CHAPTER 15
SECTION 6

MANAGEMENT DATA REPORTING

The contractor shall submit the following other management reports which may be required in either hard copy or magnetic medium. These reports shall contain information about contractor performance, plans, and problems in administering the contract. These reports shall require separate breakouts of data for network and non-network providers, TRICARE Prime and TRICARE Extra and TRICARE Standard, and catchment and noncatchment areas. The format for these reports shall be agreed upon by the Contracting Officer, Lead Agent, and the contractor. Copies of the reports are either furnished to or through the Lead Agent. Reports submitted to or through the Lead Agent shall be in the format required by the Lead Agent.

1.0. NETWORK ADEQUACY REPORTING

The contractor is required to monitor and report on the adequacy of the provider network on a monthly basis during the start up period and for the first six months of the initial health care delivery period, and quarterly thereafter. The reports shall be delivered to the Contracting Officer and the Lead Agent within 10 calendar days following the close of the reporting period and shall provide the following information by catchment area:

1.1. The number of network providers by specialty;

1.2. The number of additions and deletions during the report period to the network, by specialty;

1.3. Activities undertaken to contract with additional providers in areas lacking networks to meet the prescribed network standards;

1.4. A listing of PCMs (both civilian and military) and the number of enrollees assigned to each PCM by catchment area. The Contracting Officer may request that these reports be summarized by provider type for submission.

1.5. Network access compliance with the requirements of Chapter 5, Section 1, paragraph 2.6.

2.0. PROVIDER SATISFACTION REPORTING

The contractor shall monitor provider satisfaction with the program. Network and non-network providers shall be monitored separately. The contractor shall forward annual monitoring reports describing the results of provider surveys. The report shall include information regarding the availability of provider orientation meetings, attendance at such meetings and periodic reporting on provider satisfaction with such meetings. The contractor shall also make a summary report of provider complaints, grievances and their resolution.

The reports are due to the Contracting Officer and the Lead Agent no later than 90 calendar days after the close of each health care delivery period.

3.0. RESOURCE SHARING REPORTING AND CERTIFICATION

The contractor shall submit monthly reports prepared jointly with the MTF, and certified by the MTF, through the Lead Agent to the Contracting Officer. The contractor shall submit the report by the last working day of the month following the reporting month, identifying the number and type of personnel involved in each resource sharing project (a project may consist of more than one agreement related to the same clinical area), the MTF workload attributable to each agreement or project, and contractor-borne costs associated with each agreement or project. Data for equipment and supplies used by the contractor in support of resource sharing agreements are also to be reported. Data shall be reported and certified in accordance with the guidelines for bid price adjustment and for resource sharing and shall be aggregated separately by project, by MTF, by Lead Agent, and for the entire contract for each month. The totals by each of these divisions shall be reported for each contract option period with the last monthly report for the period. The resource sharing reports shall include:

3.1. The number of hours worked by resource sharing personnel, by agreement and by specialty or personnel type for each MTF;

3.2. The number of outpatient visits and admissions attributable to resource sharing at each MTF, by project. This number shall represent the full number of outpatient visits and/or admissions which would not have been performed at the MTF in the absence of the resource sharing agreement);

3.3. The number of outpatient visits and/or admissions "credited" to each agreement to meet the bid-price adjustment requirements.

3.4. The types and numbers of services provided for each agreement or project in addition to the number of outpatient visits and admissions as required in paragraph 3.3.; e.g., the number of treatments, procedures, tests, etc., which are not reported as admissions or outpatient visits;

3.5. The types and volumes of equipment and supplies associated with each agreement or project; and

3.6. The total salaries, compensation, and expenses paid by the contractor in support of the services provided for each agreement or project. Cash payments to MTFs shall be separately identified by the contractor and certified by the MTF for each agreement or project. (Cost information, other than cash payments to MTFs, does not require MTF certification.)

4.0. UTILIZATION MANAGEMENT REPORTING

The contractor shall report on the review activities for TRICARE Prime, TRICARE Extra, and TRICARE Standard to prevent under-utilization or over-utilization of services under Chapter 7. Separate reports shall be submitted for the TRICARE Prime, TRICARE Extra, and TRICARE Standard. Reports summarizing the activities of the utilization

management program are to be submitted on a quarterly basis, within 45 calendar days following the end of the calendar quarter. Proposed changes in pre- and post-payment screens must be reported to each Lead Agent and approved by the Contracting Officer prior to implementation of such changes. (See Chapter 14.)

4.1. Providers and Beneficiaries on Prepayment Review Report

The contractor shall forward a report to the Contracting Officer with a copy to the Lead Agent 45 calendar days following the end of each calendar quarter beginning with Option Period 1 of the providers and beneficiaries on prepayment review, listing each provider by name, specialty, and provider SSN/EIN and each beneficiary by social security number, relationship code, and date of birth. The report shall include the basis for placing the provider and/or beneficiary on prepayment review, the number of services suspended, the number of services denied, and the dollar amounts suspended and denied.

4.2. Case Management Report

The contractor shall report monthly on those cases under case management. This report is due ten calendar days following the end of the reporting month to the Contracting Officer with a copy to the Lead Agent. The report shall detail case management activities, benefit modifications granted, costs incurred and avoided, and it shall describe the level of patient/family satisfaction.

5.0. QUALITY MANAGEMENT ACTIVITY REPORT

The contractor shall provide a monthly report to the Contracting Officer and the Lead Agent of the activities and results of the contractor's quality management and Program Integrity Programs within ten calendar days following the end of each reporting month. In addition, minutes of the catchment area-specific quality assurance committee meetings shall be forwarded to the Contracting Officer, with a copy to the Lead Agent, quarterly within ten calendar days following the end of the quarter. The summary reports shall include:

5.1. The number of cases reviewed by clinical specialty or procedure or episode of illness and the number and type of quality of care problems identified through preestablished clinical criteria. Type of quality problems include quality of care, inefficient care, or deviation from established practice guidelines or review criteria without supporting documentation of rationale, etc. The source of problems identified should be clear (Peer review, beneficiary grievance, MHS, etc.);

5.2. The criteria sets used to evaluate care;

5.3. The assessment of the cause and scope of identified problems, corrective actions taken, and follow-up of problem resolution;

5.4. Profiles of provider performance in mortality and morbidity rates and trends; infection rates; type, number, and frequency of medical, surgical, and other procedures performed; performance against standards, criteria, indicators, and monitors; and performance on medical staff monitors (surgical case review, drug utilization review, blood usage, medical record review for inpatient and ambulatory care settings);

5.5. Turnover rates for providers in network hospitals across departments; and

5.6. Changes in privileges granted to individual providers.

6.0. CLINICAL QUALITY MANAGEMENT ANNUAL REPORT

The contractor shall submit to the Lead Agent and the office of the Assistant Secretary of Defense, (Health Affairs) [ASD(HA)] no later than 120 calendar days after the end of each calendar year, an annual report of the quality management activities, and status of the region's network. The report shall describe accomplishments in the areas of Quality Management and review specific subjects as requested by ASD(HA). See Chapter 7, Section 3, paragraph 1.0.

7.0. BENEFICIARY SERVICES AND ACCESS REPORTING

The contractor shall provide summary reports on beneficiary services and access to services. These reports shall include accurate information about the program activities, service volumes, and organizational efficiency of each service function. Copies of all reports shall be provided to the Lead Agent at the same time they are provided to the Contracting Officer in the format required by the Lead Agent.

7.1. Enrollment Reports

The contractor shall report enrollments to and disenrollments from TRICARE Prime. The report is due to the Contracting Officer and the Lead Agent by the tenth calendar day following the close of the reported month and shall be broken down by state. An annual summary report is also due 30 calendar days after the close of each health care delivery period. The monthly and annual reports shall include:

7.1.1. Enrollment data categorized by PCM assignment status (MTF vs. contractor), each catchment area, and each noncatchment area where TRICARE Prime is offered, with summary reports by state. The report shall include a breakdown of enrollees by age group (0-4, 5-14, 15-17, 18-24, 25-34, 35-44, 45-64, and 65 or older and a total), by sex of the enrollee, the status of the sponsor (active, retired, or deceased), by MTF and civilian PCMs, enrollment within residence zip codes of catchment areas and noncatchment areas where TRICARE Prime is offered and an indication (Yes or No) that the beneficiaries had used TRICARE within the 12 months prior to enrollment.

7.1.2. Disenrollment by catchment and noncatchment area and by reason for disenrollment, i.e., voluntary disenrollment (by choice) and involuntary (e.g., loss of eligibility or move out of the Region);

7.1.3. Enrollment and disenrollment summaries by state;

7.1.4. A data file provided monthly with the following enrollment data: enrollee and sponsor Social Security Numbers, enrollee’s date of birth, relevant family member prefix (FMP) coding, and PCM identification (specific MTF or contractor) for each enrollee for each catchment area or stand-alone clinic;

7.1.5. Enrollment portability data including number of transfers-in for the month, number of transfers-out for the month, number of regular enrollments (for comparison purposes to see how many enrollments are due to transfers vs. new), number of transfer requests pending at the end of the month, and percent of transfers-in completed in 12 workdays and the percent of transfers-out completed in four workdays.

7.2. Health Care Finder and Beneficiary Satisfaction Reports

The contractor shall provide summary reports which distinguish between enrolled and nonenrolled populations for health care finders and beneficiary satisfaction. These reports shall include:

7.2.1. Within ten calendar days following the end of each contract quarter, submit to the Contracting Officer and the Lead Agent a Health Care Finder activity report by MTF and a summary report by state. The reports must include:

7.2.1.1. the number of referrals for TRICARE Prime, TRICARE Extra, and TRICARE Standard beneficiaries (by enrolled and nonenrolled populations) and for non-TRICARE eligible beneficiaries (by beneficiary category, i.e., Medicare eligible, active duty family member, parent, etc.);

7.2.1.2. the source and reason for referral;

7.2.1.3. the provider type to whom the beneficiary was referred; and

7.2.1.4. the number of prior authorizations by medical/surgery and mental health services and by both inpatient and outpatient services.

7.2.2. Contractor-initiated beneficiary satisfaction surveys must be approved by TMA, (refer to Chapter 12, Section 2, paragraph 4.0.). The following provisions apply only if a survey has been approved as required. Annually, submit to the Contracting Officer and the Lead Agent within 45 calendar days following the close of each health care delivery period, beneficiary satisfaction reports for enrolled and nonenrolled populations by each catchment and noncatchment area and a summary report by state. Copies of catchment area specific reports shall be provided to the MTF Commander at the same time reports are provided the Contracting Officer. The reports must include:

7.2.2.1. disenrollments from TRICARE Prime;

7.2.2.2. satisfaction status of current enrollees (if contractor-designed surveys are approved by TMA);

7.2.2.3. description of activities undertaken to improve enrollee satisfaction where satisfaction is less than 90% in TRICARE Prime.

8.0. REPORTS TO MTF COMMANDER

The contractor shall submit to the MTF Commander the following reports with information specific to their MTF or catchment area (frequencies shall be the same as those specified previously). A copy of all MTF specific reports plus a summary report of all MTFs

in the region shall be provided to the Lead Agent at the same time the reports are provided to MTF Commanders. Only information concerning the specific Lead Agent's region should be provided. All reports shall be submitted in the format required by the Lead Agent.

- Network adequacy reports
- Resource sharing reports
- Enrollment reports
- Provider and beneficiary satisfaction surveys (refer to paragraph 7.2.2. above for information on beneficiary surveys)
- Health Care Finder reports
- Fraud and abuse reports
- Utilization management reports
- Case management reports
- Enrollment Program progress reports
- Quality management activity reports
- Clinical quality management annual reports
- Resource support reports

9.0. STAFFING LEVEL REPORT

Annually, the contractor shall prepare and submit to the Contracting Officer and the Lead Agent a staffing report in the contractor's own format, 30 calendar days after the end of each option period. The staffing levels, to include anticipated hires for vacancies, shall reflect status as of the last day of the reported option period.

10.0. RESOURCE SUPPORT REPORT

The contractor shall provide to the Lead Agent, the appropriate MTF Commander in accordance with the report submission requirements specified in the Lead Agent requirements, and the Contracting Officer a monthly report detailing all resource support program (see Chapter 16, Section 3) activities which occurred during the previous month. The contractor shall provide a separate report for each MTF and a summary report for the Lead Agent and the Contracting Officer.

10.1. This report shall be multi-part and shall include the following divisions:

10.1.1. Task Order Requirements received from the Lead Agent during the previous month and the status of each,

10.1.2. Delivery Orders received from the Contracting Officer during the previous month and the status of each,

10.1.3. A status for each Task Order Requirement received during a prior reporting period until one month following the receipt of a Delivery Order, and

10.1.4. A status for each Delivery Order received during a prior reporting period.

10.2. For all active Delivery Orders issued by the Contracting Officer, the contractor shall also provide the following:

10.2.1. The number of resource support personnel by delivery order and by specialty or personnel type working in each MTF;

10.2.2. The number of hours worked by resource support personnel, by delivery order, and by specialty or personnel type for each MTF;

10.2.3. The types and volumes of equipment and supplies associated with each delivery order;

10.2.4. The types and numbers of services provided for each delivery order, i.e., the number of visits, treatments, procedures, tests, etc.;

10.2.5. The total salaries, compensation, and expenses paid by the contractor in support of the services provided for each delivery order; and

10.2.6. The number of admissions and/or visits attributable to each delivery order.