

**Statewide Medicaid Managed Care (SMMC)
Managed Care Plan
Report Guide
Effective 4-1-19**

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Section One: Overview and Reporting Requirements

Chapter 1: General Overview

Purpose of Report Guide

The SMMC Managed Care Plan Report Guide (Report Guide) is a companion to each Managed Care Plan's Contract (Contract) with the Agency for Health Care Administration (Agency). It provides details of plan reporting requirements including instructions, location of templates, and submission directions.

This Report Guide provides report guidance and requirements for the following types of Managed Care Plans:

- ✓ Managed Medical Assistance Health Maintenance Organizations (MMA HMOs)
- ✓ Managed Medical Assistance Capitated Provider Service Networks (MMA Capitated PSNs)
- ✓ Managed Medical Assistance Specialty Plans (MMA Specialty Plans)
- ✓ Managed Medical Assistance Children's Medical Services Plan (MMA CMS Plan)
- ✓ Comprehensive Long-term Care Plans (Comprehensive LTC Plans)
- ✓ Long-term Care Plus Plans (LTC Plus Plans)
- ✓ Dental Plans (DPs)

Note: MMA HMO, MMA PSN, MMA Specialty, MMA CMS, Comprehensive LTC and LTC Plus Plans are collectively referred to as "health plans".

Chapter 2, General Reporting Requirements, covers the general report submission and certification requirements for the health plans and the Dental Plans (DPs). After these introductory chapters, the remaining chapters cover any specific report certification information and specific individual report instructions.

The reports in the Report Guide Table of Contents are in alphabetical order by the name of the report.

Within each individual report chapter, the following report-specific items are covered:

- Managed Care Plan types that are required to provide the report.
- Report purpose.
- Report frequency requirements and due dates.
- Report submission requirements.
- Specific instructions and requirements for completion, including any variances specific to a particular Managed Care Plan type.
- Location of report templates, based on the Report Guide effective date.

Reading this Report Guide will produce the following four results:

- An understanding of the Managed Care Plan's responsibility for report submissions.
- A clear concept of what each report requires and how it is best fulfilled.
- Knowledge of the specific report format that is required.
- A single location for all report requirements for all contractual non-X-12 reports that must be submitted by the Managed Care Plans to the Agency.

This Report Guide is referenced in each Managed Care Plan's Contract with the Agency, and each report is summarized in the Contract's Summary of Reporting Requirements Table.

The Managed Care Plan must comply with all applicable reporting requirements set forth in its Contract and this Report Guide. All of the applicable reports within the Report Guide are a contractual obligation of the Managed Care Plan to the Agency, and the Managed Care Plans are responsible for their accurate completion and timely submission as specified in the Contract and Report Guide. Non-compliant Managed Care Plans are subject to liquidated damages and sanctions as specified in the Contract.

Report Guide Updates

As specified in each Managed Care Plan Contract, the Agency reserves the right to modify reporting requirements periodically. The Agency will post updates at

http://ahca.myflorida.com/Medicaid/statewide_mc/report_guide.shtml

In general, the Report Guide may change on a semi-annual basis, in April and October. The Report Guide document, along with all applicable report templates to be used with that version of the Report Guide, will be posted to an Agency web page with the specific Report Guide effective date. Each new Report Guide that is published will have a separate web page. For example, the Report Guide that is effective on April 1, 2019, will be posted to an Agency web page titled "Medicaid Managed Care Plan Report Guide - (Effective 4-1-2019)", along with all associated report templates. If a technical change is made to a template before the next Report Guide version is published, a revised template will be posted to the web page with its new effective date. If a substantive change is made to a template before the next Report Guide version is published, the Agency will formally notify the Managed Care Plans of the revised requirements.

Report Guide Templates

The Agency report templates must be used as specified in this Report Guide. No alterations or duplication must be made to the report templates by the Managed Care Plan. The report templates can be found by using the link that is located above, in the "Report Guide Updates" section, to access the Agency website, and then selecting the appropriate Report Guide web page that corresponds with the Report Guide effective date. For any report that has alternate template instructions listed under the "Report Template" section of the report chapter, the alternate instructions must be followed by the Managed Care Plan.

The DPs must complete the entire report template if there is no dental tab in the template. If a dental tab exists within the template, the DPs must complete the dental tab only. If the report chapter states that there is a separate template for dental reporting, the DPs must complete only the dental template. The DPs must submit the files using the standard naming convention, unless

there is a designated file name listed in the report chapter under the section labeled "Submission". In such cases, the DPs must use the designated file name instead of the standard file naming convention.

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Chapter 2: General Reporting Requirements

General Report Certification Requirements

In addition to the specific report requirements found in subsequent chapters, all Managed Care Plans are responsible for fulfilling basic requirements that apply to all submissions. As specified in the Contract provisions, general reporting requirements include the following:

The Managed Care Plan's chief executive officer (CEO), chief financial officer (CFO) or an individual who directly reports to the CEO or CFO and who has delegated authority to certify the Managed Care Plan's reports, must attest, based on his/her best knowledge, information and belief, that all data submitted in conjunction with the reports and all documents requested by the Agency are accurate, truthful and complete (see 42 CFR 438.606(a) and (b)). The Managed Care Plan must submit its attestation at the same time it submits the certified data reports (see 42 CFR 438.606(c)).

Some chapters have designated file names and/or formats for these federally required attestations (also referred to as "certifications"). However, for chapters where a file name and/or format is not designated, Managed Care Plans must create and submit a PDF file with a file name as outlined in the "Report Naming and Identification" section below.

The attestation can simply state:

"I, <<NAME OF PLAN OFFICIAL>>, certify that all data and all documents submitted for the following are accurate, truthful, and complete to the best of my knowledge, information and belief." <<List Report Name(s) and Report Period(s) >>.

The attestation must be on the plan's letterhead, signed by the official referenced on the attestation itself, and it must include the official's specific title. The attestation submitted by the Managed Care Plan must list the name(s) and reporting period(s) of the report(s) being submitted. One attestation is required for each set of report(s) being submitted at the same time. For example:

- If a Managed Care Plan is submitting one weekly report and four quarterly reports at the same time on February 2, 2019, the Managed Care Plan would submit one attestation listing all five reports being submitted.
- If a Managed Care Plan is submitting one weekly report on February 2, 2019, and four quarterly reports on February 3, 2019, a separate attestation would be required for each submission. The attestation for the weekly report submitted February 2nd would contain the name and reporting period covered for the weekly report. A separate attestation would be submitted on February 3rd for the submissions of the four quarterly reports and would contain the name(s) and reporting period(s) covered by each of the quarterly reports.

The attestation (and delegation of authority if applicable) must be scanned and submitted to the Agency as one PDF file, and must be submitted with the certified data reports. The attestation PDF file must be submitted to the applicable managed care plan attestation folder located on the Agency SFTP site.

Report Accuracy and Submission Timeliness

- The written delegation of authority must be submitted with the attestation and renewed each calendar year.
- The deadline for report submission referred to in the Contract provision is the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.
- If a reporting due date falls on a weekend or holiday, the report is due to the Agency on the following business day. State-recognized holidays can be found on the State of Florida's website at <http://myflorida.com>.

SFTP Site Access

Most reports are submitted to the Agency's SFTP site:

- SMMC CY18-23 SFTP site.

To access the SFTP site, contact your Agency contract manager.

Report Naming and Identification

A standard file naming convention has been established for all reports and attestations (including supporting submission documents) with the following exceptions:

- Well Child Visit Report (CMS-416) and FL 80% Screening
- Provider Network File
- Suspected/Confirmed Fraud and Abuse Reporting
- Achieved Savings Rebate (ASR) Financial Reports
- Non-Special Needs (Non-SNP) Financial Reports
- Case Manager and Provider Training Report
- Provider Network and Qualifications Report
- Reports submitted directly to the Agency's Fiscal Agent or other delegated entities outside of the Agency that maintain their own file naming convention.
- Attestations must use the following naming convention: "ABCYYYYMMDDA", where ABC stands for the Managed Care Plan's three-character identifier from the Plan Identifier Table, YYYY stands for the four-digit year in which the report(s) are being submitted, MM stands for the two-digit month in which the report(s) are being submitted, DD stands for the two-digit day on which the report/attestation is submitted to the Agency, and A stands for the attestation. If multiple batches of reports and attestations are submitted in one day, a two-digit numeric indicator will be added after the "A". For example, if there are two batches of reports submitted at different times on February 2, 2019, requiring two separate attestations, the naming convention of the first file would be – "ABCYYYYMMDDA" and the naming convention of the second file would be – "ABCYYYYMMDDA02".

Other than for the exceptions noted in this Chapter, the standard file naming convention uses the plan name identifier as well as a unique 4-digit number assigned to each report and submission document with an attestation. There are also codes for the report year, report year type and frequency of each report. These codes are provided in the Plan Identifier Table, Report Code Identifier Table, Report Year Type Table and the Frequency Code Table, respectively, later in this chapter. The plan name identifiers, report code identifiers, report year type identifiers and report frequency codes are all used as part of this standard SMMC file naming convention.

- The standard file naming convention is as follows:
 - The Managed Care Plan's three-character identifier from the Plan Identifier Table
 - Four-digit year in which the report is due
 - Two-digit month in which the report is due
 - One-character identifier for the report's year type from the Report Year Type Table
 - One-character identifier for the report frequency from the Frequency Code Table
 - Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period). When submitting a weekly report that contains data that falls within a week that overlaps two months, the report name will contain the week in which the data reporting started. For example, the report naming convention for a month that contains five weeks, with the last week in the month consisting of Monday and Tuesday followed by the first day of the following month on Wednesday, would use the frequency code of "W05", as there are five weeks in the month and the data being reported started during the fifth week.
 - Four-digit report code identifier from the Report Code Identifier Table
 - For resubmissions: Two digits representing the submission number after the report code number.
- There are **NO** dashes, spaces or other characters between each field.
- For reports that require supplemental documents, the document must be submitted in a .zip file using the file naming convention for that report. This .zip file may not be password protected.

Resubmitted or Corrected Reports

- Resubmitted or corrected reports are accepted on or before the due date only. Resubmitted or corrected reports must be submitted with the same file name as the original report. **Exception:** If the resubmission is due to a correction needed for an incorrect file name, the file must be resubmitted using the correct file naming convention.
- Resubmissions after a report due date are only accepted when the Agency or Agency designee requests a resubmission of a report previously submitted. The Managed Care Plan shall submit the report using the original naming convention with the addition of a two-digit numeric indicator after the report code number to indicate subsequent submissions. For example, the naming convention of the first report submitted on October 30, 2019 would be (ABC201910CM090145); the naming convention of the second report submitted on November 3, 2019 would be (ABC201910CM09014502) – with the addition of the numeric value '02" after the report code number.
- Submission of multiple variable reports on the same day will be accepted. The Managed Care Plan shall submit the report using the variable report naming convention with the

addition of a numeric indicator after the report code number to indicate subsequent submissions. For example, the naming convention of the first variable report submitted on October 30th would be (ABC201910CV300159); the naming convention of the second variable report submitted on October 30th would be (ABC201910CV3015902) – with the addition of the numeric value “02” after the report code number.

- Late submissions must be filed with the information required for the on-time filing. For example: a report due in July, but filed in August, must state the month of July (07) not August (08), in the file name. A report due in December 2019, but filed in January 2020, must state the year 2019 in the file name (not January 2020).
- Examples of standard file naming conventions are provided at the end of this chapter.

For any report that has a designated file name listed in the individual Report Guide chapter under the section labeled “Submission”, the designated file name must be used instead of the standard file naming convention. Please submit all such reports and their accompanying attestations in the file formats designated within the “Submission” sections of the report chapters.

Some reports will require the use of a two-digit numeric county code. The two-digit numeric county codes to be used for all such reports are provided on the County Code Table in following pages.

General Submission and Size Limits

In addition to complying with the designated file naming convention and format, the following requirements must be adhered to:

1. The Managed Care Plan may not alter or change report templates in any way.
2. The Agency’s email server security protocol allows documents with the “.zip” file extension; however, for reports or documents emailed to the Agency, the file must be within a ten (10) megabyte size limit. If larger files must be sent, the Managed Care Plan must discuss potential alternative delivery methods with its Agency contract manager.

Additional Reporting Format Instructions

If any of the reports contained in this Report Guide require enrollee identifying information that is not available to the Managed Care Plan (such as enrollee full name or Medicaid ID number for pending eligible enrollees), the plan may include available enrollee identifying information.

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SMMC MMA PLAN IDENTIFIER TABLE	
Plan Identifier	Plan Name
BST	Best Care Assurance d/b/a Vivida Health
NBD	Community Care Plan
PRS	Florida True Health d/b/a Prestige Health Choice
LHT	Lighthouse Health Plan
MCH	Miami Children's Health Plan
Plan Identifier	Specialty Plan Name
SHP	Clear Health Alliance – HIV/AIDS Specialty Plan
STW	Staywell - SMI Specialty Plan
SUN	Sunshine State - Child Welfare Specialty Plan
MCC	Magellan Complete Care – SMI Specialty Plan
CMS	Children's Medical Services – CMS Specialty Plan

SMMC LTC PLUS PLAN IDENTIFIER TABLE	
Plan Identifier	Plan Name
FCC	Florida Community Care (FCC)

SMMC COMPREHENSIVE PLAN IDENTIFIER TABLE	
Plan Identifier	Plan Name
COV	Coventry d/b/a Aetna Better Health of Florida
HUM	Humana Medical Plan
MOL	Molina Health Care of Florida
SHP	Simply Health Care Plan
SUN	Sunshine State Health Plan
URA	United Health Care Plan
STW	Wellcare of Florida d/b/a Staywell Health Plan

DENTAL PLAN IDENTIFIER TABLE	
Plan Identifier	Plan Name
DQT	DentaQuest of Florida
LIB	Liberty Dental Plan of Florida
MCA	Managed Care of North America

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Summary Table of Managed Care Plan Reports (non X-12 Reports)

The table below lists the following Managed Care Plan reports required by the Agency. These reports must be submitted as indicated in the Summary of Reporting Requirements table (below) and as specified in the Medicaid Managed Care Plan Report Guide and the Managed Care Plan Contracts. Please refer to this table as needed. Additional reporting requirements are specified in the Managed Care Plan Contracts.

Plan Type Table	
Type	Plans
LTC	Comprehensive LTC Plan / LTC Plus Plan
MMA	MMA HMO, MMA Capitated PSN, MMA Specialty Plan
CMS	MMA CMS Plan
Dental	Dental Plan

Report Year Type Table	
Report Year Type	Report Year Period
K = Contract	09/01 – 08/31
F = Federal	10/01 – 09/30
S = State	07/01 – 06/30
C = Calendar	01/01 – 12/31

Frequency Code Table	
Report Frequency	Reporting Data Period
A = Annually	Last two digits of year's data being reported
S = Semi-annually	01 or 02 for first or second data period being reported
Q = Quarterly	Two digits for quarter of data being reported (01, 02, 03, 04)
M = Monthly	Two-digit month of data being reported
V = Variable	Two-digit day of submission date (01-31)
W = Weekly	Two digits for week of data being reported (01, 02, 03, 04, 05)

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SUMMARY OF REPORTING REQUIREMENTS
With Report Code Identifier Information

Managed Care Plan Report Name	Report Chapter	LTC	MMA	CMS	Dental	Report Year Type	Report Code	Submission Frequency Code
Achieved Savings Rebate Financial Reports	3	X	X	X	X	C	N/A	A & Q
Actual Value of Enhanced Payment (AVEP) MMA Physician Incentive Program (MPIP) Report	4	X	X	N/A	N/A	F	0194	S
Additional Network Adequacy Standards Report – UNDER DEVELOPMENT	5	N/A	X	X	N/A		TBD	TBD
Administrative Subcontractors and Affiliates Report	6	X	X	X	X	C	0100	Q
Adverse and Critical Incident Summary Report	7	X	X	X	X	C	0120	M
Annual Fraud and Abuse Activity Report	8	X	X	X	X	S	0133	A
Appointment Wait Times Report	9	X	X	X	X	C	0172	Q
Case Management File Audit Report	10	X	N/A	N/A	N/A	C	0102	Q
Case Manager and Provider Training Report	11	X	N/A	N/A	N/A	C	N/A	A
Case Manager Caseload Report	12	X	N/A	N/A	N/A	C	0151	M
Claims Aging Report & Supplemental Filing Report <ul style="list-style-type: none"> • Capitated Claims Aging Report • Fee-for-Service Claims Aging Report 	13	X	X	X	X	C	0108 0109	M
Critical Incident Report- Individual	14	X	N/A	N/A	N/A	C	0118	V
Denial, Reduction, Suspension or Termination of Services Report	15	X	N/A	N/A	N/A	C	0125	M
Denied/Suspended/Terminated Provider Report	16	X	X	X	X	S	0193	Q
Enhanced Care Coordination Report	17	X	X	X	N/A	C	0186	M

Managed Care Plan Report Name	Report Chapter	LTC	MMA	CMS	Dental	Report Year Type	Report Code	Submission Frequency Code
Enrollee Complaints, Grievances, and Appeals Report	18	X	X	X	X	C	0127	M
Enrollee Help Line Statistics Report – UNDER DEVELOPMENT	19	X	X	X	X	C	TBD	TBD
Enrollee Roster and Facility Residence Report	20	X	N/A	N/A	N/A	C	0129	M
ER Visits for Enrollees without PCP Appointment Report	21	N/A	X	X	N/A	C	0182	A
Estimated Value of Enhanced Reimbursement (EVER) MMA Physician Incentive Program (MPIP) Report	22	N/A	X	N/A	N/A	C	0198	A
Health Risk Assessment Report	23	N/A	X	X	N/A	C	0201	Q
Healthy Behaviors Report	24	N/A	X	X	X	C	0180	Q
Hernandez Settlement Agreement Survey	25	N/A	X	N/A	N/A	C	0168	A
Hernandez Settlement Ombudsman Log	26	N/A	X	N/A	N/A	C	0170	Q
Institutions of Mental Disease (IMD) Reimbursement Report	27	N/A	X	N/A	N/A	C	0199	S
Inter-Rater Reliability (IRR) Report	28	X	X	X	X	C	0200	Q
Marketing Agent Status Report	29	X	X	X	X	C	0157	V & Q
Marketing/Public/Educational Events Report <ul style="list-style-type: none"> Marketing/Public/Educational Events Report Amendment to a reported event change 	30	X	X	X	X	C	0159 0160	V & M
Medical Foster Care Services Report	31	N/A	X	X	N/A		0202	M
Member Satisfaction Improvement Report – UNDER DEVELOPMENT	32	X	X	X	X		TBD	TBD

Managed Care Plan Report Name	Report Chapter	LTC	MMA	CMS	Dental	Report Year Type	Report Code	Submission Frequency Code
Missed Services Report	33	X	N/A	N/A	N/A	C	0131	M
Non-Emergency Transportation Missed Trips Report	34	X	X	X	N/A	C	0196	M
Non-Emergency Transportation Timeliness Report – UNDER DEVELOPMENT	35	X	X	X	N/A	C	TBD	TBD
Non-Special Needs Plan (Non-SNP) Financial Report	36	N/A	X	N/A	N/A	C	N/A	A
Participant Direction Option (PDO) Roster Report	37	X	N/A	N/A	N/A	C	0137	M
Patient Responsibility Report	38	X	N/A	N/A	N/A	K	0139	A
PCP/PDP Appointment Report	39	X	X	X	X	C	0191	A
Performance Measures Report- LTC & MMA <ul style="list-style-type: none"> HEDIS Auditor Certification with Audit Review Table Interactive Data Submission System (IDSS) file 	40	X	X	X	X	C	0141 0143 0144	A
Pre-Admission Screening and Resident Review (PASRR) Report	41	X	X	X	N/A	C	0184	Q
Provider Complaint/Appeal Report	42	X	X	X	X	C	0145	M
Provider Network and Qualifications Report	43	X	N/A	N/A	N/A	C	N/A	Q
Provider Network File	44	X	X	X	X	C	N/A	W
Quarterly Fraud & Abuse Activity Report	45	X	X	X	X	S	0195	Q
Residential Psychiatric Treatment Report	46	N/A	X	X	N/A	C	0188	M
Service Authorization Performance Outcome Report	47	N/A	X	X	X	C	0197	M
Supplemental HIV/AIDS Report	48	N/A	X	N/A	N/A	C	0174	M

Managed Care Plan Report Name	Report Chapter	LTC	MMA	CMS	Dental	Report Year Type	Report Code	Submission Frequency Code
Suspected/Confirmed Fraud and Abuse Reporting	49	X	X	X	X	S	N/A	V
Suspected/Confirmed Waste Reporting	50	X	X	X	X	S	0192	Q
Unable to Provide Case Management Report	51	X	N/A	N/A	N/A	C	0176	M
Well Child Visit Report (CMS-416) and FL- 80% Screening	52	N/A	X	X	X	F	N/A	A

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COUNTY CODE TABLE			
COUNTY NAME	COUNTY ID	AHCA AREA/REGION	DCF CIRCUIT
Alachua	01	03	08
Baker	02	04	08
Bay	03	02	14
Bradford	04	03	08
Brevard	05	07	18
Broward	06	10	17
Calhoun	07	02	14
Charlotte	08	08	20
Citrus	09	03	05
Clay	10	04	04
Collier	11	08	20
Columbia	12	03	03
Desoto	14	08	12
Dixie	15	03	03
Duval	16	04	04
Escambia	17	01	01
Flagler	18	04	07
Franklin	19	02	02
Gadsden	20	02	02
Gilchrist	21	03	08
Glades	22	08	20
Gulf	23	02	14
Hamilton	24	03	03
Hardee	25	06	10
Hendry	26	08	20
Hernando	27	03	05
Highlands	28	06	10
Hillsborough	29	06	13
Holmes	30	02	14
Indian River	31	09	19
Jackson	32	02	02
Jefferson	33	02	14
Lafayette	34	03	03
Lake	35	03	05
Lee	36	08	20
Leon	37	02	02
Levy	38	03	08

COUNTY CODE TABLE			
COUNTY NAME	COUNTY ID	AHCA AREA/REGION	DCF CIRCUIT
Liberty	39	02	02
Madison	40	02	03
Manatee	41	06	12
Marion	42	03	05
Martin	43	09	19
Miami-Dade	13	11	11
Monroe	44	11	16
Nassau	45	04	04
Okaloosa	46	01	01
Okeechobee	47	09	19
Orange	48	07	09
Osceola	49	07	09
Palm Beach	50	09	15
Pasco	51	05	06
Pinellas	52	05	06
Polk	53	06	10
Putnam	54	03	07
Santa Rosa	57	01	01
Sarasota	58	08	12
Seminole	59	07	18
St. Johns	55	04	07
St. Lucie	56	09	19
Sumter	60	03	05
Suwannee	61	03	03
Taylor	62	02	03
Union	63	03	08
Volusia	64	04	07
Wakulla	65	02	02
Walton	66	01	01
Washington	67	02	14

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File Naming Convention Examples

Example: File Name **ABC201910KA180139 =**

ABC Managed Care Plan
2018 Patient Responsibility Report due October 1, 2019

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2019
- Two-digit month in which report is due = 10
- One-character identifier for the report's year type from the Report Year Type Table = K
- One-character identifier for report frequency from the Frequency Code Table = A
- Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period) = 18 (Reporting Data Period 2018)
- Four-digit report code identifier for the Patient Responsibility Report = 0139

Example: File Name **ABC201904CQ010102=**

ABC Managed Care Plan
1st Quarter 2019 Case Management File Audit Report due April 30, 2019

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2019
- Two-digit month in which report is due = 04
- One-character identifier for report year type from the Report Year Type Table = C
- One-character identifier for report frequency from the Frequency Code Table = Q
- Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period) = 01 (Reporting Data Period 1st Quarter ending 03/31/2019)
- Four-digit report code identifier for the Case Management File Audit Report = 0102

Example: File Name **ABC201910CM090131.xls=**

ABC Managed Care Plan
September 2019 Missed Services Report due October 30, 2019

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2019
- Two-digit month in which report is due = 10
- One-character identifier for the report's year type from the Report Year Type Table = C
- One-character identifier for report frequency from the Frequency Code Table = M
- Two digits indicating the specific data period being reported from the Frequency Code Table (Reporting Data Period) = 09 (September reporting period)
- Four-digit report code identifier for the Missed Services Report = 0131

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Section Two: Reports

Chapter 3: Achieved Savings Rebate (ASR) Financial Reports

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with unaudited quarterly and annual Achieved Savings Rebate (ASR) Financial Reports that detail plan financial operations and performance for the applicable reporting period.

FREQUENCY & DUE DATES:

With the exception of the first quarter (Q1) unaudited quarterly ASR Financial Report, unaudited quarterly ASR Financial Reports are due to the Agency on the fifteenth (15th) of the second month following the end of the reporting calendar quarter, with claims paid through the end of the reporting period. The Q1 unaudited quarterly ASR Financial Report is due to the Agency by June 1. Each subsequent quarter's report shall include restated versions of previously submitted quarters, paid through the end of the current reporting period. The ASR Exhibit within the ASR Financial Report shall lag one quarter and be prepared using restated financial data. The quarterly ASR Financial Report shall be submitted with the certification of the CEO or CFO attesting to its accuracy, as discussed in Chapter 2, General Reporting Requirements, using the naming convention as described in Chapter 2.

Unaudited annual ASR Financial Reports are due to the Agency by May 1 following the end of the reporting calendar year, allowing for ninety (90) calendar days of claims runout. The following shall be submitted as part of the unaudited annual ASR Financial Report:

- One copy of the annual ASR Financial Report;
- Actuarial certification of incurred claims;
- Claim lag template;
- Certification by the CEO or CFO, as discussed in Chapter 2, General Reporting Requirements, using the naming convention as described in Chapter 2.

SUBMISSION:

The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- For the unaudited quarterly submissions:
Comprehensive LTC Plans, LTC Plus Plans, MMA HMOs, MMA Capitated PSNs, MMA CMS Plan, and Dental Plans must submit the completed and accurate ASR Financial

Report template as an Excel file and named ASR***YYQ#.xlsx (or ASR-Dental***YYQ#.xlsx), where *** is the Managed Care Plan's three-character identifier from the Plan Identifier Table (see Chapter 2), YY are the last two digits of the calendar year being reported, and # is the one digit of the quarter being reported (i.e., ABC Managed Care Plan's submission for the 1st quarter of 2015 would be named ASRABC15Q1.xlsx or (ASR-DentalABC15Q1.xlsx)). MMA Specialty Plans must submit the completed and accurate ASR Financial Report template as an Excel file and named ASR-S***YYQ#.xlsx, where *** is the Managed Care Plan's three-character identifier from the Plan Identifier Table (see Chapter 2) YY are the last two digits of the calendar year being reported, and # is the one digit of the quarter being reported (i.e., ABC Managed Care Plan's submission for the 1st quarter of 2015 would be named ASR-SABC15Q1).

- a. The jurat page (included in the financial statement report template), which must be submitted separately as a PDF file and named ASR***YYQ#-jurat.pdf (or ASR-Dental***YYQ#-jurat.pdf or ASR-S***YYQ#-Jurat.pdf), where *** is the Managed Care Plan's three-character identifier, YY are the last two digits of the calendar year being reported, and # is the one digit of the quarter being reported. This jurat page must be signed only by the Managed Care Plan's chief executive officer (CEO). Delegate signatures will not be accepted.
 - b. A report attestation as described in Chapter 2.
- For the unaudited annual submissions:
- a. The completed and accurate ASR Financial Report template (or ASR-Dental Financial Report template), which must be submitted as an Excel file and named ASR***YYYY.xlsx (or ASR-Dental***YYYY.xlsx), where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported.
 - b. The jurat page (included in the financial statement report template), which must be submitted as a PDF file and named ASR***YYYY-jurat.pdf (or ASR-Dental***YYYY-jurat.pdf or ASR-S***YYYY-jurat.pdf), where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported. This jurat page must be signed only by the Managed Care Plan's CEO. **Delegate signatures will not be accepted.**
 - c. A report attestation, as described in Chapter 2, for the completed and accurate financial statement report template.
 - d. An actuarial certification of incurred claims, which must be submitted as a PDF file and named ASR***YYYY-act.pdf (or ASR-Dental***YYYY-act.pdf or ASR-S***YYYY-act.pdf), where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported.
 - e. Claim lags for the reporting year, which must be submitted as an Excel file and named ASR***YYYY-claims.xlsx (or ASR-Dental***YYYY-claims.xlsx or ASR-S***YYYY-claims.xlsx), where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported. Claim lags must be reported using the Agency's template, as specified in the Report Template section of

this chapter. Instructions for completing the Claim Lags template are included in the template.

INSTRUCTIONS:

1. The Managed Care Plan must complete the financial reporting submission requirements using the Excel file template provided at the Agency's website, as specified in the Report Template section of this chapter, to report the following sets of financial data as applicable to each Managed Care Plan:

Quarterly ASR Financial Report:

- MMA Revenue & Expense Schedule (Summary and Regional);
- MMA Subcapitation Schedule (Summary);
- MMA Expanded Benefits (Summary);
- MMA Related-Party Schedule (Summary);
- Enhanced MPIP Schedule (Summary);
- LTC Revenue & Expense Schedule (Summary and Regional);
- LTC Subcapitation Schedule (Summary);
- LTC Expanded Benefits (Summary)
- LTC Related-Party Schedule (Summary);
- ASR Exhibit.

Annual ASR Financial Report:

- MMA Revenue & Expense Schedule (Summary and Regional);
- MMA Subcapitation Schedule (Summary);
- MMA Expanded Benefits (Summary);
- MMA Related-Party Schedule (Summary);
- Enhanced MPIP Schedule (Summary);
- LTC Revenue & Expense Schedule (Summary and Regional);
- LTC Subcapitation Schedule (Summary);
- LTC Expanded Benefits (Summary);
- LTC Related-Party Schedule (Summary);
- ASR Exhibit;
- ASR Claim Lag template.

Quarterly ASR-Dental Financial Report:

- Dental Revenue & Expense Schedule (Summary and Regional);
- Dental Expanded Benefits (Summary);
- Dental Related-Party Schedule (Summary);
- ASR Exhibit.

Annual ASR-Dental Financial Report:

- Dental Revenue & Expense Schedule (Summary and Regional);
- Dental Expanded Benefits (Summary);
- Dental Related-Party Schedule (Summary);
- ASR Exhibit;
- ASR Dental Claim Lag template.

Refer to the current ASR Financial Report template and current ASR-Dental Financial Report template for additional general instructions as well as schedule-specific instructions. Instructions for the Claim Lag template are included in the template itself.

2. It is the responsibility of the Managed Care Plan to use the most current financial statement report template, as specified by the Agency.
3. The Managed Care Plan must complete the Revenue & Expense schedules for each region in which the Managed Care Plan has a contract.
4. The Managed Care Plan must use generally accepted accounting principles (GAAP) in preparing the ASR Financial Reports.
5. The Managed Care Plan must submit financial statements that are specific to the operations of the Managed Care Plan rather than to a parent or umbrella organization.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. Dental Plans must use the ASR-Dental Financial Report template, and MMA and LTC plans must use the ASR Financial Report template.

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Chapter 4: Actual Value of Enhanced Payment (AVEP) MMA Physician Incentive Program (MPIP) Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with semi-annual reports detailing payments incurred by the Managed Care Plans' qualified providers, and the number of unduplicated enrollees served by qualified providers with enhanced payments, pursuant to s. 409.967(2)(a), F.S.

FREQUENCY & DUE DATES:

The MMA Physician Incentive Program (MPIP) reporting year begins on October 1st and ends on September 30th of each year. The Actual Value of Enhanced Payment (AVEP) MPIP Report is due to the Agency on May 15th for Quarters 1 and 2, and on November 15th for Quarters 3 and 4.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- MMA Physician Incentive Program Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

For the reporting period, the report must include:

- Managed Care Plan Name
- Managed Care Plan Representative's Name
- Managed Care Plan Representative's Email Address
- Date Report Completed
- This report must include all qualified physicians as originally submitted by the health plan on the Qualified Provider List, regardless of whether the physician received payment, and must accurately reflect all incurred payments at or above the Medicare rate, including amounts paid under a separate contracting arrangement, consistent with the total reported by the Managed Care Plan on the Achieved Savings Rebate (ASR) Report.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

Chapter 5: PLACEHOLDER for Additional Network Adequacy Standards Report

UNDER DEVELOPMENT

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Chapter 6: Administrative Subcontractors and Affiliates Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is for Managed Care Plans to report ownership and financial information for all subcontractors¹ and affiliates² to which the Managed Care Plan has delegated any responsibility or service for the Medicaid product line. This is an informational reporting mechanism only. The inclusion of an entity on this report does not constitute Agency approval of the Managed Care Plan's subcontract or relationship with that entity. Entities already reported in the Provider Network File must not be included on this report.

FREQUENCY & DUE DATES:

This report is due quarterly within fifteen (15) calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- The Managed Care Plan's Administrative Subcontractors and Affiliates Report.
- A report attestation described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the report using the Agency's template via the applicable SFTP site to the plan-specific file folder in the following manner. To meet the requirement for report submission, all applicable fields must be completed by the Managed Care Plan for each business entity being reported unless instructions specify otherwise. If a field is not applicable, enter N/A. In this report, do not include entities already reported in the Provider Network File.

Header rows on the template are numbered above header titles. Drop-down selection boxes with pre-populated values and help boxes are located throughout the template. Use one line of entry for each subcontractor/affiliate. If the subcontractor/affiliate has more than one owner (see 13a through 13c), complete fields 1 through 12 for each owner. Template fields are as follows:

1. Managed Care Plan Identifier: Enter the Managed Care Plan's three-character identifier.

¹ For purposes of this report, "subcontractor" means any person or entity with which the Managed Care Plan has contracted or delegated administrative functions, services or responsibilities for providing services under this Contract, excluding those persons or entities reported by the Managed Care Plan in the Provider Network File.

² For purposes of this report, "affiliate" or "affiliated person" means: (1) Any person or entity who directly or indirectly manages, controls, or oversees the operation of the Managed Care Plan, regardless of whether such person or entity is a partner, shareholder, owner, officer, director, agent, or employee of the entity. (2) Any person or entity who has a financial relationship with the Managed Care Plan as defined by 42 CFR 438.320 (1), and/or, (3) An individual or entity who meets the definition of an affiliate as defined in 48 CFR 19.101.

2. Managed Care Plan Name: Enter the name of the Managed Care Plan.
3. Managed Care Plan Base ID Medicaid Provider Number: Provide the primary Medicaid Base ID provider number of the Managed Care Plan including leading zeroes when applicable. Field length is seven digits.
4. Reporting Year: Select the Calendar Year being reported.
5. Reporting Quarter: Select the Quarter in the Calendar Year being reported.
6. Subcontractor/Affiliate Name: Enter the name of the Managed Care Plan's subcontractor or affiliate being reported. Entities already reported in the Provider Network File are not to be included on this report.
7. Business Entity Type: Select whether the entity being reported is a subcontractor of the Managed Care Plan, an affiliate of the Managed Care Plan, or both an affiliate and a subcontractor.
8. Tax I.D. (SSN/FEIN): Enter the tax identification number of the subcontractor or affiliate. Only nine numeric characters are allowed. Leading zeroes will be applied to any entry that is less than nine digits.
9. Correspondence Address: Enter the mailing or correspondence address of the subcontractor or affiliate being reported using the:
 - a. Street Address or P.O. Box
 - b. City
 - c. State (two-character identifier)
 - d. Zip Code (five digits)
 - e. Country
10. Subcontractor/Affiliate Physical Address:
 - a. Street Address
 - b. City
 - c. State (two-character identifier)
 - d. Zip Code (five digits)
 - e. Country
11. Parent Company Name (if applicable):
 - a. If the subcontractor/affiliate being reported is a subsidiary, enter the name of the parent company.
 - b. State: Select the state where the parent company is located.
 - c. Country: Select the country where the parent company is located.
12. Service Type: Enter service type(s) subcontracted or delegated by the Managed Care Plan to the subcontractor/affiliate. Service type examples include but are not limited to member services, third-party administrator, claims processing, fulfillment vendor (printing and mailing), provider credentialing, provider contracting, and provider services. Separate each service type description using a semi-colon.
13. Subcontractor/Affiliate Ownership: If the subcontractor/affiliate has more than one owner, complete fields 1 through 12, along with 13a, 13b, and 13c, for each owner/organization name.

- a. Last Name (or Organization Name): Enter the last name of the individual or the name of the organization having ownership of the subcontractor or affiliate. Enter one name or organization per line.
 - b. First Name: Enter the first name of the individual having ownership of the subcontractor or affiliate (if applicable). If not applicable, enter N/A. Enter one name per line.
 - c. Percent Ownership: Using a decimal point, enter the numerical value of the ownership percentage of the subcontractor/affiliate. Do not use the % character. NOTE: If the decimal point is not manually inserted, the system will automatically insert the decimal followed by two zeroes.
14. Payment Methodology: Select the Managed Care Plan's payment method for the subcontractor/affiliate services from the drop-down box. Options are "Contingency Fee," "Capitation" (per enrollee), "Cost Reimbursement," "Fixed per Unit Price" or "Other." If "Other" is selected, explain the payment methodology in field 14a.
- a. Payment Methodology - Other: This is an open text field. Describe the Managed Care Plan's payment method for subcontractor or affiliate services when "other" is selected in field 14.
15. Subcontract Beginning Date: Select the MM/DD/YYYY of the beginning of the subcontract.
16. Subcontract End Date: Select the MM/DD/YYYY of the end of the subcontract.
17. Downstream Delegation of Services: Select Yes or No, as appropriate, if the subcontractor or affiliate further subcontracts or delegates to another entity any services or functions under the Managed Care Plan's Medicaid contract obligation(s).
18. Comments: This is an open text, narrative field, provided for other relevant information or comments regarding this report.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 7: Adverse and Critical Incident Summary Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to monitor all Managed Care Plans' adverse and critical incident reporting and management system for adverse and critical incidents that negatively impact the health, safety or welfare of enrollees. This includes all service delivery settings applicable to enrollees.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Adverse and Critical Incident Summary Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must create the Adverse and Critical Incident Summary Report in the format and layout specified in the report template.
2. For the reporting month, the report must include but not be limited to:
 - Plan Name
 - Plan Type (MMA, LTC Plus, Comprehensive LTC, Dental Plan (DP))
 - Plan Medicaid ID (seven digits)
 - Date (Month/Year)

VARIATIONS BY MANAGED CARE PLAN TYPE:

MMA plans and DHPs will complete the "MMA and DP" tab, Adverse Incident Summary. Comprehensive LTC plans and LTC Plus plans will complete the "MMA and DP" tab, Adverse Incident Summary, and the LTC tab, Critical Incidents Summary.

REPORT TEMPLATE

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 8: Annual Fraud and Abuse Activity Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency a summarized annual report on the Managed Care Plan's experience in implementing an anti-fraud plan and conducting or contracting for investigations of possible fraudulent or abusive acts for the prior State Fiscal Year (SFY).

Note: All dollar amounts are to be reported for any overpayment, fraud, or abuse acts.

As used in this report, the terms "overpayment," "fraud," and "abuse" are defined and are referenced in Attachment II, Core Contract Provisions, Section I, Definitions and Acronyms.

FREQUENCY & DUE DATES:

This report is due annually by September 1.

SUBMISSION:

The Managed Care Plan must submit the following to the Agency's Office of Medicaid Program Integrity's MPI-MC SFTP site. Contact the Agency's MPI Business Manager (MPI Site Administrator) for access information via MPI-MCU@ahca.myflorida.com or 850-412-4600.

- The Managed Care Plan's Annual Fraud and Abuse Activity Report saved in XLS format, and submitted as an electronic file. The Managed Care Plan must use the file naming convention described in Chapter 2.
- A report attestation described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must complete the Annual Fraud and Abuse Activity Report using the report template provided on the Agency website (see the "Report Template" section of this chapter).
2. The Managed Care Plan must submit a blank report template even if no fraud and abuse activities are recorded. This type of submittal must also include a completed attestation.
3. Refer to the current Annual Fraud and Abuse Activity Report template for additional general instructions as well as specific instructions.

Requests for access to the MPI-MC SFTP site must be made through the Plan Contract Manager to the Agency's MPI-MC Site Administrator at MPI-MCU@ahca.myflorida.com. The Managed Care Plan user must implement Agency-approved FTP client software, such as FileZilla, or utilize the web-transfer client protocol provided by AHCA. Security credentials (a single user ID and password) will be provided via encrypted email once the new user's registration is approved. Use the appropriate host name for the MPI-MC SFTP site: sftp.ahca.myflorida.com, port 2232.

Below is information regarding the MPI-MC SFTP site location:

Site Name:	MPI-MC
Host:	sftp.ahca.myflorida.com
Port:	2232
Site Management URL:	https://sftp.ahca.myflorida.com:4432/manageaccount

When access is granted to new users, login credentials will be sent via secure email from MPI-MC SFTP Admin <FTP@ahca.myflorida.com>. If you already have an account, but do not know your username or password, you may retrieve them by accessing the Site Management page (<https://sftp.ahca.myflorida.com:4432/manageaccount>). If you are unable to retrieve your username or password, please contact MPI-MCU@ahca.myflorida.com or call 850-412-4600. It is recommended that you test your account access several days prior to the report due date.

Access for up to three plan staff may be granted to the MPI-MC SFTP account. Requests to add or delete access to your account must be submitted to MPI Business Manager at MPI-MCU@ahca.myflorida.com. The request must come from the Managed Care Plan's contract manager via email and contain the last name, first name, phone number and business email of the user(s). Any account that is not used for a period of 90 days will automatically be disabled due to inactivity.

To prevent spam filtering, users must add MPI-MCU@ahca.myflorida.com to their safe senders list. This address is also used to send expired password notification to users.

The Plan Contract Manager is responsible for plan user security and must maintain the user security access for plan staff. The MPI-MC SFTP site is limited to submitting and retrieving electronic file information within the managed care plan-specific folder. The managed care plan password is reissued by email only to the approved registered user (account holder), and will expire every 90 days in accordance with the Agency's security protocol. Password reset reminders and instructions will be sent to the registered user (account holder) seven days prior to expiration, and upon expiration. The Managed Care Plan must successfully submit a test file within 10 calendar days after the password is issued and as requested by the Agency.

The registered user (account holder) will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The account holder will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be automatically cleared by the system. Users can have the block cleared immediately by contacting the MPI-MC Site Administrator (MPI Business Manager) at 850-412-4600.

Entering the incorrect username (i.e., a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in 60 seconds. This form of lockout must be cleared by AHCA's network staff. The external user must contact the MPI-MC Site Administrator (MPI Business Manager) for MPI reporting at MPI-MCU@ahca.myflorida.com or 850-412-4600 to resolve this issue.

Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Plan Contract Manager and must include the user's full name, position title, and business email address. The Plan Contract Manager must submit the request by email to MPI-MCU@ahca.myflorida.com.

The Managed Care Plan must submit the Annual Fraud and Abuse Activity Report via the MPI-MC SFTP site to the plan-specific file folder, using the same format as the XLS template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 9: Appointment Wait Times Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with confirmation of the Managed Care Plan's examination and regular review of a statistically valid sample of PCP, specialist, behavioral health, and dental offices' average appointment wait times to ensure these provider offices are held accountable to contractually obligated standards for enrollees receiving MMA and dental benefits. (MMA - See Contract Attachment B, Exhibit B-1, Section VIII, Provider Network; Dental - See Contract Attachment B, Section VIII, Provider Services).

FREQUENCY & DUE DATES:

This report is due quarterly, within fifteen (15) calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the Managed Care Plan must submit the following to the applicable SFTP site:

- The completed report using the Agency-supplied template, which must be submitted as an XLSX file and named using the file naming convention as described in Chapter 2 of this guide.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. MMA:

- a) The Managed Care Plan must submit the completed report using the Agency's supplied template (see the "Report Template" section of this chapter). The Managed Care Plan must refer to Attachment B, Section VIII, Provider Network, of the Managed Care Plan Contract for pertinent wait time definitions.
 - i. On the Cover Sheet of the report template, the Managed Care Plan must:
 - 1) Indicate which quarter is being reported; and
 - 2) Submit the methodology used to determine a "statistically valid" sample.
- b) On the Urgent Appointments Sheet of the report template, the Managed Care Plan must:
 - i. Indicate the Individual NPI, Name and Location of the provider.
 - ii. Indicate the value (number) for the actual wait time reported in the quarter, for the medical or behavioral provider, with and without a required prior authorization. Simply inputting contract standard wait times is not acceptable.
- c) On the Non-Urgent Appointments Sheet of the report template, the Managed Care

Plan must:

- i. Indicate the Individual NPI, Name and Location of the provider.
- ii. Indicate the value (number) for the actual wait time being reported in the quarter, for the behavioral health, ancillary, PCP, and specialty provider. Simply inputting contract standard wait times is not acceptable.

2. Dental:

a) The Dental Plan (DP) must submit the completed report using the Agency's supplied template (see the "Report Template" section of this chapter). The Dental Plan must refer to Attachment B, Section VIII of the Dental Plan Contract for pertinent wait time definitions.

- i. On the Cover Sheet of the report template, the DP must:
 - 1) Indicate which quarter is being reported; and
 - 2) Submit the methodology used to determine a "statistically valid" sample.

b) On the PDP Wait Times Sheet of the report template, the DP must:

- i. Indicate the value (number) for the actual wait time being reported in the quarter, for dental services. Simply inputting contract standard wait times is not acceptable.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations

REPORT TEMPLATE:

The Agency's template consists of the following:

- A MMA Cover Sheet
- A MMA Urgent Appointments Template
- A MMA Non-Urgent Appointments Template
- A Dental Cover Sheet
- A Dental Template

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 10: Case Management File Audit Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to ensure that the Managed Care Plan has an internal monitoring system in place for its case management program, and that enrollees receiving LTC services are receiving quality care.

FREQUENCY & DUE DATES:

This report is due quarterly, within thirty (30) calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Case Management File Audit Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Case Management File Audit Report in the format and layout specified in the report template. Please see the Case Management File Audit Report Operational Guidelines for additional guidance on how to review the files.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Case Management File Audit Report Operational Guidelines can be found on the SMMC webpage for Agency-Approved Contract Materials http://ahca.myflorida.com/Medicaid/statewide_mc/plans_FY18-23.shtml. There are no additional report template instructions unique to this report chapter.

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Chapter 11: Case Manager and Provider Training Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to gather data on performance measures for the Centers for Medicare and Medicaid Services on the following: the most recent date direct hire and contracted Long-term Care case managers received abuse, neglect, and exploitation training and Alzheimer's disease and dementia training; and whether Direct Service Providers that are mandated to report abuse, neglect, and exploitation have received appropriate training.

FREQUENCY & DUE DATES:

This report is due annually on June 1st for the prior twelve-month period.

SUBMISSION:

The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- For the Case Manager and Provider Training Report:
 - The completed Case Manager and Provider Training Report template submitted as an Excel file and named: *****CMTraining_mmddyyyy**, where ******* is the Managed Care Plan's three-character identifier from the Plan Identifier Table (see Chapter 2), and "mmddyyyy" represents the two-digit month, two-digit day, and four-digit year of the report due date. For example, ABC Managed Care Plan's submission in 2017 for June 1, 2016 through May 31, 2017 would be named "ABCCMTraining_06012017".
 - A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Case Manager and Provider Training Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 12: Case Manager Caseload Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to ensure that enrollees receiving LTC services are receiving quality case management services, by monitoring the caseload requirements.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Case Manager Caseload Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Case Manager Caseload Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 13: Claims Aging Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with assurance that claims are processed timely and payment systems comply with the federal and State requirements, whichever is more stringent.

FREQUENCY & DUE DATES:

This report is due monthly, within thirty (30) calendar days after the end of each month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- For the monthly submissions:
 - a. The completed Claims Aging Report template, which must be submitted as an XLSX file and named using the file naming convention as described in Chapter 2.
 - b. A report attestation described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must complete the monthly Claims Aging Report(s) using the report template provided on the Agency website (see the "Report Template" section of this chapter).
2. The Managed Care Plans with nursing facility claims must complete the Denied or Suspended Nursing Facility Claims Report tab of the Claims Aging Report template.
3. Dental Plans (DPs) must complete the Dental Services Claims Report tab of the Claims Aging Report template.
4. Claims data must be Medicaid only.
5. Claims data reported is for clean claims adjudicated during the reporting period (see template).

VARIATIONS BY MANAGED CARE PLAN TYPE:

None.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 14: Critical Incident Report- Individual

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to monitor Long-term Care Plans' critical incident reporting and management system for critical incidents that negatively impact the health, safety or welfare of Long-term Care enrollees. This includes critical incidents in all service delivery settings applicable to enrollees.

FREQUENCY & DUE DATES:

This report is due immediately upon occurrence and **no later than twenty-four (24) hours** after detection or notification.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following via secure, encrypted email to the Agency's Managed Care Plan Contract manager:

- Critical Incident Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Long-term Care Plan must report the following to the Agency in accordance with the format set forth in the Critical Incident Report template:

- Plan Name
- Plan Medicaid ID (nine digits)
- Today's Date (Date the plan is reporting to the Agency) (MM/DD/YYYY)
- AHCA Area/Region (from drop down list)
- Enrollee's County of Residence
- Enrollee's Medicaid ID (ten digits)
- Enrollee's full name (first, last)
- Date of incident (MM/DD/YYYY)
- Facility (Yes/No)
- Name of facility or Unit (if applicable)
- Facility Type (choose from drop down: Adult Daycare, Adult Family Care Home, Doctor's Office, Home Health or Other type of provider)
- Address of incident
- ICD-10 Code for Diagnosis
- Incident Type (select from drop down list)
- Details of Incident

- Follow-up Planned
- Assigned Provider
- Staff Involved
- Witnesses
- Date Reported to Plan
- Report Submitted By
- Risk Manager Name
- Date Resolved (MM/DD/YYYY)

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 15: Denial, Reduction, Termination or Suspension of Services Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to monitor for trends in the amount and frequency that the Managed Care Plan denies, reduces, terminates or suspends services, including both home and community-based and nursing facility services, for enrollees receiving LTC services.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Denial, Reduction, Termination or Suspension of Services Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Denial, Reduction, Termination or Suspension of Services Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 16: Denied/Suspended/Terminated Provider Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency's Office of Medicaid Program Integrity (MPI), with a quarterly report from the Managed Care Plan regarding the Managed Care Plan's determinations to deny, suspend, and terminate providers from participation in the Managed Care Plan's network. 42 CFR 438.608(a)(4) requires the Managed Care Plan to report information regarding a network provider's circumstances that may affect the provider's eligibility to participate in the Managed Care Program. This requirement includes information regarding the Managed Care Plan's determinations to deny a provider from participating, or to suspend or terminate a provider from continued participation in the Managed Care Plan's network. Notwithstanding any other provision of law or contract, failure to comply with these reporting requirements will be subject to sanctions.

Note: This report does not replace the Managed Care Plan's requirement to report all suspected/confirmed fraud and abuse, within 15 calendar days of detection, to Medicaid Program Integrity in accordance with contractual requirements.

See also: Suspected/Confirmed Fraud and Abuse Report Guide chapter.

FREQUENCY & DUE DATES:

This report is due quarterly, within fifteen (15) calendar days after the end of the quarter being reported.

SUBMISSION:

To comply with the Denied/Suspended/Terminated Provider Report requirements, the Managed Care Plan must submit the following via the MPI SFTP site:

- The template provided with all required fields completed.
- The report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must perform the following:

1. In the template provided, on the tab "Denials" the Managed Care Plan must provide the following information relative to providers denied from network participation by the Managed Care Plan during the reporting quarter:
 - a. The appropriate Reporting Year;
 - b. The appropriate Reporting Quarter;

- c. The Managed Care Plan three-character identifier;
 - d. Provider's Name in its entirety;
 - e. Provider's Tax Identification Number (TIN);
 - f. Provider's NPI, if applicable;
 - g. Provider's Medicaid ID number, if applicable;
 - h. Provider Type from drop down;
 - i. The Date the provider is effectively denied from participating in the Managed Care Plan's network;
 - j. The primary Reason the Managed Care Plan denied the provider's participation;
 - k. Indication of whether or not the provider had been Previously Denied participation;
 - l. Additional details or Comments relevant to the Managed Care Plan's denial determination that are not captured elsewhere in the report.
2. In the template provided, on the tab "Participation Suspensions" the Managed Care Plan must provide the following information relative to providers suspended from network participation by the Managed Care Plan during the reporting quarter:
- a. The appropriate Reporting Year;
 - b. The appropriate Reporting Quarter;
 - c. The Managed Care Plan three-character identifier;
 - d. Provider's Name in its entirety;
 - e. Provider's TIN;
 - f. Provider's NPI, if applicable;
 - g. Provider's Medicaid ID number;
 - h. Provider Type from drop down;
 - i. The Effective Date of provider's suspension from participation in Managed Care Plan's network;
 - j. The End Date of the provider's suspension from participation in the Managed Care Plan's network;
 - k. The primary Reason the Managed Care Plan suspended the provider's network participation;
 - l. Additional details or Comments relevant to the Managed Care Plan's suspension determination that are not captured elsewhere in the report.
3. In the template provided, on the tab "Payment Suspensions Activities" the Managed Care Plan must provide the following information relative to providers suspended from network participation by the Managed Care Plan during the reporting quarter:
- a. The appropriate Reporting Year;
 - b. The appropriate Reporting Quarter;
 - c. The Managed Care Plan three-character identifier;
 - d. Provider's Name in its entirety;
 - e. Provider's TIN;
 - f. Provider's NPI, if applicable;
 - g. Provider's Medicaid ID number;
 - h. Provider Type from drop down;
 - i. The Effective Date of provider's payment suspension from participation in Managed Care Plan's network;
 - j. The End Date of the provider's payment suspension from participation in the Managed Care Plan's network;
 - k. The primary Reason the Managed Care Plan suspended the provider's payments from participation;

- I. Additional details or Comments relevant to the Managed Care Plan's payment suspension determination that are not captured elsewhere in the report.
4. In the template provided, on the tab "Terminations" the Managed Care Plan must provide the following information relative to providers terminated from network participation by the Managed Care Plan during the reporting quarter:
 - a. The appropriate Reporting Year;
 - b. The appropriate Reporting Quarter;
 - c. The Managed Care Plan three-character identifier;
 - d. Provider's Name in its entirety;
 - e. Provider's TIN;
 - f. Provider's NPI, if applicable;
 - g. Provider's Medicaid ID number;
 - h. Provider Type from drop down;
 - i. The Effective Date of provider's termination from participation in the Managed Care Plan's network;
 - j. The primary Reason the Managed Care Plan terminated the provider's network participation;
 - k. Additional details or Comments relevant to the Managed Care Plan's termination determination that are not captured elsewhere in the report.
5. The Managed Care Plan's Contract Manager must obtain access to the MPI SFTP site through the Agency's MPI Business Manager (or designated representative) to upload electronic file (supplemental) documentation (See Annual Fraud and Abuse Report chapter for access instructions).
6. The registered user (Managed Care Plan Contract Manager) will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary account holder (Plan Contract Manager) will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be automatically cleared by the system. Users can have the block cleared immediately by contacting their AHCA MPI-MC Site Administrator (MPI Business Manager) at 850-412-4600.
7. Entering the incorrect username (i.e. a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in sixty (60) seconds. The external user must contact the AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPI-MCU@ahca.myflorida.com or 850-412-4600 to resolve this issue.
8. Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Managed Care Plan Contract Manager and must include the user's full name, position title, and business email address. The Managed Care Plan must submit the request by email to MPI-MCU@ahca.myflorida.com.
9. Any additional supporting documentation to the Denied/Suspended/Terminated Provider Report must be HIPAA-compliant and may be submitted through the MPI SFTP site.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 17: Enhanced Care Coordination Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is for Managed Care Plans to report on enhanced care coordination for enrollees under the age of twenty-one (21) years receiving skilled nursing facility (NF) or private duty nursing (PDN) services.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteenth (15) days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Enhanced Care Coordination Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Enhanced Care Coordination Report in the format and layout specified in the report template. The report shall include information on all plan enrollees under the age of twenty-one (21) years, receiving NF or PDN services.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- A workbook with 3 tabs which include the following:
 - Instructions – explains how to complete the template.
 - Community Enrollees
 - Nursing Facility Enrollees

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

Chapter 18: Enrollee Complaints, Grievances and Appeals Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide a monthly record of all complaints, grievances, and appeals in accordance with the terms of the Contract.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Enrollee Complaints, Grievances, and Appeals Report using the template provided. The completed enrollee template including MMA, LTC, and Dental data, as applicable on the labeled tab for the appropriate month, must be submitted as an XLSX file and named using the file naming convention as described in Chapter 2 of this guide.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must file one Enrollee Complaints, Grievances, and Appeals Report for MMA, LTC, and Dental data using the template provided.
2. The Managed Care Plan must complete the Enrollee Complaints, Grievances and Appeals Report as specified on the instructions tab of the report template provided on the Agency website.
3. The Managed Care Plan must only use the permissible drop down options for any column that has a drop down menu.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- A workbook with 26 tabs which include the following:
 - Instructions – explains how to complete the template.

- Codes – provides report definitions and codes explaining the types of complaints, grievances, appeals, dispositions, and county code information.
- Jan-Dec G&A – Each month has a separate worksheet for reporting enrollee grievances and appeals received by the Managed Care Plan during the reported timeframe.
- Jan-Dec C – Each month has a separate worksheet for reporting enrollee complaints received by the Managed Care Plan during the reporting timeframe.

The Agency templates can be found using the directions in Chapter 1.

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Chapter 19: PLACEHOLDER for Enrollee Help Line Statistics Report

UNDER DEVELOPMENT

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Chapter 20: Enrollee Roster and Facility Residence Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide information on the current physical location of each enrollee receiving LTC services. The report may be used for disaster recovery planning and relief, and is also designed to track individuals who are transitioning between settings (e.g., nursing facility to community and vice versa).

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Enrollee Roster and Facility Residence Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

This report must include all enrollees currently enrolled in the Managed Care Plan.

The Managed Care Plan must submit the Enrollee Roster and Facility Residence Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 21: ER Visits for Enrollees without PCP/PDP Appointment Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency information regarding the number of emergency room visits by enrollees with MMA or Dental Plan benefits who have not had at least one appointment with their primary care provider (PCP) or primary dental provider (PDP) during the reporting year.

FREQUENCY & DUE DATES:

This report is due annually, by January 15th, for the prior calendar year.

SUBMISSION:

Using the file naming convention described in Chapter 2, the managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- ER Visits for Enrollees without PCP/PDP Appointment Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must use the ER Visits for Enrollees without PCP/PDP Appointment Report Template as provided below.
2. For the reporting year, the report must include but not be limited to:
 - Plan Name
 - Plan Medicaid ID (seven digit)
 - Reporting Year – Year for which data is being reported
 - Enrollee's Full Name (Last, First, Middle Initial)
 - Enrollee's Medicaid ID
 - Date of Service
 - Enrollee's County of Residence

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

**Chapter 22: Estimated Value of Enhanced Reimbursement (EVER)/Qualified Provider
MMA Physician Incentive Program (MPIP) Report**

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with information regarding the estimated value of the plan's MMA Physician Incentive Program (MPIP). The report is designed to capture estimates at the individual qualified provider level.

FREQUENCY & DUE DATES:

The first submission for the Estimated Value of Enhanced Reimbursement (EVER)/Qualified Provider Report will be due on the first day of the fourth month after the month in which the plan receives enrollment for its final region. Thereafter, the report is due annually, no later than April 1 of each year.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- EVER/Qualified Provider Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the EVER/Qualified Provider Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 23: Health Risk Assessment Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to monitor completion of health risk assessments within the specified timeframe of completion (within 60 days of enrollment).

FREQUENCY & DUE DATES:

This report is due quarterly, within fifteen (15) calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Health Risk Assessment Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Health Risk Assessment Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 24: Healthy Behaviors Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to monitor all Managed Care Plans' data related to their healthy behaviors programs, pursuant to s. 409.973(3), F.S., including caseloads for each healthy behavior program and the amount and types of rewards/incentives offered for each program. The population to be reported includes all enrollees receiving MMA or Dental Plan (DP) benefits.

FREQUENCY & DUE DATES:

This report is due quarterly, within fifteen (15) calendar days after the end of the quarter being reported.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Completed Healthy Behaviors Report template found in the Agency Report Guide.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Healthy Behaviors Report consists of three tabs: MMA HB Report Summary, DP HB Report Summary, and HB Report Details. In the summary tabs, the Managed Care Plan must report only newly enrolled individuals in Healthy Behaviors programs for each reporting quarter. In the summary tabs, quarterly reporting of enrollee participation in Healthy Behaviors programs must be unduplicated throughout the year; however, the HB Report Details tab must include a list of all enrollees and the programs in which the enrollees participated throughout the year.
2. The Managed Care Plan must supply all of the Healthy Behaviors information required in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

Chapter 25: Hernandez Settlement Agreement Survey

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with annual settlement agreement surveys related to Hernandez et.al. v. Medows (Case number 02-20964 Civ-Gold/Simonton), commonly referred to as the Hernandez Settlement Agreement (HSA), conducted by the Managed Care Plan on no less than 5% of all participating pharmacy locations in an effort to ensure compliance with the HSA, for enrollees receiving MMA benefits.

FREQUENCY & DUE DATES:

This report is due annually, on or before August 1, for the prior calendar year.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the Managed Care Plan must submit the following to the applicable SFTP site:

- The HSA survey template.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must conduct HSA surveys of no less than 5% of all participating pharmacy locations.
2. The Managed Care Plan must not include any participating pharmacy locations that the Managed Care Plan found to be in complete compliance with the HSA requirements within the previous twelve (12) months.
3. The Managed Care Plan must require all participating pharmacy locations that fail any part of the HSA survey to undergo mandatory training within six months and then be re-evaluated within one month of the Managed Care Plan's HSA training to ensure compliance.
4. The Managed Care Plan must ensure that it complies with all requirements set forth in Policy Transmittal 06-01, Hernandez Settlement Requirements, which is located on the Agency web page together with the HSA survey template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 26: Hernandez Settlement Ombudsman Log

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with details regarding any enrollee issues related directly to the settlement agreement Hernandez et.al. v. Medows (Case number 02-20964 Civ-Gold/Simonton), commonly referred to as the Hernandez Settlement Agreement (HSA), for enrollees receiving MMA benefits.

FREQUENCY & DUE DATES:

This report is due quarterly, fifteen (15) calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the Managed Care Plan must submit the following to the applicable SFTP site:

- The Agency supplied HSA template.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must maintain a log of all correspondence and communications from enrollees relating to the HSA Ombudsman process using the provided Agency template.
2. For each line in the report, use "1" to indicate a Comprehensive LTC Plan issue and use "2" to indicate an MMA Plan issue.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations

REPORT TEMPLATE:

1. The template has five (5) spreadsheets — one (1) plan information sheet, and four (4) quarterly spreadsheets

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 27: Institution for Mental Diseases (IMD) Reimbursement Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with the total number of inpatient days per calendar month in care in an Institution for Mental Diseases (IMD) for enrollees between the ages of 21 through 64 years of age.

FREQUENCY & DUE DATES:

This report is due semi-annually. The report for the period January 1 through June 30 is due on the 15th of the second month (August 15) following the end of the reporting period. The report for the period July 1 through December 31, with restated data for January 1 through June 30, is due to the agency 90 days after the end of the reporting period (March 31).

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- IMD Reimbursement Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the IMD Reimbursement Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 28: Inter-rater Reliability Report (IRR)

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with information regarding the health plan's quality assurance and quality improvement program. The health plan shall conduct inter-rater reliability audits of at least 1% of service authorization decisions per reviewer (nurses, therapists, physicians, etc.). Each reviewer must maintain an 85% accuracy rate.

FREQUENCY & DUE DATES:

This report is due quarterly, thirty (30) days after the end of each quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must use the Inter-Rater Reliability Report Template as provided below.

2. For the reporting quarter, the report must include:

- Plan Name
- Plan Medicaid ID (seven digit)
- Date Report Submitted (MM/DD/YYYY)
- Reporting Year and Quarter (YY/Q#)
- Report Submitted by:
- Reviewer Name (First, Last)
- Reviewer Profession (e.g., nurse, therapist, physician, etc.)
- Service Types Reviewed

- Total Authorization Decisions Made within the Reporting Quarter
- Sample Size Audited
- Percentage of Decisions Audited
- Reviewer Accuracy Rate

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 29: Marketing Agent Status Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to demonstrate compliance with the applicable state licensure and/or appointment laws by ensuring Managed Care Plans register and maintain the status of their marketing agents.

FREQUENCY & DUE DATES:

This report is due quarterly, within forty-five (45) calendar days after the end of the reporting quarter. A variable report is required within fifteen (15) days after a new marketing agent's appointment to the Plan, when there are any changes to the information provided at the time the Managed Care Plan registered the marketing agent with the Agency, or when an agent's appointment with the Managed Care Plan is terminated.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the Managed Care Plan must submit the following to the applicable SFTP site:

- The completed marketing agent status template, which must be submitted as an XLSX file and named using the file naming convention as described in Chapter 2 of this guide.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must complete the quarterly Marketing Agent Status Report as specified on the instructions tab of the report template using the appropriate report template provided on the Agency website.
2. The Managed Care Plan is required quarterly to submit status information for all marketing agents employed by the Plan.
3. The Managed Care Plan must only use the permissible drop down options for any column that has a drop down menu.
4. After a marketing agent has been reported to the Agency as being terminated, then they are to be omitted from the next quarterly report.
5. The Managed Care Plan must submit a blank report template even if no marketing agents are employed. This type of submittal must also include an attestation.

6. A variable Marketing Agent Status Report is due within fifteen (15) days after a new marketing agent's appointment to the Plan, or when there are any changes to the information provided at the time the Managed Care Plan registered the marketing agent with the Agency (i.e., last name change, renewal of license), or when an agent's appointment with the Managed Care Plan is terminated.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- A workbook with two (2) worksheet tabs which include the following:
 1. Instructions – explains how to complete the template.
 2. Marketing Agent Status – contains marketing agent information.

The Agency templates can be found using the directions in Chapter 1.

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Chapter 30: Marketing/Public/Educational Events Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide written notice to the Agency of the Managed Care Plan's intent to attend marketing, public, and educational events.

FREQUENCY & DUE DATES:

This report is due monthly, no later than the fifteenth (15th) calendar day of the month prior to the event month. Variations to the report originally submitted are due in advance of the scheduled event. If an event is cancelled or the Managed Care Plan decides not to attend less than forty-eight (48) hours prior to the event, the Managed Care Plan shall immediately (upon notification) submit such changes to the Agency. Any changes to events originally submitted shall be submitted through a variable Marketing/Public/Educational Events Report.

SUBMISSION:

Using the file naming convention as described in Chapter 2 of this guide, the Managed Care Plan must submit the following to the applicable SFTP site:

- A Marketing/Public/Educational Events Report using the Agency-supplied template. **The month used in the naming convention will represent the month the event will occur.**
- A variable Marketing/Public/Educational Events Report is to be submitted when there is any change to an original reported submittal of a marketing, public, or educational event. The variable event report needs to clearly indicate the change that is being made regarding the event and only contain those events impacted by the change. A comment indicating the reason for the change must be provided for each variable Marketing/Public/Educational Events Report entry. **The month used in the naming convention will be the same month the event was originally scheduled to occur.**
- A report attestation as described in Chapter 2. The month used in the naming convention will represent the month the event will occur.
- Supplemental documentation for all events reported, including variable Marketing/Public/Educational Events Reports, is also required. Confirmation shall be submitted via any of the following:
 - ✓ Event notices/flyers;
 - ✓ Invitation letters/emails;
 - ✓ Approval notices from any entity whose space is being utilized; and/or
 - ✓ Written approval from an affected state agency.

Supplemental documentation for all events must contain, at a minimum:

- Date(s) the event is scheduled to occur
- Full address of the event (including city, state, ZIP code, and suite or unit number, if applicable)
- Event's scheduled start and end time

For variable event reports, the supplemental documentation submitted must clearly indicate the change that is being made from the original event submittal (i.e., change in event time or notice of event cancellation).

Supplemental documentation is not required in the event of a change in marketing agent, inclement weather, or if the plan decides not to attend.

Supplemental documentation must be submitted in a .zip file using the file naming convention of the marketing/public/educational events report. This .zip file may not be password protected. The month used in the naming convention will represent the month the event will occur.

INSTRUCTIONS:

1. The Managed Care Plan must complete the Marketing/Public/Educational Events Report as specified on the instructions tab of the reporting template using the appropriate report template provided on the Agency website.
2. A variable Marketing/Public/Educational Events Report submittal is required when there is any change to an original submittal of a marketing, public, or educational event, including instances where the event is not cancelled but the plan decides not to attend. The variable event report needs to clearly indicate the new action taken and only contain those events where a change or difference has occurred from the original Marketing/Public/Educational Events Report. A comment indicating the reason for the change must be provided for each variable Marketing/Public/Educational Events Report entry.

Note: A variable event report cannot be used to submit a new event to the Agency.

3. The Managed Care Plan must only use the permissible drop down options for any column that has a drop down menu.
4. The Managed Care Plan must submit a blank report template if there are no planned events to report for the month. This type of submittal must also include an attestation.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- ❖ A workbook with two (2) worksheet tabs that include the following:
 - Instructions - explains how to complete the template.
 - Monthly Events Report – contains marketing, public and educational event information.

The Agency templates can be found using the directions in Chapter 1.

Chapter 31: Medical Foster Care Services Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with information regarding enrollees under the age of twenty-one (21) years, who are receiving Medical Foster Care services.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Medical Foster Care Services Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Medical Foster Care Services Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 32: PLACEHOLDER for Member Satisfaction Improvement Report

UNDER DEVELOPMENT

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Chapter 33: Missed Services Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to monitor all missed facility and non-facility services covered by the Managed Care Plan for enrollees receiving LTC services for the previous month in accordance with the Long-term Care Contract/Exhibit.

FREQUENCY & DUE DATES:

This report is due monthly, within thirty (30) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Missed Services Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Missed Services Report in the format and layout specified in the report template.

For months without missed services, the Managed Care Plan shall submit a report explaining that no authorized covered services were missed during the reported month.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 34: Non-Emergency Transportation Missed Trips Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to monitor all non-emergency transportation trips, in accordance with the Statewide Managed Care Plan Contract, that were missed (the enrollee was not picked up) during the reporting month.

FREQUENCY & DUE DATES:

This report is due monthly, within thirty (30) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Non-Emergency Transportation Missed Trips Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must submit the Non-Emergency Transportation Missed Trip Report for all enrollees for whom the Managed Care Plan was aware had a non-emergency transportation service scheduled with the Managed Care Plan and the trip was missed. For purposes of this report, missed trip includes the following:
 - a. When a trip to an SMMC Contract-covered service or benefit, or other Medicaid service, is missed (Leg A), or
 - b. When a trip from an SMMC Contract-covered service or benefit, or other Medicaid service, was missed (Leg B), or
 - c. When the entire trip was missed (both Leg A and Leg B).

Note: The Managed Care Plan must include in this report all non-emergency transportation complaints received from the Agency during the reporting month for missed trips that occurred during the reporting month.

2. This report also includes non-emergency transportation missed trips when the transportation was requested outside of the Managed Care Plan's stated advance notification policy if:

- a. Transport to a Contract-covered service or benefit, or other Medicaid service, was required to timely access such services in accordance with the access requirements in the SMMC Contract, or
 - b. The unscheduled non-emergency transportation trip was authorized by the Managed Care Plan (e.g., hospital discharge request, urgent care trip, etc.).
3. The Managed Care Plan must complete the Non-Emergency Transportation Missed Trips Report as specified on the instructions tab of, and in the format and layout of, the report template provided on the Agency website.
4. Each monthly submission must include all data fields on the report template for the non-emergency missed trips known to the Managed Care Plan during the reporting month, including the reason for each missed trip, unless the report template indicates the field may be left blank.
5. For months without any non-emergency transportation missed trips known to the Managed Care Plan, the Managed Care Plan shall submit only the attestation specifying that there were no non-emergency transportation missed trips that occurred during the reporting month that were known by the Managed Care Plan during the reported month.

If later a missed trip was made known to the Managed Care Plan that did not get reported in a previous Non-Emergency Transportation Missed Trips Report, the Managed Care Plan shall submit this trip in the Non-Emergency Transportation Missed Trips Report for the reporting period month in which the missed trip was made known to the Managed Care Plan. The Managed Care Plan shall explain this in the Comments column of the report.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency template can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 35: PLACEHOLDER for Non-Emergency Transportation Timeliness Report

UNDER DEVELOPMENT

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Chapter 36: Non-Special Needs Plan (Non-SNP) Financial Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with unaudited annual Non-Special Needs Plan (Non-SNP) Financial Report that details plan financial operations and performance for the applicable reporting period.

FREQUENCY & DUE DATES:

Unaudited annual Non-SNP Financial Report is due to the Agency by May 1 following the end of the reporting calendar year, allowing for ninety (90) calendar days of claims runout. The following shall be submitted as part of the unaudited annual Non-SNP Financial Report:

- One copy of the annual Non-SNP Financial Report;
- Certification by the CEO or CFO, as discussed in Chapter 2, General Reporting Requirements, using the naming convention as described in Chapter 2.

SUBMISSION:

The managed care plan must submit the required documentation via email to MDA_ACTUARIAL@ahca.myflorida.com:

- For the unaudited annual submissions:
 - a. The completed and accurate Non-SNP Financial Report template, which must be submitted as an Excel file and named ***NonSNPYYYY.xlsx, where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported.
 - b. The jurat page (included in the financial report template), which must be submitted as a PDF file and named ***NonSNPYYYY-jurat.pdf, where *** is the Managed Care Plan's three-character identifier, and YYYY are the four digits of the calendar year being reported. This jurat page must be signed only by the Managed Care Plan's CEO. **Delegate signatures will not be accepted.**

INSTRUCTIONS:

1. The Managed Care Plan must complete the financial reporting submission requirements using the Excel file template provided at the Agency's website, as specified in the Report Template section of this chapter, to report the following sets of financial data as applicable to each Managed Care Plan:

Annual Non-SNP Financial Report:

- Non-SNP Revenue & Expense Schedule (Summary and Regional);
 - Refer to the current Non-SNP Financial Report template for additional general instructions as well as schedule-specific instructions.
2. It is the responsibility of the Managed Care Plan to use the most current financial statement report template, as specified by the Agency.
 3. The Managed Care Plan must complete the Revenue & Expense schedules for each region in which the Managed Care Plan has a contract.
 4. The Managed Care Plan must use generally accepted accounting principles (GAAP) in preparing the Non-SNP Financial Report.
 5. The Managed Care Plan must submit financial statements that are specific to the operations of the Managed Care Plan rather than to a parent or umbrella organization.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 37: Participant Direction Option (PDO) Roster Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide information about the total number of participants enrolled in and total number of participants who have discontinued participation from the Participant Direction Option (PDO), for enrollees receiving LTC services. The report includes the PDO services provided to each participant, the PDO services that were discontinued during the report month and the reasons for discontinuing participation.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- Participant Direction Option (PDO) Roster Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must create the Participant Direction Option (PDO) Roster Report in the format and layout specified in the report template.
2. For the reporting month, the report must include a list of all PDO participants.
3. The report will also include any participants who were disenrolled from the PDO for the month being reported and the reasons for discontinuing participation.

Note: If a participant does not have any direct service workers receiving a paycheck for more than thirty (30) calendar days, the participant must be reported as disenrolled from PDO.

4. The report will include the PDO services that each PDO participant is currently receiving and the PDO services that the disenrolled participant was receiving up until disenrollment.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 39: PCP/PDP Appointment Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency information regarding the number of enrollees with MMA benefits who have not had an appointment with their primary care provider (PCP) or primary dental provider (PDP) within their first year of enrollment.

FREQUENCY & DUE DATES:

This report is due annually, by January 15th, for the prior calendar year.

SUBMISSION:

Using the file naming convention described in Chapter 2, The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- PCP/PDP Appointment Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

This report shall include enrollees who have been enrolled with the plan for twelve (12) consecutive months without a PCP or PDP appointment, including those whose twelve (12) consecutive month enrollment period began prior to the reporting year and ended in the reporting year.

1. The Managed Care Plan must use the PCP/PDP Appointment Report Template as provided below.

2. For the reporting year, the report must include but not be limited to:

- Plan Name
- Plan Medicaid ID (seven digit)
- Reporting Year – Year for which data is being reported
- Enrollee's Full Name (Last, First, Middle Initial)
- Enrollee's Medicaid ID
- Enrollee's County of Residence
- Enrollee's Date of Enrollment

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 40: Performance Measures Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to measure the Managed Care Plan's performance on specific Healthcare Effectiveness Data and Information Set (HEDIS), Agency-defined, and other indicators. This information is used to monitor and publicly report plan performance.

FREQUENCY & DUE DATES:

This report is due annually by July 1, for the prior calendar year.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall collect and report the following items that have been certified by a qualified auditor, to the applicable SFTP site:

- The Performance Measures Report.
- Final Audit Report (FAR) documents with attachments, if any, as a Word document or PDF file prepared by the NCQA Licensed Organization for Medicaid audits conducted. At a minimum, the report must include the final audit statement, the auditor's methods in conducting the audit, and information systems standard compliance findings.
- A report attestation as described in Chapter 2.
- The Interactive Data Submission System (IDSS) file (for Managed Care Plans generating an IDSS file as part of their HEDIS process) with the Performance Measures Report as both an Excel and Comma Separated Values (.csv) file.
- A HEDIS Record of Administration, Data Management, and Processes (Roadmap) that was completed as part of the HEDIS Compliance Audit process.

INSTRUCTIONS:

See the "Variations By Managed Care Plan Type" section below.

VARIATIONS BY MANAGED CARE PLAN TYPE:

MMA Plans: The MMA Managed Care Plan must create and report its required MMA Performance Measures according to the instructions for MMA Performance Measures and the MMA Performance Measures Specifications Manual.

Comprehensive LTC Plans and LTC Plus Plans: The Comprehensive LTC Plans and the LTC Plus Plans must create and report required LTC & MMA Performance Measures according to the

instructions for LTC & MMA Performance Measures and the LTC and MMA Performance Measures Specifications Manuals.

Dental Plans: The Dental Plan must create and report its required Dental Performance Measures according to the instructions for Dental Performance Measures and the Dental Performance Measures Specifications Manual.

REPORT TEMPLATE:

The MMA, LTC, and Dental Performance Measures Specifications Manuals can be found in the Report Guide web pages by following the instructions in Chapter 1 of this document. **Note: As of the publication date of this Report Guide, the performance measure specifications manuals have not been updated. The manuals will be revised once the annual HEDIS specifications become available and the Managed Care Plans will be notified.**

The Agency templates can be found using the directions in Chapter 1. **Note: As of the publication date of this Report Guide, the performance measures report template has not been updated. The template will be revised once the annual HEDIS specifications become available and the Managed Care Plans will be notified.**

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Chapter 41: Preadmission Screening and Resident Review (PASRR) Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is for Managed Care Plans to report PASRR completion date(s) (Level I PASRR screen, and if applicable, the Level II PASRR determination, and Resident Review) for enrollees entering or residing in a Medicaid-certified nursing facility (NF) during the reporting quarter. Once the Managed Care Plan has reported the date of the enrollee's Level I PASRR screen and the Level II PASRR determination, if applicable, the enrollee's PASRR information is not required on subsequent quarterly reports unless a Resident Review occurs, or the enrollee is discharged to a community setting and seeks admission to a NF at a later date.

FREQUENCY & DUE DATES:

This report is due quarterly, within 15 calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- PASRR Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the PASRR Report in the format and layout specified in the report template. If no date is available, use zeros. For example, 00/00/0000.

Template fields are as follows:

Managed Care Plan Information

Enter the following Managed Care Plan information:

- Managed Care Plan name
- Seven-digit Managed Care Plan identification number
- Managed Care Plan contact's name
- Managed Care Plan contact's email address
- Ending date of the reporting quarter (MM/DD/YYYY)
- Date of the report submission (MM/DD/YYYY)

Enter the following enrollee information:

- Enrollee Name (Last, First)
- Enrollee date of birth – (MM/DD/YYYY)
- Enrollee age in years

- Enrollee Medicaid ID (ten digits)
- Date of the enrollee's initial admission to the NF – (MM/DD/YYYY)
- Date of the enrollee's Level I PASRR screen – (MM/DD/YYYY)

Type of Admission:

- Click in the drop down menu to select the type of admission. Choose only one:
 1. Provisional admission
 2. Hospital discharge exemption
 3. Neither a provisional admission nor hospital discharge exemption
 4. Respite

PASRR Process Validation:

- Serious mental illness, intellectual disability or related conditions, or both, indicated on the completed Level I PASRR screen? – Enter: Yes/No (Y/N)
- Enter the date of the completed Level II PASRR determination, as applicable – (MM/DD/YYYY). Use “not applicable” (N/A) if no Level II PASRR is necessary
- Enter the date of the completed Resident Review, as applicable – (MM/DD/YYYY)
- For enrollees who receive a Level II PASRR evaluation and determination, use the drop down box to delineate if specialized services or specialized rehabilitative services are being provided. If none, leave blank.
- For enrollees who receive recommended specialized services or specialized rehabilitative services, note if the services are on the enrollee's NF care plan. – Enter Y/N or N/A
- Enter the NF license number

Comments:

- The Managed Care Plan may enter comments pertaining to the enrollee. If 00/00/0000 is used in date columns, a comment is required as to why no date was entered.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 42: Provider Complaint /Appeal Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to assist the Agency (or its designee) in monitoring the Managed Care Plan's provider complaint system. The Managed Care Plan shall establish and maintain a provider complaint system that permits a provider to dispute the Managed Care Plan's policies, procedures, or any aspect of a Managed Care Plan's administrative functions, including proposed actions, claims, billing disputes, and service authorizations. This report will detail the nature of the complaint or appeal, timeline of the complaint/appeal, as well as the resolution.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- The completed Provider Complaint/Appeal Report template, which must be submitted as an XLSX file.
- A report attestation, as described in Chapter 2 for the completed Provider Complaint/Appeal Report template.

INSTRUCTIONS:

1. The Managed Care Plan must complete the Provider Complaint/Appeal Report as specified on the instructions tab of the report template using the appropriate template provided on the Agency website.
2. The Managed Care Plan must only use the permissible drop down options for any column that has a drop down menu.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- A workbook with thirteen (13) tabs which includes the following:
- Instructions – explains how to complete the template, including reasons for the nature of the complaint/appeal, and complaint/appeal disposition.

- January-December – Each month has a separate worksheet for reporting provider complaints/appeals received by the Managed Care Plan during the reported timeframe.

The Agency templates can be found using the directions in Chapter 1.

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Chapter 43: Provider Network and Qualifications Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to gather data on the qualifications of providers for the Centers for Medicare and Medicaid Services waiver performance measures.

FREQUENCY & DUE DATES:

This report is due quarterly, within fifteen (15) calendar days after the end of the reporting quarter.

SUBMISSION:

The managed care plan must submit the required documentation to the applicable SFTP site, as specified in Chapter 2:

- For the Provider Network and Qualifications Report:
 - The completed Provider Network and Qualifications Report template submitted as an Excel file and named: ***PNVQualificationsReport_mmddyyyy, where *** is the Managed Care Plan's three-character identifier from the Plan Identifier Table (see Chapter 2), and "mmddyyyy" represents the two-digit month, two-digit day, and four-digit year of the report due date. For example, ABC Managed Care Plan's submission due July 1, 2017 would be named "ABCPNVQualificationsReport_07012017".
 - A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must create the Provider Network and Qualifications Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 44: Provider Network File

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency (or its designee) with up-to-date provider network information.

FREQUENCY & DUE DATES:

This report (a full file refresh) is due weekly on Thursday by 5:00 p.m. EST.

SUBMISSION:

1. The Managed Care Plan must submit the following files with the specified file naming conventions to the Agency's choice counseling vendor's SFTP site server.
 - Provider/Group/Hospital (PG)
 - Service Location (SL)
 - End of Transmission (EN)

Position	Format	Description
1-2	@ (2)	PG = Provider / Group File
		SL = Service Location File
		EN = End of Transmission File
3-5	@ (3)	The three letter code for the Managed Care Plan submitting the file.
6-13	D (8)	The date of the file submission in YYYYMMDD format.
14-23	@ (9)	Files submitted by plans must have a .dat extension. Files created by AHS in response to submissions will have a .response extension.

Choice counseling vendor SFTP site:

URL: fftp.automated-health.com

Connection Type: SFTP (SSH connection – a pop up will ask you to trust a key certificate – once you trust the certificate, the connection will be established)

IP address: 206.17.164.205 (only if required for firewall rules, everyone must use the URL)

Port: 22

2. All Managed Care Plans must submit the following to the Agency via the applicable SFTP site:
 - A signed attestation specifically addressing the accuracy and completeness of the Provider Network File submission, as well as the online provider database/directory

matching the most recent provider network file submitted to the Agency, as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must create the Provider Network Files in the format and layout described in the Provider Network Verification File Specification document located at: www.flmedicaidmanagedcare.com/pnv, log in and download the latest file specification.
2. The Managed Care Plan must ensure that this is an electronic representation of the plan's network of contracted providers, not a listing of entities for whom claims have been paid.
3. Plans needing technical assistance for submitting Provider Network Files to, or retrieving Provider Network Response Files from, the **Choice Counseling vendor's** SFTP directory must contact the following helpdesk for assistance: AHSFL-Helpdesk@automated-health.com. For more immediate concerns regarding the submission of provider network files, plans may contact 412-367-3030 ext. 2900.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

Notwithstanding the instructions in Chapter 1, the Agency-supplied template must be used as specified in the Provider Network Verification File Specification document. No alterations or duplication must be made to the report template by the Managed Care Plan. The Agency-supplied Provider Network Verification File Specification provides detailed and specific information regarding the Provider Network File and the Provider Network Response File, and can be found on the Agency's choice counselor Web page at www.flmedicaidmanagedcare.com.

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Chapter 45: Quarterly Fraud and Abuse Activity Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency's Office of Medicaid Program Integrity (MPI), with a quarterly ongoing comprehensive fraud and abuse prevention activity report from the Managed Care Plan regarding their investigative, preventive, and detective activity efforts. This report allows the Managed Care Plan to demonstrate its due diligence for fraud and abuse compliance, including utilization control; to safeguard against unnecessary or inappropriate use of Medicaid services, excess payments, and underutilization; assess quality, and take necessary corrective action to ensure program effectiveness. This report is implemented as an adjunct tool in statewide surveillance for managed care fraud and abuse. This report is a supplemental comprehensive summary regarding the quarterly status, progression, and outcome of the Managed Care Plan's previously reported referrals (via online) of suspected/confirmed fraud and abuse. (See Report Guide chapter: Suspected/Confirmed Fraud and Abuse Reporting).

Note: This summary report does not replace the Managed Care Plan's requirement to report all suspected/confirmed fraud and abuse, within 15 calendar days of detection, to Medicaid Program Integrity in accordance with contractual and statutory requirements.

See also: Suspected/Confirmed Fraud and Abuse Report Guide chapter.

FREQUENCY & DUE DATES:

This report is due quarterly, within fifteen (15) calendar days after the end of the quarter being reported.

SUBMISSION:

To comply with the Quarterly Fraud and Abuse Activity Report (QFAAR) requirements, the Managed Care Plan must submit the following via the MPI SFTP site:

- The template provided with all required fields completed.
- The report attestation as described in Chapter 2.

INSTRUCTIONS:

Note: New records must be entered in the same fiscal year quarter as the date reported to MPI using the online fraud and abuse report form. The Managed Care Plan must be cognizant of the need to reconcile numbers reported to MPI and be able to provide explanations for any variances and discrepancies between reports and reported numbers (See Report Guide chapters "Annual Fraud and Abuse Activity Report", "Quarterly Fraud and Abuse Activity Report", and "Suspected/Confirmed Fraud and Abuse Reporting").

The Managed Care Plan must perform the following:

1. In the template provided, on the tab “Summary of Fraud and Abuse” the Managed Care Plan must provide the following information relative to the quarter’s fraud and abuse activities:
 - a. The reporting period for which the report is being submitted;
 - b. The Medicaid Managed Care Plan name for which the report is being submitted;
 - c. The Medicaid Managed Care Plan Medicaid ID or IDs for which the report is being submitted;
 - d. A summary, by quarter, of the instances of suspected/confirmed fraud and abuse identified by the Managed Care Plan, broken into categories as provided on the template;
 - e. A summary, by quarter, of the recoveries, sanctions, and fines, made relative to fraud and abuse by the Managed Care Plan, broken into categories as provided on the template.

2. In the template provided, on the tabs “Q1 Details of Fraud and Abuse”, “Q2 Details of Fraud and Abuse”, “Q3 Details of Fraud and Abuse”, and “Q4 Details of Fraud and Abuse”, the Managed Care Plan must include the following information relative to the quarter’s activities regarding instances of suspected/confirmed fraud and abuse identified:
 - a. Indicate the appropriate Reporting Year;
 - b. Indicate the appropriate Reporting Quarter;
 - c. Indicate the Managed Care Plan three-character identifier;
 - d. Select which reporting quarter the complaint was first reported to MPI via the online complaint form;
 - e. List the MPI case tracking system Complaint Number for the issue being identified;
 - f. List the Managed Care Plan Case Tracking ID for the issue being identified;
 - g. Select the Provider Type from drop down;
 - h. List the Provider’s or Recipient’s Tax Identification Number (TIN);
 - i. Select the Entity Type under review;
 - j. State the Provider’s or Entity’s Name in its entirety;
 - k. Indicate the reported entity’s Medicaid ID number, if applicable;
 - l. Indicate the reported entity’s NPI, if applicable;
 - m. Indicate the Date the issue was first detected by the Managed Care Plan;
 - n. Indicate the Specific Date the issue was first reported to MPI by the Managed Care Plan via the online complaint form;
 - o. Select whether the Allegations Type being reported is Fraud or Abuse;
 - p. Select the general Category of the Primary Allegation being reported;
 - q. Select the general Category of the Secondary Allegation being reported;
 - r. Select the Detection Tool used to identify the issue being reported;
 - s. Indicate the Preliminary Overpayment Amount identified by the Managed Care Plan;
 - t. Indicate the Final Overpayment Amount identified for recovery;
 - u. Indicate the total Amount of all Fines and Sanctions the plan imposed on the provider for the issue being reported, if applicable;
 - v. Indicate the total Settlement Amount between the Managed Care Plan and the provider, if applicable;
 - w. Indicate the total Amount Recovered from the provider through the Managed Care Plan’s audit/recovery activity to date;
 - x. Indicate the plan’s total Amount Lost to the provider;
 - y. Select the Complaint Status as either Open or Closed, with the disposition that applies;

- z. List the other Entities/Agencies to which the Managed Care Plan has reported the complaint;
 - aa. Select the type of Corrective Action the Managed Care Plan has taken with the provider;
 - bb. Select the Number of Times the Managed Care Plan has Reviewed the provider within the previous five-year period;
 - cc. Provide Detailed Information related to the progression of the Managed Care Plan's review;
 - dd. Provide any Additional Details or Comments relevant to the Managed Care Plan's review that are not captured elsewhere in the report.
3. The Managed Care Plan's Contract Manager must obtain access to the MPI SFTP site through the Agency's MPI Business Manager (or designated representative) to upload electronic file (supplemental) documentation (See Annual Fraud and Abuse Report chapter for access instructions).
 4. The registered user (Managed Care Plan Contract Manager) will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary account holder (Managed Care Plan Contract Manager) will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be automatically cleared by the system. Users can have the block cleared immediately by contacting their AHCA MPI-MC Site Administrator (MPI Business Manager) at 850-412-4600.
 5. Entering the incorrect username (i.e. a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in sixty (60) seconds. The external user must contact the AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPI-MCU@ahca.myflorida.com or 850-412-4600 to resolve this issue.
 6. Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Managed Care Plan Contract Manager and must include the user's full name, position title, and business email address. The Managed Care Plan must submit the request by email to MPI-MCU@ahca.myflorida.com.
 7. Any additional supporting documentation to the Quarterly Fraud and Abuse Activity Report must be HIPAA-compliant and may be submitted through the MPI SFTP site.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

Chapter 46: Residential Psychiatric Treatment Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with information regarding enrollees under the age of twenty-one (21) years who are receiving residential psychiatric treatment in Statewide Inpatient Psychiatric Program (SIPP) or Therapeutic Group Care (TGC) placements.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Residential Psychiatric Treatment Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Residential Psychiatric Treatment Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 47: Service Authorization Performance Outcome Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with information regarding the outcome of service authorizations and timeliness from the Managed Care Plan(s) for SMMC and Dental enrollees.

FREQUENCY & DUE DATES:

This report is due monthly, within fifteen (15) calendar days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan must submit the following to the applicable SFTP site:

- Service Authorization Performance Outcome Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must submit the Service Authorization Performance Outcome Report in the format and layout specified in the report template.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 48: Supplemental HIV/AIDS Report

PLAN TYPES

The following Managed Care Plans may submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

To help ensure that the Agency maintains up-to-date records of all dual eligible SMMC enrollees receiving MMA benefits who have been diagnosed with HIV/AIDS and might not have been identified by the Agency's monthly disease determination algorithm. Submission of this report will help to ensure that Managed Care Plans are compensated at the proper rate. Submission of this report is optional for all applicable SMMC Managed Care Plans.

FREQUENCY & DUE DATES

Due monthly – if submitting this report, Managed Care Plans must submit by the 10th of each month, for the prior month.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the Managed Care Plan shall submit the following to the MDA applicable SFTP Site (server: sftp.ahca.myflorida.com, Port: 2226) in the "MPA/ToMPA/HIV-AIDS Supplemental/" subdirectory:

- A fixed-width text file containing the variables identified in the "Instructions" section of this chapter.
- A report attestation (see Chapter 2).

INSTRUCTIONS:

1. The fixed width file must contain the following variables:
 - a. Enrollee's Medicaid ID (ten digits)
 - b. Enrollee's Date of Birth (YYYYMMDD)
 - c. Managed Care Plan identification number (nine digits)
2. The Managed Care Plan must submit a **cumulative** list of dual eligible enrollees having HIV or AIDS. The list must contain only those who are currently enrolled in the Managed Care Plan. Once the Managed Care Plan has begun submitting enrollees, the Managed Care Plan must continue to submit a cumulative listing each month in order to continue to receive the appropriate HIV/AIDS capitation payment.
3. Capitation rates generated by the submitted reports will be applied to Managed Care Plans for the following month's enrolled population. (For example, the report submitted in May 2014 would result in capitation payment for June 2014.)
4. No file or attestation is due if the Managed Care Plan chooses not to submit this supplemental data file.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

Notwithstanding the instructions in Chapter 1, the file submitted must be a fixed-width text file. Below is an example of what a record on the file might look like:

123456789019800101987654321

The above record indicates that the enrollee with Recipient ID 1234567890 and birth date January 1, 1980 is enrolled in the Managed Care Plan with a Medicaid Managed Care Plan Provider ID number of 987654321.

Additional information regarding the algorithm used by the Agency to identify HIV and AIDS recipients as well as a listing of diagnosis codes can be found in the Report Guide web pages by following the instructions in Chapter 1 of this document.

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Chapter 49: Suspected/Confirmed Fraud and Abuse Reporting

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is for Managed Care Plans to report all suspected or confirmed fraud and abuse under state and/or federal law relative to the Managed Care Plan contract and/or Florida Medicaid, including occupational fraud and abuse. Failure to report instances of suspected or confirmed fraud and abuse is a violation of law and subject to the penalties provided by law. Notwithstanding any other provision of law, failure to comply with these reporting requirements will be subject to sanctions.

FREQUENCY & DUE DATES:

The suspected/confirmed fraud and abuse report is submitted via the online Medicaid fraud and abuse complaint form and is due within fifteen (15) calendar days of detection.

SUBMISSION:

The Managed Care Plan must complete and submit the following Agency electronic data entry complaint form online to the Agency's Office of Medicaid Program Integrity (MPI):

- a. The Agency's online electronic data entry complaint form can be found at

<https://apps.ahca.myflorida.com/mpi-complaintform/>

INSTRUCTIONS:

The Managed Care Plan must report suspected or confirmed fraud and abuse relative to the Managed Care Plan's contract and Florida Medicaid. All suspected or confirmed instances of fraud and abuse under state and/or federal law are to be reported to MPI within fifteen (15) calendar days of detection by filing the online report.

1. All suspected or confirmed instances of fraud and abuse must include all of the following complainant information:
 - a. Complainant name;
 - b. Email address;
 - c. City;
 - d. State;
 - e. Zip code;
 - f. Telephone number.
2. All suspected or confirmed instances of fraud and abuse must include the following information relative to the Managed Care Plan submitting the report:

- a. Use the dropdown box to indicate the appropriate reporting entity. Select the Managed Care Plan name. Subcontractors reporting on behalf of a Managed Care Plan are required to indicate the Managed Care Plan for which they are reporting;
 - b. Managed Care Plan-Medicaid ID number (nine digits). When a subcontractor is reporting on behalf of a Managed Care Plan, the subcontractor will utilize the Managed Care Plan nine-digit Medicaid Provider ID number. When a Managed Care Plan has more than one Medicaid Provider ID, the Managed Care Plan will use the most appropriate of their assigned Medicaid Provider IDs;
 - c. Differentiate whether the Fraud or Abuse is suspected or confirmed through use of the appropriate checkbox;
 - d. Select whether the report is regarding suspected or confirmed fraud or abuse through use of the appropriate checkbox;
 - e. If the report is describing suspected or confirmed fraudulent activities, indicate whether or not the suspected or confirmed fraud has been reported to the Medicaid Fraud Control Unit (MFCU) through use of the appropriate checkbox;
 - i. If the instance is suspected or confirmed fraud, please provide the date it was or will be reported to MFCU through use of the provided date box;
 - f. Indicate the date of discovery for the suspected or confirmed fraud or abuse that is being reported. The Managed Care Plan must enter the date of discovery using the date box provided;
 - g. Indicate whether the complaint is about a provider, recipient, or Managed Care Plan.
3. All suspected or confirmed instances of provider fraud and abuse must include the following information relative to the provider and allegations. When the nature of the behavior is fraud or abuse, each instance and each provider, recipient, or Managed Care Plan must be separately reported by way of the on-line report form:
- a. Name of the provider being reported;
 - b. Provider type;
 - c. Provider's Florida Medicaid provider number. If the provider is not enrolled as a Medicaid provider, state this information in the narrative field. If reporting a provider who does not have a Medicaid provider number, the Managed Care Plan must include the NPI number and/or license number (if applicable), and identifying information in the narrative field;
 - d. Provider National Provider Identifier (NPI) number;
 - e. Provider's Tax Identification number;
 - f. Describe the suspected activities (including background, persons involved, events, dates, and locations);
 - i. Nature of complaint, summarize the suspected or confirmed fraud or abuse (who, what, when, where, why, and how of the situation);
 - ii. Source of complaint/detection tool(s) utilized (how was the issue detected);
 - iii. If additional information/documents are being submitted via MPI's SFTP site, indicate and identify the documents that will be included in the submission;
 - g. Plan Contact name for follow-up information regarding the complaint;
 - h. Plan contact phone number;
 - i. Street address for where the issue occurred;
 - j. Provider contact information;
 - k. Select appropriate current case status from dropdown menu: (Audit, Investigation, Recoupment, Closed, Assessment, or Other) If Other, provide details;
 - l. Identify if a potential overpayment has been identified;
 - m. Identify if the overpayment has been recovered and, if applicable, the current amount of the overpayment recovered;

- n. Indicate whether additional information will be uploaded to the MPI SFTP site.
4. All suspected or confirmed instances of enrollee fraud and abuse under state and/or federal law are to be reported to MPI within fifteen (15) calendar days of detection by filing the online report. The report must contain, at a minimum:
 - a. The enrollee's Medicaid ID number (ten digits);
 - b. The enrollee's full name;
 - c. The enrollee's date of birth;
 - d. The enrollee's Medicaid ID number (ten digits);
 - e. A description of the acts allegedly involving suspected fraud or abuse and case status;
 - i. Nature of complaint, summarize the suspected or confirmed fraud or abuse (who, what, when, where, why, and how of the situation);
 - ii. Source of complaint/detection tool(s) utilized (how was the issue detected);
 - iii. If additional information/documents are being submitted via MPI's SFTP site, indicate and identify the documents that will be included in the submission;
 - f. Select appropriate current case status from dropdown menu: (Audit, Investigation, Recoupment, Closed, Assessment, or Other) If Other, provide details;
 - g. Identify if a potential overpayment has been identified;
 - h. Identify if the overpayment has been recovered and, if applicable, the current amount of the overpayment recovered;
 - i. Indicate whether additional information will be uploaded to the MPI SFTP site.
 5. Reporting all suspected or confirmed instances of internal fraud and abuse relating to the provision of and payment for Medicaid services including, but not limited to fraud and abuse related to the Managed Care Plan contract and/or Florida Medicaid that is other than provider and enrollee fraud and abuse (e.g., internal/occupational fraud and abuse to the Managed Care Plan – allegations regarding Managed Care Plan employees/management, subcontractors, vendors, delegated entities). The online report must contain, at a minimum:
 - a. Name of the individual or Managed Care Plan being reported;
 - b. Provider type;
 - c. Florida Medicaid provider number of the Managed Care Plan being reported. If the allegation is regarding an individual that is not enrolled as a Medicaid provider, state this information in narrative field. If reporting an individual who does not have a Medicaid provider number, the Managed Care Plan must include identifying information in narrative field;
 - d. National Provider Identifier (NPI) number of the Managed Care Plan being reported. If the allegation is regarding an individual who does not have this information, it must be stated in the narrative field. Where the nature of the behavior is fraud or abuse, each instance and each Managed Care Plan or individual, must be separately reported by way of the on-line report form;
 - e. Tax Identification number of the Managed Care Plan being reported. If the allegation is regarding an individual who does not have this information it must be stated in the narrative field. Where the nature of the behavior is fraud or abuse, each instance and each Managed Care Plans or individual must be separately reported by way of the on-line report form;
 - f. Describe the suspected activities (including background, persons involved, events, dates, and locations).
 - i. Nature of complaint, summarize the suspected or confirmed fraud or abuse (who, what, when, where, why, and how of the situation);
 - ii. Source of complaint/detection tool(s) utilized (how was the issue detected);

- iii. If additional information/documents are being submitted via MPI's SFTP site, indicate and identify the documents that will be included in the submission;
 - g. Plan Contact name for follow-up information regarding the complaint;
 - h. Plan contact phone number;
 - i. Street address for where the issue occurred;
 - j. Managed Care Plan's or individual(s)' contact information;
 - k. Select appropriate current case status from dropdown menu: (Audit, Investigation, Recoupment, Closed, Assessment, or Other) If Other, provide details;
 - l. Identify if a potential overpayment has been identified;
 - m. Identify if the overpayment has been recovered and, if applicable, the current amount of the overpayment recovered;
 - n. Indicate whether additional information will be uploaded to the MPI SFTP site.
6. The Managed Care Plan may submit supplemental information via the MPI SFTP site. Reporting via the SFTP site is not a substitute for using the required online Medicaid Fraud and Abuse Complaint Form.
 7. The Plan's Contract Manager must obtain access to the MPI SFTP site through the Agency's MPI Business Manager (or designated representative) to upload electronic file (supplemental) documentation. (See Annual Fraud and Abuse Report chapter for access instructions).
 8. The registered user (Plan Contract Manager) will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary account holder (Plan Contract Manager) will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be automatically cleared by the system. Users can have the block cleared immediately by contacting their AHCA MPI-MC Site Administrator (MPI Business Manager) at 850-412-4600.
 9. Entering the incorrect username (i.e. a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in sixty (60) seconds. This form of lockout must be cleared by AHCA's network staff. The external user must contact the AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPI-MCU@ahca.myflorida.com or 850-412-4600 to resolve this issue.
 10. Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Plan Contract Manager and must include the user's full name, position title, and business email address. The Managed Care Plan must submit the request by email to MPI-MCU@ahca.myflorida.com.
 11. Any additional supporting documentation to the online Fraud and Abuse report must be HIPAA-compliant and may be submitted to the MPI SFTP site.
 12. A system-generated acknowledgement from the intake unit at MPI occurs for each online fraud and abuse form (report) received.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

Notwithstanding the instructions in Chapter 1, the Managed Care Plan must use the template on MPI's general website located at:

http://ahca.myflorida.com/Executive/Inspector_General/medicaid.shtml

The Medicaid fraud and abuse complaint report form is available online at:

<https://apps.ahca.myflorida.com/mpi-complaintform/>

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Chapter 50: Suspected/Confirmed Waste Reporting

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to document Managed Care Plan reporting of instances of waste as required by the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) (Final Rule). 42 CFR 438.608(a)(7) requires the Managed Care Plan to report waste to the state Medicaid program integrity unit. Notwithstanding any other provision of law, failure to comply with these reporting requirements will be subject to sanctions.

FREQUENCY & DUE DATES:

The suspected/confirmed waste report is due quarterly, within fifteen (15) calendar days after the end of the quarter being reported.

SUBMISSION:

To comply with the Suspected/Confirmed Waste Reporting requirements, the Managed Care Plan must submit the following via the MPI SFTP site:

- The template provided with all required fields completed.
- The report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan must report suspected or confirmed instances of waste relative to the Managed Care Plan's contract and Florida Medicaid. All suspected or confirmed instances of waste under state and/or federal law are to be reported to MPI.

1. In the template provided, on the tab "Summary of Waste" the Managed Care Plan must provide the following information relative to the quarter's activities in waste recoveries:
 - a. The reporting period for which the report is being submitted;
 - b. The Medicaid Health Plan name for which the report is being submitted;
 - c. The Medicaid Health Plan Medicaid ID or IDs for which the report is being submitted;
 - d. A summary, by quarter, of the instances of suspected/confirmed waste identified relative by the Managed Care Plan, broken into categories as provided on the template;
 - e. A summary, by quarter, of the overpayment recoveries made relative to waste by the Managed Care Plan broken, into categories as provided on the template.
2. In the template provided, on the tab "Details of Waste Efforts" the Managed Care Plan must include the following information relative to the quarter's activities regarding instances of suspected/confirmed waste identified, including overpayment recoveries:

- a. Indicate the appropriate reporting quarter;
 - b. Indicate the Managed Care Plan 3 letter identifier;
 - c. Managed Care Plan Internal Tracking ID for the issue being listed;
 - d. Date Recovery was initiated, MMDDYYYY format;
 - e. Indicate the reporting quarter the issue was first reported;
 - f. Status of the Recovery, ongoing or closed pertaining specifically to the line;
 - g. Entire Project Completion Date, MMDDYYYY format, only to be reported when whole project is closed;
 - h. Waste Recovery Category defined as: Cost Share, Credit Balance, Data Mining, DRG Validation, Medical Records Review, Retro-terms, Settlements, Subrogation, TPL, Other, Vendor Name;
 - i. Provider or Recipient Indicator
 - j. Provider or Recipient Last Name, if an entity this field may be blank;
 - k. Provider or Recipient First Name, if an entity this field may be blank;
 - l. Provider or Recipient Middle Initial, if an entity this field may be blank;
 - m. Entity Name, required if there is not an individual listed;
 - n. Provider Type from drop down;
 - o. City of provider or member's location where issue occurred;
 - p. Provider's National Provider Identifier if a provider;
 - q. Provider or Recipients Tax Identification Number (TIN);
 - r. Provider's Medicaid Provider ID;
 - s. Preliminary Overpayment Amount Identified;
 - t. Updated Overpayment Amount Identified;
 - u. Final Overpayment Amount Identified;
 - v. Overpayment Amount Recovered this quarter;
 - w. Overpayment Collection Method defined as: Provider Submitted Check, Plan Initiated Withhold, or Plan Initiated Recoupment;
 - x. A summary of the audit findings in the summary area, must include details of the recovery including what the audit was of and how many claims were involved.
3. The Plan's Contract Manager must obtain access to the MPI SFTP site through the Agency's MPI Business Manager (or designated representative) to upload electronic file (supplemental) documentation. (See Annual Fraud and Abuse Report chapter for access instructions).
 4. The registered user (Plan Contract Manager) will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary account holder (Plan Contract Manager) will be notified by email when the account has been locked. The account lockout will last for 30 minutes, and then it will be automatically cleared by the system. Users can have the block cleared immediately by contacting their AHCA MPI-MC Site Administrator (MPI Business Manager) at 850-412-4600.
 5. Entering the incorrect username (i.e. a username that does not exist) will cause the user's IP address to be blocked. For the IP address block to take place, the user must attempt to connect with the incorrect username more than five times in sixty (60) seconds. This form of lockout must be cleared by AHCA's network staff. The external user must contact the AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPI-MCU@ahca.myflorida.com or 850-412-4600 to resolve this issue.
 6. Termination of access is required in instances where there is a change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Plan Contract Manager and must include the user's full name, position title, and business email

address. The Managed Care Plan must submit the request by email to MPI-MCU@ahca.myflorida.com.

7. Any additional supporting documentation to the Suspected/Confirmed Waste report must be HIPAA-compliant and may be submitted to the MPI SFTP site.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 51: Unable to Provide Case Management Report

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan/LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to formalize and establish LTC plans' reporting of enrollees receiving LTC services for whom the plans are unable to provide case management. This includes members who are unable to be located and/or contacted, members refusing services, members who have moved out of region and members who have moved out of state.

FREQUENCY & DUE DATES:

This report is due monthly, within five (5) business days after the end of the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the Managed Care Plan shall submit the following to the applicable SFTP site:

- LTC Plan Unable to Provide Case Management Report using the template provided.
- A report attestation as described in Chapter 2.

INSTRUCTIONS:

The Managed Care Plan shall include an enrollee in this report for each reporting month in which the Managed Care Plan is unable to provide case management for any 60- day period, which includes the reporting month. The enrollee shall remain on the Unable to Provide Case Management Report until located/contacted, disenrolled or no longer refusing services.

One Excel workbook shall be submitted for each plan. The plan shall insert additional rows as necessary to completely report on all enrollees for whom it has been unable to provide case management.

The Managed Care Plan shall report the following to the Agency in accordance with the format set forth in the Unable to Provide Case Management Report Template:

- Classifications
- Managed Care Plan Identification number (nine digits)
- Plan's Name
- Enrollee's Medicaid ID (ten digits)
- Enrollee's Last Name
- Enrollee's First Name
- Enrollee's DOB (Date of Birth) (MM/DD/YYYY)
- Last Phone Number Utilized (000-000-0000)
- Last Known Mailing Address

- Last Known Residential Address
- Residential City
- Residential State (two-character identifier)
- County
- Region (two digits)
- Region by Zip Code (two digits)
- Date of Death (if applicable, MM/DD/YYYY)
- Last Date That Services Were Provided (MM/DD/YYYY)
- Comments: Due Diligence in Contacting the Enrollee

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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Chapter 52: Well Child Visit Report (CMS-416) and FL 80% Screening

PLAN TYPES

The following Managed Care Plans must submit this report:

- Comprehensive LTC Plan / LTC Plus Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan
- Dental Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with data documenting the Managed Care Plan's program and compliance with federal and state statutory requirements regarding Well Child Visit screening and participation, for enrollees receiving MMA benefits.

FREQUENCY & DUE DATES:

The Audited Well Child Visit (CMS-416) and FL 80% Screening Ratio Report is due annually; the Audited Report Summary and the Letter of Opinion from an Independent Auditor (certified HEDIS compliance auditor) is due on or before July 1 following the end of the reporting federal fiscal year (October 1 through September 30).

SUBMISSION:

The Managed Care Plan must submit the following to the applicable SFTP site:

- For the Audited Well Child Visit (CMS-416) and FL 80% Screening Ratio Report:
 - a. The completed Audited Well Child Visit and FL 80% Screening Ratio Agency-supplied template submitted as an Excel file and named: A-WELLCHILD-***yyyy.xls, where "***" is the Managed Care Plan's three-character identifier from the Plan Identifier Table (see Chapter 2) and "yyyy" represents the four-digit federal fiscal year being reported. For example, ABC Managed Care Plan's submission for October 1, 2013 – September 30, 2014 would be named "A-WELLCHILD-ABC1314.xls").
 - b. The independent auditor's report summary and letter of opinion, which must be submitted as a PDF file and named AO-WELLCHILD-***yyyy.pdf, where "***" is the Managed Care Plan's three-character identifier from the Plan Identifier Table (see Chapter 2) and "yyyy" represents the four digits of the federal fiscal year being reported. For example, ABC Managed Care Plan's submission for October 1, 2013 – September 30, 2014 would be named "AO-WELLCHILD-ABC1314.pdf").
 - c. The attestation as described in Chapter 2.

INSTRUCTIONS:

1. The audited HEDIS Report does not meet the contractual obligation for submission of the Well Child Visit report. Note: the audited Well Child Visit report is required for compliance with federal and state law.

2. Report age based upon the child's age as of September 30 of the federal fiscal year. All case months must be reported as the age on September 30.
3. Services provided to individuals prior to them turning 21 during the report year must be counted in the 19-20 year age group even though these individuals are not counted in the 19-20 age category on Line 1. Count all Well Child Visit services, referrals and dental services in the appropriate lines.
4. Count only Well Child Visit services that were completed when eligibles were enrollees of the reporting HMO/PSN. Do not count Well Child Visit services performed by other HMOs or PSNs.
5. Do not count the MediKids population in the data reported.
6. Do not report sick visits or episodic visits provided to children unless an initial or periodic screen was also performed during the visit. However, it may reflect a screen outside of the normal state periodicity schedule that is used as a "catch-up" Well Child Visit screening. (A catch-up Well Child Visit screening is defined as a complete screening that is provided to bring a child up-to-date with the State's screening periodicity schedule.) Use data reflecting date of service within the federal fiscal year for such screening services or other documentation of such services furnished under capitated arrangements.
7. All fields in the templates must be completed according to the services required under contract.
8. Note: Line 11 in the report must include the number of individuals who were referred for corrective treatment. This element does not include correction of health problems during the course of a screening examination. Please refer to the CMS-416 Instructions tab in the Excel template for further details regarding line 11 data.
9. Line 14 in the report must include the number of children receiving blood lead screenings. Blood lead tests done on persons who have been diagnosed or treated for lead poisoning must not be counted. Do not make entries in the shaded columns. Please refer to the CMS-416 Instructions tab in the Excel template for further details regarding line 14 data.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency templates can be found using the directions in Chapter 1. There are no additional report template instructions unique to this report chapter.

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