

2010 Military Health System Conference

T3: Managed Care Support Contract (MCSC) Features

Sharing Knowledge: Achieving Breakthrough Performance

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January 27, 2010



TRICARE Management
Activity

Title: T3: MCSC Contract Features



- HIGHLIGHT THE KEY FEATURES OF THE REGIONAL T3 MANAGED CARE SUPPORT CONTRACTS
- SHOW HOW T3 DIFFERS FROM THE CURRENT (TNEX) REGIONAL CONTRACTS

Title: T3: MCSC Contract Features



- REVIEW T3 REQUIREMENTS FOR:
 - Provider Networks
 - Enrollment
 - Referral Management
 - Medical Management
 - Customer Service
 - Claims Processing
 - Management
 - Standards/Incentives/Guarantees

Title: T3: MCSC Contract Features



■ PROVIDER NETWORKS

- T3 requires a managed, stable, high-quality network which supplements clinical services provided in Military Treatment Facilities.
- Provider networks required to ensure all access standards are met in all Prime Service Areas (PSAs). PSAs are areas where contractor must offer enrollment in compliance with the travel time access standard.

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- Provider Networks --continued--
 - T3 PSAs are required around MTFs and BRAC sites; include all zip codes within or intersected by a 40-mile radius. **TNEX Difference:** All the current South Region is considered a PSA. The North and West Regions have expanded PSAs in some non-MTF/non-BRAC areas, or for some PSAs with an MTF, an area greater than that of the 40-mile radius around the MTF.

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- Provider Networks --continued--
 - T3 North Region has 92 PSAs (67 MTF, 25 BRAC); South has 82 PSAs (69 MTF, 13 BRAC); and West has 113 PSAs (94 MTF, 19 BRAC)

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■ ENROLLMENT

- Contractor performs all enrollment actions (enrollments, disenrollments, transfers, PCM assignments) using DEERs.
- MTF Commander sets enrollment priorities for MTF enrollment areas (beneficiaries residing within MTF's travel time access standard for primary care).

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- Enrollment --continued--
 - ***New for T3:*** Any beneficiary currently enrolled to a civilian PCM outside the PSA can continue enrollment as long as they are within 100 miles of an available PCM in the PSA (and waives access standards). New enrollments to the network for beneficiaries residing outside a PSA are allowed provided there is unused network capacity and the PCM is less than 100 miles from the beneficiary's residence.

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- Enrollment --continued--
 - Payment of enrollment fees by payroll allotment, electronic funds transfer (EFT), or credit card. ***TNEX Difference:*** No longer able to pay enrollment fees by check except for initial payments or on an exception basis.)
 - Beneficiary web enrollment still available as an enrollment option.

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■ REFERRAL MANAGEMENT

- Referrals still required for most specialty care/care not provided by PCM. ***New for T3:*** Currently reviewing options for urgent health care referrals.
- MTFs have right of first refusal (ROFR) in all PSAs. Referrals to MTF must meet one-hour travel time access standard.

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- Referral Management --continued--
 - Referral requests between contractor and MTF by fax or other agreed upon electronic method.
 - 96% of referrals for Prime enrollees shall be to an MTF or civilian network provider.
 - Each referral request evaluated by contractor to determine that it is a covered TRICARE benefit – if not, beneficiary must be notified (does not apply to care for ADSMs).

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■ MEDICAL MANAGEMENT

- Ensure that all civilian care is medically necessary, appropriate and complies with TRICARE benefit policy.
- Preauthorizations: All adjunctive dental care; organ/stem cell transplants; inpatient mental health/substance abuse care; outpatient mental health care after 8th visit; hospice care; and all care for ECHO. Contractor may propose additional authorization reviews.

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- Medical Management --continued--
 - Contractor is considered a multi-function Peer Review Organization (PRO) and must follow all rules, standards and procedures of TRICARE PRO Program.
 - Must operate a case management program designed to manage the health care of individuals with high-cost conditions or with specific diseases for which evidenced-based clinical management programs exist.

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- Medical Management --continued--
 - Must operate a disease management program for: Asthma, Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Cancer Screening, Depression and Anxiety Disorder.
TNex Difference: Does not include Cancer Screening, Depression and Anxiety Disorder.

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- Medical Management/Disease Mgmt --cont--
 - Government identifies and risk stratifies the beneficiary population that will be included in the DM Program.
 - Must make telephone contact and conduct baseline assessment with at least 50% of identified beneficiaries within 12 months.
 - Contractor's DM Program must meet national accreditation standards.

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- Medical Management --continued--
 - Must operate a clinical quality management program (CQMP) which results in demonstrable quality improvement in health care provided to beneficiaries and in the process and services delivered by the contractor. Includes the requirement to identify and resolve potential quality issues.

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- CUSTOMER SERVICE

- Contractor shall provide comprehensive, readily accessible customer services that include multiple, contemporary avenues of access (e.g., email, World Wide Web, telephone, facsimile) for the MHS beneficiary. Telephone services must be available from 8 a.m. to 6 p.m.

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- Customer Service --continued--
 - Establish an MOU with TMA's C&CS Directorate, use the Government's national suite of TRICARE educational materials, use mandatory formats to ensure one look and feel of all regional educational material, and produce regional provider education material.
TNex Difference: Provider education material currently produced by TMA.

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- Customer Service --continued--
 - Establish TRICARE Service Centers (TSCs) at sites specified by the Government. T3 requires 192 TSCs; the majority of which are located either in an MTF or on a military installation. (52 TSCs in the North, 59 in the South, and 81 in the West.)

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- Customer Service --continued--
 - **New for T3:** Must have ability to deploy mobile Service Assist Teams (SATs) to perform customer service functions to disaster areas, Active/Reserve component troop mobilization areas, BRAC areas, or any area required by the TRO Director.
 - Provide 40 hours of customer service support to MTFs. (Examples include in-processing briefings, specialty or focused TRICARE briefings). **TNex Difference:** 10 hours per week v. 40 per month.

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■ CLAIMS PROCESSING

- Establish, maintain, and monitor an automated information system to ensure claims are processed in an accurate and timely manner. Includes requirements for verifying eligibility; determining benefit policy; correctly applying deductibles, cost-shares, copays, and referrals/authorizations; accurately coordinating benefits with other health insurances; and accurately reimbursing network and non-network claims.

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- Claims Processing --continued--
 - Process claims for all regional Prime enrollees and for all non-Prime enrollees who reside in the region no matter where care is received (except in foreign areas). **TNex Difference:** Currently regional contractors process claims for their beneficiaries for care received in foreign areas.

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- Claims Processing --continued--
 - The contractor shall establish and operate a system for two-way, real-time interactive Internet Based Claims Processing (IBCP) by providing web-based connectivity to the claims system.
 - Requires a percentage of all claims be submitted electronically. **TNex Difference:** Required network providers to submit all claims electronically.

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- Claims Processing --continued--
 - Provide an Explanation of Benefits (EOB) to each beneficiary and/or provider for every claim processed. A monthly summary statement may be used. ***TNex Difference:*** Contractors are not required to send EOBs to beneficiaries if there are no out-of-pocket expenses or to network providers.

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■ MANAGEMENT FUNCTIONS

- Establish and operate an internal quality management/quality improvement program (includes both clinical and administrative operations).
- Develop and implement, in conjunction with each MTF and the Regional Director, a contingency program designed to ensure that health care services are continuously available as MTFs respond to war, deployments, training contingencies, special operations, and natural disasters.

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- MANAGEMENT --continued--
 - The contractor shall participate in each MTF's installation-level contingency exercise twice each calendar year.
 - Participate twice each calendar year in round table meetings with the Government, other contractors, and any other participants as necessary. ***TNex Difference***: Participate in quarterly round table meetings.

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- **MANAGEMENT --continued--**
 - Locate a senior executive (with certain authorities) within a 15-minute drive of the TRO.
 - Provide authorized personnel unlimited electronic access to all TRICARE related data maintained by the contractor.
 - Contractor (and its subcontractors) must meet all DoD security and privacy requirements (DIACAP, HIPAA, Privacy Act, etc.). ***New for T3:*** To meet PKI requirement, contractors will need CAC cards.

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- MANAGEMENT --continued--
 - The contractor may enter into Clinical Support Agreements (CSAs) to provide services required by MTF Commanders. The Contracting Officer (PCO) will incorporate CSA task orders by modification to the contract. ***TNex Difference:*** Any authorized contracting officer has authority to issue task orders under the indefinite-quantity CLIN of the contract.

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- MANAGEMENT --continued--
 - Develop a plan for identifying resource sharing opportunities. Respond to MTFs within 30 days of a written request for consideration of a potential resource sharing opportunity. **TNex Difference:** T3 includes only external resource sharing – no internal resource sharing requirements.

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- MANAGEMENT --continued--
 - ***New for T3:*** Contractor reports are similar to TNex, but all reporting requirements (e.g., report description/frequency) are now included as an attachment to the contract (CDRLs) rather than in the TRICARE Manuals.

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- MANAGEMENT --continued--
 - ***New for T3:*** Establish an MOU with the TRICARE Pharmacy contractor for the purpose of addressing such things as pharmacy utilization data, program integrity issues, case management, TPL, and claims jurisdiction issues.

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- MINIMUM KEY PERFORMANCE STANDARDS
 - Preauthorizations/Authorizations: The contractor shall issue determinations (following receipt of request and all required information) on at least:
 - 90% of all requests within 2 working days
 - 100% of requests within 5 working days

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- Performance Standards --continued--
 - Referrals: Must issue a referral decision on at least:
 - 90% of all requests within 2 working days (***TNext Difference***: 85% within 2 working days)
 - 100% of requests within 5 working days
 - 96% of all referrals shall be to an MTF or civilian network provider. (***New for T3***: Includes enrollees who reside outside PSAs and expands on/better clarifies exceptions.)

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- Performance Standards --continued--
 - Claims Processing Timeliness:
 - 98% of retained claims shall be processed within 30 calendar days
 - 100% of all claims (retained and excluded) within 90 days
 - TNex Difference
 - 95% of retained claims within 30 calendar days
 - 100% of retained claims within 60 calendar days
 - 100% of excluded claims within 120 calendar days

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- Performance Standards --continued--
 - Claims Processing Accuracy
 - Claim Payment Errors: The absolute value of the payment errors shall not exceed 2% of total billed charges for the first two option periods. Remaining option periods shall not exceed 1.75%. **TNex Difference:** 2% for all option periods.
 - Claim Occurrence Errors: The occurrence error rate shall not exceed 3%.

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■ Performance Standards - --continued--

- Electronic Claims Rate Standard: The following % of all claims will be submitted electronically (after a specified % of claims are excluded):

OP	No.	So.	West
1	74%	78%	77%
2	77%	81%	80%
3	79%	83%	82%
4	80%	84%	83%
5	81%	85%	84%

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- Performance Standards --continued--
 - Routine Written Inquiries: Provide a final response as follows:
 - 85% within 15 calendar days of receipt
 - 97% within 30 calendar days of receipt
 - 100% within 45 calendar days of receipt
 - Priority Written Inquiries: Provide a final response as follows:
 - 85% within 10 days of receipt
 - 100% within 30 days of receipt

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- Performance Standards --continued--
 - Walk-in Inquiries: Walk-in inquiries shall be acknowledged and assisted by a service representative:
 - 95% within 15 minutes
 - 99% within 20 minutes
 - ***TNex Difference***: 95% within 5 minutes and 100% within 10 minutes

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- Performance Standards --continued--
 - Telephone Inquiries:
 - Blockage rates shall never exceed 5%.
 - 95% of all calls shall be answered within 2 rings by an ARU. The caller will have two choices: transfer to an automated unit or to an individual.
 - When transferred to an automated unit, 100% of calls must be acknowledged within 20 seconds.

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- Performance Standards --continued--
 - Telephone Inquiries –continued-
 - When transferred to an individual, 90% of all calls must be answered within 30 seconds. **TNex Difference:** 80% within 20 seconds and 95% within 30 seconds.
 - Total “on-hold” time for 95% of calls shall not exceed 30 seconds.

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- Performance Standards --continued--
 - Telephone Inquiries --continued--
 - 85% of inquiries shall be fully and completely answered during the initial telephone call. **TNex Difference:** 80% during the initial call.
 - 99.5% not fully answered initially shall be answered within 10 business days. **TNex Difference:** 95% in 10 calendar days and 100% in 20 calendar days.

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- HEALTH CARE UNDERWRITING INCENTIVES

- Network Discount Incentive: Purpose is to encourage contractors to proactively negotiate discounts with network providers thereby reducing health care costs. For care provided by network providers, contractors earn 10% of discount savings after a 2% minimum discount is exceeded.

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- Health Care Underwriting Incentives --cont--
 - Network Usage Incentive: Purpose is to promote a higher percent of usage of network providers, thereby potentially reducing health care costs. Can only result in either no payment or a negative incentive. Contractor will be “penalized” if the percentage of network claims for Prime enrollees does not meet or exceed a minimum performance standard.

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- Underwriting Incentives/Network Usage
--cont--
 - North/South Region:
 - OP2 87%
 - West Region:
 - OP2 73%
 - Standard increases 1% each subsequent Option Period.

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- Health Care Underwriting Incentives --cont--
 - National Cost Trend Incentive: Purpose is to motivate contractor cost-control efforts for Prime enrollees (non-MTF) by comparing annual trends in health care costs in the region to a sub-set of the National Health Expenditures (NHE) trends reported by the Centers for Medicare & Medicaid (CMS).

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■ PERFORMANCE INCENTIVES

- Clinical Quality Incentive: Positive payments can be earned for improvements in the following seven performance metrics (similar to HEDIS measures):
 - Cervical Cancer Screening
 - Breast Cancer Screening
 - Asthma Use of Medication
 - Colorectal Screening
 - Diabetes Management: A1c Testing, Lipid Testing and Retinal Screening

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- Performance Incentives --continued--
 - Program Integrity Incentive: Positive incentive to encourage contractors to detect fraud and abuse and to submit well-documented cases to TMA. Payment is based on the number of cases referred and the quality of cases referred as determined by the TMA Office of Program Integrity.

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- Performance Incentives --continued--
 - EMC Submission Incentive: Positive or negative incentive based on performance against EMC Submission Rate standards. Can earn positive incentive for every claim that exceeds minimum standard. If standard is not met, penalty for every claim that is below the minimum standard.

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■ PERFORMANCE GUARANTEES

- Must guarantee that performance will meet or exceed standards in the following areas. If not, monetary withholds apply.
 - Telephone Answering Speed
 - Initial Telephone Call Resolution Rate
 - Final Telephone Call Resolution Rate
 - Claims Processing Timeliness within 30 Days
 - Claims Processing Timeliness within 90 Days
 - TED Edit Accuracy