# STATEMENT ON TRICARE IN DOD REGIONS 3 AND 4

SUBMITTED BY:

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SENATE ARMED SERVICES COMMITTEE
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## STATEMENT OF

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## INTRODUCTION

Mr. Chairman and members of the Committee, thank you for the opportunity to speak to you today regarding the Department of Defense (DoD) TRICARE Program. I am Gene Shields, President and CEO of Humana Military Healthcare Services, Inc. (HMHS). HMHS is a wholly owned subsidiary of Humana Inc., one of the nation s largest publicly traded managed health care companies. HMHS was formed in 1993 to concentrate on Department of Defense (DoD) opportunities like TRICARE, by assembling a group of key managers who understand health plan operations and the delivery of care to military beneficiaries. We are the managed care support contractor for DoD Regions 3 and 4, which encompasses the southeastern United States. Included in these regions are Alabama, Florida, Georgia, the eastern third of Louisiana, Mississippi, South Carolina, and Tennessee. Approximately 1.1 million DoD beneficiaries are eligible to receive health care benefits under this contract which began delivery of health care on July 1, 1996. HMHS has subcontracted with Blue Cross/Blue Shield of South Carolina, d/b/a Palmetto Government Benefit Administrators (PGBA), to process TRICARE claims.

My statement today will cover a number of areas:
TRICARE Program Implementation Challenges
HMHS Initiatives
Program Successes
DoD Initiatives and Recommendations

## PROGRAM IMPLEMENTATION AND CHALLENGES

There are significant challenges inherent with the nationwide implementation of a healthcare delivery system to serve over 8 million service members, retirees and their families. It is important to remember that change is always difficult and when change impacts a system of this magnitude, there will be bumps in the road. The road, is nonetheless, a good one.

The TRICARE system offers choices never before available to military beneficiaries. It is a generous benefit and very affordable when compared to many health benefit plans. It is also a significant improvement over the benefit available in the past. I recognize that each member of this committee has heard of TRICARE problems and concerns from some of your constituents. We must certainly respond to each individual concern, and advance the system, but I would caution against extrapolating individual issues and anecdotes to overall system performance. Neither should we ignore recurring, known shortcomings that can respond to coordinated, well-considered corrections. The difficulty, of course, is in distinguishing between the two. Those distinctions have been entrusted to the TRICARE Management Activity (TMA) to carefully evaluate the real nature and extent of problems and respond accordingly with program changes, beneficiary education or contractor sanctions. I believe they are doing a superb job in pursuing that balance. In considering the present TRICARE problems, it is important to place them in context.

It is important to remember the Military Health System (MHS) as it existed before TRICARE. The old CHAMPUS program was very confusing to those who seldom relied on CHAMPUS during their active service and, during periods of robust Military Treatment Facilities (MTFs), even into retirement. Errors were made on claims, collection notices were sent and, as one former fiscal intermediary reported to me, phone blockage rates often exceeded 90 percent even years into a contract. Further disadvantages of the old system were runaway costs and virtually no monitoring of the appropriateness or quality of non-MTF care. The DoD took a bold step to introduce managed care to the entire country and overseas in the space of only four years. It brought additional lower cost options to beneficiaries, placed focus on quality, accessible civilian networks, authorized new levels of preventive care and established an infrastructure for review and appeals that protected patient rights. While this major change was underway, DoD also faced the necessity to close or right-size numerous MTFs which unfortunately required many beneficiaries to rely on this strange, new TRICARE program. It is hard to imagine a more difficult environment in which to introduce a new program. The problem was further compounded by the fact that the MHS and the Managed Care Support contractors were introducing managed care to

areas of the country where it had never been before. Some communities were not only wary but hostile to this new initiative. Contractors were given seven (7) months or less to transition in and start the new contracts. Providers had to be contracted and trained, beneficiaries had to be educated, and claims systems that had been built for the standard CHAMPUS program had to be modified to incorporate network affiliations, authorizations and referrals, two new benefit and rate structures, as well as the thousands of inquiries that the new options would generate. The early months of all contracts are invariably tumultuous as each new entity forms and responds to the uniqueness of each new contract area as well as the complex requirements of the government system. Each new contractor, whatever their previous successes and experience, finds the TRICARE program has challenges that can overwhelm even the best laid plans and intentions. A close partnership between the government and the contractors must form to deal with unforeseen problems or differing expectations. The partnership must then expand to include the providers who are critical to success. The ultimate outcome of that partnering must result in a program that succeeds in meeting beneficiary needs.

We are encouraged that a recent government sponsored beneficiary survey shows growing satisfaction with TRICARE. When enrollees in TRICARE Prime were asked whether they would re-enroll in Prime, most said they would. The highest levels of favorable responses to this question were in TRICARE regions that have been in operation since early 1997 or before. When TRICARE beneficiaries indicated that they knew a lot about TRICARE Prime, their satisfaction ratings were higher.

In general, beneficiaries need time to adjust to change and to thoroughly understand the program. The entire system needs time to stabilize and I applaud your recognition of that fact and your passage of recent legislation allowing the extension of the current contracts (at the DoD s discretion, based on contractor performance). TRICARE is successful in DoD Regions 3 and 4 and I am certain the information that follows will support my beliefs. Recognizing our success, however, does not mean we are content. HMHS and the DoD, as a team, must advance the system and keep an eye toward continuous program improvements. HMHS welcomes the opportunities we have had and look forward to more

opportunities to work with the DoD Health Affairs and the TRICARE Management Activity (TMA) to further refine and enhance this healthcare system.

## CLAIMS

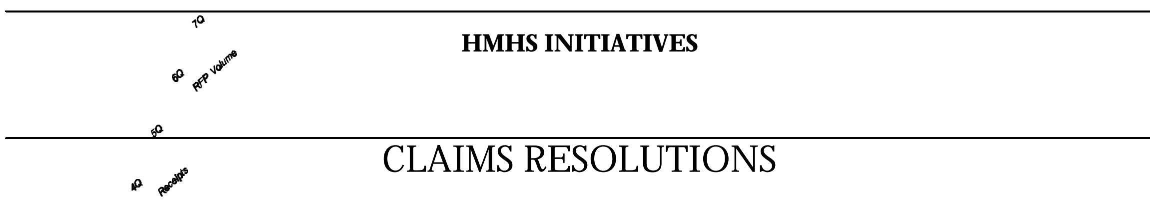
Perhaps the single greatest area of concern among beneficiaries and providers revolves around payment of claims. Claims adjudication is by nature a complicated process. HMHS and PGBA must contend not only with the claims payment issues faced by commercial plans but also the additional complications introduced by DoD requirements.

When awarded a TRICARE contract, the initial hurdle any contractor must face is hiring and training adequate staff in a limited period of time. The so-called Transition Period is the time between the contract award and the start of delivery of health care. Under our contract PGBA was given a seven (7) month period to hire and train a staff of approximately 850 employees as promised in our proposal based on the expected claims volumes provided in the Request for Proposal (RFP). During this time, each employee was extensively trained on the claims processing system and DoD policy including the Code of Federal Regulations (CFR), the Operations Manuals, the Policy Manuals, the Automated Data Processing Manuals, and the RFP. PGBA was diligent and successful in these training efforts.

In Regions 3 and 4, the next hurdle was encountered shortly after health care delivery began. The volume of claims received was 35 percent higher than the DoD had estimated. (See Figure 1.) This increase manifested itself in approximately 8,000 additional claims per day, which PGBA was not staffed to process. As a result, the number of pended claims, or those claims waiting to be processed, quickly rose to a level higher than desired.

Figure 1: Claims Volume

Source: PGBA Workload Reports



**HMHS INITIATIVES**

## CLAIMS RESOLUTIONS

In response, HMHS and PGBA quickly began initiatives to address the increasing level of pended claims. Contingency plans were established to assist providers who were not being paid, PGBA hired and trained additional staff to meet the increased demand, and root causes of problems were systematically addressed.

The first step to remedy this situation was to pay those providers who were harmed by slow claims reimbursement. HMHS responded with advance payments to providers who had excessive pended claims. Good faith payments were offered to providers who voiced their concerns regarding timeliness of claims payment and to less vocal providers who were also harmed. HMHS proactively created reports to identify both large and small practices or institutions which might be having cash-flow concerns.

PGBA also took significant steps to ensure claims were paid in a more timely fashion. Approximately 110 additional claims processors, 70 telephone representatives and five (5) systems programmers were hired and trained to meet this increased volume of work. Once these employees completed their training regimen, a positive trend in processing timeliness began that continues to this day.

## UNDERLYING CAUSES

But advance payments and more people were not the complete answer. Root causes of claims problems had to be identified and eliminated. A major initiative at HMHS was to implement systems enhancements related to new managed care requirements and inserting appropriate warnings and edits to guide adjudicators to correct decisions. HMHS has conducted weekly systems meetings with PGBA over the last 2 1/2 years with over 100 system changes made to enhance and speed claims processing. At the same time, we recognized that many beneficiary problems were factors beyond HMHS or PGBA control. These included beneficiary compliance and confusion, provider billing errors, benefit limitations and DoD policy. Figure 2 provides a view of the source of the problem and relative frequency based on DoD and congressional inquiries received during the past six months.

Figure 2: Root Causes of Priority Inquiries, August 1998 January 1999

It is obvious that external action was necessary because, to the beneficiary, problems need to be fixed, no matter the source.

Many other efforts have been implemented to address these external problems. These include programs to educate and assist providers in the claims filing process, a program to encourage electronic claim filing, a process to assist beneficiaries when claims problems occur, and education materials that help beneficiaries understand and use their benefits appropriately. HMHS is also proud to have worked with DoD to find ways of simplifying program requirements and increase provider and beneficiary satisfaction.

In response to provider concerns, HMHS established a number of SWAT Teams. SWAT teams are composed of representatives of HMHS, military personnel, PGBA and other subcontractors as needed. These associates go on-site to visit providers who have concerns or problems. Team visits are typically for a week or more and involve a complete review and evaluation of all aspects of claims submission. Invariably we have found opportunities for

providers and hospitals to improve their billing practices, and improvement opportunities for HMHS and PGBA. In addition to addressing immediate concerns, this problem solving partnership has built trust and improved the satisfaction of providers. As a result of one such effort, a Medical Center President stated, In all my time in the healthcare business no payer had ever come on site to help resolve claims issues. Humana Military is to be congratulated. HMHS strives to raise all providers to this level of satisfaction. These teams have worked with numerous individual providers, provider groups and institutions.

We have used these opportunities to identify process improvements, and teach providers how to avoid errors on claims submissions. In several instances we found that the electronic claims vendor the provider had chosen was not providing error reports back to the physicians. The claims were not corrected and resubmitted and therefore did not pay. Others received reconciliation reports, but did not know what to do with them.

When used correctly, the electronic method of claims (EMC) filing improves filing accuracy and speeds processing. A promotion was launched, therefore, to increase the number of providers who file electronically. Providers and institutions with large claim volumes were identified and contacted regarding this capability. Information System representatives assisted providers with software and linkage issues. In some instances free software is offered to increase the incentive for providers to use this method of filing.

There are several advantages to both providers and beneficiaries when electronic filing is used. Providers are able to identify claims with missing or discrepant information almost immediately. As a result, they can fix the information at that time and resubmit the claim without waiting for manual intervention from a claims processor. PGBA experience shows that EMC claims pay faster than non-EMC claims. For instance, in the fourth quarter of 1998, electronic claims paid approximately ten (10) days faster than paper claims.

The efforts to increase the volume of electronic claims have been successful. The number of EMC claims has steadily increased over the past year. (See Figure 3.) This trend has peripheral advantages as well. As the number of EMC claims increases, the more time is

freed for PGBA representatives to concentrate on the remaining paper claims. Electronic filing benefits everyone and is an initiative that HMHS and PGBA continue to pursue.

Figure 3: Volume of Electronic Claims, July 1996 December 1998

Source: PGBA Quarterly Trend Report

In spite of all efforts, there are times when a beneficiary is subjected to collection activity. On those thankfully rare occasions, HMHS is dedicated to helping those beneficiaries who incorrectly, or correctly, receive collection agency notices. Collection activity is generally the last phase of a multi-step problem, which often involves the provider, the contractor, other payors, the government and the beneficiary.

Regardless of the cause of the collection notice, the process HMHS has in place focuses on resolution of the problem. We have publicized our service to military leadership and beneficiaries through newsletters and meetings. When an HMHS or PGBA representative learns of collection activity, initial research is conducted to determine the nature of the problem. If the issue is more complex, an HMHS CHAMPUS/TRICARE representative takes the initiative to research the problem and takes any necessary step to resolve the issue. These steps often include contacting the provider and collection agency to have the recoupment action halted until the situation is clarified. The highest priority is given to correcting the problem, whatever the cause. Of course, there are times when the collection action is appropriate and the patient owes the money, then the HMHS representative can help make that determination and explain it to the affected parties.

# BENEFICIARY AND PROVIDER EDUCATION

Yet another challenge in implementing a new healthcare system is the education of both beneficiaries and providers. A recent TRICARE Management Activity survey found that the more beneficiaries knew about TRICARE Prime, the more satisfied they were. HMHS has far exceeded all contractual requirements in developing materials for both beneficiaries and providers to help them understand the TRICARE program. The HMHS Marketing staff makes every effort to explain how to use TRICARE in terms beneficiaries can easily understand. We try to write from the beneficiary s point of view by anticipating their questions and defining TRICARE principles in everyday language. Feedback from our associates, our customers, congressional offices, process improvement teams, and our providers help us identify areas where additional education efforts need to be focused in order to increase beneficiary understanding of the TRICARE program. These materials help our customer service staff answer beneficiary questions more quickly and accurately thereby providing consistent customer service. We believe these efforts improve beneficiary satisfaction, increase knowledge of DoD requirements, and thereby help to make TRICARE a more effective program.

The cornerstone of our marketing and beneficiary education materials is the *TRICARE Choices* Brochure, which covers major TRICARE topics in detail. In addition, we have found that beneficiary acceptance and understanding of the TRICARE program is improved by creating targeted brochures that address a particular topic. By focusing on topics that are commonly addressed by our TRICARE Service Center (TSC) staff and beneficiary services (BSR) line, we can proactively educate our beneficiaries on TRICARE topics that are sometimes difficult to understand. These brochures are available through TSCs, through our BSR line, at many MTFs and in text form on our website.

Some examples of the targeted brochures that have been very successful include:

*Traveling With TRICARE Prime Brochure:*

This brochure was created as a result of feedback from beneficiaries as a tool to help TRICARE Prime members understand how to obtain care when they are away from home. It helps them understand the difference between routine, urgent, and emergent care while showing them how to meet their medical needs within the TRICARE Prime benefit structure. Our TRICARE Service Centers distribute over 8,000 of these brochures every month.

*Enrollment Portability Brochure:*

This brochure was created as a means to explain the enrollment portability process to beneficiaries who are coming into or leaving our region. It is structured in a how to and commonly asked questions format to ease the beneficiary through the portability process. Our TRICARE Service Centers distribute over 7,000 of these brochures every month.

*TRICARE At Your Service Brochure:*

This brochure was developed as a result of the efforts of a process improvement team at HMHS. After reviewing the usage of the various HMHS and subcontractor phone lines, this team worked to improve phone line menus and streamline the process for reaching customer service representatives. The brochure was created to help beneficiaries in Regions 3 and 4 choose the right customer service line the first time, thereby reducing their frustration and helping HMHS better manage call volumes. This brochure is relatively new and is currently being used at a rate of nearly 7,000 per month.

*Health Care Information Line Brochure:*

This brochure was originally designed to mail directly to beneficiaries to encourage the use of our Health Care Information Line. This toll-free line is staffed by registered nurses who answer beneficiary questions about health issues. It includes two wallet cards and a refrigerator magnet. We now encourage TSCs, MTFs, and network providers to distribute the brochure to encourage beneficiaries to use the Health Care Information Line. This brochure recently won an award from the Public Relations Society of America for design. Over 10,000 of these brochures are distributed per month.

*Deciding Which Road to Take? Brochure:*

This is a tool that provides a simple, introductory piece of material for those who are new to TRICARE. We collaborated with our Lead Agents to conduct focus group research to determine what topics concerned them most and how they would like it presented. What we found from talking to our beneficiaries is that there is no good way to simply discuss the TRICARE program without leaving out key information that the beneficiary is likely to stumble over later. The end result was this large brochure in a roadmap format. It gives the TRICARE basics and refers the beneficiary to other sources for in-depth explanations of the benefits. Over 5,500 of these brochures are used each month by our service centers.

There are many other marketing pieces targeted toward specific situations or beneficiary groups such as:
TRICARE and Medicare Brochure

TRICARE Choices for College Students:

Referral Guidelines Brochure

TRICARE and Military Retirement Brochure

The final education piece that a beneficiary receives is the Explanation of Benefits (EOB). The EOB is the last step in the process of receiving and being reimbursed for care. We have found that there are times when beneficiaries cannot tell what has been paid for their care or what amount (if

any) they owe the provider. In response to these concerns, a new format to the Explanation of Benefits (EOB) will be introduced later this year. This new EOB format is designed to answer these final payment questions, not raise additional ones.

EDUCATING PROVIDERS

In addition to educating beneficiaries, HMHS has consistently gone beyond contract requirements to help our network providers understand and work with TRICARE. In addition to the SWAT team efforts previously discussed, a Provider Welcome Kit was created specifically to give new providers the information they need to successfully work within TRICARE program requirements. This kit includes flyers on a variety of topics including Third Party Liability, Filing of Electronic Claims, and Other Health Insurance. A copy of the HMHS Provider Handbook, a laminated TRICARE co-pay chart, a voluntary prescription drug formulary and a rolodex card listing HMHS service contacts for providers is also included. Quarterly provider newsletters are also distributed that focus on common billing errors and solutions.

HMHS continues to look for new and better ways to communicate with and inform our providers. Our broadcast fax system can send a notice to all or part of our provider network if an announcement needs to be made concerning changes to policy or procedure. Providers can also access copies of the latest provider newsletters and other provider information through our HMHS website.

## TRICARE SIMPLIFICATION

I am pleased to report that HMHS works closely with the senior members of the DoD to identify and implement ways to further refine and improve the TRICARE Program. I am sure that each of you and the DoD will agree that the TRICARE program is very complex and there are opportunities to simplify the program and make it easier for all users of the system. HMHS offered to work with DoD to identify some of those areas and examine potential changes. In fact, we dedicated a group of our most senior associates to review the program in detail and develop recommendations. DoD in turn established a working group consisting of TMA staff and representatives from all of the managed care support contractors. The group recommended more than 50 changes to current TRICARE policies that will enhance and simplify the system. Some examples of recommendations that have been approved by TMA include streamlined provider certification requirements, and a move toward less prescriptive utilization management procedures, claims payment procedures, and a greater reliance on standard industry practices.

One such initiative involves refinement of Health Care Service Record (HCSR) reporting requirements. This data provides the DoD detailed information regarding the disposition of claims. According to the DoD, each record includes 145 data elements that are obtained from four separate sources. Some of these data requirements are unique to TRICARE claims and some of these sources are not readily available to commercial insurance carriers. In this regard they can be an obstacle for providers who are willing to submit claims electronically but who find that their office management system will not accommodate these unique data elements without reprogramming. HCSR records are transmitted to the DoD on a daily basis and are used to maintain a database. The DoD is reevaluating the necessity of all HCSR edits and data requirements in consideration of new national reporting requirements with which all health plans must comply. HMHS strongly supports the reduction of unique reporting requirements for HCSRs.

Another initiative to improve TRICARE claims processing considered by the DoD is the elimination of the requirement to authorize providers. Currently, all TRICARE

contractors must verify each provider s licensure, education and experience at the start of each contract and again every two years. If a provider fails to supply information to validate the required information, TRICARE is prohibited from cost-sharing services rendered by that provider. DoD has reconsidered the requirement and has concluded that once a provider s education has been validated, each state in which the provider practices has the responsibility to ensure proper licensing has been obtained. Other than new providers, the DoD is now considering the elimination of this authorization requirement. HMHS supports this initiative as a means to eliminate some paperwork requirements for providers and eliminate the possibility that a beneficiary could visit the same doctor they saw six months ago and experience a delay in claim payment because the provider must be reauthorized.

Another initiative considered by the DoD involves the return and tracking of claims with missing or discrepant information. Today, if a claim is received by PGBA which does not include a piece of data that is vital to the adjudication of the claim, such as the diagnosis, PGBA is required to enter the claim into the system and request the information from the party that filed the claim. These claims are tracked and aged by the system while PGBA awaits the receipt of the requested information. If the required data is not received after 35 days, the claim will deny. The DoD is considering allowing TRICARE contractors to return these claims with the request for additional information without entering it into the system. As pointed out by the DoD, this initiative will yield several benefits. The cumbersome task of tracking initial and follow-up requests will be eliminated thus freeing personnel to adjudicate complete claims. Additionally, claims processing timeliness reporting will yield more accurate results. Current reports are skewed by those claims waiting on information. Contractors have no control over the return of the information, yet their performance is adversely affected.

In tandem with this change, the DoD is also tightening the claims processing time standards. Rather than processing 75 percent of all claims within 21 days, the DoD will require 95 percent of clean claims to be processed in 30 days and 100 percent in 60 days. HMHS supports any initiative to provide increased customer service. However, without

changes in other restrictive processing requirements, this change may be counter-productive. There are many examples of cumbersome requirements that may be effective in a few cases, however, they add significantly to the time it takes to process a claim. For instance, there are DoD policies which require PGBA to perform medical review on certain claims before they can be paid. Under the managed care environment of TRICARE, many of these situations have already been reviewed during the prior authorization process. The pre-claim medical review still required by DoD is a duplicative effort that adds significantly to the processing time of those claims. Decreasing the time allowed to process claims without easing some processing burdens is not realistic. The process must not only be made faster, it must be made better.

There are other initiatives under consideration, which have great potential to improve TRICARE for the DoD, beneficiaries, providers and contractors. HMHS is enthusiastic about many of these advancements and welcomes the opportunity to participate in the development of these programs. HMHS is supports any initiative that makes TRICARE claims processing less prescriptive and closer to that of commercial insurance plans.

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## PROGRAM SUCCESSES

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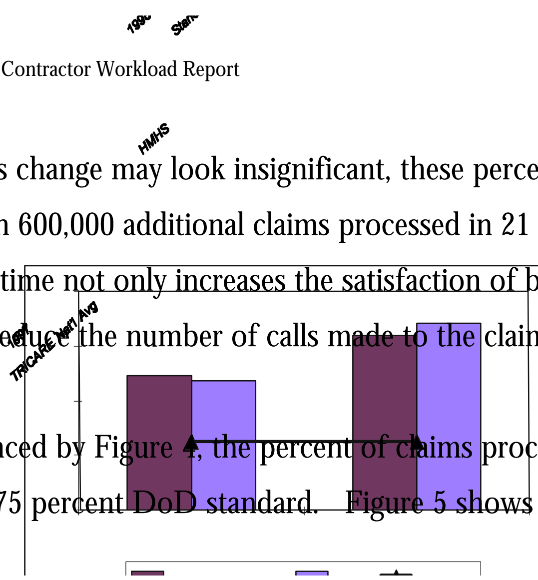
## CLAIMS PERFORMANCE

The results of these wide ranging claims improvement efforts are encouraging. During 1998 Region 3 and 4 claims were processed more timely than the average of all TRICARE contractors compared to 1997 when timeliness was below the national average. (See Figure 4.)

Figure 4: Claims Processed in 21 Days



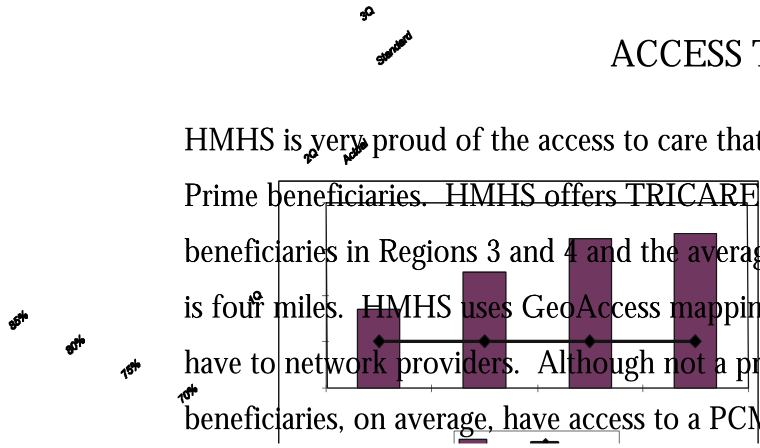

Source: DoD Contractor Workload Report

While this change may look insignificant, these percentage point improvements resulted in more than 600,000 additional claims processed in 21 days or less in 1998, than in 1997. This response time not only increases the satisfaction of beneficiaries and providers, but also is likely to reduce the number of calls made to the claims service line.

As evidenced by Figure 4, the percent of claims processed in 21 days is consistently higher than the 75 percent DoD standard. Figure 5 shows that the trend is increasingly positive.

Figure 5: Trend of Claims Processed in 21 Days During 1998

Source: Monthly Cycle-Time Aging Report




## ACCESS TO CARE

HMHS is very proud of the access to care that we have been able to create for TRICARE Prime beneficiaries. HMHS offers TRICARE Prime to approximately 98 percent of beneficiaries in Regions 3 and 4 and the average distance to a Primary Care Manager (PCM) is four miles. HMHS uses GeoAccess mapping software to monitor the access beneficiaries have to network providers. Although not a precise measurement, GeoAccess indicates that beneficiaries, on average, have access to a PCM, specialist, pharmacy, hospital, emergency room, OB/GYN, mental health provider, and mental health facility within four to ten miles of their home. Beneficiaries who are enrolled in Prime or who want to use the expanded benefits available in the TRICARE Extra program are typically able to reach a provider in a matter of minutes. This compares to DoD guidelines of a 30 minute drive time limit from PCMs and emergency rooms and a 60 minute drive time limit for all other provider types. In addition, TRICARE imposes access guidelines on contracted providers. Beneficiaries should have access to their PCM on a same-day basis, either by phone or appointment. Patients with an acute illness should not have to wait more than 24 hours for an appointment. Appointments for routine visits should be scheduled within one week and preventive health appointments should be made within four weeks. In the office, wait times should not exceed 30 minutes for non-emergencies. In emergency situations, beneficiaries are instructed to go directly to the nearest emergency room.

HMHS conducts site visits for all of our contracted network providers, either annually for existing providers or within 90 days for newly contracted providers, to ensure compliance with all TRICARE requirements, including access to care standards. The results of these site visits are reviewed with the provider. Corrective action plans and follow-up visits are discussed and established with the provider whenever TRICARE standards are not being maintained.

HMHS monitors access to healthcare and network adequacy on a continuous basis using a variety of management tools. Our TRICARE Service Center Beneficiary Service Representatives call ten percent of all beneficiaries given a referral to inquire about the quality of care received and the waiting time for appointments. Another ten percent of referred beneficiaries are sent a written survey inquiring about their appointment with the network provider. There are suggestion boxes at each TRICARE facility and on our website which allow us to consider and utilize customer input regarding TRICARE services. The small number of beneficiary grievances are monitored and investigated to determine potential issues with access or the quality of TRICARE network care. The aforementioned reports and suggestions are reported to the Area Field Offices, Regional Executive Directors and HMHS senior staff to ensure that our beneficiaries receive the services they deserve.

These access requirements only apply to those providers who have contracted to be in the TRICARE Prime network. Beneficiaries who have chosen to use the TRICARE Standard coverage may use the services of any authorized provider, but HMHS has no contractual authority to influence access. Quality of care issues, however, are monitored for both network and non-network providers.

## NETWORK DEVELOPMENT

One of the biggest challenges facing HMHS at the start-up of the TRICARE contract was recruiting providers in areas with little or no managed care experience to join our network of providers. What started out as a challenge has proven to be one of our greatest successes. The few areas within Regions 3 and 4 that are not completely developed as part of the network are locations with few beneficiaries, or lack an adequate provider base to support network expansion.

Overall, HMHS has developed its network of TRICARE providers to include 6,000 PCMs, 22,900 medical specialists, 370 hospitals, 220 psychiatric hospitals, 1,050 psychiatric providers and 6,200 pharmacies. Additionally, 25 Veterans Affairs facilities have been contracted to provide services to TRICARE beneficiaries. Provider turnover rates for

HMHS established networks are less than four and one half percent annually, which we understand to be comparable to the turnover rates of national commercial plans.

We assist beneficiaries in finding a provider by telephone, by printed directory and via our website. The HMHS website was developed to provide an additional resource for TRICARE beneficiaries and providers to get program information. Site usage information indicates that we have had over 42,000 hits on the site in a one month period. Usage of the Provider Locator function has grown from less than 2,000 uses per month in January of 1998 to an average of over 12,000 uses per month currently. Typically, 85 percent of those using the Provider Locator are searching for a provider type rather than looking up a particular provider name. The site also contains the latest beneficiary and provider brochures and newsletters.

HMHS can build its network based only on the existing beneficiary and provider infrastructure and community constraints. One of the most common barriers to providers joining the network is TMAC[1] pricing, especially in the pediatric and OB/GYN specialties. In many small towns there are simply not enough providers to foster competition. The problem can be exacerbated by closure or down-sizing of MTFs when the civilian community does not have the capacity to absorb new workload and, due to low reimbursement, are unwilling to build such capacity. It then becomes extremely important for the branch of service, TMA, the MTF and the contractor to work closely to find or build solutions.

HMHS has far exceeded our contractual obligations for contracted providers. However, HMHS does not sacrifice quality in the pursuit of a large provider base. All of the providers that comprise the HMHS TRICARE network have met rigorous credentialing standards before being accepted into the network. While we are proud of our accomplishments in developing our provider network, we are not resting on our accomplishments. Network development remains an active, ongoing process. HMHS is

[1] TRICARE Maximum Allowable Charge: Physician reimbursement rate established by the DoD. Updated annually, based on survey of prevailing charges across the county and adjusted for locality.

committed to building and maintaining a network of quality providers to ensure that TRICARE beneficiaries are assured quality care.

*Veterans Affairs Medical Center Contracts*

As previously stated, HMHS has contracted with 25 Veterans Affairs (VA) facilities to provide services to TRICARE beneficiaries. While the primary mission of the VA is to provide care to veterans with service connected disabilities, TRICARE beneficiaries can receive quality care from the VA system when unused capacity is available. Each VA facility is staffed with healthcare providers who are familiar with the healthcare needs of the military beneficiary and each facility has received JCAHO accreditation. HMHS anticipates the addition of 5 more VA facilities in 1999.

To date, the VA facilities have provided over 19,000 services to TRICARE beneficiaries. The VA facilities have increased the number of services available to TRICARE beneficiaries by 30 percent and currently nearly 800 TRICARE Prime enrollees have chosen a VA facility as their Primary Care Manager. Overall utilization of VA services has tripled from 1997 to 1998.

## TELEPHONE ACCESS

Another area in which HMHS and PGBA have succeeded is that of beneficiary and provider access to toll-free line services. Providing timely telephone service responses typically presents problems during the transition period for most contractors. HMHS was no exception in the early months of our contract. Unexpectedly high claims volumes and inquiries resulted in more calls to all of our Claims and Customer Services toll free lines than we were staffed to receive, and as a result, phone response times were less than satisfactory. As soon as the increased workload trends were identified, HMHS and PGBA hired and trained over 200 additional staff members to handle the increased workload. As training was completed in early 1997 and these new associates began to operate independently, great progress was made in telephone and walk-in customer service.

Telephone call blockage rates improved every quarter in 1998. While the new DoD TRICARE standards allow a 20 percent blockage rate (meaning a caller will get a busy signal 20 percent of the time when they call); HMHS has a zero blockage rate. Currently, 100 percent of beneficiary calls to our claims associates reach a voice response system within 20 seconds compared to the contract requirement of 90 percent in 120 seconds and if desired, they can usually speak to a live person in under two minutes. As call blockage rates declined, the number of calls received also has declined since they are typically answered on the first try.

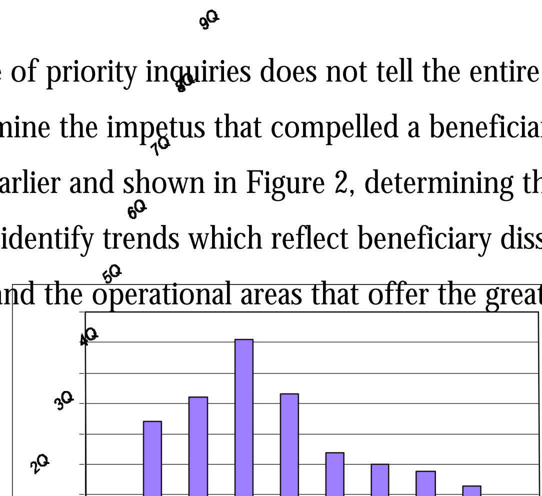
## PRIORITY INQUIRIES

One method HMHS uses to gauge the success of program implementation is monitoring the volume of priority inquiries received from government officials and offices like yours. Due to the size and complexity of the TRICARE program, the possibility of eliminating congressional inquiries is not possible. However, it is our goal to keep these instances to a minimum and, to this end, we intend to make every inquiry a learning experience.

Since the completion of our first contract year, the volume of written inquiries from congressional offices has been reduced by 50 percent from a high of 300 inquiries a month to approximately 135 inquiries a month during the last quarter of 1998. (See Figure 6) This decrease in inquiries received is the result of HMHS concerted effort to make the most of the feedback received from congressional offices in order to improve our services and avoid repeating the inevitable missteps that occur during the implementation process.

Figure 6: Volume of Priority Written Inquiries

However, the volume of priority inquiries does not tell the entire story. HMHS analyzes each inquiry to determine the impetus that compelled a beneficiary to sit down and write to you. As mentioned earlier and shown in Figure 2, determining the root cause of these inquiries allows us to identify trends which reflect beneficiary dissatisfaction with the TRICARE program and the operational areas that offer the greatest opportunity to



improve our services.  This analysis also gives HMHS a unique and invaluable perspective on how the TRICARE program on the whole can be optimized to better satisfy all parties involved.

For instance, 14 percent of the priority correspondence received over the past six months is attributable to beneficiary misinterpretation of, or dissatisfaction with DoD policy. Feedback received from inquiries such as these allows us to provide constructive, well-informed input to the government regarding possible improvements in, or the simplification of DoD policy.

HMHS also pays special attention to the inquiries received as a result of an error made by HMHS or our subcontractors.  Beyond researching these inquiries thoroughly and resolving the beneficiary s concern, we ask ourselves:  What can we do as an organization to keep this situation from happening again?  Answering this question allows us to make positive internal changes, and the experience gained from this process gives us the foresight to avoid similar situations before they occur.  Efforts such as these have resulted in more than a 25 percent decrease in priority inquiries received due to errors made by HMHS or a subcontractor when comparing the last two quarters of 1998 to the same period of the previous year.  Results like these are very rewarding and we fully intend to improve upon this success in the future.

Continuously improving beneficiary education is an example of this proactive approach. Many of the items discussed in priority correspondence become the topic of articles in military-based publications, marketing brochures and quarterly newsletters.

## TRICARE PRIME ENROLLMENT

Our expectation of TRICARE Prime enrollment for the third contract year, which ends June 1999, was 375,400. HMHS has already enrolled more than 470,000 beneficiaries, surpassing our total goal for the duration of the existing TRICARE Region 3 and 4 contract. In fact, HMHS surpassed our five-year goal in the first 18 months of operation. Over 50,000 new beneficiaries enrolled last year in addition to a 92 percent re-enrollment rate for existing TRICARE Prime beneficiaries. HMHS feels that this is a sound indicator of increasing beneficiary satisfaction.

## TRICARE PRIME PORTABILITY

Enrollment portability is a recent enhancement that allows TRICARE Prime beneficiaries to transfer their enrollment from one contractor to another without a break in Prime coverage. When moving, a beneficiary contacts the new contractor and completes a new enrollment form and chooses a Primary Care Manager in their new location. The enrollment becomes effective in the new region on the date the new contractor receives the form. The contractors work together to coordinate an enrollment transfer between the two regions to ensure that the transition is seamless and easy for the beneficiary. It takes approximately two days to complete the transfer once it is received from the former contractor. All phases of TRICARE portability have been implemented throughout the TRICARE regions through the partnering efforts of the TRICARE contractors with the DoD.

# PARTNERING

Probably the most important key to making the TRICARE system work is effective partnering between the government and the managed care support contractor. We have been very successful in that venue in Regions 3 and 4. In fact, as a testament to this, HMHS and the Lead Agent and MTFs in Region 3 have been named as a finalist in the 1999 Astra Pharmaceuticals National Managed Health Care Congress (NMHCC) Partnership Award. The winner will be announced at the NMHCC Conference at the end of March. Our partnership in improving quality and access to care, and reduced healthcare costs justify our consideration for this prestigious award.

## IMPROVED QUALITY OF CARE

Within DoD Health Services Region 3, the HMHS Team has partnered with the Government to implement the Clinical Quality Management Program. Monitoring and evaluation processes have been jointly designed to examine individual adverse medical occurrences as well as the overall quality of services within given time intervals trended over time. As a result, the Clinical Quality Management Program has resulted in demonstrable quality improvements.

Together with the Government, HMHS uses statistically valid research methods which adjust for age, sex, and case complexity. The process thus generates specific information to support improvements in the health status of the TRICARE eligible population in the Southeast and supports decisions by the DoD Health Services Lead Agent, military hospital and clinic commanders, and the Assistant Secretary of Defense for Health Affairs. The Clinical Quality Management Program is based on a belief that delivery of healthcare services is a process that can be continuously refined and enhanced.

## IMPROVED ACCESS TO CARE

An illustrative example of this collaborative partnership approach can be found in the case of network development in Valdosta, Georgia. In 1996, local providers were suspicious of

the Humana Military Healthcare Services Team. In fact, one highly respected medical leader expressed the following sentiment: We ve run the last two managed care companies out of town. What makes you think you re any different? The difference, it turned out, was that the Humana Military Healthcare Services Team successfully partnered with the local Air Force hospital and the TRICARE Region 3 Lead Agent to ensure that superior service would accompany network membership. When claim volumes strained the capabilities of the fiscal intermediary, a SWAT Team was deployed to fix problems experienced by the local hospital and Physician Hospital Organization (PHO). Working in tandem with military officials, the SWAT Team quickly and thoroughly resolved hundreds of claims problems and facilitated timely reimbursement. Their efforts were lauded by a local hospital official. The ultimate winners in this scenario were local Military Health System beneficiaries whose access to earned benefits was preserved

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**DOD INITIATIVES/RECOMMENDATIONS**

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## PHARMACY

HMHS applauds the efforts of the DoD and Congress to develop an integrated pharmacy program. A comprehensive pharmacy benefit and a single patient profile will enhance the quality of care that our beneficiaries receive. This initiative will eliminate stovepipes of data and give the DoD the ability to screen prescriptions for drug interactions, drug duplicates, and other potentially harmful clinical occurrences, regardless of which outlet the beneficiary chooses to use to obtain their prescriptions. We are awaiting additional information and details on the implementation of this effort. We believe that each of the current contractors should be an integral part of fleshing out the details necessary to ensure this program is successful. There are several areas that we hope the DoD will consider in their implementation of this program.

There is one avenue for obtaining prescription drugs that appears to be excluded from this plan: paper claims submitted by the non-network civilian pharmacy or by the beneficiary. We recommend that those encounters be included in the national database.

We look for assurances that this program will be complimentary and not an obstacle to the pharmacy benefit and pharmacy claims adjudication.

Finally, and most importantly, this must be customer friendly to both the pharmacy and the beneficiary. There must be override capabilities and a help desk to assist with problems.

## TRICARE PRIME REMOTE

To meet military missions, active duty members often find themselves stationed in remote areas or areas geographically separated from a military installation. In an effort to provide a consistent medical benefit, the DoD has instituted TRICARE Prime Remote. It has been implemented in only a few Regions to date. This program is designed to provide TRICARE Prime to active duty service members and their families stationed in these areas. While this program has not yet been implemented in Regions 3 and 4, HMHS is prepared for this requirement. HMHS expanded prime offering and networks will allow us to carry out this requirement quickly when called upon to do so. As already stated, approximately 98 percent of beneficiaries can enroll in Prime. We welcome active duty members to use our already established networks.

## TRICARE SENIOR PRIME

HMHS has had the unique opportunity to support the TRICARE Senior Prime (TSP) demonstration program at Keesler Air Force Base. Health care delivery began December 1, 1998. The multitude of tasks required to begin this initiative could not have been completed without the strong partnership demonstrated between Keesler and HMHS. This partnership has been recognized and remarked on by representatives of both the Health Care Financing Administration and the General Accounting Office. The result of all these efforts is a well received and successful program. Approximately 2,700 beneficiaries have submitted applications to become a TRICARE Senior Prime member. TSP is an admirable effort on the part of the congress and the DoD to meet the expectations of older military retirees.

## Y2K

An area of concern to all Americans is the impact of the year 2000 (Y2k) issue on critical services. Healthcare is certainly near the top of that list. We are pleased to report sound progress in eliminating Y2K as a cause for concern. HMHS and it s subcontractors have completed internal systems upgrades and testing. We will soon participate with DoD in end to end testing of all contractor and DoD integrated systems. We believe the results of these tests will show that we will be able to provide uninterrupted healthcare services to our beneficiaries.

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## SUMMARY

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Since TRICARE began in Regions 3 and 4, many hurdles have been overcome. The challenges could not have been met by any one entity, but the strong partnership between HMHS, our subcontractors, and providers and all levels of the DoD, have enabled beneficiaries in the southeast to benefit from the advantages afforded by the TRICARE program. HMHS looks forward to continued partnering efforts as TRICARE becomes an even stronger program.