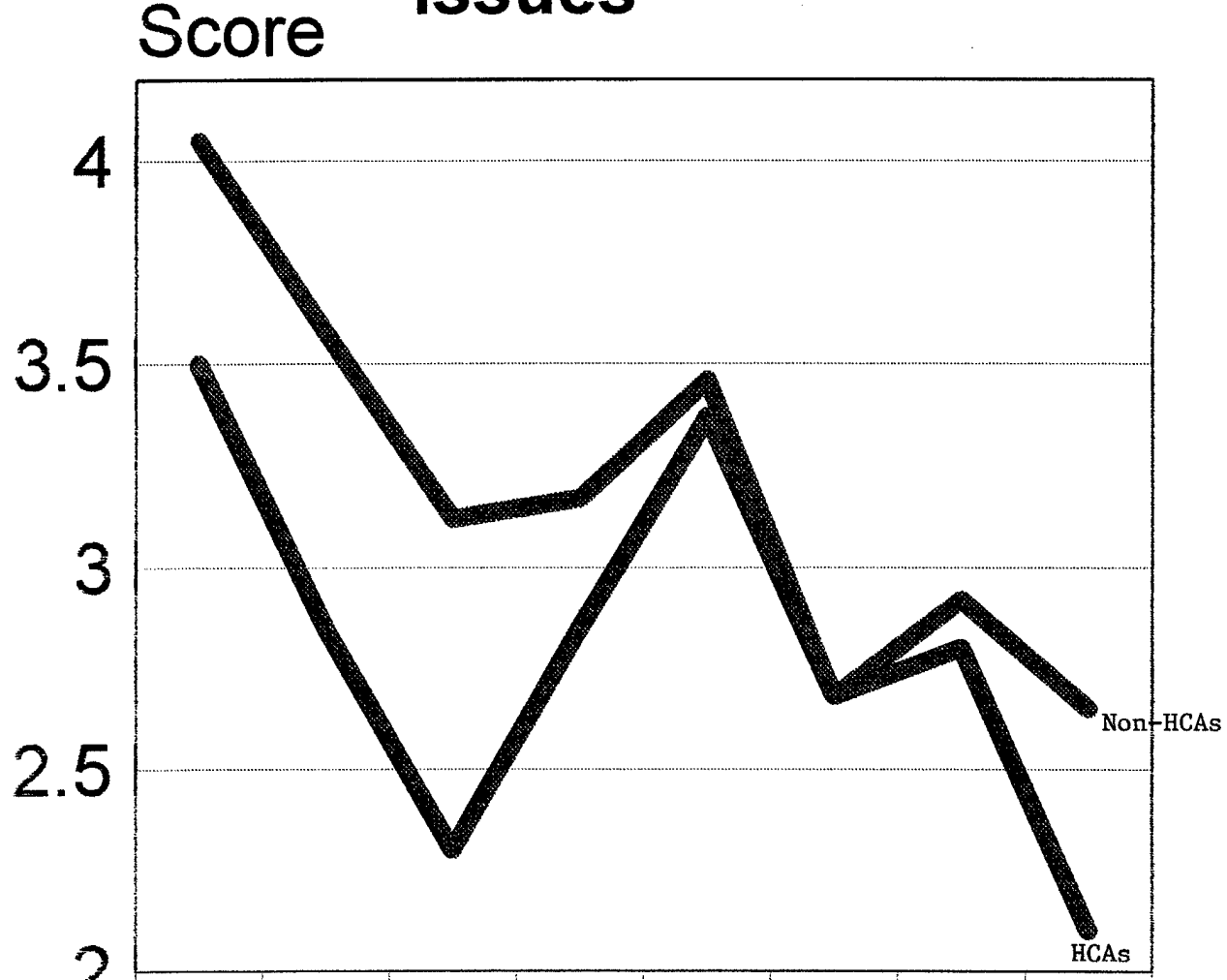
Potential Threats. This topic requires separate discussion from the issues discussed above because many of the potential threats do not correspond to the ten major issues in questions 5 through 11. Some issues (inappropriate staffing, inadequate information systems, etc.) do correspond to the ten major issues, but many others do not. United Health Care listed thirteen threats in their SWOT analysis, and the fourteen potential threats listed in the survey roughly corresponded to the SWOT analysis.

Respondents listed time constraints, ability to provide all Medicare services and lack of HCFA reimbursement as the three most significant threats. These threats were ranked considerably higher than the other eleven potential threats. Quality of Care Provided was ranked last, well below any other potential threats.

Table 4-14

Healthcare Administrators (HCAs) vs. Non-HCAs

Quality Assurance/Quality Management Issues



	5	6	7	8	9	10	11	12
HCAs	3.5	2.85	2.3	2.85	3.37	2.68	2.8	2.1
Non-HCAs	4.05	3.58	3.12	3.17	3.46	2.68	2.92	2.65

HCAs Non-HCAs

All demographic sub-groups agreed that time constraints posed the greatest threat, and no significant differences were identified. Throughout this entire process, DoD Health Affairs staff have set unrealistic implementation dates, and this has been identified as one of the largest and most chronic problems in the entire Medicare demonstration process. When United Health Care performed the DoD Medicare Modeling and Impact Study in July, 1996, the study stated "the short time frame allocated to DoD for the Demonstration implementation (one month after presentation of United Health Care's business plan) is the most dangerous shortcoming of the project. United Health Care's existing HMOs, which have well established systems and models to draw upon, typically require nine to twelve months to implement a risk contract. DoD, which does not possess these advantages, is attempting to initiate a plan within one month" (United Health Care 1996).

This implementation date was eventually pushed back until passage of legislation, and after legislation failed to pass, the Medicare "simulation" project was established with an implementation date of 1 Feb 97. When the surveys were distributed in November, 1996, the respondents did not feel they would be ready to begin health care delivery by 1 Feb 97. DoD HA continued to endorse the 1 Feb 97 start date until January, 1997, when they finally realized this was not possible. The final dates established included local marketing beginning 1 April 97, enrollment beginning 1 May 97 and healthcare delivery beginning 1 Jun 97. The staff at Madigan has been preparing for implementation since release of the United Health Care study on 26 July 96. The total time from release of the study until actual healthcare delivery at Madigan will be 10

months, 5 days. In the end, Madigan staff has been provided adequate time to implement this program, but the numerous unrealistic implementation dates set by DoD HA throughout the past ten months have resulted in unnecessary pressure and stress on all Region 11 Lead Agency and MAMC staff. This history of trying to meet unrealistic implementation dates is a primary reason for the time constraints issue being ranked first among potential threats.

Among the second and third ranked threats, three significant differences were identified. Madigan staff felt that the ability (or inability) to provide all Medicare services poses a greater threat than Lead Agency staff. This can likely be explained by the fact that the Madigan staff respondents are largely made up of healthcare providers who may actually have to provide these services, many of which they are unfamiliar with. Finally, Physicians and other non-Healthcare Administrators (non-HCAs) felt that lack of HCFA reimbursement poses a smaller threat than HCAs. Based on this finding, it appears that HCAs are more confident than non-HCAs in being able to make this demonstration work without the financial resources that would be attained through HCFA reimbursement.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

This study has provided an analysis of the activities undertaken by Region 11 Lead Agency and Madigan Army Medical Center (MAMC) staff in planning and preparing for the implementation of a TRICARE Senior Demonstration of Military Managed Care. The study utilized a survey instrument and identified management's perceptions about the relative importance of TRICARE Senior Demonstration implementation issues, time and coordination requirements for managing the issues, learning requirements during the process of demonstration implementation, and management's perception about the potential threats to the ultimate success of the TRICARE Senior Demonstration. Survey results of the Region 11 Lead Agency management were compared and contrasted with survey results of MAMC management to identify significant differences in issue perception at a regional level versus an MTF level. Additionally, results were compared and contrasted among the following demographic sub-groups:

1. Healthcare Administrators (HCAs) vs. non-HCAs
2. Healthcare Administrators (HCAs) vs. Physicians
3. Physicians vs. non-Physicians
4. Nurses vs. non-Nurses
5. Clinical positions vs. Administrative positions
6. New employees vs. other employees

Region 11 and Madigan have provided a "test-bed" for numerous initiatives and demonstrations within the MHSS. Region 11 was the first region with a full TRICARE managed care contract and is the demonstration site for the Geographically Separated Units (GSU) demonstration project. Region 11 Lead Agency staff and Madigan staff

have become extremely proficient at leading the MHSS into new areas such as TRICARE, the GSU demonstration program and the TRICARE Senior demonstration program.

The Lead Agency management staff and MAMC management staff have performed extensive work in preparing for the TRICARE Senior demonstration. Their perceptions of the most important issues can provide a source of invaluable information for management staff of other Lead Agencies and MTFs that will likely implement some form of Medicare subvention in the future. The discussion of the ten major issues, the discussion of the potential threats, and the comparison of results among demographic sub-groups can further help define management priorities when implementing a similar program.

The utility of this project may be somewhat diminished by the fact that Medicare Subvention legislation did not pass in September, 1996. If legislation had passed, only two regions would have been involved in the demonstration, and this project could have been utilized by the remaining ten regional Lead Agencies and countless MTFs upon implementation of Medicare Subvention throughout the entire MHSS. The TRICARE Senior Demonstration, however, will be implemented at seven MTFs across five TRICARE regions. Because of the increased numbers of facilities and regions, the utility of this project will likely be limited to the remaining seven regional Lead Agencies and MTFs located within those regions.

Further research could prove interesting in this area. In particular, it would be useful to administer the survey to the staff at DoD Health Affairs and compare their

results against Region 11 Lead Agency staff results and Madigan staff results. The priority of issues from the view of the policy makers and staffers at DoD HA would certainly provide an interesting comparison. Another possible avenue for further research would be an analysis of the TRICARE Senior Demonstration after implementation has occurred. It would be interesting to note any changes in management's perception of issues after the demonstration program is fully implemented and operating.

Regardless of the amount of information provided, military healthcare leaders may not be adequately prepared for the myriad of issues and political influences that disrupt the planning process and emotional equilibrium of the organization. The current atmosphere in the 105th Congress is very favorable to passing Medicare Subvention legislation, and as Medicare Subvention becomes more widespread throughout the MHSS, it is expected that news of its implementation will be known only a few months or possibly only weeks in advance. Advance identification of critical issues, rather than discovery of them when they emerge as problems, may facilitate effective management of such issues. There is great uncertainty when venturing into any new health care program at a medical facility. As a management tool, more information is needed when there is greater uncertainty. Since Medicare risk contracting is a relatively unknown operation for military managers, additional information, especially this information gained from actual experience, will provide an effective management tool to lead agencies and MTF's having to implement similar programs in the future.

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SECTION II

SWOT ANALYSIS

S.W.O.T. analysis is a method utilized by businesses to effectively summarize their present status and their future potential. It compels corporate analysts to consolidate large amounts of information regarding the firm into a selective evaluation of those factors which will have the greatest effect on the firm's success. S.W.O.T. analysis consolidates this information into four descriptions:

(1) **Strengths** refer to internal factors within the firm that provide it with a competitive advantage.

(2) **Weaknesses** refer to internal factors within the firm that provide it with a competitive disadvantage.

(3) **Opportunities** are factors or events which would benefit the firm, but are outside of the firm's control.

(4) **Threats** are factors or events which would harm the firm, but are outside of the firm's control.

The technique of S.W.O.T. analysis can be applied to the Demonstration Project, providing a synopsis of the issues facing the DoD as it prepares to implement the program. The following section evaluates DoD's strengths and weaknesses, and describes opportunities and threats for the Project.

STRENGTHS

- **Market Clout:** DoD has substantial leverage (money, large potential markets, etc.) with health care service providers in the Demonstration area.
- Each health services region has a **highly developed infrastructure** for delivering health care.
- **Experience:** DoD health care system has extensive experience with **serving the military retiree population.**
- United HealthCare's actuaries **consider the inpatient methodology** for assessing LOE to be adequate, and perhaps comparable to civilian billing **methods.**

APPENDIX A

- **Potential Turn-keys** (referring to the ability to make use of the existing resources to come up with a new product):

  = There have been **effective managed care initiatives** with the DoD health care system reform process. The Demonstration Project will be able to benefit from lessons of past initiatives;
  = DoD has a **nation-wide health care delivery network**. There is a huge potential for DoD to enjoy **economies of scale** once the Demonstration Project is successfully experimented;
  = **Functional administrative units are already in place.** The existing staff will be able to bring their experiences from managing other types of managed care initiatives into the Demonstration Project; and
  = There is strong support from DoD's administration for **Management Information System development initiatives.** MIS support for routine operations and strategic management is essential to the success of the Demonstration project.

- The Demonstration Project involves three phases. The scope and complexity of the Project grow gradually. This will help bring about a **smooth transition** at each phase of the project.

- DoD's health care system has and will continue to have a **loyal** and **well-entrenched customer base.** This gives the Demonstration Project competitive advantages in almost every aspect of management of the future military HMO.

- DoD's health care system has a reputation for **good customer service.** This image will benefit the marketing of the new product. The experience in customer service can be incorporated into the operation of such services for the Demonstration Project.

WEAKNESSES

- Complex delivery systems, which may cause integration problems.

- DoD has **limited experience** in delivering care in a reimbursement/data intensive system which is at financial risk.

- Presently, the **core elements of a successful at-risk plan** (e.g., enrollment, provider-specific contracting, utilization/care management, management information systems), are **delegated to commercial entities.** This results in nominal integration and weakens accountability.

WEAKNESSES (continued)

- The **core mission** of DoD health care providers (readiness) can **disrupt** the implementation/operation of **systems dependent on consumer access** to primary care.

- DoD **lacks** the **automated systems** to accurately track and report information necessary to measure level of effort.

- DoD **lacks systems** for **routine/standardized collection** (of claims, enrollment information, bills, etc.).

- The **method for calculating Level Of Effort (LOE) makes reimbursement** from the HCFA **unlikely**. The base year which DoD's level of effort will be calculated is 1994. Several factors will impair DoD efforts to reach this threshold:

  ⇒ Base closings have reduced DoD's potential to serve the retiree community;
  ⇒ Changes in the demographic profile of the potential beneficiary population (including age makeup and location) may reduce DoD's potential LOE;
  ⇒ HCFA regulations require the participating MTFs to serve patients within a 30 mile/30 minute radius (HCFA may be flexible on this requirement, but not beyond 40/40); if the number of patients with access is less than average regionwide access was in 1994, DoD will face another barrier in meeting LOE targets; and
  ⇒ Providers have already turned toward managed care systems, decreasing patient utilization significantly.

  Each of these factors makes it appear unlikely that DoD will ever reach the necessary LOE to receive reimbursement from HCFA.

- There is a lack of **understanding and recognition** within DoD regarding the nuances of LOE.

- The **Project** is probably **not financially feasible in Region 11**, due to low AAPCC rates, and is **only marginally feasible in Region 6**, according to United HealthCare's actuaries. The actuarial analysis assumes that outpatient MTF costs are similar to Medicare payment levels (estimated MTF costs were used for inpatient services) and that benefits remain as stated.

- United HealthCare's actuaries have found **that 93% of AAPCCs will not provide sufficient funding.** One potential explanation is that the method used to calculate AAPCCs does not attribute the DoD's costs to the MTFs.

WEAKNESSES (continued)

- **Inclusion of pharmacy costs will complicate LOE calculations.** These are not Medicare covered services, so a reduction in MTF pharmacy services would not result in added costs to the Medicare program. Additionally, significant limitations exist in the ability to capture accurate pharmacy usage data specific to Medicare-eligibles within the MTF and this population is known to have significantly higher pharmacy utilization than the under age 65 population.

- **DoD's current proposal makes no allowance for administrative costs in the determination of gains. This is a missed opportunity.** Under the ACR approach used by HCFA, Medicare risk contracts are allowed to count a reasonable level of administrative costs when determining if gains will be made requiring premium rate reductions, or benefit enhancements.

- **United HealthCare's actuaries have found that 93% of AAPCCs will not provide sufficient funding.** One potential explanation is that the method used to calculate AAPCCs does not attribute the DoD's costs to the MTFs.

- **DoD does not have a definite plan for measuring Level of Effort.** Specifically, United HealthCare has been unable to determine if LOE will be determined based upon the entire region's performance or upon participating military treatment facilities. Measuring LOE based on regional performance is dangerous; since each region contains only two participating MTFs, DoD would never achieve the level of performance needed to gain HCFA reimbursement.

- **Mandated service area reductions:** Unless HCFA makes an adjustment for DoD, it will require the MTFs to serve patients within a 30 mile/minute radius. Current catchment areas (on which LOE is based) are 40/40. Reducing the service area size may affect DoD's ability to reach LOE.

- Presently, **DoD lacks data** on Skilled Nursing Facility utilization and on whether its retirees have contracted End Stage Renal Disease. SNF and ESRD status must be tracked, because the information affects:

  ⇒ HCFA payment rates
  ⇒ prospective enrollees' eligibility to enroll in Medicare risk HMOs

- **DoD lacks consistent policies and procedures**, between health service regions and between military branches. These inconsistencies may hinder DoD in its efforts to fulfill HCFA requirements.

WEAKNESSES (continued)

- Presently, **DoD does not engage in pre-treatment or post-treatment tracking**, meaning that a patient's episodes of care cannot be identified or treated. Such "episode" information is needed to:

  ⇒ assist classifications of disease, which facilitates early intervention to prevent larger medical problems from occurring; and
  ⇒ knowledge of a patient's "episodes" allows an HMO to accurately assess whether to approve particular procedures as medically necessary.

- DoD's **policies and procedures** for its health operations **have not been designed in compliance with HCFA regulations.**

- DoD may be **incapable of transplanting** its traditional health services policies to the operation of a risk-based Medicare plan.

- **Travel between sites:** Enrollees might travel between sites to receive care. The result is that consumers would be enrolled at one site, but contributing to the other site's LOE. This represents an unknown factor in projecting risk and identifying complex cases for UM/CM focus.

- Commercial risk HMOs design their benefits, premiums, and copayments according to the characteristics of individual markets (to the extent allowed by HCFA). DoD will have to design a single benefit package to be applied nationwide. **DoD will thus have less flexibility to adapt to market conditions, local medical costs, and HCFA APR than its competitors.**

- **Start-up costs will be high.** DoD is likely to have large initial expenses (building purchases or leases, site design, communicating the new health care option to prospective enrollees, etc.). This could jeopardize the objective of cost neutrality.

- **Training and Recruiting Costs will be high.** Established commercial risk HMOs have the benefit of a low turnover. In contrast, DoD will have an entirely new set of positions to fill, the equivalent of 100% turnover. This could jeopardize the objective of cost neutrality.

- There is a **lack of consensus** within the DoD; the **regions have different goals and objectives.** This will inhibit accurate evaluation (since the purpose of the programs is unclear), risk redundancy, and hinder efforts to make the demonstration project a successful model which can be utilized elsewhere within the DoD.

WEAKNESSES (continued)

- **Information on several characteristics** of the military retiree population is **unavailable**, including:

  ⇒ age, education and income profiles of these retirees;
  ⇒ whether the prospective retirees have Medicare Part A, Part B or both;
  ⇒ how many of these retirees currently reside in skilled nursing facilities or are otherwise institutionalized.
  ⇒ whether retirees are currently enrolled in a competitor's risk HMO

  Without this information, DoD will find it very difficult to create marketing strategies, design operations effectively, or accurately assess program costs.

- Due to various constraints, the **regions are capping enrollment at less than 7,000 enrollees per region.** This will hinder efforts to achieve budget neutrality. Critical mass for a commercial HMO (**the minimum number of enrollees required for breakeven) is 10,000 members,** due to unavoidable fixed costs (staffing, information system upgrades, etc.), which can be alleviated on a per-member basis by adopting certain economies of scale. Low enrollments also increase the risk of adverse selection.

- **Capping enrollment** may **contradict** the stated program goal of **increasing retiree access** to health care.

- Potentially, **the retirees who would enroll the earliest**, before the cap was achieved, **would be the least healthy members** of the prospective population; this would result in the DoD bearing larger-than-average health care costs.

- Staffing patterns are directed by the DoD. **The MTFs will be unable to modify staffing to meet consumer demand and HCFA requirements.** Modifications directed by the DoD include mandated downsizing, teaching and rotation transfers, and physician extenders (CMPs/PAs).

- The demonstration **MTFs may encounter situations in which care is required, but not deliverable** (for example, a situation in which a facility cannot provide joint services).

- **The 93% reimbursement rate is below the standard 95% issued by HCFA to commercial risk HMOs.**

- **Numerous offices will handle HCFA reimbursements** before they reach the MTFs; these offices could divert cash flow, creating a loss potential for the participating MTFs.

WEAKNESSES (continued)

- United HealthCare's **existing HMOs allow nine to twelve months to implement a risk contract**. These HMOs have well-established systems and models to draw upon. Without these advantages, **DoD is attempting to initiate a plan within one month** (by October 1996, one month after the business plan is completed). Currently, staff have not been allocated or appropriated; information systems are not in place; training programs have yet to begin; there is a lack of information on policies and procedures; marketing and member enrollment materials have not been developed. Whether the program can be initiated by the October deadline is questionable. Perhaps a more significant risk is that the program will be initiated without sufficient care taken to ensure that the program operates effectively.

- A review of DoD literature indicates that **there are multiple visions for the outcomes of the demonstration project**. These competing visions could inhibit the adoption of sound business decision-making and plan processes.

- **The project may fail to attract consumers.** Existing DoD health programs, combined with the presence of competitor risk HMOs, may result in consumers electing to not participate in the demonstration project; consumers may determine that they already receive many of the same benefits without paying a TRICARE premium of over $200 per year.

- The **premiums** proposed for the project may be **cost-prohibitive** for potential enrollees. For a retiree not eligible for premium-free part A Medicare, who wishes to utilize hospitalization coverage, participation in the project would require payment of the TRICARE $230 annual premium, along with registering for Medicare Parts A and B. The total monthly costs for this consumer in 1996 would exceed $350 per month. (Part A at $289 a month, Part B at $42.50). In contrast, some of the competitor HMOs only charge enrollees the cost of Medicare Parts A and B (there is no additional premium required).

OPPORTUNITIES

- To meet the actual and perceived commitment of **access** to high quality Health care for the Medicare-eligibles who have served our country, while saving tax-payers money.

- To use proven experience from managed care to contain overall costs.

- The **mechanisms** identified in the Demonstration Project could potentially be used to improve TRICARE.

OPPORTUNITIES (continued)

- To gain additional **funding** and **savings**:

  ⇒ Well-defined polices and procedures, if globally used, could generate savings in administration costs; and
  ⇒ There is additional funding available from HCFA.

- The Demonstration project will offer DoD opportunities to **streamline operations** to provide health care services and **reduce the amount of contracted services.**

- The **flexibility** in HCFA approval process and privileges to waive some regulation items, as compared to a commercial risk contract provider, can result in competitive advantages and decrease administrative burdens to meet HCFA regulations.

- **Positive feedback** could enhance **readiness:**

  ⇒ There is a positive feedback loop as following:
    1) savings bring about better outcomes;
    2) better outcomes ensure the maintenance of clinical skills which are essential for positioning DoD health care system for readiness;
  ⇒ A fully integrated and continuum-based approach to health care management will undoubtedly increase readiness;
  ⇒ The positive feedback will encourage the administration to acquire skills to reallocate the provision of services away from the traditional acute and tertiary settings.

THREATS

- **DoD may be unable to meet all non-waived HCFA requirements**, considering the gaps it must resolve and the short timeframe it has to resolve them.

- **The LOE requirement will become increasingly difficult to meet if additional MTF resources are used to service CHAMPUS eligibles under TRICARE.** The proposal requires DoD to lock in the level of service to Medicare-eligibles at historic levels, which may not be feasible, given capacity requirements for CHAMPUS. At low enrollment penetration, or in areas with historically high MTF usage levels, it may be likely that all payments paid by HCFA will be returned for failure to meet LOE requirements.

THREATS (continued)

- While United HealthCare's actuaries consider DoD's LOE **methodologies** adequate, they **may not be acceptable to HCFA.**

- The **hastiness of plan implementation** could result in the program failing to provide adequate customer service and/or operating in a cost-effective manner. This **could lead to a public backlash and congressional pressure to cancel the project.**

- There is a **lack of knowledge** concerning the number of military retirees already enrolled in competitor HMOs. There is a risk that the market for the project is too limited.

- **The 30 mile/minute rule could limit the ability of the participating MTFs to attract an adequate number of enrollees.**

- **Competitors are well-established in the service area.** Potential consumers may perceive that the TRICARE and Medicare premiums required to participate in the project does not provide sufficient additional benefits to warrant their enrollment in the program. The biggest advantage of participation in the project may be the prescription drug benefit; however, retirees are currently eligible for inexpensive drugs at MTFs even if they are enrolled in a competitor's plan.

- **Competitors may have more extensive provider networks**, placing the MTFs at a competitive disadvantage.

- **DoD may be unable to hire and train staff by October 1996 who are capable of administering the program successfully.**

- **Modification of DoD health policies** to accommodate HCFA requirements might **cause confusion** among military retirees.

- **Management information systems may not be sufficiently upgraded** to sufficiently operate the program while meeting HCFA requirements. This could adversely impact consumer satisfaction and program continuation.

- **Critical deadlines may be missed.** DoD may not be prepared to submit marketing and communication materials to HCFA before August 15, 1996 (which it must do if it desires October 1 distribution). DoD must submit all materials to HCFA for review and approval at least 45 days before their planned distribution.

- The TRICARE and Medicare premium requirements for retirees may result in **adverse selection**. Those retirees requiring high cost health care will be the most likely to buy.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
DEMOGRAPHICS		
ESRD, Disabled and Skilled Nursing Facility status affects eligibility payments. The number of Military Retirees who have End Stage Renal Diseases (ESRD), are certified disabled, or who live in a Skilled Nursing Facility (SNF) will affect the payment rate received by Medicare risk HMO's for the care they are provided. •ESRD patients are not eligible for Medicare benefits unless the enrollee develops ESRD after they have already been enrolled	DoD is not currently able to track which retirees have ESRD, are certified disabled or live in a SNF.	**GAP:** *There is no information available on the prevalence of these conditions for the military retiree population. Until this information is received, neither the number of military enrollees eligible to participate in the Demonstration or the expected Average Payment Rate (APR), to be received from HCFA , can be determined accurately. As a result, there will be no method by which DoD can predict the amount of reimbursement from HCFA that it will receive.*
•HCFA requires that only those who subscribe to Medicare Parts A & B are eligible to enroll in a Medicare Risk HMO.	DoD is limiting the number of potential enrollees by requiring that all military retirees over the age of 65 (who enroll in TRICARE Prime) have both Parts A & B.	**GAP:** *Information on the number of military retirees who have Medicare Parts A & B has not been provided to date; nor have any reliable estimates on the percentages of retirees within the Demonstration who have Parts A & B been produced. Until this information is received, there can be no determination made as to how many military retirees are eligible to enroll in the Demonstration.* HCFA requires that only those eligible for Medicare Part A and Part B can enroll in an HMO can enroll; DoD must have access to information regarding who is actually eligible to enroll in the Demonstration Project.
There are military retirees currently enrolled in civilian Medicare risk HMO's who reside within the Demonstration Areas. These retirees may	DoD has no ability to track the number of military retirees who have civilian health insurance coverage in the Demonstration	**GAP:** It is unlikely that military retirees who are

APPENDIX B

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
be unlikely to enroll in the demonstration.	Areas.	satisfied with their civilian Medicare HMO coverage will be switching over to TRICARE for the purposes of this Demonstration. *Until this information has been received, there can be no determination made as to how many military retirees are likely to enroll in the Demonstration.*
•Utilization of health care services by military retirees in both the civilian and military sectors should be tracked to determine utilization patterns	DoD has no data available on the care accessed by military retirees in both the civilian and military health care sectors.	**GAP:** The total utilization of health care services cannot be accurately estimated unless data is available on the care accessed by military retirees in both the civilian and military health care sectors. *The absence of this information requires that considerable assumptions regarding utilization patterns be made in order to make any estimates of expected utilization of services or costs for providing services for the Demonstration.*
SERVICE AREA		
*HCFA requires that enrollees live either within 30 minutes or 30 miles of a participating medical facility	DoD's current catchment areas is 40 minutes or 40 miles from a primary care provider.	**GAP:** DoD's catchment areas are larger than the maximum Service Area allowed by HCFA. The gap is that there will be reduced access due to the fewer number of participating MTF's.
*HCFA generally requires that the Service Area consist of whole counties.	DoD's current Service Area analysis is measured by zip codes, resulting in the inclusion of parts of counties.	**GAP:** Catchment areas are defined by zip code rather than county. HCFA rarely allows partial counties to be included in the service area for Medicare risk or cost contracts. Altering the

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
		catchment areas to include full counties could either increase or decrease the size of the catchment (service) area.
BENEFIT LEVEL AND COMPETITIVE ANALYSIS		
√All Medicare beneficiaries enrolled in the HMO are entitled to receive at least the services covered by fee-for-service Medicare in that geographic area. The HMO must provide, or arrange to provide, all services covered by Part A and Part B of Medicare. The following services must be included: a) inpatient hospital care; b) SNF; c) physician services; d) outpatient physical therapy, occupational therapy and speech pathology services; e) ambulatory surgical center services; f) Comprehensive Outpatient Rehabilitation Facility (CORF) services; g) home health services; h) diagnostic laboratories and X-rays; I) certain pharmaceutical drugs; j) surgical dressings, splints, casts; k) braces and artificial limbs and eyes; l) prosthetic devices'; m) DME; n) X-ray, radium and radioactive isotope therapy; o) ambulance services when transportation by other means is contraindicated by the individual's condition; p) treatment of ESRD (if ESRD develops after enrollment; beneficiaries who already have ESRD are not allowed to enroll in the first place);	Currently, TRICARE Prime is delivering these services.	<u>GAP:</u> The gap is that DoD must rely on civilian contractor networks as opposed to providing the services at the MTF's. DoD's mission is to provide as much service as possible at the MTF level and keep delivery services within the Military Health System.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
q) outpatient treatment of mental illness; r) outpatient physical therapy and speech pathology services; and s) screening mammography and pap smears according to a schedule based on age and risk of developing breast or cervical cancer •HCFA requires the HMO to provide the services (listed above) as well as those listed in the HCFA Regulatory Requirements (See Legal and Policy Requirements, page 7).		
•HCFA allows members who wish to disenroll, to re-enroll as they chose to do so. There are no regulations that prohibit disenrollment or reenrollment.	**DoD currently, under TRICARE, has a 12-month Lock-In; it prohibits members from disenrolling during the first 12 months of the membership.**	GAP: The gap is that DoD will need to alter such polices in order to comply with the HCFA regulations. HCFA will not likely waive this area.
PROVIDER NETWORK		
•Any contracted-for providers must meet the HCFA requirements for the provision of Medicare services; they must be HCFA-approved providers.		*United HealthCare has not received enough information (as of 7/26/96) to determine the adequacy of the TRICARE and MTF provider networks*
ACTUARIAL ANALYSIS		
Specific information, including ESRD status, disability status, SNF status, utilization data (including ambulatory data by age for those over 65), age distribution over zip codes, is required before an accurate actuarial analysis of the Demonstration can be completed.		GAP: Large assumptions have had to be made in order to calculate projected utilization, cost and HCFA payment data. Assumptions may affect accuracy of analysis. *DoD either does not have access to, or has not yet provided, all of the necessary data.*
United HealthCare will not operate a Medicare risk product in a particular market unless it is believed that the product is reasonably [illegible]cially feasible.		**GAP: The gap is that, according to the actuarial analysis, the program, as proposed, will not likely be feasible in San Antonio.**

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
HCFA requires that Medicare beneficiaries are assured adequate access to services.		**GAP: Also, the Demonstration calls for enrollment up to the capacity of the MTFs. In many areas of the TRICARE program, the MTFs have sustained their capacity. IF there is Demonstration enrollment, care will need to be referred outside the MTF system which would lead to additional costs and would be a barrier to meeting the LOE.**
DoD submitted pharmacy costs as a portion of the LOE budget development.		**GAP: The gap is that pharmaceutical costs are not Medicare benefits and should be excluded from the LOE budget development. Since pharmacy costs are a covered benefit, they should be counted for the determination of "gains" which trigger future premium reductions. The should not be included in the determination of whether or not historic LOE has been met.**
ADMINISTRATION, STAFFING AND COSTS		
•The HMO has personnel and systems sufficient to cover all administrative and managerial aspects of the plan. •The HMO's staff (per plan) includes the following positions: a) Director of Operations, b) Sales Manager, c) Sales Representatives, d) Sales Supervisor, e) Telemarketing Representative, f) Telemarketing Supervisor, g) Compliance Manager, h) Marketing Manager, i) Advertising Supervisor, j) Network Manager, k) Grievance and Appeals Supervisor, l) Member Service Representative, m) Member Service Supervisor, n) Retention and Verification Representative, o)Retention and Verification	Currently, these requirements are fulfilled through a collaborative process of support from specific offices within Health Affairs, the Lead Agent and the Military Treatment Facilities	GAP: DoD lacks a sufficient number of personnel that are trained in Medicare Plan Administration.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
Supervisor, p) Medicare Case Manager,		
*The HMO's operations are managed by an executive whose appointment and removal are under the control of the HMO's policymaking body. •The CEO and Board of Directors control the appointment and removal of the HMO executive.	Currently, local operation of the Medicare demonstration will be the responsibility of the MTF Commanders. MTF Commanders are active duty officers whose appointment and removal are under the control of the Service to which they belong and the Surgeon General.	GAP: No gap exists as long as there are mechanisms in place that can appoint and remove the executive in charge of the Medicare demonstration .
*The HMO has sufficient administrative capability to carry out the requirements of the Medicare Contract. •Structured organization is necessary, with clear lines of authority and communication; the CEO and, ultimately, the Board of Directors, exercise oversight and control over policies and personnel.	Informational materials and training is provided by HA and the Regional Lead Agent. The Lead Agent provides information to the MTF's on new or revised Medicare requirements. The MTF provides updates to staff and providers. Some agents have been to HCFA for training; this training was not extensive but was available.	GAP: There are no current Medicare Training Manuals that are the property of DoD. Nor, is the entire staff adequately trained and ready to operate a Medicare plan.
OPERATIONS		
Appeals		
*The HMO establishes, maintains, and informs all enrollees, in writing, of the appeals procedures for all organization determinations. •If the organization determination is partial or fully adverse to the member, in the form of claim denial or verbal denial, then a written notice in the form of explanation of benefits or denial letter is issued which details the reasons for the determination. It outlines the member's right to reconsideration and the right to be represented by an attorney in the reconsideration. The document informs the member of the process for filing requests. √The written information should be provided to members in each of the following situations: a) at the initial enrollment with membership materials, b)the annual rights notice, c)upon	All hospitals currently conform to JCAHO requirements. The "Patient's Bill of Rights" is posted in common areas of the MTF. The patient representatives are posted with names, photos, and phone number so that any member can ask questions and receive the necessary information. Retirees enrolled in TRICARE receive newsletters and enrollment information. MTF's hold annual health fairs where they receive information on DoD's health plans.	GAP: There is no definitive process to ensure that all customers receive written information on the appeals process.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
request by the enrollee or his/her representative.		
•The HMO develops procedures to assure that contracting providers are fully informed of appeals procedures and their responsibility to provide written notice of adverse initial determination to the enrollee when service is denied. The HMO monitors these procedures and accepts requests for reconsideration filed within 60 days of the initial determination. •The notice of adverse determination informs the member that he/she must file the request within 60 days of the date of the notice that a determination will be made within 60 days from the date the request for reconsideration is received in the Medicare Complete office.	DoD has provided no information regarding the contracting provider's responsibility to inform members about their right to appeal.	GAP: DoD has no policy to monitor procuedres which ensure that contractors are informed of their obligations.
•The HMO properly identifies complaints which involve initial determinations for: a) reimbursement for emergency or urgently needed services, b) services furnished by nonafilliated providers or suppliers that the enrollee believes is covered by the HMO contract and should have been furnished, arranged for, or reimbursed by the HMO, or c) services which the HMO refuses to provide that the enrollee believes should be furnished through the HMO and the enrollee has not received outside the CMP. •A dispute about organization determinations, which is a determination concerning the rights of an enrollee with regard to services covered by Medicare that are furnished by the organization, and any determination made concerning a, b and c above.	Currently, appeals and grievances are defined appropriately by DoD. However, the patients operate through the same channels and procedures regardless of whether it is a grievance or an appeal. The process begins with a patient representative.	GAP: DoD has no structured appeals and grievance procedures following HCFA regulations regarding determining if a claim is an initial determination or a grievances. From there, the process must go through the appropriate steps to reach a final determination

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
•The HMO makes an initial determination within 60 days of the enrollee's request for the services or for request for a payment of a service. Failure to provide a notice constitutes an adverse initial determination which the enrollees may appeal. •The organization determination must be made within 30 days for all "clean" claims and 60 days of receiving the request for all "non-clean" claims. A "clean" claim is one that has no defect or impropriety an does not require additional information from a source outside the plan.		GAP: DoD lacks definitive procedures for making organization determinations regarding claims. *DoD has not provided information regarding the nature of initial determinations.*
•The HMO's decision to deny payment for claims or refusal to provide or authorize a service is an adverse initial determination. The notice of the adverse initial determination: a) states the specific reasons for the denial, b) informs the enrollee of the right to a reconsideration, c) includes information regarding availability of legal assistance, and d) provides parties to the reconsideration reasonable opportunity to present evidence relating to the issue in dispute, in person as well as in writing. •If the organization determination is partially or fully adverse to the member, in the form of claim denial or verbal denial, then a written notice in the form of explanation of benefits or denial letter is issued which details the reason for the determination and outlines the member's right to reconsideration and right to be represented by an attorney in the reconsideration. The document informs the member that he/she may provide additional ence to support the claim in person or in	There is no information regarding how DoD makes an equivalent determination. While there is an grievance process, the format is dissimilar to HCFA's procedure.	GAP: DoD does not have a standardized method for notices of adverse determination. *DoD has not provided information relating to the notice given for adverse determinations*

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CHAMPUS Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
writing.		
•Any party to an initial determination who is dissatisfied with that determination may request a reconsideration of the determination after responding to the claim. The request for a reconsideration must be filed within 60 days from the date of the notice of the initial determination.	DoD procedures for second determinations are limited to an internal process.	**GAP:** There is no process by which an initial determination may be reconsidered.
•If the HMO recommends partial or complete affirmation of the initial adverse determination, the HMO must prepare a written explanation and forward the entire case file to HCFA, which makes a reconsidered determination.	DoD does not currently send cases to HCFA as required in the HCFA regulations.	**GAP:** DoD has no mechanism in place for sending HCFA copies of case files.
•The HMO assures that someone not involved in making the initial determination makes the reconsidered determination (second level of review of an adverse initial determination decision). •The written request for reconsideration is submitted to the Appeals/Grievance Coordinator for processing. The Coordinator sends a letter to the member of his/her authorized representative to acknowledge receipt of request for reconsideration. Once all pertinent information is received for reconsideration, the Coordinator, is responsible for disqualifying any member of the committee involved in the organization determination.	Current: DoD procedures: 1) Patient registers a complaint with the patient representative at the MTF, who keeps a log including, the patient's name, subject of the complain and its eventual resolution; 2) In some cases patients are asked to put their complaint in writing, and the specific department mentioned in the complaint is given the letter. The department will attempt to resolve the complaint; 3) If the patient does not receive satisfaction through these channels, the patient can bring the complaint to the hospital commander; 4) The next level of appeal is major command; if the patient is still unsatisfied, he/she can appeal to the Surgeon General; 5) The final level is the Inspector General who is external? Patients can go to the IG directly if they choose. 6) If the patient is dissatisfied, he/she can write to their congressman. A congressional liaison will be sent to research the complain, and	**GAP:** This process does not provide a process for a hearing with an ALJ nor for Judicial Review. It only ensures that no one involved in the initial determination is also involved in the reconsideration.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
	his/her findings will be sent to the congressperson and the patient.	
•The HMO either makes a fully favorable decision and issues a decision within 60 days to the enrollee, or, if the HMO is unable to make a fully favorable decision, the HMO forwards the case to HCFA within 60 days for the date of receipt of the reconsideration request. •If the Appeal/Grievance Committee upholds the organization determination in whole or in part, then a reconsideration case is prepared and sent to HCFA's contractor, Network Design Group (NDG) for review within 60 days of the date the appeal was received.•	DoD does not currently have this procedure in place; it does not forward cases to HCFA.	GAP: DoD does not meet the requirement that claims pass through HCFA because it does not have the capability.
•If HCFA's reconsideration determination is to hold the HMO liable then the HMO provides or pays for the service within 60 days from the date of HCFA's determination. •If NDG overturns the reconsideration determination in full or part, the Appeals/Grievance coordinator is responsible for having the claims paid or arranging for the provision of services and for notifying NDG of those actions within 60 days of the receipt of their notification. If an extension is desired, it should be requested in writing and include the reason for the request.	DoD has not made available information pertaining to this procedure.	GAP DoD does not necessarily have this policy consideration in place.
•If the reconsidered determination is not favorable to any party, they (except for the HMO) have a right to a hearing, before an ALJ, if the amount in controversy is $100 or more.	DoD has no hearing procedure in place.	GAP: DoD's appeals process lacks hearing procedures as required by HCFA.
•If any party to a hearing, including an HMO, is dissatisfied with the hearing decision, they	DoD has no Appeals Council, nor an equivalent.	GAP:

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
may request the Appeals Council to review the ALJ's decision.		DoD's appeals process lacks an Appeals Council or its equivalent.
•If any party is dissatisfied by the Appeals Council determination and the amount in controversy is $1,000 or more and is the final decision of HCFA, they can seek Judicial Review.	DoD has no stated policy on when a decision can be reviewed judicially.	GAP: There is no gap here because DoD cannot prevent a member from seeking relief via judicial review.
Grievances		
•The HMO properly identifies issues subject to the grievance process. Anything not subject to appeals is considered a grievance. For example; a) quality of service provided, b) long waiting times for appointments or at the physician's office, c) services covered under an optional supplemental plan, d) issues relating to premiums and involuntary disenrollment. √The internal grievance procedure must contain the following procedures: a) transmit timely grievances and complaints to appropriate decision making levels in the plan; b) take prompt appropriate action, including a full investigation , if necessary, and c) notify concerned parties of investigation results.	Appeals and grievances are processed through the same channels and procedures; no formal distinction is currently made. The same procedure has been described in the appeals section above.	GAP: There are policies and procedures set out by DoD regarding grievances; the gap is that the procedures do not follow HCFA requirements for full investigations, when necessary, nor for notification of the investigation results.
•United HealthCare defines a grievance as a member's complaint which is not an organization determination through the appeals process. This includes complaints about waiting times, physician and nurse practitioner behavior, enrollment difficulties and concerns. The plan will categorize a grievance in one of three categories 1. an informal grievance which is a complaint	DoD indicated that there is no difference between an appeal and a grievance. The two complaints are processed similarly.	GAP: The gap is that DoD does not distinguish between grievances and appeals as required by HCFA. Without two distinct procedures, DoD is not in compliance with HCFA's regulations.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
given verbally to an employee of the Plan by a member or the responsible party for the member; 2. a formal complaint which is a written complaint filed by the member or the responsible party for the member; 3. a complaint hearing is provided when a member is not satisfied with the decisions of a formal complaint. A Plan Complaint Hearing Committee will be established and resolution made within 60 days of the initial request for hearing.		
•The HMO's written grievance procedures include a thorough explanation of the steps to follow in completing the procedure and time limits for each step of the procedure.	As stated in the appeals section of this table, DoD hospitals do conform to JCAHO requirements and post the "Patient's Bill of Rights" in common areas of the MTF.	GAP: The "Patient's Bill of Rights" does not fully explain the grievance procedures as per the HCFA regulations. Nor does it list the time limits required for each step in the process.
Enrollment Requirements		
•The HMO has an effective system in place for receiving, controlling and processing applications from Medicare enrollees. Applications are dated as of the date they are received by the HMO and processed in chronological order by date or receipt.	DoD, primarily through TRICARE and CHAMPUS, has enrollment systems in place.	GAP: DoD has no systems procedures in place (manual or automated). The systems that are in place do not collect the necessary data for HCFA requirements.
•If the applicant is unable to manage his/her affairs, a court-appointed guardian or representative may execute, sign and date the application.	There is no evidence to suggest that DoD has this procedure in place with their own health care system.	GAP: DoD has no "Power of Attorney" process in place.
•Applications are on file for all current enrollees and are kept for at least one year following an enrollee's disenrollment	Not Available	GAP: DoD has no process for ensuring the applications stay on file for one year.
•The HMO notifies the applicant in writing of	DoD has enrollment procedures but nothing	GAP:

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
the receipt and/or denial prior to processing, if appropriate, of the application no later than 30 days following receipt of the application. The written notice of receipt specifies the proposed effective date of enrollment; or, if the HMO is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur.	explicitly fitting the HCFA requirements.	DoD does not have a HCFA approved letter format for notification purposes.
*The HMO transmits the applicant's enrollment information to HCFA within 30 days from the date of the application or from the date a vacancy occurs if the latter is due to capacity restrictions (or, within an additional period of time approved by HCFA).	There is no information available regarding the explicit procedures currently used by the DoD.	GAP: DoD has no system in place that follows the requisite process or timeline for the transmission of an applicant's enrollment information.
*When the HMO receives enrollment confirmation from HCFA, it promptly (within 30 days) notifies enrollees in writing of the effective date of enrollment, and sends HCFA-approved information on the rules including benefits and enrollees' rights and responsibilities.	There is no information available regarding the explicit procedures currently used by the DoD.	GAP: DoD has no system in place for the processing of HCFA-approved applications nor for following the requisite timeline.
*The HMO adheres to the requirements in requesting retroactive enrollments from the HCFA Regional Office.	There is no information available regarding the explicit procedures currently used by the DoD.	GAP: DoD has no system in place for these requests.
Disenrollment Requirements: Voluntary and Involuntary		
*The HMO promptly disenrolls Medicare enrollees upon receipt of their written request. Disenrollments are effective no earlier than the first day of the month following the month or no later than three months from the date the HMO receives the request. Enrollees are not required to submit disenrollment requests within a specified time frame in advance of the desired date. Disenrollment requests accepted by the HMO	DoD does not have a system in place for analyzing disenrollment. There is no system available for notifying HCFA of the disenrollment correctly and promptly nor for updating system information. No internal membership information system which is reconciled against HCFA records.	GAP: There is no system in place to facilitate disenrollment.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
are signed and dated by Medicare enrollees. If the enrollee is unable to manage his/her affairs, a court-appointed guardian or representative may sign and date the disenrollment request.		
•The HMO sends final notice to the enrollee confirming the date of disenrollment only after it has verified HCFA's effective date per the HCFA Monthly Transaction Replies/Monthly Activity Report Listings. Notice is sent within a reasonable amount of time (30 days) following receipt of the HCFA report.	DoD's disenrollment procedures do not follow HCFA requirements; basically the administrators interact with the contractor, the Lead Agent and the beneficiaries.	GAP: DoD has no internal membership information system in place.
•The HMO notifies Medicare enrollees, in writing, of the intent to disenroll them on an involuntary basis and mails such notices to enrollees and allows a reasonable amount of time for the enrollees to respond (at least 20 days following date of the notice) before the effective disenrollment date and prior to sending notice to HCFA. The notice contains the proposed effective date, a clear explanation of the reason for disenrollment, information on the enrollee's right to a hearing under the HMO's grievance procedure, and a reminder that the enrollee must receive services through the HMO until the effective termination date.	Under TRICARE's system, the DoD disenrolls members who were out of the Service Area or failed to pay the premiums DoD dictates that all members cannot disenroll as any time after 12 months of continuous enrollment.	GAP: The gap is that HCFA allows at will disenrollment of the beneficiaries. TRICARE prohibits disenrollment within the first 12 months. This gap will not likely be tolerated by HCFA.
•The HMO disenrolls members who move outside of the approved service area for more than 90 consecutive days.	DoD has no system of tracking the enrollees who move out of the service area.	GAP: There are no procedures in place for DoD to track such information.
•The HMO makes reasonable efforts to establish that members have permanently moved from the approved service area. Such efforts are documented in writing or evidence		GAP: There are no systems in place to complete this process.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
exists in some other form acceptable to HCFA.		
•Members who are disenrolled for fraud or abuse are only disenrolled if they knowingly provide fraudulent information which materially affects the organization or affects the applicant's eligibility to enroll, or because an enrollee intentionally permits others to use the membership card to receive HMO services.	.	GAP: DoD has no procedures in place for this tracking.
•The HMO advises HCFA of such disenrollments only after reasonable advance notice is given to enrollees.		GAP: DoD has no procedures in place for this tracking.
•The HMO maintains documents related to the decision to disenroll and reports these disenrollments to the Office of Inspector General (OIG).		GAP: DoD has no file inventory control procedures currently in place.
•The HMO disenrolls members who lose Part B entitlement effective with the month following the last month of such entitlement.	DoD does not provide for this tracking in their operations.	GAP: There is no mechanism for tracking Part A and Part B Medicare beneficiaries.
•Members who lose entitlement to Part A, but remain entitled to Part B of Medicare, automatically continue in the HMO as Part B enrollees	DoD does not provide for this tracking in their operations.	GAP: There are no mechanisms for tracking Part A and Part B Medicare beneficiaries.
•The HMO disenrolls members effective the first day of the calendar month after the month in which notice is given to them of the intended action.	DoD does not have a procedure in place to disenroll; it requires its contractors to give notice accordingly.	GAP: DoD will not be able to effectively monitor the operations of enrollment and disenrollment while relying on contractor services. The contractors must be implementing HCFA regulations.
•The HMO promptly sends a letter to the enrollee acknowledging receipt of the disenrollment request, and includes a copy of the enrollee's written request to disenroll. The	DoD has no format for disenrollment procedures.	GAP: DoD has no system in place to alert management of the changes.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
letter contains the proposed effective date, and explains that the enrollee must continue to receive health care from the HMO providers until that date.		
*The HMO correctly submits requests to HCFA's Regional Office for retroactive disenrollments in instances where the enrollee clearly failed to understand the lock-in and other related HMO rules. Supporting information is included in accordance with HCFA policy	DoD does not have a system in place for notifying HCFA of disenrollments and reenrollments.	GAP: DoD has no procedures in place to handle such cases.
Billing Requirements and Procedures		
*The HMO notifies members of the changes in its rules, at least 30 days before the effective date of the change.	DoD does follow a notification process; it does not follow HCFA's timeline.	GAP: DoD has no billing rules in place to determine whether or not to charge the members a premium.
*When the HMO incorrectly collects premiums and/or other amounts due, it refunds those amounts to members, or to others who made payments on behalf of such members	TRICARE does not currently refund premiums incorrectly collected. There is no refund mechanism for DoD.	GAP: HCFA requires refunds be paid out when necessary; since DoD has no mechanism in place for refunding any amounts due, DoD fails to comply with the regulations.
Claims Requirements and Procedures		
*The Plan's claims processing system identifies and tracks all claims including information that identifies: •provider and amount billed; •date the claim was received; •date additional development was initiated; •date the claim was adjudicated; •amount paid; •date the check was written and mailed; •reason for denial, if applicable; •procedures for claims transferred from the	DoD dictates that its contractors have similar systems in place; however, DoD does not have these systems in place to sustain a Medicare Plan without the help of a contractor.	GAP: DoD has some systems in place but not sufficient to operate a Medicare Plan on its own.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
carrier or fiscal intermediary (i.e. they should be treated like any other incoming claim).		
*The Plan's claims procedures specify timeframes for the following: •making a determination of "clean" and "non-clean" claims (i.e. within five working days of receipt); •initiating development of "non-clean" claims (i.e. within five working days of receipt); •follow up on pending claims (i.e. within 15 working days of original request for additional information with subsequent requests at 15 day intervals); •making an initial determination to pay or deny; •send a notice with appeals rights to the member if an initial determination is not made within 60 days of receipt (claim is deemed a denial, subject to appeal).	DoD does not have the concepts of "clean" and "unclean" claims. DoD relies on different time frames for the various claims procedures.	GAP: DoD does not have this time frame laid out in its policies. Their current capabilities do not meet HCFA requirements.
*The Plan makes accurate determinations of emergency-urgently needed services, covered benefits, and "clean"/"non-clean" so that claims are appropriately filed.	DoD's contractors are required to have an automated system; DoD does not, however, have an automated system to process claims accurately.	GAP: DoD is not capable of performing claims operations with their current system. They must rely on their contractors.
*The Plan's system can generate reports on a periodic basis (i.e. monthly) that reflect claims payment and denial data.	DoD's contractors can generate the necessary reports; DoD does not have this capability.	GAP: DoD does not have the current capability to generate the required reports.
*The Plan's claims processing procedures are written and available to staff	There has been no information provided regarding whether DoD has these procedures written out and available to the staff.	GAP: DoD does not meet the HCFA requirements if there is no written information available.
*The Plan pays 95% of "clean" claims from unaffiliated providers with 30 days of receipt. If the Plan's contracting providers pay claims,	DoD does not have this current percentage rate of payment.	GAP: DoD does not have this procedure in place.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √Cf...	DOD'S CURRENT CAPABILITIES	GAPS/ REQUIREMENTS NOT MET
they pay 95% of "clean" claims from unaffiliated providers within 30 days of receipt Prompt payment requirement - If claims for unaffiliated providers are not paid within 30 days of receipt of the claim the Plan is required to pay.		
*The Plan includes proper appeals language in its denial notice.	There has been no indication that DoD provides denial notices; nor is there any information regarding what information is included in the notices, if any.	GAP: If DoD has no denial notice sent out, then DoD is failing to comply with this HCFA requirement.
*The Plan notifies the beneficiary of the right to appeal if it has failed to make a determination within 60 days of receipt of the request to provide, arrange for, or reimburse for services (i.e. failure to provide notice is deemed an adverse initial determination subject to appeal).	Beneficiaries appeal to their patient representative first, and then move up the various administrative channels within the DoD.	GAP: The gap is that this appeals process does not comply with HCFA's requirements for appeals. **(See Appeals Section).**
*The Plan has procedures to identify payers which are primary to Medicare, determine the amounts payable and coordinate benefits.	DoD's contractors have this capability. DoD does not currently have the capability.	GAP: DoD does not have the systems capability.
*The Plan has procedures which detect and recover duplicate payments; that is, the Plan has procedures which match payment information received from carriers and the Part B itemization report with payments made or services provided by the Plan. The Plan has procedures which detect and recover overpayment to providers.	DoD's contractors have the capability; DoD does not require the contractors to report on Part B beneficiaries. T	GAP: DoD does not have a system to make such comparisons that are specific enough for this Demo project. While the contractors may be able to adjust their systems, the process will likely be very difficult.
Reconciliation Requirements and Procedures		
*The HMO reviews the HCFA Monthly Replies/Monthly Activity report Listings and the Maintenance Records upon receipt and appropriately follows up on a change in enrollee's status.	DoD has no reconciliation systems to carry out the requirements of HCFA	GAP: DoD has no system available to promptly and thoroughly review and reconcile the HCFA Monthly replies/Monthly Activity Report Listings and Maintenance Records.

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
*The HMO verifies its enrollees' institutional status at the beginning of each month, correctly defines such status, accurately identifies those enrollees that resided in an institution for the full month and submits such data to HCFA.	There is no information regarding whether DEERS can collect the requisite data.	GAP: The gap is that the requisite monthly reports cannot be generated and sent to HCFA as required by HCFA.
HEALTH SERVICES AND DELIVERY		
*The HMO must arrange for required Medicare services, additional services, supplemental services which the Medicare enrollee has contracted for throughout Medicare-approved providers and suppliers	DoD currently contracts a majority of services to TRICARE contractors.	GAP: The gap is that DoD, in the absence of delegated responsibilities to TRICARE, does not meet HCFA's requirements. This creates additional costs while diminishing the ability to monitor the provision of services
*Maintanance of Records: Each HMO must have an effective procedure to develop, compile, evaluate and report to HCFA, its enrollees and the general pubic, at the time and in the manner that HCFA requires, (maintaining confidentiality) necessary statistical data.	DoD AR 40-66 indicates compliance with the general requirements of record-keeping.	GAP: DoD has no current ability to automate medical record-keeping and subsequent reporting requirements cannot be met.
QUALITY ASSURANCE AND UTILIZATION MANAGEMENT		
*The HMO has an ongoing QA program for its Health services that meets the conditions described by HCFA.	MTF's have specific QA programs implemented at the MTF-level only.	GAP: The gap is that DoD lacks an integrated, consistent QA program that is operational on a TRI-service basis; the existing DoD QA program is not geared to meet the requirements of the Medicare population; and while some factors will apply, the DoD program lacks a demographically-based approach to quality management.
*The HMO must have effective procedures in place to monitor utilization of appropriate health services to control costs of basic and	Currently, DoD lacks consistent application/use of approved utilization management criteria.	GAP: The gap is that DoD is not capable of consistent

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
supplemental health services to achieve utilization goals.		monitoring of appropriate health services.
MANAGEMENT INFORMATION SYSTEMS		
•HCFA requires that the HMO have an effective system in place for receiving, controlling and processing application from Medicare enrollees. These applications are sent to HCFA within 30 days from the date of application or from the date a vacancy occurs.	DoD has a system in place and can rely on its contractors. However, these systems do not have the requisite format, organization or compilation capabilities.	GAP: The gap is that HCFA has clearly laid out its requirements for application procedures and systems. DoD is not in compliance with these systems even with its own contracting network.
•HCFA requires that HMO's have systems in place that can promptly, accurately and efficiently disenroll Medicare enrollees. These enrollees must also be tracked according to voluntary or involuntary disenrollment status.	DoD does not have a tracking procedure in place for those who have disenrolled.	GAP: The gap is that HCFA has very specific requirements for disenrollment; without a more efficient and updated MIS, DoD is not in compliance with the HCFA regulations.
•The HMO must have a system in place by which it accurately and efficiently tracks billing procedures	DoD has no MIS that tracks billing procedures and requirements per the HCFA regulations.	GAP: The gap is that HCFA has laid out specific MIS requirements for billing purposes. The HMO manual models formatting procedures for better implementation. Without addressing these requirements, DoD is not in compliance with the HCFA regulations.
•The HMO should have sufficient administrative capability to carry out the requirements of the contract (e.g. a claims system that controls and reflects claim processing cycles and payment date for individual claims).	DoD does not have MIS in place to carry out the claims processing requirements.	GAP: The gap is that since there are is no MIS in place, DoD is not complying with the HCFA standards and requirements.
REGULATORY COMPLIANCE		
•The HMO has personnel and systems sufficient for the HMO to organize, plan, control, and evaluate the financial, marketing, health services, quality assurance program,	. DoD is not fully staffed and does not have the organizational structure in place to implement a Medicare Demonstration Project.	GAP: DoD lacks sufficient staff and systems technology to effectively implement a Medicare

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements •CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS; REQUIREMENTS NOT MET
administrative and management aspects of the HMO 42 CFR 417.124(a)(2).		Plan. DoD lacks enough trained personnel as well as comprehensive MIS capabilities.
•Health Services Delivery System - The HMO arranges for required Medicare services, additional services and supplemental services which the Medicare enrollee has contracted for through Medicare-approved providers and suppliers. 42 CFR 417.101(a) and 417.	The MTF's are not capable of providing all of the Medicare services as required by HCFA. DoD must contract out those services to the civilian contractor networks.	GAP: DoD, via the MTF's, have no capacity for the following benefits: SNF, Home Health Care, Inpatient and Outpatient Mental Health, Hospice Services, Chiropractic care, DME prosthetics, organ transplants, Occupational, Physical and Speech therapy, outpatient rehab, ETOH and drug rehab, ambulance services, allergy testing and injections, mammograms and renal dialectics.
•Each HMO must have an effective procedure to develop, compile, evaluate and report to HCFA its enrollees and the general public at the time and in the manner that HCFA requires (maintaining confidentiality) necessary statistical data. 42 CFR 417.107(j).	DoD has no procedures to report to HCFA the requisite statistical data.	GAP: DoD must purchase this service from a commercial source because MTF's do not have the resources or skills to perform the legally required.
•The application forms must comply with HCFA's standards regarding format and content. An effective system for receiving, controlling and processing the applications from applicants must be in place to meet HCFA requirements. 42 CFR 471.430(a)(2)(5).	DoD and the MTF's do not currently have application forms which can be assessed; if they exist, they have not been analyzed.	GAP: DoD must purchase this service from a commercial source because MTF's do not have the resources or skills to perform the legally required tasks.
•All Medicare covered services, any additional benefits which a risk-based organization is required to furnish, and any supplemental services for which the enrollee has contracted must be made accessible to the enrollee. The HMO must consider the geographic location, hours of operation, promptness of services	DoD's current Service Area (catchment) is an approximate 40 minute/40 mile radius.	GAP: Excluding TRICARE's network, DoD cannot meet this 30 mile requirement HCFA requires a 30 minute/30 mile radius. Even though the Service Area will be expanded under the Demonstration Project, the number of primary

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
and provision of after hours service. Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area - usually within 30 minutes travel time from the beneficiary's residence. Exceptions may be made if the usual travel patterns for medical care exceed 30 minutes. Medically necessary emergency care must be available and accessible 24 hours a day, 7 days a week. 42 CFR 417 106(b), 417.416(e)(1) and HMO Manual 2160 2.		care providers (MTF's) is being reduced. This reduction in facilities diminishes the ability of DoD to properly manage and monitor the provision of Medicare benefits.
The HMO must provide supervision by a physician of other health care professionals who are involved directly in the profession of health care under 1861 of the Act. The HMO must be sure there is physician supervision over work performed by a non-physician and when the clinics or offices are open. 42 CFR 417.416(b)(2) & (3).	DoD medical personnel are usually licensed in only one state.	GAP: Most military physicians are licensed only in one state and practice in several states. Without a HCFA waiver, most physicians are not eligible to provide services to Medicare HMO enrollees through an HMO outside the state in which they are licensed.
*The applications forms must comply with HCFA's standards regarding format and content. An effective system for receiving, controlling and processing the applications from applicants must be in place and meet HCFA requirements 42 CFR 417.430(a)(2) & (5).	DoD does not currently have any application forms which can be analyzed.	GAP: DoD must purchase service from a commercial source because MTF's do not have the rescues or skills to perform the legally required tasks for transactions regarding applications and enrollment. These tasks include: disenrollment, ID card production, development of application, forms, enrollment, eligibility checks, application reviews and beneficiary counseling and training.
*The contract must provide that the HMO agrees to comply with the requirements of a PRO review of services furnished to Medicare	TRICARE uses Multi-functional PRO reviews; they both provide care AND remain in the review loop.	GAP: DoD will most likely need to contract out for a

BUSINESS REQUIREMENTS •HCFA Requirements •United HealthCare Requirements √CMP Manual	DOD'S CURRENT CAPABILITIES	GAPS: REQUIREMENTS NOT MET
enrollees. 42 CFR 417.478(a).		PRO. HCFA will not likely approve of the current Multi-function PROs in place in TRICARE.
•Each HMO must maintain written rules that pertain to appeals procedures and grievances. 42 CFR 417.124(a). (See Appeals Section)	DoD does not currently have either an appeals process that resembles HCFA's requirements; nor is there written material that clearly explains and defines those procedures.	GAP: The gap is that there are specific requirements for administrating appeals and grievances. Without written policies and procedures, DoD is not in compliance with HCFA. **(See Appeals Section)**
•The HMO must produce marketing and communication materials to prospective enrollees with adequate descriptions of rules, procedures, benefits, fees, services and other information necessary to make an informed decision about enrollment.	DoD does not currently have such marketing and communication pieces developed at this time.	GAP: The gap is that DoD will need to develop such pieces which will incur additional costs and expenses.
•The HMO must submit marketing and communications materials to HCFA no later than 45 days prior to planned distribution.	DoD does hot have these marketing pieces available at this time.	GAP: The gap is that DoD has a start date of October 1, 1996; to have these materials be ready for the start date they must be developed and submitted to HCFA no later than August 15, 1996. This leaves very little time for a detailed marketing piece.
•HCFA requires that, upon enrollment, enrollees are informed about their options regarding Advance Directives. This information must be in writing and distributed to the enrollee at the time they enroll and kept in their member file for future use.	DoD has not indicated that there are policies and procedures for implementing Advance Directives.	GAP: The gap is that if there is no policy or procedure for Advance Directive, DoD must prepare such polices and procedures and put them in writing before the enrollment process begins

MCHJ-DCA XXX Nov 1996

SUBJECT: TRICARE Medicare Prime Demonstration Project

1. The enclosed survey is being conducted as part of a research project by MAMC's Healthcare Administration Resident. You are being asked to complete the survey so that the Military Health Services System can learn from both Region 11 and MAMC's experience in implementing the TRICARE Medicare prime demonstration project (also known as Medicare Subvention or Medicare Simulation Project). The average time to complete this survey is XXX minutes.

2. Your responses will be kept anonymous and will be combined with the responses of others for inclusion in the research project. However, your survey is identified merely to assist the researcher in acknowledging your response. Identifying information will not remain with your completed survey.

3. The survey asks about your opinions on several issues. Some questions may appear more pertinent to your situation than others. Please answer each question even if you are not totally familiar with all aspects of the question.

4. Please return your completed survey to LT Toland, the Administrative Resident not later than XXX Nov.

5. If you have any questions please contact LT Toland at 968-3526, and thank you for your participation.

WILLIAM CAHILL
Colonel, MS
Deputy Commander for Administration/
Chief of Staff

Enclosure

APPENDIX C

TRICARE Medicare Prime Demonstration Project Survey

Please rate the following issues as they relate to the TRICARE Medicare Prime Demonstration Project from 1 to 5 (least to most) as each question asks by circling the number. Spaces are provided for you to add and rate up to three issues besides those already listed. If you add any, please rate all the issues-- those already listed and those you added.

1. Where do you work? Lead Agency Madigan Other

If other, please specify _____

2. Where is your primary workplace (department,division)? _____

3. What is your primary job? (i.e. Physician, Nurse, Administrator)

_____

4. How many months have you worked in your current position? _____

5. Rate the following issues according to their importance to your organization (i.e. MAMC or the Lead Agency) preparing for implementation of the TRICARE Medicare Prime Demonstration Project, with 1 being not very important and 5 being very important.

	Not Very Important				Very Important
Management Information Systems	1	2	3	4	5
Marketing/Beneficiary Education	1	2	3	4	5
Utilization Management	1	2	3	4	5
Training of MAMC Staff	1	2	3	4	5
Quality Assurance/Quality Management	1	2	3	4	5
Claims Processing/Billing	1	2	3	4	5
Enrollment/Disenrollment	1	2	3	4	5
Contracting Issues (i.e. contract modifications)	1	2	3	4	5
Meeting HCFA Standards and Requirements	1	2	3	4	5
Staffing Issues	1	2	3	4	5

OTHER (write-in):

	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

6. Rate the following issues according to their importance to you personally in preparing for implementation of the TRICARE Medicare Prime Demonstration Project, with 1 being not very important and 5 being very important.

	Not Very Important				Very Important
Management Information Systems	1	2	3	4	5
Marketing/Beneficiary Education	1	2	3	4	5
Utilization Management	1	2	3	4	5
Training of MAMC Staff	1	2	3	4	5
Quality Assurance/Quality Management	1	2	3	4	5
Claims Processing/Billing	1	2	3	4	5
Enrollment/Disenrollment	1	2	3	4	5
Contracting Issues (i.e. contract modifications)	1	2	3	4	5
Meeting HCFA Standards and Requirements	1	2	3	4	5
Staffing Issues	1	2	3	4	5
OTHER (write-in):					
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

7. Rate the following issues according to the amount of time which each required of you in preparing for implementation of the TRICARE Medicare Prime Demonstration Project. Please give issues which you feel were not very time consuming a 1, and the issues which were very time consuming a 5. Your perception of the time you spent is more important than your trying to reconstruct actual time.

	Not Very Time Consuming				Very Time Consuming
Management Information Systems	1	2	3	4	5
Marketing/Beneficiary Education	1	2	3	4	5
Utilization Management	1	2	3	4	5
Training of MAMC Staff	1	2	3	4	5
Quality Assurance/Quality Management	1	2	3	4	5
Claims Processing/Billing	1	2	3	4	5
Enrollment/Disenrollment	1	2	3	4	5
Contracting Issues (i.e. contract modifications)	1	2	3	4	5

Meeting HCFA Standards and Requirements	1	2	3	4	5
Staffing Issues	1	2	3	4	5
OTHER (write-in):					
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

8. Rate the following issues according to the lead time (prior planning) you feel was required to effectively implement them as part of the TRICARE Medicare Prime Demonstration Project, with a 1 being very little lead time and a 5 being very much lead time. Even if you did not participate, please give your perception.

	Very Little Lead Time				Very Much Lead Time
Management Information Systems	1	2	3	4	5
Marketing/Beneficiary Education	1	2	3	4	5
Utilization Management	1	2	3	4	5
Training of MAMC Staff	1	2	3	4	5
Quality Assurance/Quality Management	1	2	3	4	5
Claims Processing/Billing	1	2	3	4	5
Enrollment/Disenrollment	1	2	3	4	5
Contracting Issues (i.e. contract modifications)	1	2	3	4	5
Meeting HCFA Standards and Requirements	1	2	3	4	5
Staffing Issues	1	2	3	4	5
OTHER (write-in):					
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

9. Rate the issues according to the internal coordination which you feel is required to effectively implement them as part of the TRICARE Medicare Prime Demonstration Project, with a 1 being very little internal coordination and a 5 being very much internal coordination.

	Very Little Internal Coordination				Very Much Internal Coordination
Management Information Systems	1	2	3	4	5
Marketing/Beneficiary Education	1	2	3	4	5
Utilization Management	1	2	3	4	5
Training of MAMC Staff	1	2	3	4	5
Quality Assurance/Quality Management	1	2	3	4	5
Claims Processing/Billing	1	2	3	4	5
Enrollment/Disenrollment	1	2	3	4	5
Contracting Issues (i.e. contract modifications)	1	2	3	4	5
Meeting HCFA Standards and Requirements	1	2	3	4	5

Staffing Issues	1	2	3	4	5
OTHER (write-in):					
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

10. Rate the issues according to the coordination with entities outside the hospital you feel is required to effectively implement them as part of the TRICARE Medicare Prime Demonstration Project, with a 1 being very little external coordination and a 5 being very much external coordination.

	Very Little External Coordination				Very Much External Coordination
Management Information Systems	1	2	3	4	5
Marketing/Beneficiary Education	1	2	3	4	5
Utilization Management	1	2	3	4	5
Training of MAMC Staff	1	2	3	4	5
Quality Assurance/Quality Management	1	2	3	4	5
Claims Processing/Billing	1	2	3	4	5
Enrollment/Disenrollment	1	2	3	4	5
Contracting Issues (i.e. contract modifications)	1	2	3	4	5
Meeting HCFA Standards and Requirements	1	2	3	4	5
Staffing Issues	1	2	3	4	5
OTHER (write-in):					
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

11. Since no one in the MHSS has ever implemented a program such as TRICARE Medicare Prime before, some activities required to plan for implementation of the demonstration project were are, and some are familiar. Please rate the issues according to the amount of learning which you feel is required to manage them effectively, with a 1 being very little learning and a 5 being very much learning.

	Very Little New Learning				Very Much New Learning
Management Information Systems	1	2	3	4	5
Marketing	1	2	3	4	5
Utilization Management	1	2	3	4	5
Training of MAMC Staff	1	2	3	4	5
Quality Assurance/Quality Management	1	2	3	4	5
Claims Processing/Billing	1	2	3	4	5
Enrollment/Disenrollment	1	2	3	4	5

Contracting Issues (i.e. contract modifications)	1	2	3	4	5
Meeting HCFA Standards and Requirements	1	2	3	4	5
Staffing Issues	1	2	3	4	5
OTHER (write-in):					
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

12. Please rate the following potential threats to the success of the TRICARE Medicare Prime Demonstration Project, with 1 a very low threat and 5 being a very high threat.

	Very Low Threat				Very High Threat
Low Reimbursement Rate (AAPCC)	1	2	3	4	5
Adverse Selection	1	2	3	4	5
Not Meeting the "Level of Effort"	1	2	3	4	5
Ability to Provide all Medicare Services (SNF, Home Health, Chiropractic, etc.)	1	2	3	4	5
Quality of Care Provided	1	2	3	4	5
Inappropriate Staffing Levels	1	2	3	4	5
Time Constraints in Implementation	1	2	3	4	5
Inadequate Training	1	2	3	4	5
Limited Experience in Financially Risky Situations	1	2	3	4	5
High Start-Up Costs	1	2	3	4	5
Competition from other Medicare HMO's in the Region	1	2	3	4	5
Inadequate Marketing Capabilities	1	2	3	4	5
Inadequate Information System Capabilities	1	2	3	4	5
Inadequate Utilization Management	1	2	3	4	5
OTHER (write-in):					
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

PLEASE RETURN ALL PAGES OF THIS SURVEY TO LT TOLAND IN THE COMMAND GROUP. THANK YOU!

MCHJ-DCA 15 Nov 1996

SUBJECT: TRICARE Senior Option Medicare Subvention Simulation

1. The enclosed survey is being conducted as part of a research project by MAMC's Healthcare Administration Resident. You are being asked to complete the survey so that the Military Health Services System can learn from both Region 11 and MAMC's experience in implementing the TRICARE Senior Option Medicare Subvention Simulation Project. The average time to complete this survey is 16 minutes.

2. Your responses will be kept anonymous and will be combined with the responses of others for inclusion in the research project. The survey asks about your opinions on several issues. Some questions may appear more pertinent to your situation than others. Please answer each question even if you are not totally familiar with all aspects of the question.

3. Please return your completed survey via CC-Mail or print it out and return it by hand. You can send the completed survey to either LT Toland, the Administrative Resident, or Ms. Celia Boyce, Secretary for the DCA, not later than 27 Nov.

5. If you have any questions please contact LT Toland at 968-3526 or Ms. Boyce at 968-1210, and thank you for your participation.

WILLIAM CAHILL
Colonel, MS
Deputy Commander for Administration/
Chief of Staff

Enclosure

TRICARE Senior Option Simulation Project Survey

The Department of Defense (DoD) will conduct a simulation in which selected Military Treatment Facilities (MTFs) will operate similarly to Medicare At-risk Health Maintenance Organizations (HMOs). While this effort will not include actual Medicare reimbursement, it will attempt to simulate what would happen if DoD maintained its current level of effort and there were actual Medicare reimbursement. The goal of this simulation is to test a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries that would not increase the total federal cost for either DoD or the Health Care Financing Administration (HCFA). Madigan Army Medical Center has been selected to participate in this simulation, with enrollment beginning February 1, 1997, and health care delivery starting March 1, 1997.

Please rate the following issues as they relate to the TRICARE Senior Option Medicare Subvention Simulation Project from 1 to 5 (least to most) as each question asks. Please fill in your answer in the blanks provided for you. Spaces are provided for you to add and rate up to three issues besides those already listed. If you add any, please rate all the issues-- those already listed and those you added. Please answer all 12 questions. Thank you.

1. Which Command do you work for? (i.e.Lead Agency, Madigan, Other)

   _____

2. Where is your primary workplace (department or division name)? _____

3. What is your primary job? (Circle or put a check mark in the space)

   ___ 1. Physician in Clinical Position
   ___ 2. Physician in Administrative Position
   ___ 3. Nurse in Clinical Position
   ___ 4. Nurse in Administrative Position
   ___ 5. Health Care Administrator
   ___ 6. Other Occupation in Clinical Position
   ___ 7. Other Occupation in Administrative Setting

4. How many months have you worked in your current position? _____

5. Rate the following issues according to their importance to **YOUR ORGANIZATION** (i.e. MAMC or the Lead Agency) preparing for implementation of the TRICARE Senior Option Medicare Subvention Simulation Project, with 1 being not very important and 5 being very important.

	Not Very Important				Very Important		
Management Information Systems	1	2	3	4	5	_____	_____
Marketing/Beneficiary Education	1	2	3	4	5	_____	
Utilization Management	1	2	3	4	5	_____	
Training of MAMC Staff	1	2	3	4	5	_____	
Quality Assurance/Quality Management	1	2	3	4	5	_____	
Claims Processing/Billing	1	2	3	4	5	_____	
Enrollment/Disenrollment	1	2	3	4	5	_____	
Contracting Issues (i.e. contract modifications)	1	2	3	4	5	_____	
Meeting HCFA Standards and Requirements	1	2	3	4	5	_____	
Staffing Issues	1	2	3	4	5	_____	
OTHER (type-in or write-in):							
	1	2	3	4	5	_____	
	1	2	3	4	5	_____	
	1	2	3	4	5	_____	

6. Rate the following issues according to their importance to **YOUR POSITION** in preparing for implementation of the TRICARE Senior Option Medicare Subvention Simulation Project, with 1 being not very important and 5 being very important.

	Not Very Important				Very Important	
Management Information Systems	1	2	3	4	5	_____
Marketing/Beneficiary Education	1	2	3	4	5	_____
Utilization Management	1	2	3	4	5	_____
Training of MAMC Staff	1	2	3	4	5	_____
Quality Assurance/Quality Management	1	2	3	4	5	_____
Claims Processing/Billing	1	2	3	4	5	_____
Enrollment/Disenrollment	1	2	3	4	5	_____
Contracting Issues (i.e. contract modifications)	1	2	3	4	5	_____
Meeting HCFA Standards and Requirements	1	2	3	4	5	_____
Staffing Issues	1	2	3	4	5	_____
OTHER (type-in or write-in):						
	1	2	3	4	5	_____
	1	2	3	4	5	_____
	1	2	3	4	5	_____

7. Rate the following issues according to the **amount of time** which each required or will require in preparing for implementation of the TRICARE Senior Option Medicare Subvention Simulation Project. Please give issues which you feel are not very time consuming a 1, and the issues which are very time consuming a 5. Your perception of the time you spent or will spend is more important than your trying to reconstruct actual time.

	Not Very Time Consuming				Very Time Consuming	
Management Information Systems	1	2	3	4	5	_____
Marketing/Beneficiary Education	1	2	3	4	5	_____
Utilization Management	1	2	3	4	5	_____
Training of MAMC Staff	1	2	3	4	5	_____
Quality Assurance/Quality Management	1	2	3	4	5	_____
Claims Processing/Billing	1	2	3	4	5	_____
Enrollment/Disenrollment	1	2	3	4	5	_____
Contracting Issues (i.e. contract modifications)	1	2	3	4	5	_____
Meeting HCFA Standards and Requirements	1	2	3	4	5	_____
Staffing Issues	1	2	3	4	5	_____
OTHER (type-in):						
	1	2	3	4	5	_____
	1	2	3	4	5	_____
	1	2	3	4	5	_____

8. Rate the following issues according to the **lead time (prior planning)** you feel is required to effectively implement them as part of the TRICARE Senior Option Medicare Subvention Simulation Project, with a 1 being very little lead time and a 5 being very much lead time. Even if you did not participate, please give your perception.

	Very Little Lead Time				Very Much Lead Time	
Management Information Systems	1	2	3	4	5	_____
Marketing/Beneficiary Education	1	2	3	4	5	_____
Utilization Management	1	2	3	4	5	_____
Training of MAMC Staff	1	2	3	4	5	_____
Quality Assurance/Quality Management	1	2	3	4	5	_____
Claims Processing/Billing	1	2	3	4	5	_____
Enrollment/Disenrollment	1	2	3	4	5	_____
Contracting Issues (i.e. contract modifications)	1	2	3	4	5	_____
Meeting HCFA Standards and Requirements	1	2	3	4	5	_____
Staffing Issues	1	2	3	4	5	_____

OTHER (type-in):

1	2	3	4	5	_____
1	2	3	4	5	_____
1	2	3	4	5	_____

9. Rate the issues according to the **internal coordination** which you feel is required to effectively implement them as part of the TRICARE Senior Option Medicare Subvention Simulation Project, with a 1 being very little internal coordination and a 5 being very much internal coordination.

	Very Little Internal Coordination				Very Much Internal Coordination	
Management Information Systems	1	2	3	4	5	_____
Marketing/Beneficiary Education	1	2	3	4	5	_____
Utilization Management	1	2	3	4	5	_____
Training of MAMC Staff	1	2	3	4	5	_____
Quality Assurance/Quality Management	1	2	3	4	5	_____
Claims Processing/Billing	1	2	3	4	5	_____
Enrollment/Disenrollment	1	2	3	4	5	_____
Contracting Issues (i.e. contract modifications)	1	2	3	4	5	_____
Meeting HCFA Standards and Requirements	1	2	3	4	5	_____
Staffing Issues	1	2	3	4	5	_____

OTHER (type-in):

1	2	3	4	5	_____
1	2	3	4	5	_____
1	2	3	4	5	_____

10. Rate the issues according to the **coordination with entities outside the hospital** you feel is required to effectively implement them as part of the TRICARE Senior Opition Medicare Subvention Simulation Project, with a 1 being very little external coordination and a 5 being very much external coordination.

	Very Little External Coordination				Very Much External Coordination	
Management Information Systems	1	2	3	4	5	_____
Marketing/Beneficiary Education	1	2	3	4	5	_____
Utilization Management	1	2	3	4	5	_____
Training of MAMC Staff	1	2	3	4	5	_____
Quality Assurance/Quality Management	1	2	3	4	5	_____
Claims Processing/Billing	1	2	3	4	5	_____
Enrollment/Disenrollment	1	2	3	4	5	_____

Contracting Issues (i.e. contract modifications)	1	2	3	4	5	_____
Meeting HCFA Standards and Requirements	1	2	3	4	5	_____
Staffing Issues	1	2	3	4	5	_____
OTHER (write-in):						
	1	2	3	4	5	_____
	1	2	3	4	5	_____
	1	2	3	4	5	_____

11. Since no one in the MHSS has ever implemented a program such as the TRICARE Senior Option Medicare Subvention Simulation Project before, some activities required to plan for implementation of the demonstration project are familiar and some are not familiar. Please rate the issues according to the **amount of learning** which you feel is required to manage them effectively, with a 1 being very little learning and a 5 being very much learning.

	Very Little New Learning				Very Much New Learning	
Management Information Systems	1	2	3	4	5	_____
Marketing	1	2	3	4	5	_____
Utilization Management	1	2	3	4	5	_____
Training of MAMC Staff	1	2	3	4	5	_____
Quality Assurance/Quality Management	1	2	3	4	5	_____
Claims Processing/Billing	1	2	3	4	5	_____
Enrollment/Disenrollment	1	2	3	4	5	_____
Contracting Issues (i.e. contract modifications)	1	2	3	4	5	_____
Meeting HCFA Standards and Requirements	1	2	3	4	5	_____
Staffing Issues	1	2	3	4	5	_____
OTHER (write-in):						
	1	2	3	4	5	_____
	1	2	3	4	5	_____
	1	2	3	4	5	_____

12. Please rate the following **potential threats** to the successful implementation of the TRICARE Senior Option Medicare Subvention Simulation Project, with 1 a very low threat and 5 being a very high threat.

	Very Low Threat				Very High Threat	
No HCFA Reimbursement	1	2	3	4	5	_____
Adverse Selection ("sicker" people enrolling)	1	2	3	4	5	_____
Not Meeting the "Level of Effort"	1	2	3	4	5	_____
Ability to Provide all Medicare Services (SNF, Home Health, Chiropractic, etc.)	1	2	3	4	5	_____

Quality of Care Provided	1	2	3	4	5	_____
Inappropriate Staffing Levels	1	2	3	4	5	_____
Time Constraints in Implementation	1	2	3	4	5	_____
Inadequate Training	1	2	3	4	5	_____
Limited Experience in Financially Risky Situations	1	2	3	4	5	_____
High Start-Up Costs	1	2	3	4	5	_____
Competition from other Medicare HMO's in the Region	1	2	3	4	5	_____
Inadequate Marketing Capabilities	1	2	3	4	5	_____
Inadequate Information System Capabilities	1	2	3	4	5	_____
Inadequate Utilization Management	1	2	3	4	5	_____
OTHER (write-in):						
	1	2	3	4	5	_____
	1	2	3	4	5	_____
	1	2	3	4	5	_____

PLEASE RETURN YOUR ANSWERS TO LT TOLAND OR MS. CELIA BOYCE IN THE COMMAND GROUP VIA EITHER CC-MAIL OR HAND-DELIVERY. THANK YOU!

Last Name	First Name	Rank	Dept./Division	Service
Aiken	David	LTC	Personnel	Chief
Allison	Dennis	COL	Anesthesia	Anest. Nursing Svc.
Andersen	Charles	COL	Surgery	Chief
Arnot	Dave	COL	Family Practice	Optometry
Ayala	Sharon	GS	PAO	Asst. Chief
Bannister	Frank	MAJ	Medicine	Admin. Officer
Bender	Gregory	LTC	Radiology	Chief
Bolesh	David	LTC	Anesthesia	Surgical Services Center
Booth	Van	COL	NWRMC	NWRMC
Brown	George	BG	Commander	Commander
Bryant	Bud	COL	Logistics	Chief
Byrne	Robert	MAJ	BHS	Clinical Psychology
Cahill	William	COL	DCA	DCA
Cargill	George	COL	Lead Agency	Utilization Management
Carstensen	Mary	MAJ	Lead Agency	Health Care Support
Casey	Elmer	COL	Lead Agency	Medical Director
Casey	Linda	COL	Nursing	Critical Care
Chapman	Carl	GS	Readiness	Chief
Cheney	Ruth	COL	Lead Agency	Clinical Operations
Condra	Gary	LTC	Lead Agency	PA&E
Cooper	Ronald	COL	Medicine	Inf. Disease/Education
Craghead	Robert	COL	Pharmacy	Chief
Cushner	Howard	COL	Medicine	Nephrology
Danforth-Lewis	Lisa	GS	QSD	Risk Management
Davis	Gary	COL	OB/GYN	GYN Svc.
Dettori	Joseph	COL	Physical Med.	Physical Therapy
Diamond	Donna	LTC	Anesthesia	CMS
Dillard	Thomas	LTC	Medicine	Pulm/Critical Care
Doherty	Frank	GS	Lead Agency	Logistics
Eggebroten	William	COL	Surgery	Asst. Chief
Eibe	Dennis	MAJ	Lead Agency	PA&E
Evans	Suzanne	LTC	Managed Care	Utilization Management
Evans	Paul	COL	Family Practice	Chief
Fitch	Bert	GS	IMD	Automation Mgt.
Fletcher	JoAnne	GS	Lead Agency	Contracting Services
Flynn	Fredrick	COL	Medicine	Neurology
Foster	Michael	LTC	XO	XO
Greenfield	Nancy	GS	QSD	Chief
Gunzenhauser	Jeffrey	LTC	Preventive Med.	Asst. Chief
Haradon	Geri	LT	Lead Agency	PA&E
Hemman	Eileen	LTC	Managed Care	Chief
Henderson	Rich	GS	QSD	Analyst
Hildreth	Pamela	LTC	Nursing	Surgical Nsg. Svc.
Hober	Chris	GS	Lead Agency	Marketing
Hume	Roderick	LTC	OB/GYN	OB Svc.
Irvin	Thomas	LTC	Medicine	Rheumatology
Jarrett	Robert	COL	Pediatrics	Chief
Jeffers	Duane	LTC	Medicine	Primary Care/Internal Med.

Jennings	Bonnie	COL	Nursing	Asst. Chief
Jones	Robert	COL	Medicine	Endocrinology/Research
Jones	Casey	COL	Surgery	Orthopedic
Kelley	James	COL	Pathology	Chief
Kelly	Patrick	COL	Ed. Resources	Chief
King	Kristin	COL	Nutrition Care	Chief
Knapp	Brian	LTC	RMD	Chief
Krauss	Margot	LTC	Preventive Med.	Epidem. & Disease Control
Kuehler	Gregory	GS	BHS	BHS Coordinator
Kumar	Shashi	COL	Physical Med.	Chief
Levesque	John	LTC	Managed Care	
Loomis	Becky	LTC	Lead Agency	Managed Care Operations
Mader	Thomas	COL	Surgery	Ophthalmology
Maniece	Doron	LT COL	Lead Agency	Network & Service Centers
Meines	Mike	GS	PAO	Chief
Meines	Catherine	GS	QSD	Credentials
Meyer	Dennis	GS	Lead Agency	Operations
Minnick	Kristine	CAPT	Lead Agency	Chief of Staff
Mobley	Robery	1LT	Managed Care	
Mohat	Jon	1LT	Managed Care	Admin Officer
Moon	Michael	COL	Anesthesia	
Moore	Dan	COL	Clinical Inv.	Chief
Morgenstern	Larry	COL	OB/GYN	Chief
Muggelberg	Marcia	LTC	Medicine	Allergy
Myrick	Bertha	LTC	Anesthesia	PACU
Nechanicky	Jeff	MAJ	Human Resources	Chief
Nichols	Carrol	GS	QSD	Staff Development
Perez	Romeo	COL	OB/GYN	Asst. Chief
Petty	Clayton	CAPT	Anesthesia	Chief
Petty	Michael	GS	Lead Agency	Planning Division
Phillip	Douglas	COL	Preventive Med.	Chief
Phyall	Gertdell	LTC	Nursing	OB/GYN
Pickett	Catherine	LTC	IMD	Chief
Porr	Darrel	COL	DCCS	DCCS
Potter	Mark	LTC	OB/GYN	GYN Oncology
Powell	John	LTC	BHS	Chief
Prieur	Jan	GS	Lead Agency	Credentialing & RM
Quintana	Betty	GS	Contracting	Contracting
Reed	Lester	COL	Medicine	Chief
Reeve	Rose	GS	Lead Agency	Contracting
Rice	Matthew	COL	Emergency Med.	Chief
Richmond	Barney	GS	Facilities	Chief
Rickard	James	MAJ	CSD	Clinical Support
Riggan	Judith	COL	Physical Med.	Occupational Therapy
Saye	Jack	COL	Nursing	Amb. Nsg. Svc.
Scaniffe	Joseph	LTC	Anesthesia	Clinical Services
Schall	David	COL	Surgery	Otolaryngology
Scheele	Harriet	COL	Nursing	Clinical Nursing Support
Schempp	Catherine	LTC	Nursing	Consoliidated Ed.

Schofer	Glen	COL	Nursing	Medical Nsg. Svc.
Sherman	Richard	LTC	Clinical Inv.	Asst. Chief
Sherrell	Susan	GS	Lead Agency	Contracting
Simmons	Carol	GS	Managed Care	Supplemental Care
Smith	Rod	GS	Lead Agency	IMD
Smith	David	LTC	PAD	Chief
Snyder	Karl	COL	Lead Agency	RHSO
Sorensen	Gregory	COL	Medicine	Dermatology
Stafford	Darrell	LTC	IG	IG
Steger	Robert	COL	BHS	Social Work Services
Stephens	Veronica	GS	Managed Care	CHAMPUS
Sylvia	Bruce	LTC	Pathology	Lab
Tollefson	David	COL	Surgery	Vascular
Tsuchida	Amy	LTC	Medicine	Gastroenterology
Turella	Giorgio	COL	Medicine	Readiness
Vanatta	Jo Ellen	COL	Nursing	Chief
Voegele	Terry	GS	Managed Care	PA&E
Weber	Julie	MAJ	RMD	Nurse Methods Analyst
Weese	Sharon	LTC	Readiness	Training Division
Werschkul	John	COL	Surgery	Neurosurgery
Whitfield	Mary	MAJ	Lead Agency	PA&E
Whitney-Teeple	Elizabeth	MAJ	Lead Agency	IMD
Williard	William	LTC	Surgery	General Surgery
Wilson	John	GS	RMD	Management Branch
Wilson	Lawrence	MAJ	Emergency Med.	Asst. Chief
Zubritzky	Desi	LCDR	Lead Agency	Enrollment

Question 5. Rate the following issues according to their importance to YOUR ORGANIZATION ...

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
INFORMATION SYSTEMS	62	3	2	5	4.57	.69	.474
STAFFING ISSUES	62	3	2	5	4.47	.78	.614
MARKETING ISSUES	62	4	1	5	4.37	1.04	1.079
TRAINING (MAMC STAFF)	62	4	1	5	4.27	.94	.891
UTILIZATION MANAGEMENT	62	3	2	5	4.25	.92	.841
ENROLLMENT/DISENROLLMENT	62	4	1	5	4.21	1.06	1.119
CONTRACTING ISSUES	62	4	1	5	4.11	1.13	1.282
QUALITY ASSURANCE	62	4	1	5	3.87	.97	.934
CLAIMS/BILLING ISSUES	62	4	1	5	3.87	1.06	1.131
HCFA STANDARDS	62	4	1	5	3.79	1.15	1.316
Valid N (listwise)	62						

Question 6. Rate the following issues according to their importance to YOUR POSITION .....

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
STAFFING ISSUES	62	4	1	5	3.98	1.36	1.852
INFORMATION SYSTEMS	62	4	1	5	3.87	1.36	1.852
TRAINING (MAMC STAFF)	62	4	1	5	3.82	1.27	1.624
UTILIZATION MANAGEMENT	62	4	1	5	3.66	1.43	2.031
MARKETING ISSUES	62	4	1	5	3.61	1.36	1.848
CONTRACTING ISSUES	62	4	1	5	3.44	1.41	1.984
QUALITY ASSURANCE	62	4	1	5	3.34	1.37	1.865
HCFA STANDARDS	62	4	1	5	3.34	1.46	2.129
ENROLLMENT/DISENROLLMENT	62	4	1	5	3.32	1.46	2.124
CLAIMS/BILLING ISSUES	62	4	1	5	2.94	1.32	1.733
Valid N (listwise)	62						

Question 7. Rate the following issues according to the AMOUNT OF TIME which each required or will require ...

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
STAFFING ISSUES	62	4	1	5	3.54	1.24	1.527
INFORMATION SYSTEMS	62	4	1	5	3.52	1.40	1.954
UTILIZATION MANAGEMENT	62	4	1	5	3.32	1.43	2.058
TRAINING (MAMC STAFF)	62	4	1	5	3.30	1.31	1.716
HCFA STANDARDS	62	4	1	5	3.23	1.31	1.719
MARKETING ISSUES	62	4	1	5	3.21	1.52	2.300
CONTRACTING ISSUES	62	4	1	5	3.03	1.50	2.261
ENROLLMENT/DISENROLLMENT	62	4	1	5	2.95	1.41	1.981
QUALITY ASSURANCE	62	4	1	5	2.85	1.27	1.602
CLAIMS/BILLING ISSUES	62	4	1	5	2.46	1.39	1.920
Valid N (listwise)	62						

Question 8. Rate the following issues according to the LEAD TIME (PRIOR PLANNING) you feel is required ...

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
MARKETING ISSUES	62	4	1	5	4.25	1.14	1.300
INFORMATION SYSTEMS	62	4	1	5	4.21	1.04	1.086
CONTRACTING ISSUES	62	4	1	5	4.11	1.15	1.315
STAFFING ISSUES	62	4	1	5	3.95	1.19	1.424
TRAINING (MAMC STAFF)	62	4	1	5	3.89	1.03	1.053
UTILIZATION MANAGEMENT	62	4	1	5	3.79	1.07	1.151
ENROLLMENT/DISENROLLMENT	62	4	1	5	3.77	1.21	1.456
HCFA STANDARDS	62	4	1	5	3.70	1.19	1.421
CLAIMS/BILLING ISSUES	62	4	1	5	3.44	1.25	1.561
QUALITY ASSURANCE	62	4	1	5	3.06	1.08	1.176
Valid N (listwise)	62						

Question 9. Rate the following issues according to the INTERNAL COORDINATION which you feel is required ...

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
INFORMATION SYSTEMS	62	4	1	5	4.20	.94	.879
TRAINING (MAMC STAFF)	62	4	1	5	4.13	1.06	1.130
UTILIZATION MANAGEMENT	62	4	1	5	4.00	1.01	1.016
STAFFING ISSUES	62	4	1	5	3.98	1.05	1.098
MARKETING ISSUES	62	4	1	5	3.83	1.10	1.219
ENROLLMENT/DISENROLLMENT	62	4	1	5	3.80	.95	.911
HCFA STANDARDS	62	4	1	5	3.75	1.08	1.167
CONTRACTING ISSUES	62	4	1	5	3.66	1.13	1.266
QUALITY ASSURANCE	62	4	1	5	3.43	1.08	1.160
CLAIMS/BILLING ISSUES	62	4	1	5	2.92	1.18	1.387
Valid N (listwise)	62						

Question 10. Rate the following issues according to the EXTERNAL COORDINATION you feel is required ...

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
MARKETING ISSUES	62	4	1	5	4.42	.91	.826
CONTRACTING ISSUES	62	4	1	5	4.15	1.05	1.109
ENROLLMENT/DISENROLLMENT	62	4	1	5	3.88	1.10	1.216
INFORMATION SYSTEMS	62	4	1	5	3.74	1.18	1.395
HCFA STANDARDS	62	4	1	5	3.73	1.11	1.240
CLAIMS/BILLING ISSUES	62	4	1	5	3.54	1.25	1.552
UTILIZATION MANAGEMENT	62	4	1	5	3.17	1.09	1.185
STAFFING ISSUES	62	4	1	5	2.86	1.18	1.392
QUALITY ASSURANCE	62	4	1	5	2.68	1.00	.998
TRAINING (MAMC STAFF)	62	4	1	5	2.59	1.22	1.479
Valid N (listwise)	62						

Question 11. Please rate the following issues according to the AMOUNT OF NEW LEARNING you feel is required ...

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
HCFA STANDARDS	62	4	1	5	4.07	1.07	1.143
INFORMATION SYSTEMS	62	4	1	5	3.89	.99	.987
TRAINING (MAMC STAFF)	62	4	1	5	3.62	1.04	1.087
MARKETING ISSUES	62	4	1	5	3.61	1.26	1.583
CONTRACTING ISSUES	62	4	1	5	3.58	1.16	1.354
UTILIZATION MANAGEMENT	62	4	1	5	3.48	1.14	1.299
ENROLLMENT/DISENROLLMENT	62	4	1	5	3.38	1.27	1.612
CLAIMS/BILLING ISSUES	62	4	1	5	3.32	1.23	1.524
STAFFING ISSUES	62	4	1	5	3.05	1.06	1.129
QUALITY ASSURANCE	62	4	1	5	2.88	1.04	1.085
Valid N (listwise)	62						

Question 12. Rate the following POTENTIAL THREATS ...

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
TIME CONSTRAINTS	62	4	1	5	4.26	.85	.718
ABILITY TO PROVIDE ALL MEDICARE SERVICES	62	4	1	5	4.25	1.03	1.070
NO HCFA REIMBURSEMENT	62	4	1	5	4.23	1.08	1.160
INAPPROPRIATE STAFFING	62	4	1	5	3.98	1.09	1.196
START-UP COSTS	62	4	1	5	3.97	1.07	1.146
LACK OF EXPERIENCE	62	4	1	5	3.85	1.11	1.241
NOT MEETING LEVEL OF EFFORT	62	4	1	5	3.85	1.14	1.305
INADEQUATE INFORMATION SYSTEMS	62	4	1	5	3.80	1.16	1.338
INADEQUATE TRAINING	62	4	1	5	3.75	1.13	1.267
INADEQUATE MARKETING	62	4	1	5	3.69	1.06	1.132
ADVERSE SELECTION	62	4	1	5	3.52	1.35	1.823
INADEQUATE UTILIZATION MANAGEMENT	62	4	1	5	3.25	1.28	1.628
COMPETITION FROM OTHER MEDICARE HMO'S	62	4	1	5	3.25	1.29	1.661
QUALITY OF CARE	62	4	1	5	2.48	1.49	2.217
Valid N (listwise)	62						

CLAIMS PROCESSING/BILLING ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	4	1	5	3.87	1.06	1.131
Question 6	62	4	1	5	2.94	1.32	1.733
Question 7	62	4	1	5	2.46	1.39	1.920
Question 8	62	4	1	5	3.44	1.25	1.561
Question 9	62	4	1	5	2.92	1.18	1.387
Question 10	62	4	1	5	3.54	1.25	1.552
Question 11	62	4	1	5	3.32	1.23	1.524
Valid N (listwise)	62						

CONTRACTING ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	4	1	5	4.11	1.13	1.282
Question 6	62	4	1	5	3.44	1.41	1.984
Question 7	62	4	1	5	3.03	1.50	2.261
Question 8	62	4	1	5	4.11	1.15	1.315
Question 9	62	4	1	5	3.66	1.13	1.266
Question 10	62	4	1	5	4.15	1.05	1.109
Question 11	62	4	1	5	3.58	1.16	1.354
Valid N (listwise)	62						

ENROLLMENT/DISENROLLMENT ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	4	1	5	4.21	1.06	1.119
Question 6	62	4	1	5	3.32	1.46	2.124
Question 7	62	4	1	5	2.95	1.41	1.981
Question 8	62	4	1	5	3.77	1.21	1.456
Question 9	62	4	1	5	3.80	.95	.911
Question 10	62	4	1	5	3.88	1.10	1.216
Question 11	62	4	1	5	3.38	1.27	1.612
Valid N (listwise)	62						

APPENDIX G

MEETING HCFA STANDARDS AND REQUIREMENTS

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	4	1	5	3.79	1.15	1.316
Question 6	62	4	1	5	3.34	1.46	2.129
Question 7	62	4	1	5	3.23	1.31	1.719
Question 8	62	4	1	5	3.70	1.19	1.421
Question 9	62	4	1	5	3.75	1.08	1.167
Question 10	62	4	1	5	3.73	1.11	1.240
Question 11	62	4	1	5	4.07	1.07	1.143
Valid N (listwise)	62						

MANAGEMENT INFORMATION SYSTEMS ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	3	2	5	4.57	.69	.474
Question 6	62	4	1	5	3.87	1.36	1.852
Question 7	62	4	1	5	3.52	1.40	1.954
Question 8	62	4	1	5	4.21	1.04	1.086
Question 9	62	4	1	5	4.20	.94	.879
Question 10	62	4	1	5	3.74	1.18	1.395
Question 11	62	4	1	5	3.89	.99	.987
Valid N (listwise)	62						

MARKETING/BENEFICIARY EDUCATION ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	4	1	5	4.37	1.04	1.079
Question 6	62	4	1	5	3.61	1.36	1.848
Question 7	62	4	1	5	3.21	1.52	2.300
Question 8	62	4	1	5	4.25	1.14	1.300
Question 9	62	4	1	5	3.83	1.10	1.219
Question 10	62	4	1	5	4.42	.91	.826
Question 11	62	4	1	5	3.61	1.26	1.583
Valid N (listwise)	62						

QUALITY ASSURANCE/QUALITY MANAGEMENT ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	4	1	5	3.87	.97	.934
Question 6	62	4	1	5	3.34	1.37	1.865
Question 7	62	4	1	5	2.85	1.27	1.602
Question 8	62	4	1	5	3.06	1.08	1.176
Question 9	62	4	1	5	3.43	1.08	1.160
Question 10	62	4	1	5	2.68	1.00	.998
Question 11	62	4	1	5	2.88	1.04	1.085
Valid N (listwise)	62						

STAFFING ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	3	2	5	4.47	.78	.614
Question 6	62	4	1	5	3.98	1.36	1.852
Question 7	62	4	1	5	3.54	1.24	1.527
Question 8	62	4	1	5	3.95	1.19	1.424
Question 9	62	4	1	5	3.98	1.05	1.098
Question 10	62	4	1	5	2.86	1.18	1.392
Question 11	62	4	1	5	3.05	1.06	1.129
Valid N (listwise)	62						

TRAINING OF MAMC STAFF

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	4	1	5	4.27	.94	.891
Question 6	62	4	1	5	3.82	1.27	1.624
Question 7	62	4	1	5	3.30	1.31	1.716
Question 8	62	4	1	5	3.89	1.03	1.053
Question 9	62	4	1	5	4.13	1.06	1.130
Question 10	62	4	1	5	2.59	1.22	1.479
Question 11	62	4	1	5	3.62	1.04	1.087
Valid N (listwise)	62						

UTILIZATION MANAGEMENT ISSUES

Descriptive Statistics

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Question 5	62	3	2	5	4.25	.92	.841
Question 6	62	4	1	5	3.66	1.43	2.031
Question 7	62	4	1	5	3.32	1.43	2.058
Question 8	62	4	1	5	3.79	1.07	1.151
Question 9	62	4	1	5	4.00	1.01	1.016
Question 10	62	4	1	5	3.17	1.09	1.185
Question 11	62	4	1	5	3.48	1.14	1.299
Valid N (listwise)	62						

INFERENCES BASED ON SIGNIFICANT SURVEY RESULTS (GROUPED BY COMPARISON GROUP):

LEAD AGENCY STAFF VS. MADIGAN STAFF

CONTRACTING ISSUES - Lead Agency staff (mean = 3.67, st. dev. = 1.45) felt contracting issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 2.78, st. dev. = 1.46)
F(1,59) = 4.167, p<.046

CONTRACTING ISSUES - Lead Agency staff (mean = 4.60, st. dev. = .51) felt contracting issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.39, st. dev. = 1.10)
F(1,59) = 16.858, p<.000

CONTRACTING ISSUES - Lead Agency staff (mean = 4.67, st. dev. = .49) felt contracting issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.99, st. dev. = 1.15)
F(1,59) = 4.926, p<.030

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.33, st. dev. = .72) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan Staff (mean = 3.61, st. dev. = 1.29)
F(1,59) = 4.259, p<.043

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.33, st. dev. = .62) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.64, st. dev. = .99)
F(1,59) = 6.502, p<.013

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.00, st. dev. = 1.00) felt enrollment/disenrollment issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.23, st. dev. = 1.26)
F(1,59) = 4.664, p<.035

MANAGEMENT INFORMATION SYSTEMS - Lead Agency staff (mean = 4.73, st. dev. = .46) felt management information systems issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 4.01, st. dev. = .99)
F(1,59) = 7.455, p<.008

MANAGEMENT INFORMATION SYSTEMS - Lead Agency staff (mean = 4.40, st. dev. = .83) felt ~~contracting~~ information systems issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.52, st. dev. = 1.22)
F(1,59) = 6.759, p<.012

MARKETING/BENEFICIARY EDUCATION - Lead Agency staff (mean = 4.47, st. dev. = .64) felt marketing/beneficiary education issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.60, st. dev. = 1.14)
F(1,59) = 7.751, p<.007

INADEQUATE MARKETING CAPABILITIES - Lead Agency staff (mean = 4.27, st. dev. = .80) feel that inadequate marketing capabilities pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.47, st. dev. = 1.07)
F(1,59) = 7.011, p<.010

STAFFING ISSUES - Madigan staff (mean = 4.65, st. dev. = .57) felt staffing issues were much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.87, st. dev. = 1.06)
F(1, 59) = 13.65, p<.000

STAFFING ISSUES - Madigan staff (mean = 4.20, st. dev. = 1.26) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.27, st. dev. = 1.49)
F(1, 59) = 5.631, p<.021

STAFFING ISSUES - Madigan staff (mean = 3.86, st. dev. = .96) felt staffing issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 2.53, st. dev. = 1.51)
F(1,59) = 16.072, p<.000

INADEQUATE STAFFING LEVELS - Madigan staff (mean = 4.13, st. dev. = .93) feel that inadequate staffing levels pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.47, st. dev. = 1.41)
F(1,59) = 16.072, p<.000

UTILIZATION MANAGEMENT - Lead Agency staff (mean = 3.73, st. dev. = .88) felt Utilization Management issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.01, st. dev. = 1.10)
F(1,59) = 5.355, p<.024

ABILITY TO PROVIDE ALL MEDICARE SERVICES - Madigan staff (mean = 4.47, st. dev. = .78) feel that the our ability (or inability) to provide all Medicare services poses a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.73, st. dev. = 1.39)
F(1,59) = 6.658, p<.012

HEALTHCARE ADMINISTRATORS (HCAs) VS. NON-HCAs

CLAIMS PROCESSING/BILLING - Healthcare Administrators (HCAs) (mean =1.95, st. dev. = 1.28) felt claims processing/billing required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 2.70, st. dev. = 1.38).
F(1,60) = 4.192, p<.045

CONTRACTING ISSUES - Healthcare Administrators (HCAs) (mean = 4.56, st. dev. = .82) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.90, st. dev. = 1.23)
F(1,60) = 4.623, p<.036

CONTRACTING ISSUES - Healthcare Administrators (HCAs) (mean = 4.07, st. dev. = 1.13) felt contracting issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.47, st. dev. = 1.08)
F(1,60) = 4.015, p<.050

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (mean = 4.24, st. dev. = .79) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.59, st. dev. = .96)
F(1,60) = 6.994, p<.010

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.40, st. dev. = .82) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.64, st. dev. = 1.14)
F(1,60) = 7.135, p<.010

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.29, st. dev. = .93) felt marketing/beneficiary education issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.62, st. dev. = 1.12)
F(1,60) = 5.460, p<.023

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.77, st. dev. = .42) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.26, st. dev. = 1.03)
F(1,60) = 4.565, p<.037

MEETING HCFA STANDARDS AND REQUIREMENTS - Healthcare Administrators (HCAs) (mean = 4.55, st. dev. = .88) felt meeting HCFA standards and requirements issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.84, st. dev. = 1.08)
F(1,60) = 6.689, p<.026

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 3.5, st. dev. = 1.00) felt Quality Assurance/Quality Management was much **less** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.05, st. dev. = .91).
F(1,60) = 4.608, p<.036

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 2.85, st. dev. = 1.42) felt Quality Assurance/Quality Management was much **less** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.58, st. dev. = 1.29).
F(1,60) = 4.060, p<.048

QUALITY ASSURANCE/QUALITY MANAGEMENT - Healthcare Administrators (HCAs) (mean = 2.30, st. dev. = 1.22) felt Quality Assurance/Quality Management issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.12, st. dev = 1.21)
F(1,60) = 6.155, p<.016

STAFFING ISSUES - Health Care Administrators (HCAs) (mean = 3.30, st. dev. = 1.39) felt staffing issues were much **less** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.31, st. dev. = 1.24).
F(1,60) = 8.372, p<.005

STAFFING ISSUES - Healthcare Administrators (HCAs) (mean = 3.00, st. dev. = 1.30) felt staffing issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.80, st. dev. = 1.13)
F(1,60) = 6.134, p<.016

TRAINING OF MAMC STAFF - Healthcare Administrators (HCAs) (mean = 2.80, st. dev. = 1.54) felt training of MAMC staff required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.53, st. dev. = 1.13)
F(1,60) = 4.457, p<.039

UTILIZATION MANAGEMENT - Healthcare Administrators (HCAs) (mean = 2.75, st. dev. = 1.52) felt Utilization Management issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.60, st. dev. = 1.33)
F(1,60) = 5.012, p<.029

LIMITED EXPERIENCE IN FINANCIALLY RISKY SITUATIONS - Healthcare Administrators (HCAs) (mean = 3.40, st. dev. = 1.27) feel that limited experience in financially risky situations poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.07, st. dev. = .97)
F(1,60) = 5.207, p<.026

NO HCFA REIMBURSEMENT - Healthcare Administrators (HCAs) (mean = 3.75, st. dev. = 1.33) feel that not receiving HCFA reimbursement poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.46, st. dev. = .86)
F(1,60) = 6.364, p<.014

HEALTHCARE ADMINISTRATORS VS. PHYSICIANS

CONTRACTING ISSUES - Healthcare Administrators (HCAs) (mean = 4.56, st. dev. = .82) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 3.74, st. dev. = 1.28)
F(1,37) = 5.682, p<.022

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.20, st. dev. = .89) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.42, st. dev. = 1.26)
F(1,37) = 4.991, p<.032

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (mean = 4.24, st. dev. = .79) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.57, st. dev. = 1.07)
F(1,37) = 5.020, p<.031

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.40, st. dev. = .82) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.67, st. dev. = 1.29)
F(1,37) = 4.471, p<.041

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.65, st. dev. = .75) felt marketing/beneficiary education issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.95, st. dev. = 1.31)
F(1,37) = 4.289, p<.045

MEETING HCFA STANDARDS AND REQUIREMENTS - Healthcare Administrators (HCAs) (mean = 4.55, st. dev. = .88) felt meeting HCFA standards and requirements issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 3.74, st. dev. = 1.24)
F(1,37) = 5.593, p<.023

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 3.5, st. dev. = 1.00) felt Quality Assurance/Quality Management was much **less** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.05, st. dev. = .62).
F(1,60) = 4.243, p<.046

QUALITY ASSURANCE/QUALITY MANAGEMENT - Physicians (mean = 3.21, st. dev. = 1.03) felt quality assurance/quality management issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 2.30, st. dev. = 1.22)
F(1,37) = 6.311, p<.016

STAFFING ISSUES - Physicians (mean = 4.21, st. dev. = 1.27) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Health Care Administrators (HCAs) (mean = 3.30, st. dev. =1.38)
F(1,37) = 4.585, p<.039

STAFFING ISSUES - Physicians (mean = 3.95, st. dev. = 1.08) felt staffing issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 3.00, st. dev. = 1.30)
F(1,37) = 6.118, p<.018

TRAINING OF MAMC STAFF - Physicians (mean = 3.84, st. dev. = 1.01) felt training of MAMC staff required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 2.80, st. dev. = 1.54)
F(1,37) = 6.144, p<.018

LIMITED EXPERIENCE IN FINANCIALLY RISKY SITUATIONS - Healthcare Administrators (HCAs) (mean = 3.40, st. dev. = 1.27) feel that limited experience in financially risky situations poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.15, st. dev. = .96)
F(1,37) = 4.279, p<.046

NO HCFA REIMBURSEMENT - Healthcare Administrators (HCAs) (mean = 3.75, st. dev. = 1.33) feel that not receiving HCFA reimbursement poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.59, st. dev. = .95)
F(1,37) = 5.084, p<.030

PHYSICIANS VS. NON-PHYSICIANS

TRAINING OF MAMC STAFF - Physicians (mean = 3.84, st. dev. = 1.01) felt training of MAMC staff required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.05, st. dev. = 1.36)
F(1,60) = 5.096, p<.028

INADEQUATE TRAINING - Physicians (mean = 3.25, st. dev. = 1.23) feel that inadequate training poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.98, st. dev. = 1.01)
F(1,60) = 5.936, p<.018

UTILIZATION MANAGEMENT - Physicians (mean = 3.32, st. dev. = 1.11) felt Utilization Management issues required **less** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 4.00, st. dev. = 1.00)
F(1,60) = 5.688, p<.020

UTILIZATION MANAGEMENT - Physicians (mean = 2.70, st. dev. = .95) felt Utilization Management issues required much **less** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.38, st. dev. = 1.09)
F(1,60) = 5.415, p<.023

INADEQUATE UTILIZATION MANAGEMENT - Physicians (mean = 2.75, st. dev. = 1.29) feel that inadequate utilization management poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.47, st. dev. = 1.22)
F(1,60) = 4.368, p<.041

NURSES VS. NON-NURSES

MANAGEMENT INFORMATION SYSTEMS - Nurses (mean = 4.86, st. dev. = .38) felt Management Information Systems were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.74, st. dev. = 1.39)
F(1,60) = 4.394, p<.040

MEETING HCFA STANDARDS AND REQUIREMENTS - Nurses (mean = 4.57, st. dev. = .53) felt meeting HCFA standards and requirements was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.18, st. dev. = 1.47)
F(1,60) = 6.102, p<.016

MEETING HCFA STANDARDS AND REQUIREMENTS - Nurses (mean = 4.29, st. dev. = .49) felt that meeting HCFA standards and requirements required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-nurses (mean = 3.09, st. dev. = 3.09, st. dev. = 1.32)
F(1,60) = 5.542, p<.022

QUALITY ASSURANCE/QUALITY MANAGEMENT - Nurses (mean = 4.57, st. dev. = .53) felt quality assurance/quality management was much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.78, st. dev. = .98).
F(1,60) = 4.375, p<.041

UTILIZATION MANAGEMENT - Nurses (mean = 5.00, st. dev. = .00) felt Utilization Management was much **more** important issue to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.49, st. dev. = 1.43)
F(1,60) = 7.732, p<.007

CLINICAL POSITIONS VS. ADMINISTRATIVE POSITIONS

CLAIMS PROCESSING/BILLING - People working in Clinical Positions (mean = 4.5, st. dev. = .53) felt claims processing/billing was much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people in working in Administrative Positions (mean = 3.75, st. dev. = 1.10).
F(1,60) = 4.406, p<.040

ENROLLMENT/DISENROLLMENT - People working in Administrative positions (mean = 3.12, st. dev. = 1.35) felt enrollment/disenrollment issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in Clinical positions (mean = 2.10, st. dev. = 1.45)
F(1,60) = 4.624, p<.036

INADEQUATE INFORMATION SYSTEMS CAPABILITIES - People working in administrative positions (mean = 3.96, st. dev. = 1.10) feel that inadequate information systems pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in clinical positions (mean = 2.98, st. dev. = 1.14)
F(1,60) = 6.591, p<.013

STAFFING ISSUES - People working Clinical Positions (mean = 4.90, st. dev. = ..32) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in Administrative Positions (mean = 3.81, st. dev. = 1.41)
F(1,60) = 5.835, p<.019

NEW EMPLOYEES VS. OTHER EMPLOYEES

ENROLLMENT/DISENROLLMENT - New Employees (mean = 4.18, st. dev. = 1.33) felt enrollment/disenrollment was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.14, st. dev. = 1.43)
F(1,60) = 4.95, p<.030

MARKETING/BENEFICIARY EDUCATION - New Employees (mean = 4. 45), st. dev. = .52) felt Marketing/Beneficiary Education was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.43, st. dev. = 1.42)
F(1,60) = 5.505, p<.022

STAFFING ISSUES - New Employees (mean = 4.82, st. dev. = .41) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.80, st. dev. = 1.43)
F(1,60) = 5.366, p<.024

TRAINING OF MAMC STAFF - New Employees (mean = 4.55, st. dev. = .93) felt training of MAMC staff was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.67, st. dev. = 1.29)
F(1,60) = 4.554, p<.037

INFERENCES BASED ON SIGNIFICANT SURVEY RESULTS (GROUPED BY ISSUE):

CLAIMS PROCESSING/BILLING

CLAIMS PROCESSING/BILLING - People working in Clinical Positions (mean = 4.5, st. dev. = .53) felt claims processing/billing was much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people in working in Administrative Positions (mean = 3.75, st. dev. = 1.10).
F(1,60) = 4.406, p<.040

CLAIMS PROCESSING/BILLING - Healthcare Administrators (HCAs) (mean =1.95, st. dev. = 1.28) felt claims processing/billing required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 2.70, st. dev. = 1.38).
F(1,60) = 4.192, p<.045

ENROLLMENT/DISENROLLMENT

ENROLLMENT/DISENROLLMENT - New Employees (mean = 4.18, st. dev. = 1.33) felt enrollment/disenrollment was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.14, st. dev. = 1.43)
F(1,60) = 4.95, p<.030

ENROLLMENT/DISENROLLMENT - People working in Administrative positions (mean = 3.12, st. dev. = 1.35) felt enrollment/disenrollment issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in Clinical positions (mean = 2.10, st. dev. = 1.45)
F(1,60) = 4.624, p<.036

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.33, st. dev. = .72) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan Staff (mean = 3.61, st. dev. = 1.29)
F(1,59) = 4.259, p<.043

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.20, st. dev. = .89) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.42, st. dev. = 1.26)
F(1,37) = 4.991, p<.032

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.33, st. dev. = .62) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.64, st. dev. = .99)
F(1,59) = 6.502, p<.013

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (mean = 4.24, st. dev. = .79) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.59, st. dev. = .96)
F(1,60) = 6.994, p<.010

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (mean = 4.24, st. dev. = .79) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.57, st. dev. = 1.07)
F(1,37) = 5.020, p<.031

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.40, st. dev. = .82) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.64, st. dev. = 1.14)
F(1,60) = 7.135, p<.010

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.40, st. dev. = .82) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.67, st. dev. = 1.29)
F(1,37) = 4.471, p<.041

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.00, st. dev. = 1.00) felt enrollment/disenrollment issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.23, st. dev. = 1.26)
F(1,59) = 4.664, p<.035

MANAGEMENT INFORMATION SYSTEMS

MANAGEMENT INFORMATION SYSTEMS - Nurses (mean = 4.86, st. dev. = .38) felt Management Information Systems were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.74, st. dev. = 1.39) **F(1,60) = 4.394, p<.040**

MANAGEMENT INFORMATION SYSTEMS - Lead Agency staff (mean = 4.73, st. dev. = .46) felt management information systems issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 4.01, st. dev. = .99) **F(1,59) = 7.455, p<.008**

MANAGEMENT INFORMATION SYSTEMS - Lead Agency staff (mean = 4.40, st. dev. = .83) felt ~~contracting~~ information systems issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.52, st. dev. = 1.22) **F(1,59) = 6.759, p<.012**

INADEQUATE INFORMATION SYSTEMS CAPABILITIES - People working in administrative positions (mean = 3.96, st. dev. = 1.10) feel that inadequate information systems pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in clinical positions (mean = 2.98, st. dev. = 1.14) **F(1,60) = 6.591, p<.013**

MARKETING/BENEFICIARY EDUCATION

MARKETING/BENEFICIARY EDUCATION - New Employees (mean = 4. 45), st. dev. = .52) felt Marketing/Beneficiary Education was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.43, st. dev. = 1.42)
F(1,60) = 5.505, p<.022

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.65, st. dev. = .75) felt marketing/beneficiary education issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.95, st. dev. = 1.31)
F(1,37) = 4.289, p<.045

MARKETING/BENEFICIARY EDUCATION - Lead Agency staff (mean = 4.47, st. dev. = .64) felt marketing/beneficiary education issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.60, st. dev. = 1.14)
F(1,59) = 7.751, p<.007

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.29, st. dev. = .93) felt marketing/beneficiary education issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.62, st. dev. = 1.12)
F(1,60) = 5.460, p<.023

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.77, st. dev. = .42) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.26, st. dev. = 1.03)
F(1,60) = 4.565, p<.037

INADEQUATE MARKETING CAPABILITIES - Lead Agency staff (mean = 4.27, st. dev. = .80) feel that inadequate marketing capabilities pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.47, st. dev. = 1.07)
F(1,59) = 7.011, p<.010

MEETING HCFA STANDARDS AND REQUIREMENTS

MEETING HCFA STANDARDS AND REQUIREMENTS - Nurses (mean = 4.57, st. dev. = .53) felt meeting HCFA standards and requirements was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.18, st. dev. = 1.47)
F(1,60) = 6.102, p<.016

MEETING HCFA STANDARDS AND REQUIREMENTS - Nurses (mean = 4.29, st. dev. = .49) felt that meeting HCFA standards and requirements required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-nurses (mean = 3.09, st. dev. = 3.09, st. dev. = 1.32)
F(1,60) = 5.542, p<.022

MEETING HCFA STANDARDS AND REQUIREMENTS - Healthcare Administrators (HCAs) (mean = 4.55, st. dev. = .88) felt meeting HCFA standards and requirements issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.84, st. dev. = 1.08)
F(1,60) = 6.689, p<.026

MEETING HCFA STANDARDS AND REQUIREMENTS - Healthcare Administrators (HCAs) (mean = 4.55, st. dev. = .88) felt meeting HCFA standards and requirements issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 3.74, st. dev. = 1.24)
F(1,37) = 5.593, p<.023

QUALITY ASSURANCE/QUALITY MANAGEMENT

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 3.5, st. dev. = 1.00) felt Quality Assurance/Quality Management was much **less** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.05, st. dev. = .91).
F(1,60) = 4.608, p<.036

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 3.5, st. dev. = 1.00) felt Quality Assurance/Quality Management was much **less** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.05, st. dev. = .62).
F(1,60) = 4.243, p<.046

QUALITY ASSURANCE/QUALITY MANAGEMENT - Nurses (mean = 4.57, st. dev. = .53) felt quality assurance/quality management was much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.78, st. dev. = .98).
F(1,60) = 4.375, p<.041

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 2.85, st. dev. = 1.42) felt Quality Assurance/Quality Management was much **less** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.58, st. dev. = 1.29).
F(1,60) = 4.060, p<.048

QUALITY ASSURANCE/QUALITY MANAGEMENT - Healthcare Administrators (HCAs) (mean = 2.30, st. dev. = 1.22) felt Quality Assurance/Quality Management issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.12, st. dev = 1.21)
F(1,60) = 6.155, p<.016

QUALITY ASSURANCE/QUALITY MANAGEMENT - Physicians (mean = 3.21, st. dev. = 1.03) felt quality assurance/quality management issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 2.30, st. dev. = 1.22)
F(1,37) = 6.311, p<.016

STAFFING ISSUES

STAFFING ISSUES - Madigan staff (mean = 4.65, st. dev. = .57) felt staffing issues were much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.87, st. dev. = 1.06)
F(1, 59) = 13.65, p<.000

STAFFING ISSUES - Madigan staff (mean = 4.20, st. dev. = 1.26) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.27, st. dev. = 1.49)
F(1, 59) = 5.631, p<.021

STAFFING ISSUES - New Employees (mean = 4.82, st. dev. = .41) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.80, st. dev. = 1.43)
F(1,60) = 5.366, p<.024

STAFFING ISSUES - People working Clinical Positions (mean = 4.90, st. dev. = ..32) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in Administrative Positions (mean = 3.81, st. dev. = 1.41)
F(1,60) = 5.835, p<.019

STAFFING ISSUES - Health Care Administrators (HCAs) (mean = 3.30, st. dev. = 1.39) felt staffing issues were much **less** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.31, st. dev. = 1.24).
F(1,60) = 8.372, p<.005

STAFFING ISSUES - Physicians (mean = 4.21, st. dev. = 1.27) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Health Care Administrators (HCAs) (mean = 3.30, st. dev. =1.38)
F(1,37) = 4.585, p<.039

STAFFING ISSUES - Madigan staff (mean = 3.86, st. dev. = .96) felt staffing issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 2.53, st. dev. = 1.51)
F(1,59) = 16.072, p<.000

STAFFING ISSUES - Healthcare Administrators (HCAs) (mean = 3.00, st. dev. = 1.30) felt staffing issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.80, st. dev. = 1.13)
F(1,60) = 6.134, p<.016

STAFFING ISSUES - Physicians (mean = 3.95, st. dev. = 1.08) felt staffing issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 3.00, st. dev. = 1.30)
F(1,37) = 6.118, p<.018

INADEQUATE STAFFING LEVELS - Madigan staff (mean = 4.13, st. dev. = .93) feel that inadequate staffing levels pose a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.47, st. dev. = 1.41)
F(1,59) = 16.072, p<.000

TRAINING OF MAMC STAFF

TRAINING OF MAMC STAFF - New Employees (mean = 4.55, st. dev. = .93) felt training of MAMC staff was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.67, st. dev. = 1.29)
F(1,60) = 4.554, p<.037

TRAINING OF MAMC STAFF - Healthcare Administrators (HCAs) (mean = 2.80, st. dev. = 1.54) felt training of MAMC staff required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.53, st. dev. = 1.13)
F(1,60) = 4.457, p<.039

TRAINING OF MAMC STAFF - Physicians (mean = 3.84, st. dev. = 1.01) felt training of MAMC staff required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.05, st. dev. = 1.36)
F(1,60) = 5.096, p<.028

TRAINING OF MAMC STAFF - Physicians (mean = 3.84, st. dev. = 1.01) felt training of MAMC staff required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 2.80, st. dev. = 1.54)
F(1,37) = 6.144, p<.018

INADEQUATE TRAINING - Physicians (mean = 3.25, st. dev. = 1.23) feel that inadequate training poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.98, st. dev. = 1.01)
F(1,60) = 5.936, p<.018

UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT - Nurses (mean = 5.00, st. dev. = .00) felt Utilization Management was much **more** important issue to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.49, st. dev. = 1.43)
F(1,60) = 7.732, p<.007

UTILIZATION MANAGEMENT - Healthcare Administrators (HCAs) (mean = 2.75, st. dev. = 1.52) felt Utilization Management issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.60, st. dev. = 1.33)
F(1,60) = 5.012, p<.029

UTILIZATION MANAGEMENT - Physicians (mean = 3.32, st. dev. = 1.11) felt Utilization Management issues required **less** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 4.00, st. dev. = 1.00)
F(1,60) = 5.688, p<.020

UTILIZATION MANAGEMENT - Lead Agency staff (mean = 3.73, st. dev. = .88) felt Utilization Management issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.01, st. dev. = 1.10)
F(1,59) = 5.355, p<.024

UTILIZATION MANAGEMENT - Physicians (mean = 2.70, st. dev. = .95) felt Utilization Management issues required much **less** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.38, st. dev. = 1.09)
F(1,60) = 5.415, p<.023

INADEQUATE UTILIZATION MANAGEMENT - Physicians (mean = 2.75, st. dev. = 1.29) feel that inadequate utilization management poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.47, st. dev. = 1.22)
F(1,60) = 4.368, p<.041

OTHER ISSUES

ABILITY TO PROVIDE ALL MEDICARE SERVICES - Madigan staff (mean = 4.47, st. dev. = .78) feel that the our ability (or inability) to provide all Medicare services poses a **greater** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.73, st. dev. = 1.39)
F(1,59) = 6.658, p<.012

LIMITED EXPERIENCE IN FINANCIALLY RISKY SITUATIONS - Healthcare Administrators (HCAs) (mean = 3.40, st. dev. = 1.27) feel that limited experience in financially risky situations poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.07, st. dev. = .97)
F(1,60) = 5.207, p<.026

LIMITED EXPERIENCE IN FINANCIALLY RISKY SITUATIONS - Healthcare Administrators (HCAs) (mean = 3.40, st. dev. = 1.27) feel that limited experience in financially risky situations poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.15, st. dev. = .96)
F(1,37) = 4.279, p<.046

NO HCFA REIMBURSEMENT - Healthcare Administrators (HCAs) (mean = 3.75, st. dev. = 1.33) feel that not receiving HCFA reimbursement poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.46, st. dev. = .86)
F(1,60) = 6.364, p<.014

NO HCFA REIMBURSEMENT - Healthcare Administrators (HCAs) (mean = 3.75, st. dev. = 1.33) feel that not receiving HCFA reimbursement poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.59, st. dev. = .95)
F(1,37) = 5.084, p<.030

INFERENCES BASED ON SIGNIFICANT SURVEY RESULTS (GROUPED BY SURVEY QUESTION):

5. Rate the following issues according to their importance to **your organization** (i.e. MAMC or the Lead Agency) in preparing for implementation of the TRICARE Medicare Subvention Simulation Project, with 1 being not very important and 5 being very important.

CLAIMS PROCESSING/BILLING - People working in Clinical Positions (mean = 4.5, st. dev. = .53) felt claims processing/billing was much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people in working in Administrative Positions (mean = 3.75, st. dev. = 1.10).
F(1,60) = 4.406, p<.040

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 3.5, st. dev. = 1.00) felt Quality Assurance/Quality Management was much **less** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.05, st. dev. = .91).
F(1,60) = 4.608, p<.036

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 3.5, st. dev. = 1.00) felt Quality Assurance/Quality Management was much **less** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.05, st. dev. = .62).
F(1,60) = 4.243, p<.046

QUALITY ASSURANCE/QUALITY MANAGEMENT - Nurses (mean = 4.57, st. dev. = .53) felt quality assurance/quality management was much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.78, st. dev. = .98).
F(1,60) = 4.375, p<.041

STAFFING ISSUES - Madigan staff (mean = 4.65, st. dev. = .57) felt staffing issues were much **more** important to the organization in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.87, st. dev. = 1.06)
F(1, 59) = 13.65, p<.000

No Significant Differences between:

1. New Employees (less than six months in current position) vs. others.
2. HCA's vs. Physicians
3. Physicians vs. non-Physicians

6. Rate the following issues according to their importance to **your position** in preparing for implementation of the TRICARE Medicare Subvention Simulation Project, with 1 being not very important and 5 being very important.

ENROLLMENT/DISENROLLMENT - New Employees (mean = 4.18, st. dev. = 1.33) felt enrollment/disenrollment was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.14, st. dev. = 1.43)
F(1,60) = 4.95, p<.030

MEETING HCFA STANDARDS AND REQUIREMENTS - Nurses (mean = 4.57, st. dev. = .53) felt meeting HCFA standards and requirements was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.18, st. dev. = 1.47)
F(1,60) = 6.102, p<.016

MANAGEMENT INFORMATION SYSTEMS - Nurses (mean = 4.86, st. dev. = .38) felt Management Information Systems were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.74, st. dev. = 1.39)
F(1,60) = 4.394, p<.040

MARKETING/BENEFICIARY EDUCATION - New Employees (mean = 4. 45), st. dev. = .52) felt Marketing/Beneficiary Education was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.43, st. dev. = 1.42)
F(1,60) = 5.505, p<.022

QUALITY ASSURANCE/QUALITY MANAGEMENT - Health Care Administrators (HCAs) (mean = 2.85, st. dev. = 1.42) felt Quality Assurance/Quality Management was much **less** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.58, st. dev. = 1.29).
F(1,60) = 4.060, p<.048

STAFFING ISSUES - Madigan staff (mean = 4.20, st. dev. = 1.26) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 3.27, st. dev. = 1.49)
F(1, 59) = 5.631, p<.021

STAFFING ISSUES - New Employees (mean = 4.82, st. dev. = .41) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.80, st. dev. = 1.43)
F(1,60) = 5.366, p<.024

STAFFING ISSUES - People working Clinical Positions (mean = 4.90, st. dev. = ..32) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in Administrative Positions (mean = 3.81, st. dev. = 1.41)
F(1,60) = 5.835, p<.019

STAFFING ISSUES - Health Care Administrators (HCAs) (mean = 3.30, st. dev. = 1.39) felt staffing issues were much **less** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.31, st. dev. = 1.24).
F(1,60) = 8.372, p<.005

STAFFING ISSUES - Physicians (mean = 4.21, st. dev. = 1.27) felt staffing issues were much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Health Care Administrators (HCAs) (mean = 3.30, st. dev. =1.38)
F(1,37) = 4.585, p<.039

TRAINING OF MAMC STAFF - New Employees (mean = 4.55, st. dev. = .93) felt training of MAMC staff was much **more** important to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than other employees (mean = 3.67, st. dev. = 1.29)
F(1,60) = 4.554, p<.037

UTILIZATION MANAGEMENT - Nurses (mean = 5.00, st. dev. = .00) felt Utilization Management was much **more** important issue to their positions in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-Nurses (mean = 3.49, st. dev. = 1.43)
F(1,60) = 7.732, p<.007

No Significant Differences Between:

1. Physicians vs. Non-Physicians

7. Rate the following issues according to the **amount of time** which each required or will require in preparing for implementation of the TRICARE Medicare Subvention Simulation Project. Please give issues which you feel are not very time consuming a 1, and the issues which are very time consuming a 5. Your perception of the time you spent or will spend is more important than your trying to reconstruct actual time.

CLAIMS PROCESSING/BILLING - Healthcare Administrators (HCAs) (mean =1.95, st. dev. = 1.28) felt claims processing/billing required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 2.70, st. dev. = 1.38).
F(1,60) = 4.192, p<.045

CONTRACTING ISSUES - Lead Agency staff (mean = 3.67, st. dev. = 1.45) felt contracting issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 2.78, st. dev. = 1.46)
F(1,59) = 4.167, p<.046

ENROLLMENT/DISENROLLMENT - People working in Administrative positions (mean = 3.12, st. dev. = 1.35) felt enrollment/disenrollment issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than those people working in Clinical positions (mean = 2.10, st. dev. = 1.45)
F(1,60) = 4.624, p<.036

MEETING HCFA STANDARDS AND REQUIREMENTS - Nurses (mean = 4.29, st. dev. = .49) felt that meeting HCFA standards and requirements required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-nurses (mean = 3.09, st. dev. = 3.09, st. dev. = 1.32)
F(1,60) = 5.542, p<.022

QUALITY ASSURANCE/QUALITY MANAGEMENT - Healthcare Administrators (HCAs) (mean = 2.30, st. dev. = 1.22) felt Quality Assurance/Quality Management issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.12, st. dev = 1.21)
F(1,60) = 6.155, p<.016

QUALITY ASSURANCE/QUALITY MANAGEMENT - Physicians (mean = 3.21, st. dev. = 1.03) felt quality assurance/quality management issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 2.30, st. dev. = 1.22)
F(1,37) = 6.311, p<.016

STAFFING ISSUES - Madigan staff (mean = 3.86, st. dev. = .96) felt staffing issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Lead Agency staff (mean = 2.53, st. dev. = 1.51)
F(1,59) = 16.072, p<.000

STAFFING ISSUES - Healthcare Administrators (HCAs) (mean = 3.00, st. dev. = 1.30) felt staffing issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.80, st. dev. = 1.13)
F(1,60) = 6.134, p<.016

STAFFING ISSUES - Physicians (mean = 3.95, st. dev. = 1.08) felt staffing issues required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 3.00, st. dev. = 1.30)
F(1,37) = 6.118, p<.018

TRAINING OF MAMC STAFF - Healthcare Administrators (HCAs) (mean = 2.80, st. dev. = 1.54) felt training of MAMC staff required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.53, st. dev. = 1.13)
F(1,60) = 4.457, p<.039

TRAINING OF MAMC STAFF - Physicians (mean = 3.84, st. dev. = 1.01) felt training of MAMC staff required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.05, st. dev. = 1.36)
F(1,60) = 5.096, p<.028

TRAINING OF MAMC STAFF - Physicians (mean = 3.84, st. dev. = 1.01) felt training of MAMC staff required much **more** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than Healthcare Administrators (HCAs) (mean = 2.80, st. dev. = 1.54)
F(1,37) = 6.144, p<.018

UTILIZATION MANAGEMENT - Healthcare Administrators (HCAs) (mean = 2.75, st. dev. = 1.52) felt Utilization Management issues required much **less** time in preparing for implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.60, st. dev. = 1.33)
$F(1,60) = 5.012$, $p<.029$

No Significant Differences between:

1. New Employees vs. Other Employees

8. Rate the following issues according to the **lead time (prior planning)** you feel is required to effectively implement them as part of the TRICARE Medicare Subvention Simulation Project, with a 1 being very little lead time and a 5 being very much lead time. Even if you did not participate, please give your perception.

CONTRACTING ISSUES - Healthcare Administrators (HCAs) (mean = 4.56, st. dev. = .82) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.90, st. dev. = 1.23)
F(1,60) = 4.623, p<.036

CONTRACTING ISSUES - Healthcare Administrators (HCAs) (mean = 4.56, st. dev. = .82) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 3.74, st. dev. = 1.28)
F(1,37) = 5.682, p<.022

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.33, st. dev. = .72) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan Staff (mean = 3.61, st. dev. = 1.29)
F(1,59) = 4.259, p<.043

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.20, st. dev. = .89) felt enrollment/disenrollment issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.42, st. dev. = 1.26)
F(1,37) = 4.991, p<.032

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.65, st. dev. = .75) felt marketing/beneficiary education issues required **greater** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.95, st. dev. = 1.31)
F(1,37) = 4.289, p<.045

UTILIZATION MANAGEMENT - Physicians (mean = 3.32, st. dev. = 1.11) felt Utilization Management issues required **less** lead time (prior planning) to effectively implement them as part of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 4.00, st. dev. = 1.00) **F(1,60) = 5.688, p<.020**

No Significant Differences between:

1. People in clinical positions vs. people in administrative positions
2. New employees vs. other employees
3. Nurses vs. non-nurses

9. Rate the issues according to the **internal coordination** which you feel is required to effectively implement them as part of the TRICARE Medicare Subvention Simulation Project, with a 1 being very little internal coordination and a 5 being very much internal coordination.

CONTRACTING ISSUES - Lead Agency staff (mean = 4.60, st. dev. = .51) felt contracting issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.39, st. dev. = 1.10)
F(1,59) = 16.858, p<.000

CONTRACTING ISSUES - Healthcare Administrators (HCAs) (mean = 4.07, st. dev. = 1.13) felt contracting issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.47, st. dev. = 1.08)
F(1,60) = 4.015, p<.050

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.33, st. dev. = .62) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.64, st. dev. = .99)
F(1,59) = 6.502, p<.013

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (mean = 4.24, st. dev. = .79) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.59, st. dev. = .96)
F(1,60) = 6.994, p<.010

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (mean = 4.24, st. dev. = .79) felt enrollment/disenrollment issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.57, st. dev. = 1.07)
F(1,37) = 5.020, p<.031

MARKETING/BENEFICIARY EDUCATION - Lead Agency staff (mean = 4.47, st. dev. = .64) felt marketing/beneficiary education issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.60, st. dev. = 1.14)
F(1,59) = 7.751, p<.007

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.29, st. dev. = .93) felt marketing/beneficiary education issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.62, st. dev. = 1.12)
$F(1,60) = 5.460, p<.023$

MANAGEMENT INFORMATION SYSTEMS - Lead Agency staff (mean = 4.73, st. dev. = .46) felt management information systems issues required much **greater** internal coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 4.01, st. dev. = .99)
$F(1,59) = 7.455, p<.008$

No Significant Differences between:

1. People in clinical positions vs. people in administrative positions
2. New employees vs. other employees
3. Physicians vs. non-physicians
4. Nurses vs. non-nurses

10. Rate the issues according to the **coordination with entities outside the hospital** you feel is required to effectively implement them as part of the TRICARE Medicare Subvention Simulation Project, with a 1 being very little external coordination and a 5 being very much external coordination.

CONTRACTING ISSUES - Lead Agency staff (mean = 4.67, st. dev. = .49) felt contracting issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.99, st. dev. = 1.15)
F(1,59) = 4.926, p<.030

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.40, st. dev. = .82) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.64, st. dev. = 1.14)
F(1,60) = 7.135, p<.010

ENROLLMENT/DISENROLLMENT - Healthcare Administrators (HCAs) (mean = 4.40, st. dev. = .82) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Physicians (mean = 3.67, st. dev. = 1.29)
F(1,37) = 4.471, p<.041

MANAGEMENT INFORMATION SYSTEMS - Lead Agency staff (mean = 4.40, st. dev. = .83) felt ~~contracting~~ Information Systems issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.52, st. dev. = 1.22)
F(1,59) = 6.759, p<.012

MARKETING/BENEFICIARY EDUCATION - Healthcare Administrators (HCAs) (mean = 4.77, st. dev. = .42) felt enrollment/disenrollment issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.26, st. dev. = 1.03)
F(1,60) = 4.565, p<.037

UTILIZATION MANAGEMENT - Lead Agency staff (mean = 3.73, st. dev. = .88) felt Utilization Management issues required much **greater** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.01, st. dev. = 1.10)
F(1,59) = 5.355, p<.024

UTILIZATION MANAGEMENT - Physicians (mean = 2.70, st. dev. = .95) felt Utilization Management issues required much **less** external coordination to implement as part of the TRICARE Medicare Subvention Simulation Demonstration than non-physicians (mean = 3.38, st. dev. = 1.09) **F(1,60) = 5.415, p<.023**

No Significant Differences between:

1. People in clinical positions vs. people in administrative positions
2. New employees vs. other employees
3. Nurses vs. non-nurses

11. Since no one in the MHSS has ever implemented a program such as the TRICARE Medicare Subvention Simulation Project before, some activities required to plan for implementation of the demonstration project are familiar and some are not familiar. Please rate the issues according to the **amount of learning** which you feel is required to manage them effectively, with a 1 being very little learning and a 5 being very much learning.

ENROLLMENT/DISENROLLMENT - Lead Agency staff (mean = 4.00, st. dev. = 1.00) felt enrollment/disenrollment issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than Madigan staff (mean = 3.23, st. dev. = 1.26)
F(1,59) = 4.664, p<.035

MEETING HCFA STANDARDS AND REQUIREMENTS - Healthcare Administrators (HCAs) (mean = 4.55, st. dev. = .88) felt meeting HCFA standards and requirements issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 3.84, st. dev. = 1.08)
F(1,60) = 6.689, p<.026

MEETING HCFA STANDARDS AND REQUIREMENTS - Healthcare Administrators (HCAs) (mean = 4.55, st. dev. = .88) felt meeting HCFA standards and requirements issues required much **more** new learning to manage them effectively in implementing the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 3.74, st. dev. = 1.24)
F(1,37) = 5.593, p<.023

No Significant Differences between:

1. People in clinical positions vs. people in administrative positions
2. New employees vs. other employees
3. Physicians vs. non-physicians
4. Nurses vs. non-nurses

LIMITED EXPERIENCE IN FINANCIALLY RISKY SITUATIONS - Healthcare Administrators (HCAs) (mean = 3.40, st. dev. = 1.27) feel that limited experience in financially risky situations poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.07, st. dev. = .97)
F(1,60) = 5.207, p<.026

LIMITED EXPERIENCE IN FINANCIALLY RISKY SITUATIONS - Healthcare Administrators (HCAs) (mean = 3.40, st. dev. = 1.27) feel that limited experience in financially risky situations poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.15, st. dev. = .96)
F(1,37) = 4.279, p<.046

NO HCFA REIMBURSEMENT - Healthcare Administrators (HCAs) (mean = 3.75, st. dev. = 1.33) feel that not receiving HCFA reimbursement poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than non-HCAs (mean = 4.46, st. dev. = .86)
F(1,60) = 6.364, p<.014

NO HCFA REIMBURSEMENT - Healthcare Administrators (HCAs) (mean = 3.75, st. dev. = 1.33) feel that not receiving HCFA reimbursement poses a **smaller** potential threat to the successful implementation of the TRICARE Medicare Subvention Simulation Demonstration than physicians (mean = 4.59, st. dev. = .95)
F(1,37) = 5.084, p<.030

No Significant Differences between:

1. New employees vs. other employees
2. Nurses vs. non-nurses