MONTHLY REPORTS

TMA requires the contractor to prepare and submit routine workload and management reports used to establish a uniform format for recording data on contractor operations and to provide historical data for continued evaluation of contractor performance. While the data contained in the reports are essential to TMA for purposes of program management, they are equally essential for a contractor's management of the program. A contractor is accountable for assuring that reports contain accurate and complete data. Each contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. In addition, the contractor shall establish a quality assurance program to assure a high degree of reporting accuracy. All reports must be supported with sufficient documentation and audit trails by the contractor for TMA on-site and desk audit inspections. An officer of the contractor shall sign and date each report submitted to attest to the accuracy and completeness of the report.

1.0. NETWORK ADEQUACY REPORT

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 in accordance with contract requirements thereafter. The reports shall be delivered to the Contracting Officer and the Regional Director within 10 calendar days following the close of the reporting period and shall provide the following information by *Prime service* area:

- The number of network providers by specialty;
- The number of additions and deletions during the report period to the network, by specialty;
- Activities undertaken to contract with additional providers in areas lacking networks to meet the prescribed network standards;
- A listing of PCMs (both civilian and military) and the number of enrollees assigned to each PCM by *Prime service* area. The Contracting Officer may request that these reports be summarized by provider type for submission.
- Network access compliance with the requirements of 32 CFR 199.17(p)(5).

2.0. NETWORK INADEQUACY REPORT

Monthly, by the tenth calendar day following the end of the reported month, the contractor shall report to the Government any instances of network inadequacy relative to the Prime and/or Extra service areas and shall submit a corrective action plan with each

notice of an instance of network inadequacy. Network inadequacy is defined as any occurrence of a prime beneficiary being referred to a network provider outside of the time and/or distance standards (except when the beneficiary waives access standards) or any beneficiary being referred to a non-network provider.

3.0. NETWORK STATUS REPORT

Monthly, by the tenth calendar day following the end of the reported month, the contractor shall report to the Government the status of the network in each prime service area. The report shall include:

- The number of fully qualified network providers, by speciality, by prime service area, and shall contain a narrative report of network management activities over the last reporting period.

- A brief description of activities planned during the next reporting period.

4.0. TRICARE PRIME ENROLLMENT REPORT

The contractor shall report enrollments to and disenrollments from TRICARE Prime. The report is due to the Contracting Officer and the Regional Director by the fifteenth 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:

- Enrollment data categorized by PCM assignment status (MTF vs. contractor), each *Prime service* area, and each non-*Prime service* 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 *Prime service* areas and non-*Prime service* 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.

- Disenrollment by *Prime service* and non-*Prime service* 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);

- Enrollment and disenrollment summaries by state;

- 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 *Prime service* area or stand-alone clinic;

- 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.

5.0. MONTHLY ENROLLMENT REPORT

5.1. The contractor shall submit a monthly Enrollment Report to each MTF and a consolidated report to the Regional Office, and a copy to TMA, containing the following information:

5.1.1. Total MTF enrollments by clinic and primary care manager.

For example:	Internal Medicine XYZ MTF	10,000
	Dr. Jones	1,500
	Dr. Smith	1,500
	Dr. Adams	1,000
	Dr. Franklin	1,000
	Dr. Washington	1,000
	Dr. Lincoln	500
	Dr. Carter	1,500
	Dr. Nixon	1,500
	Dr. Clinton	500

5.1.2. Total TRICARE Prime/Plus openings per MTF per clinic.

5.1.3. New enrollments during the reporting period per MTF per clinic.

5.1.4. Disenrollments during the reporting period per MTF per clinic per PCM by reason.

For example:	Internal Medicine XYZ MTF	1,550
	Dr. Jones (Physician Transferred	1,500
	Dr. Smith	50
	Patient moved	30
	Patient died	10
	Patient dissatisfied w/MD	2
	Patient unable to access MD	2
	Failure to pay enrollment	6

5.1.5. Total enrollments to network PCMs by prime service area.

5.1.6. New enrollments during the reporting period to network PCMs by Prime service area.

5.1.7. Disenrollments from network PCM, by reason, by prime service area, during the reporting period.

5.1.8. Total number of enrollment discrepancies by DMIS ID for each MTF and the network.

6.0. IMPLEMENTATION OF ENROLLMENT PLAN REPORT

6.0.1. In addition to other contractually required enrollment reports, the contractor, within 30 calendar days following the start of health care delivery, and within 10 calendar days following the close of each calendar month through the seventh month following the start of health care delivery, shall provide a report to TMA on progress made in implementing TMA approved enrollment plan. The report shall identify those areas in the contractor's approved start-up plan to be serviced by TRICARE Prime in which enrollment significantly exceeds or falls short of the targets established by the contractor in the approved enrollment plan, and outline corrective action plans for any deficiencies in the contractor's enrollment process which are significant deviations from the approved enrollment plan.

7.0. MONTHLY REFERRAL REPORT

The contractor shall report monthly the number of referrals processed to the appropriate MTF and Regional Office during the reporting period by MTF. The report shall include:

- Number of referrals received by the contractor by clinical speciality (i.e. orthopedics, urology).
- Number referred to MTF/MTFs within access standards by speciality.
- Number of referrals accepted by MTF by speciality.
- Number of referrals rejected by MTF by speciality.
- Number referred to a network provider within access standard.
- Number referred to a non-network provider by speciality within access standards and the reason for each non-network referral.
- Number of referrals failing to meet access standards and the reason.
- Percentage of all referrals during reporting in which the results of the completed referral were communicated in writing to the initiating provider within *the standard*.

8.0. RESOURCE SHARING REPORTING AND CERTIFICATION

The contractor shall submit monthly reports prepared jointly with the MTF, and certified by the MTF, through the Regional Director 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. 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:

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

- 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);

- The types and numbers of services provided for each agreement or project other than the number of outpatient visits and/or admissions reported in the above paragraph; e.g., the number of treatments, procedures, tests, etc., which are not reported as admissions or outpatient visits;

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

- 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.)

9.0. MEDICAL MANAGEMENT REPORT

The contractor shall report the performance of its medical management program (MMP) on a monthly basis to the appropriate MTF and Regional Office. The report shall include:

- Number of patients, by prime service area, in the medical management program, by medical management program component (e.g., case management, disease management, high cost, etc., based on the contractor's proposal).

- Affect of the MMP on MTF optimization to include care/treatment required; source of care; cost-control; timeliness; integration of MTF and purchased care services; access to clinical services; non-clinical services required and obtained, including funding source; and future requirements and treatment/funding sources.

10.0. QUALITY MANAGEMENT ACTIVITY REPORT

The contractor shall provide a monthly report to the Contracting Officer and the Regional Director 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 *region level* quality *management* committee meetings shall be forwarded to the Contracting Officer, with a copy to the Regional Director, quarterly

within ten calendar days following the end of the quarter. The summary reports shall include:

- 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.);

- The criteria sets used to evaluate care;

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

- 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, blood usage, medical record review for inpatient and ambulatory care settings);

- Turnover rates for providers in network hospitals across departments; and

- Changes in privileges granted to individual providers.

11.0. BENEFICIARY SERVICES AND ACCESS REPORTS

The contractor shall provide monthly 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 Regional Director at the same time they are provided to the Contracting Officer in the format required by the Regional Director.

12.0. EDUCATION PRESENTATION REPORT

12.1. The Education Presentation Report shall be reported each month by region and copies submitted electronically by the 10th working day of each month to each of the following:

- Regional Director or designee

- MTF Commander of Designee

- TMA Contracting Office and Contracting Officer Representative

- TMA Communications and Customer Service Directorate

12.2. The report shall capture the following information:

- Calendar of briefings held during the prior month
- Number of attendees at each briefing
- Type of attendees by beneficiary category
- Location of briefing
- Duration of briefing
- Volume and type of materials distributed at each briefing
- Summarize major issues/questions brought out at the briefing
- Suggested follow-up actions to briefings
- Major facility issues/concerns
- Projected briefing schedule for the following month
- Participating briefers (name and organization)
- Contractor suggested changes (i.e., content of briefings, materials, etc.)

13.0. TOLL-FREE TELEPHONE REPORT

The contractor shall provide the following report to TMA and the appropriate Regional Director in the required format to arrive by the 15th calendar day of each month for the previous month. This report shall include:

- All lines busy (ALB) in percentage.
- Total calls attempting to reach the contractor.
- Total calls received.
- Percent of calls answered within two rings by the ARU.
- Percent of calls answered by an individual within 20 seconds
- Percent of calls answered by an individual within 30 seconds.
- Number of calls exceeding 30 seconds hold time during the entire telephone call.
- Number of calls totally answered during the initial telephone contact.
- Number of substantive call-backs within two working days.

- Number of calls not fully completed within ten calendar days.
- Number of calls not fully completed within 20 calendar days.

14.0. CUSTOMER SATISFACTION REPORT

Monthly, by the tenth calendar day following the end of the reported month, the contractor shall report to the Government the state of customer satisfaction during the previous reporting period. The report shall be provided to the Regional Office and the Contracting Officer. The Customer Satisfaction Report shall include:

- The contractor's measurement of satisfaction, by category, to include active duty personnel, dependents of active duty, retirees and other eligible beneficiaries under age 65;
- Network providers;
- Non-network providers;
- MTF providers; and
- MTF Commanders.

15.0. PRODUCTIVITY REPORT

Monthly, by the tenth calendar day following the end of the reported month, the contractor shall report to the Regional Office and Contracting Officer the previous months actual productivity for each area where the contractor has proposed customer service/TSC standards. Examples of standards include telephone blockage rate, call abandonment rate, telephone and walk-in wait times, written inquiry response rate, etc. The contractor shall correlate this report with the customer satisfaction report and provide and action plan addressing all areas of customer dissatisfaction.

16.0. DEBT COLLECTION ASSISTANCE OFFICER PROGRAM COLLECTION REPORT

Reports of all completed collection cases shall be furnished to the Office of Claims Collection Evaluation at TMA-Aurora in an Excel spreadsheet format on a monthly basis, by the 15th calendar day of the following month. Reports shall include:

- Name of sponsor
- Sponsor SSN
- Service of sponsor
- Status of sponsor
- Name of patient

- Relationship to sponsor
- Healthcare option involved in collection (Prime, Extra or Standard)
- Date(s) of service at issue
- Date of claim(s) submission
- Provider participation status on claim
- Claim development history
  - Was claim developed, and when
  - Reason for development
  - Was requested information received, and when
- Claim adjudication and payment history
  - Amount billed
  - Amount allowed
  - Reason(s) for difference
  - Cost share amount(s)
  - Amount applied to deductible
  - Amount paid
    - To provider
    - To beneficiary
  - Payment date
  - Payee
  - Remaining beneficiary liability and reason
  - Any other information pertinent to understanding the resolution of the case (e.g., letter to provider, provider assent to contact MCSC prior to any future collection actions, etc.).

17.0. FINANCIAL REPORTS

See Chapter 3, Section 10.