

**Statewide Medicaid Managed Care (SMMC)
Managed Care Plan
Report Guide
Effective 4-1-17**

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Section One: Overview and Reporting Requirements

Chapter 1: General Overview

Purpose of Report Guide

The Report Guide is a companion to each SMMC 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
- ✓ Managed Medical Assistance Children's Medical Services (MMA CMS)
- ✓ Comprehensive Long-term Care (LTC) Plans

Note: This edition of the Report Guide solely reflects the requirements of LTC and MMA Managed Care Plans.

Chapter 2, General Reporting Requirements, covers the general report submission and certification requirements for the SMMC Managed Care Plans. After these introductory chapters, the remaining chapters cover any specific report certification information and specific individual report instructions.

The individual report chapters are organized in the following manner (all in respective alphabetical order):

1. Attachment II, Core Contract Provisions (CORE) – these reports apply to both LTC and MMA plans.
2. Attachment II, Exhibit II-B, Long-term Care Program – these reports apply to LTC plans.
3. Attachment II, Exhibit II-A, Managed Medical Assistance Program – these reports apply to MMA plans.

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 should 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 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 to:

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 October 1, 2016, will be posted to an Agency web page titled "SMMC Report Guide - (Effective 10-1-2016)", 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 Plan 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, under “Report Guide Updates”, 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 instead of accessing the Agency Report Guide web pages.

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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 should 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 examples:

- If a Managed Care Plan is submitting one weekly report and four quarterly reports at the same time on February 2, 2015, 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, 2015, and four quarterly reports on February 3, 2015, 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 FTP site. A sample delegation of authority letter is provided by the Agency at:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/Managed_Care_contracting/MHMO/med_prov_1215.shtml.

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>.
- All reports filed on a quarterly basis must be filed on a calendar year quarter.

SMMC SFTP Site Access

Most reports are submitted to the Agency's SMMC SFTP site. To access the SMMC 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:

- CHCUP (CMS-416) and FL 80% Screening
- Provider Network File
- Quarterly Fraud and Abuse Activity Report
- Suspected/Confirmed Fraud and Abuse Reporting
- Achieved Savings Rebate (ASR) Financial Reports
- 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, 2015, 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 should 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, 2015 would be (ABC201510CM090145); the naming convention of the second report submitted on November 3, 2015 would be (ABC201510CM09014502) – 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 (ABC201510CV300159); the naming convention of the second variable report submitted on October 30th would be (ABC201510CV3015902) – 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 2014, but filed in January 2015, must state the year 2014 in the file name (not January 2015).
- 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 should 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 should 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 should 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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| PLAN IDENTIFIER TABLE | |
|------------------------------|---|
| Plan Identifier | Comprehensive LTC Plan Name |
| AMG | Amerigroup |
| COV | Coventry d/b/a Aetna Better Health of Florida |
| MOL | Molina |
| SUN | Sunshine |
| URA | United |

| Plan Identifier | LTC Plan Name |
|------------------------|----------------------|
| AEC | American Eldercare |

| Plan Identifier | MMA Plan Name |
|------------------------|---|
| PHC | AHF d/b/a Positive Healthcare Florida HIV/AIDS Specialty Plan |
| BET | Better Health, LLC |
| MCC | Magellan Complete Care, LLC |
| PRS | Prestige Health Choice |
| CHA | Simply d/b/a Clear Health Alliance HIV/AIDS Specialty Plan |
| SHP | Simply |
| NBD | South Florida Community Care Network |
| STW | Wellcare d/b/a Staywell Health |
| SUN | Sunshine State Health Plan, Inc. Child Welfare Specialty Plan |
| CMS | Children's Medical Services (CMS) Plan |
| HUM | Humana |

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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 SMMC Report Guide and the SMMC Managed Care Plan Contracts. Please refer to this table as needed. Additional reporting requirements are specified in the SMMC Managed Care Plan Contracts.

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

SUMMARY OF REPORTING REQUIREMENTS with Report Code Identifier Information

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|---|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|-----------------------------|
| CORE REPORTS | | | | | | |
| Achieved Savings Rebate Financial Reports | Section IX. and XIV. | 3 | C | N/A | Annually Quarterly | SMMC SFTP Site |
| Achieved Savings Rebate Financial Reports Attestation | | | | N/A | | |
| Administrative Subcontractors and Affiliates Report | Section XII. and XIV. | 4 | C | 0100 | Quarterly | SMMC SFTP Site |
| Administrative Subcontractors and Affiliates Report Attestation | | | | N/A | | |
| Annual Fraud and Abuse Activity Report | Section VIII. and XIV. | 5 | S | 0133 | Annually | MPI-MC SFTP Site |
| Annual Fraud and Abuse Activity Report Attestation | | | | N/A | | |
| Claims Aging Report & Supplemental Filing Report | Section VIII. and XIV. | 6 | C | | Quarterly | SMMC SFTP Site |
| Capitated Claims Aging Report | | | | 0108 | | |
| Fee-for-Service Claims Aging Report | | | | 0109 | | |
| Claims Aging Report Attestation | | | | N/A | | |
| | | | | | | |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|--|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|-----------------------|
| Adverse and Critical Incident Summary Report | Section VII. and XIV. | 7 | C | 0120 | Monthly | SMMC SFTP Site |
| Adverse and Critical Incident Summary Report Attestation | | | | N/A | | |
| Enrollee Complaints, Grievances, and Appeals Report | Section IV. and XIV. | 8 | C | 0127 | Monthly | SMMC SFTP Site |
| Enrollee Complaints, Grievances, and Appeals Report Attestation | | | | N/A | | |
| Marketing Agent Status Report | Section IV. D.5.g. | 9 | C | 0157 | Variable/ Quarterly | SMMC SFTP Site |
| Marketing Agent Status Report Attestation | | | | N/A | | |
| Marketing/Public/Educational Events Report | Section I.A. and Section III.D.14 | 10 | C | | Variable/ Monthly | SMMC SFTP Site |
| Marketing/Public/Educational Events Report | | | | 0159 | | |
| Amendment to a reported event change | | | | 0160 | | |
| Market/Public/Educational Events Report Attestation | | | | N/A | | |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|--|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|---|
| Performance Measures Report | Section VII. | 11 | C | | Annually | SMMC SFTP Site |
| Performance Measures Report- LTC & MMA | | | | 0141 | | |
| Performance Measures Report Attestation | | | | N/A | | |
| HEDIS Auditor Certification with Audit Review Table | | | | 0143 | | |
| Interactive Data Submission System (IDSS) file | | | | 0144 | | |
| HEDIS NCQA Patient-Level Detail File | | | | 0190 | | |
| Provider Complaint Report | Section VI. and XIV. | 12 | C | 0145 | Monthly | SMMC SFTP Site |
| Provider Complaint Report Attestation | | | | N/A | | |
| Provider Network File | Section VI. and XIV. | 13 | C | N/A | W | Choice Counseling Vendor SFTP Site |
| Provider Network File Attestation | | | | | | |
| Provider Termination and New Provider Notification Report | Section VI. and XIV. | 14 | C | 0147 | Weekly | SMMC SFTP Site |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|--|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|---|
| Provider Termination and New Provider Notification Report Attestation | | | | N/A | | |
| Quarterly Fraud & Abuse Activity Report | Section VIII. and XIV. | 15 | C | N/A | Quarterly | OIG MPI Web-based Application Site |
| Quarterly Fraud & Abuse Activity Report | | | | N/A | | |
| Suspected/Confirmed Fraud and Abuse Reporting | Section VIII. and XIV. | 16 | C | N/A | Variable | Agency's Online Electronic Data Entry Complaint Form |
| Suspected/Confirmed Fraud and Abuse Reporting Attestation | | | | | | |
| Pre-Admission Screening and Resident Review (PASRR) Report | Section V.E.5. | 17 | C | 0184 | Quarterly | SMMC SFTP Site |
| Pre-Admission Screening and Resident Review (PASRR) Report Attestation | | | | N/A | | |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|---|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|---|
| Enhanced Care Coordination Report | Exhibit II-A, Section V.E.2. | 18 | C | 0186 | Monthly | SMMC SFTP Site |
| Enhanced Care Coordination Report Attestation | | | | N/A | | |
| LONG-TERM CARE REPORTS | | | | | | |
| Critical Incident Report- Individual | Section VII. and XIV. | 19 | C | 0118 | Variable | MCP Contract Manager via email |
| Critical Incident Report- Individual Attestation | | | | N/A | | |
| Case Management File Audit Report | Exhibit II-B, Section V. and XIV. | 20 | C | 0102 | Quarterly | SMMC SFTP Site |
| Case Management File Audit Report Attestation | | | | N/A | | |
| Case Management Monitoring and Evaluation Report | Exhibit II-B, Section V. and XIV. | 21 | C | | Quarterly | SMMC SFTP Site |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|---|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|-----------------------|
| Case Management Monitoring and Evaluation Report | | | | 0104 | | |
| Case Management Monitoring and Evaluation Report Attestation | | | | N/A | | |
| Annual Roll-Up (4 th Quarter Only) | | | | 0106 | | |
| Annual Roll-Up Attestation | | | | N/A | | |
| Case Manager Caseload Report | Exhibit II-B, Section V. and XIV. | 22 | C | 0151 | Monthly | SMMC SFTP Site |
| Case Manager Caseload Report Attestation | | | | N/A | | |
| Denial, Reduction, Suspension or Termination of Services Report | Exhibit II-B, Section V. and XIV | 23 | C | 0125 | Monthly | SMMC SFTP Site |
| Denial, Reduction, Suspension or Termination of Services Report Attestation | | | | N/A | | |
| Enrollee Roster and Facility Residence Report | Exhibit II-B, Section V. and XIV. | 24 | C | 0129 | Monthly | SMMC SFTP Site |
| Enrollee Roster and Facility Residence Report Attestation | | | | N/A | | |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|--|--|----------------------|---------------------|-------------|----------------------|-----------------------|
| Missed Services Report | Exhibit II-B, Section V. and XIV. | 25 | C | 0131 | Monthly | SMMC SFTP Site |
| Missed Services Report Attestation | | | | N/A | | |
| Participant Direction Option (PDO) Roster Report | Exhibit II-B, Section V. and XIV | 26 | C | 0137 | Monthly | SMMC SFTP Site |
| Participant Direction Option (PDO) Roster Report Attestation | | | | N/A | | |
| Patient Responsibility Report | Exhibit II-B, Section V. and XIV. | 27 | K | 0139 | Annually | SMMC SFTP Site |
| Patient Responsibility Report Attestation | | | | N/A | | |
| Unable to Locate/Contact Enrollee Report | Exhibit II-B, Section V.E.5 | 28 | C | 0176 | Monthly | SMMC SFTP Site |
| Unable to Locate/Contact Enrollee Report Attestation | | | | N/A | | |
| MANAGED MEDICAL ASSISTANCE REPORTS | | | | | | |
| CHCUP (CMS-416) and FL- 80% Screening | Exhibit II-A, Section V. and XIV. | 29 | F | N/A | Annually | SMMC SFTP Site |
| CHCUP (CMS-416) and FL- 80% Screening Attestation | | | | | | |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|--|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|-----------------------|
| ER Visits for Enrollees without PCP Appointment Report | Exhibit II-A, Section V. and XIV. | 30 | C | 0182 | Annually | SMMC SFTP Site |
| ER Visits for Enrollees without PCP Appointment Report Attestation | | | | N/A | | |
| Healthy Behaviors Report | Exhibit II-A, Section V. and XIV. | 31 | C | 0180 | Quarterly | SMMC SFTP Site |
| Healthy Behaviors Report Attestation | | | | N/A | | |
| Hernandez Settlement Agreement Survey | Exhibit II-A, Section V. and XIV. | 32 | C | 0168 | Annually | SMMC SFTP Site |
| Hernandez Settlement Agreement Survey Attestation | | | | N/A | | |
| Hernandez Settlement Ombudsman Log | Exhibit II-A, Section V. and XIV. | 33 | C | 0170 | Quarterly | SMMC SFTP Site |
| Hernandez Settlement Ombudsman Log Attestation | | | | N/A | | |
| PCP Appointment Report (IN DEVELOPMENT) | Exhibit II-A, Section V. and XIV. | 34 | C | TBD | Annually | SMMC SFTP Site |

| SMMC Report Name | Contract Att. II, (or Exhibit) Location) | Report Guide Chapter | Reporting Year Type | Report Code | Submission Frequency | Submit To |
|---|---|-------------------------------------|--------------------------------|------------------------|---------------------------------|-----------------------|
| PCP Appointment Report Attestation | | | | TBD | | |
| Timely Access/PCP Wait Times Report | Exhibit II-A, Section VI. and XIV. | 35 | C | 0172 | Annually | SMMC SFTP Site |
| Timely Access/PCP Wait Times Report Attestation | | | | N/A | | |
| Supplemental HIV/AIDS Report | Exhibit II-A, Section XIV. | 36 | C | 0174 | Monthly | SMMC SFTP Site |
| Supplemental HIV/AIDS Report Attestation | | | | N/A | | |
| Residential Psychiatric Treatment Report | TBD | 37 | C | 0188 | Monthly | SMMC SFTP Site |
| Residential Psychiatric Treatment Report Attestation | | | | N/A | | |
| | | | | | | |

| 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 **ABC201410KA130139 =**

ABC Managed Care Plan
2013 Patient Responsibility Report due October 1, 2014

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2014
- 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) = 13 (Reporting Data Period 2013)
- Four-digit report code identifier for the Patient Responsibility Report = 0139

Example: File Name **ABC201404CQ010102=**

ABC Managed Care Plan
1st Quarter 2014 Case Management File Audit Report due April 30, 2014

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2014
- 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 03/31/2014)
- Four-digit report code identifier for the Case Management File Audit Report = 0102

Example: File Name **ABC201410CM090131.xls=**

ABC Managed Care Plan
September 2014 Missed Services Report due October 30, 2014

- Managed Care Plan's three-character identifier = ABC
- Four-digit year in which report is due = 2014

- 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: Core Reports

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Chapter 3: Achieved Savings Rebate (ASR) Financial Reports

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 runoff. 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 following to the SMMC SFTP site:

- For the unaudited quarterly submissions:
 - a. The completed and accurate ASR Financial Report template, which must be submitted as an Excel file and named ASR***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").
 - b. 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, 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.**
 - c. A report attestation as described in Chapter 2.
- For the unaudited annual submissions:
 - a. The completed and accurate ASR Financial Report template, which must be submitted as an Excel file and named ASR***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, 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, 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, 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 Reports:

- MMA Revenue & Expense Schedule (Summary and Regional);
- MMA Subcapitation Schedule (Summary);
- MMA Related-Party Schedule (Summary);
- MMA Physician Compensation Schedule (Summary);
- LTC Revenue & Expense Schedule (Summary and Regional);
- LTC Subcapitation Schedule (Summary);
- LTC Related-Party Schedule (Summary);
- ASR Exhibit.

Annual ASR Financial Report:

- MMA Revenue & Expense Schedule (Summary and Regional);
- MMA Subcapitation Schedule (Summary);
- MMA Related-Party Schedule (Summary);
- MMA Physician Compensation Schedule (Summary);
- LTC Revenue & Expense Schedule (Summary and Regional);
- LTC Subcapitation Schedule (Summary);
- LTC Related-Party Schedule (Summary);
- ASR Exhibit;
- Claim Lag template.

Refer to the current ASR 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 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 4: Administrative Subcontractors and Affiliates Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

| | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input checked="" type="checkbox"/> | MMA HMO |
| <input checked="" type="checkbox"/> | MMA Capitated PSN |
| <input checked="" type="checkbox"/> | MMA Specialty Plan |
| <input checked="" type="checkbox"/> | MMA CMS 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 SMMC SFTP site:

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

INSTRUCTIONS:

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.

The Managed Care Plan must submit the report using the Agency's template via the SMMC 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.
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 5: Annual Fraud and Abuse Activity Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

| | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input checked="" type="checkbox"/> | MMA HMO |
| <input checked="" type="checkbox"/> | MMA Capitated PSN |
| <input checked="" type="checkbox"/> | MMA Specialty Plan |
| <input checked="" type="checkbox"/> | MMA CMS 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 as 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 the Inspector General/Medicaid Program Integrity's MPI-MC SFTP site. Contact the Agency's MPI Business Manager (MPI Site Administrator) for access information via MPIBusiness.Manager@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 MPIBusiness.Manager@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 MPIBusiness.Manager@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 MPIBusiness.Manager@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 should add MPIBusiness.Manager@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 MPIBusiness.Manager@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 MPIBusiness.Manager@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 6: Claims Aging Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 quarterly, within forty-five (45) 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 SMMC SFTP site:

- For the quarterly 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 quarterly Claims Aging Report(s) using the report template provided on the Agency website (see the “Report Template” section of this chapter).
2. Claims data must be Medicaid only.

3. Claims data must not be run for this report until at least 31 calendar days after the end of the report quarter but before the due date for filing (45 calendar days after the reported quarter).
4. 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 7: Adverse and Critical Incident Summary Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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. Please reference the Core Contract provisions, Attachment II, Section I, Definitions, Adverse Incident and Critical Incident.

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 SMMC SFTP site:

- 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, Comprehensive)
 - Plan Medicaid ID (seven digits)
 - Date (Month/Year)

VARIATIONS BY MANAGED CARE PLAN TYPE:

MMA plans will complete the MMA tab, Adverse Incident Summary.

Comprehensive plans will complete the MMA 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: Enrollee Complaints, Grievances and Appeals Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

| | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input checked="" type="checkbox"/> | MMA HMO |
| <input checked="" type="checkbox"/> | MMA Capitated PSN |
| <input checked="" type="checkbox"/> | MMA Specialty Plan |
| <input checked="" type="checkbox"/> | MMA CMS 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 following to the SMMC SFTP site:

- Enrollee Complaints, Grievances, and Appeals Report using the template provided. The completed enrollee template including MMA and LTC data, as applicable on the labeled tab for the appropriate month, must be submitted as an XLS 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 and LTC data using the template provided.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- A workbook with 28 tabs (24 of which are monthly representations) which include the following:
 1. Instructions – explains how to complete the template.
 2. Codes – provides report definitions and codes explaining the types of complaints, grievances, appeals, dispositions, and county code information.
 3. 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.
 4. Summary G&A – Do not enter data into the Summary tab of the worksheet. As the Managed Care Plan completes each monthly worksheet, the data is captured and reported in aggregate on the Summary tab.
 5. Jan-Dec C – Each month has a separate worksheet for reporting enrollee complaints received by the Managed Care Plan during the reporting timeframe.
 6. Summary C – Do not enter data into the Summary tab of the worksheet. As the Managed Care Plan completes each monthly worksheet, the data is captured and reported in aggregate on the Summary tab.

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: Marketing Agent Status Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 or, if needed, a variable report within fifteen (15) days after a new marketing agent's appointment to the Plan.

SUBMISSION:

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

- The completed marketing agent status template, which must be submitted as an XLS 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 using the appropriate report template provided on the Agency website (see the "Report Template" section of this chapter).
2. The Managed Care Plan is required quarterly to submit status information for all Marketing Agents employed by the Plan.
3. After a Marketing Agent has been reported as being terminated, then they are to be omitted from the next quarterly report.

4. The Managed Care Plan must submit a blank report template even if no Marketing Agents are employed. This type of submittal must also include a completed jurat and attestation.
5. A variable Marketing Agent Status Report is due within fifteen (15) days after a new marketing agent's appointment to the Plan.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- A workbook with three (3) worksheet tabs which include the following:
 1. Instructions – explains how to complete the template.
 2. Jurat – contains Managed Care Plan contact information.
 3. Marketing Agent Status – contains marketing agent information.

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: Marketing/Public/Educational Events Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMSN 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 plan decides not to attend less than forty-eight (48) hours prior to the event, the 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 SMMC 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 is not required in the event of inclement weather or if the plan decides not to attend.

This document should 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 using the appropriate report template provided on the Agency website (see the “Report Template” section of this chapter).
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.
3. 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 a completed attestation.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency’s template consists of the following:

- ❖ A workbook with three (3) worksheet tabs that include the following:
 - Instructions - Definitions – explains how to complete the template.
 - Plan Info Sheet – provides managed care plan information.
 - Monthly Events Report – contains marketing, public and educational event information.

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 11: Performance Measures Report LTC & MMA

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 SMMC SFTP site:

- The Performance Measures Report.
- The HEDIS Auditor certification with Audit Review Table.
- 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 an Excel file.
- The HEDIS NCQA Patient-Level Detail File (for Managed Care Plans generating an IDSS file as part of their HEDIS process) with the Performance Measures Report as an Excel file.

INSTRUCTIONS:

See the Variations By Managed Care Plan Type section below.

VARIATIONS BY MANAGED CARE PLAN TYPE:

LTC Plan Type Variations: The LTC Managed Care Plan must create and report its required LTC Performance Measures (PMs) according to the instructions for LTC Performance Measures and the LTC Performance Measures Specifications Manual.

MMA Plan Type Variations: The MMA Managed Care Plan must create and report its required MMA Performance Measures (PMs) according to the instructions for MMA Performance Measures and the MMA Performance Measures Specifications Manual.

Comprehensive LTC Plan Type Variations: The Comprehensive LTC Plan must create and report its required LTC & MMA Performance Measures (PMs) according to the instructions for LTC & MMA Performance Measures and the LTC and MMA Performance Measures Specifications Manuals.

REPORT TEMPLATE:

The MMA and LTC Performance Measures Specifications Manuals can be found in the Report Guide web pages by following the instructions in Chapter 1 of this document.

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: Provider Complaint Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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, timeline of the complaint, 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 SMMC SFTP site:

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

INSTRUCTIONS:

1. The Managed Care Plan must complete the Provider Complaint 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 outlined on the template for region, county, file type, the nature of the complaint, description of the complaint disposition, and disposition status.
3. The Managed Care Plan must enter the dates for when the complaint was received, the date the disposition notice was sent to the provider, and the date of disposition as MM/DD/YYYY.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency's template consists of the following:

- A workbook with fourteen (14) tabs (twelve (12) of which are monthly representations as described in paragraph b. below) which includes the following:
 - a. Instructions – explains how to complete the template, including reasons for the nature of the complaint and complaint disposition.
 - b. January-December – Each month has a separate worksheet for reporting provider complaints received by the managed care plan during the reported timeframe. The Managed Care Plan must indicate the total MMA and LTC complaints for each month.
 - c. Summary – No data can be entered into the Summary worksheet. As the Managed Care Plan completes each monthly worksheet, the data is automatically updated in the aggregate on the Summary worksheet.

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: Provider Network File

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 should 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 should use the URL)

Port: 22

2. All Managed Care Plans must submit the following to the Agency via the SMMC SFTP site:
 - A signed attestation specifically addressing the accuracy and completeness of the Provider Network File submission, 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 should 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 14: Provider Termination and New Provider Notification Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency with notice in the event of a suspension, termination, or withdrawal of providers from participation in the Managed Care Plan's network; to provide the Agency with notice of new providers; and to provide documentation that the Managed Care Plan has performed enrollee notification in accordance with the provisions of the Managed Care Plan Contract.

FREQUENCY & DUE DATES:

This report is due weekly on Wednesday by 5:00 p.m. EST.

SUBMISSION:

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

- The completed Provider Termination and New Provider Notification Report template including LTC and/or MMA data on the appropriate tab, which must be submitted as an XLS file.
- The report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must submit provider terminations and new/replacement providers for the prior reporting week using the Agency-supplied template. This submission must occur even when no provider terminations, suspensions, withdrawals, or new provider contracts occurred. The Managed Care Plan must indicate "none" in the first line of the report if there are no such changes.

2. The Managed Care Plan must report behavioral health provider terminations separately from long-term care or medical provider terminations using the appropriate “Medical Provider Term” labeled tab: “Medical Provider Term” or “Beh Health Provider Term” as labeled for LTC and/or MMA data.
3. The Managed Care Plan must report new/replacement providers separately from behavioral health, long-term care, or medical provider information using the appropriate “New Provider Information” labeled tab: “MMA or LTC New Provider” or “MMA or LTC Behavioral Health Provider Term”.

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: Quarterly Fraud and Abuse Activity Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency's Office of the Inspector General/Medicaid Program Integrity (MPI), with a quarterly ongoing comprehensive fraud, abuse and waste 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, abuse and waste 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, abuse and waste. 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, abuse and waste. (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, abuse and waste, 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 Quarterly Fraud and Abuse Activity Report (QFAAR) requirements, the Managed Care Plan must submit the following:

- The web-based QFAAR report to the Agency Office of the Inspector General/Medicaid Program Integrity (MPI) via the web-based application site.
- The report attestation as described in Chapter 2. The attestation must be named according to the instructions within the application on the “Submit Report” page.

INSTRUCTIONS:

Note: New records should be entered in the same calendar quarter as the date reported to MPI using the online fraud and abuse report form. The Managed Care Plan should 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. Obtain access to MPI’s web-based application QFAAR site by browsing to the URL and clicking on the “New Users Register Here” link.
2. Complete the online user registration form (See paragraph 3. below for details) and click “submit.”
3. Follow the directions to create a new user account. Using the drop-down selection, select the applicable (Health Plan) Managed Care Plan name. Complete the online registration form using a business email account and click “submit.” After clicking the Submit button, if the user registered successfully, the user will be directed to the registration results page. Note: The user’s account is not active at this time/this step. The user will be required to print out the user agreement form. The user should read and complete the User Account Agreement form and sign the acknowledgement for the terms of the User Account Agreement. The Plan Contract Manager is the management approval that must be obtained by signature on the form. The Plan Contract Manager’s signature on the user agreement is sufficient to request individual access. Send the completed user agreement via email, fax or mail, using the information listed on the form.
4. Activation of access will not occur until the form is received by MPI and the Plan Contract Manager’s signature is verified. When access is approved by Agency MPI staff, an email will be generated to the user applicant, notifying the user of password activation or denial. The Plan Contract Manager must be current and have signed an MPI Signature Verification Form for MPI to keep on file (this communication may occur by email or fax). The system allows for password changes by the approved user, but only with inserting the approved user’s correct user ID. If the approved user cannot remember their correct user ID, the user must re-register with a new user ID. MPI will deny access for any registrant that does not use a business email address.

5. The web-based application allows the user to reset his/her own password as long as the user is able to use his/her user name. If the user name is forgotten, the user must reapply for access approval, complete a new user agreement, and select a new user name other than the prior user name.
6. **The Plan Contract Manager must notify the Agency (see #7) to request deactivation (termination of access/request to remove a user) of a Managed Care Plan staff member's password, and to block access of said staff member to the web-based QFAAR application. Deactivation is required in the instances of change of responsibilities or employee termination.**
7. Termination of access is required in the instances of change of responsibilities or employee termination. A request to terminate a user's access must be submitted by the Managed Care Plan's Plan Contract Manager and must also include the User's Full Name, Position Title, and Business Email Address. This request must be submitted by email to qfaar@ahca.myflorida.com.
8. The Managed Care Plan must submit the Quarterly Fraud and Abuse Activity Report via MPI's web-based application. When registering as a first-time user, the registrant must first select its applicable Managed Care Plan name in the "Health Plan" drop-down box. When entering records, the approved user must select the appropriate contract type applicable for each record, related to the fraud and abuse issue being reported. Records may only be entered for the current quarter when the following conditions have been met:
 - a. Records from all previous quarters have been submitted, and
 - b. It is the 16th of the month or later for the current quarter.

Note: On the web-based application, if "other" is selected for any data element, a narrative box will open. The narrative box is required to be completed to describe or define what is meant by "other." If fines, sanctions, or recoupment is selected, a pop up box will open to enter the dollar amount. Detailed instructions are available through the web-based application.

For each new record entry, select the appropriate Medicaid Contract Type, by selecting either: COMP = (MMA+LTC), MMA Only, LTC, or Specialty as related to the fraud and abuse issue being reported for each record.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations.

REPORT TEMPLATE:

Notwithstanding the instructions in Chapter 1, the Agency's web-based application must be used as specified in the Report Guide. No alterations or duplication must be made by the Managed Care Plan to the report resulting from the Agency's web-based application. This application can be found at:

<https://apps.ahca.myflorida.com/QFAAR/login.aspx>

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Chapter 16: Suspected/Confirmed Fraud and Abuse Reporting

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan

REPORT PURPOSE:

The purpose of this report is for Managed Care Plans to report all suspected or confirmed fraud, abuse, and waste 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, abuse, and waste 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 the Inspector General/Medicaid Program Integrity (MPI):

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

https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx

INSTRUCTIONS:

The Managed Care Plan must report suspected or confirmed fraud, abuse, and waste relative to the Managed Care Plan's contract and Florida Medicaid. All suspected or confirmed instances of fraud, abuse, and waste 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, abuse, and waste should 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, abuse, and waste should 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, Abuse, or Waste is suspected or confirmed through use of the appropriate checkbox;
 - d. Select whether the report is regarding suspected or confirmed fraud, abuse, or waste 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, abuse, or waste 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, abuse, and waste should include the following information relative to the provider and allegations. Additionally, when the nature of the behavior is waste, as opposed to fraud or abuse, specific instances involving multiple providers, recipients, or Managed Care Plans may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, 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. Where the nature of the behavior is waste, as opposed to fraud or abuse, specific instances involving multiple providers, may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, where 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;
 - e. Provider's Tax Identification number. Where the nature of the behavior is waste, as opposed to fraud or abuse, specific instances involving multiple providers, may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, where the nature of the behavior is fraud or abuse, each instance and each provider 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, abuse or waste (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, abuse, and waste under state and/or federal law is 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). Where the nature of the behavior is waste, as opposed to fraud or abuse, specific instances involving multiple recipients may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, where the nature of the

- behavior is fraud or abuse, each instance and each recipient must be separately reported by way of the on-line report form;
- b. The enrollee's full name. Where the nature of the behavior is waste, as opposed to fraud or abuse, specific instances involving multiple recipients may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, where the nature of the behavior is fraud or abuse, each instance and each recipient must be separately reported by way of the on-line report form;
 - c. The enrollee's date of birth. Where the nature of the behavior is waste, as opposed to fraud or abuse, specific instances involving multiple recipients may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, where the nature of the behavior is fraud or abuse, each instance and each recipient must be separately reported by way of the on-line report form;
 - d. The enrollee's Medicaid ID number (ten digits). Where the nature of the behavior is waste, as opposed to fraud or abuse, specific instances involving multiple recipients may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, where the nature of the behavior is fraud or abuse, each instance and each recipient must be separately reported by way of the on-line report form;
 - e. A description of the acts allegedly involving suspected fraud, abuse, or waste and case status;
 - i. Nature of complaint, summarize the suspected or confirmed fraud, abuse or waste (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, abuse, and waste relating to the provision of and payment for Medicaid services including, but not limited to fraud, abuse, and waste acts related to the Managed Care Plan contract and/or Florida Medicaid that is other than provider and enrollee fraud, abuse, and waste (e.g., internal/occupational fraud, abuse, and waste 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 waste, as opposed to fraud or abuse, specific instances involving multiple Managed Care Plans or individuals, may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, 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 waste, as opposed to fraud or abuse, specific instances involving multiple Managed Care Plans or individuals, may be submitted by a single on-line form supplemented by additional information uploaded to the MPI SFTP site. However, 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, abuse or waste (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 MPIBusiness.Manager@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 MPIBusiness.Manager@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/InspectorGeneral/fraud_complaintform.aspx

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Chapter 17: Preadmission Screening and Resident Review (PASRR) **Report**

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

- | | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input checked="" type="checkbox"/> | MMA HMO |
| <input checked="" type="checkbox"/> | MMA Capitated PSN |
| <input checked="" type="checkbox"/> | MMA Specialty Plan |
| <input checked="" type="checkbox"/> | MMA CMS 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 SMMC 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 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, note if the recommended specialized services are being provided. – Enter: Y/N or N/A
- For enrollees who receive recommended specialized services, note if the recommended specialized 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 18: Enhanced Care Coordination Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

| | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input checked="" type="checkbox"/> | MMA HMO |
| <input checked="" type="checkbox"/> | MMA Capitated PSN |
| <input checked="" type="checkbox"/> | MMA Specialty Plan |
| <input checked="" type="checkbox"/> | MMA CMS 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 SMMC 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:

Template fields are as follows:

Managed Care Plan Information

Enter the following Managed Care Plan information:

- Managed Care Plan name
- Seven (7) -digit Managed Care Plan identification number
- Reporting month

Enter the following community enrollee information:

- Enrollee Name (Last, First)
- Enrollee Medicaid ID Number (ten digits)
- Enrollee Date of Birth (MM/DD/YYYY)
- Enrollee Region (where currently residing)
- Enrollee's county of residence
- Plan enrollment effective date (MM/DD/YYYY)
- Care coordinator (Name)
- Care coordinator's last contact with legal guardian (MM/DD/YYYY)
- Date service or transition plan developed (MM/DD/YYYY). Use comment section to delineate type of plan
- Date of service or transition plan update (MM/DD/YYYY). Use comment section to delineate type of plan
- Date of most recently conducted multidisciplinary team (MDT) staffing (MM/DD/YYYY)
- Date documents submitted for long-term care plan enrollment to the Department of Elder Affairs' Comprehensive Assessment and Review for Long-term Care Services (CARES) representative, for enrollees 18 through 20 years of age only (MM/DD/YYYY). Use comment section to note the enrollee's choice of long-term care Managed Care Plan or the application submission for iBudget waiver services to the Agency for Persons with Disabilities
- Comments – Enter comments pertaining to the enrollee's enhanced care coordination. If any date column reflects 00/00/0000, a comment is required as to why no date is included.

Enter the following nursing facility enrollee information:

- Enrollee Name (Last, First)
- Enrollee Medicaid ID Number (ten digits)
- Enrollee Date of Birth (MM/DD/YYYY)
- Enrollee Region (where currently residing)
- Enrollee's county of residence
- Plan enrollment effective date
- Care coordinator's name (Last, First)
- Initial date the enrollee was admitted to the Medicaid-certified nursing facility (NF), (MM/DD/YYYY). Enter the name of the NF where admitted. May abbreviate NF name, e.g., BCC. If abbreviating, the full name of the NF must be

in the comment section. The following are acceptable abbreviations for current Florida NFs providing pediatric long-term care services:

- BCC – Broward Children’s Center, Pompano Beach, Florida
- KK – Kidz Korner, Plantation, Florida
- Sabal – Sabal Palms, Largo, Florida
- Care coordinator’s last contact with enrollee or authorized representative (MM/DD/YYYY)
- Date transition plan developed (MM/DD/YYYY)
- Date of transition plan update (MM/DD/YYYY)
- Date of most recently conducted multidisciplinary team staffing (MM/DD/YYYY)
- Freedom of Choice Certificate. Start date (date of enrollee’s or authorized representative’s signature) (MM/DD/YYYY), End date (date of expiration) (MM/DD/YYYY)
- Enrollee’s or authorized representative’s choice of setting to receive services. – Place an “X” in the institution or community setting column. If the enrollee or authorized representative desires to transition services from the NF to a community setting and a barrier exists, place an “X” in the “Transition to community at a later date” column. Provide the barrier(s) in the comment section (e.g., need a larger home, need modifications to current home, etc.). May have an “X” in more than one column.
- Date of documents submitted for long-term care plan enrollment to CARES, (enrollees 18 through 20 years of age) (MM/DD/YYYY)
- Comments – Enter comments pertaining to the enrollee’s enhanced care coordination. If any date column reflects 00/00/0000, a comment is required as to why no date is included.

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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Section Three: Long-term Care Reports

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Chapter 19: Critical Incident Report- Individual

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

| | <u>Plan Type</u> |
|-------------------------------------|------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input type="checkbox"/> | MMA HMO |
| <input type="checkbox"/> | MMA Capitated PSN |
| <input type="checkbox"/> | MMA Specialty Plan |
| <input type="checkbox"/> | MMA CMS 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. Please reference the Core Contract provisions, Attachment II, Section I, Definitions, Critical Incident.

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-9 or ICD-10 Code for Admitting 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 20: Case Management File Audit Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

- | | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input type="checkbox"/> | MMA HMO |
| <input type="checkbox"/> | MMA Capitated PSN |
| <input type="checkbox"/> | MMA Specialty Plan |
| <input type="checkbox"/> | MMA CMS 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 benefits 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 SMMC SFTP site:

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

INSTRUCTIONS:

1. The Managed Care Plan must submit the Case Management File Audit Report in the format and layout specified in the report template.
2. The sample size for this report shall be 96 randomly selected files per quarter. A separate random sample of enrollees shall be used each quarter for this report.
3. Case files submitted in the sample shall be reviewed by case management supervisors.
4. Enter the Medicaid ID of each enrollee in the column titled "Enrollee Medicaid ID Number".

5. Enter the last name of each enrollee in the column titled “Enrollee Last Name”.
6. Enter the first name of each enrollee in the column titled “Enrollee First Name”.
7. Enter the date of birth for each enrollee in the column titled “Enrollee Date of Birth”.
8. Enter the enrollment date for each enrollee in the column titled “Enrollment Date”.
9. For each enrollee, review the case file and answer the question in the corresponding column. Please see the Interpretative Guidelines tab for additional reference on how to review the files. Each field should be filled in with either Y (Yes), N (No), N/A (Not Applicable), or UTL (Unable to Locate).
10. Once the review is completed and all fields are correctly input, calculate the compliance totals for each field. “Not Applicable”, and “Unable to Locate” fields should be left out of the denominator when calculating the percentages.

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: Case Management Monitoring and Evaluation Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan

REPORT PURPOSE:

The purpose of this report is to ensure that the Managed Care Plan has a system of internal monitoring of its case management program and it is well documented, for enrollees receiving LTC benefits.

FREQUENCY & DUE DATES:

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

An annual roll-up is due within thirty (30) calendar days after the end of the fourth (4th) calendar quarter.

SUBMISSION:

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

- Quarterly Case Management Monitoring and Evaluation Report using the template provided.
- A quarterly report attestation as described in Chapter 2.
- Annual Roll-Up of all calendar quarters using the same quarterly template provided.
- An annual report attestation as described in Chapter 2.

INSTRUCTIONS:

1. The Managed Care Plan must submit the Case Management Monitoring and Evaluation Report, both quarterly and annual roll-up, in the format and layout specified in the report template.

This must include the results of:

- a. Case file audits,
 - b. Reviews to determine the timeliness of enrollee assessments performed by case managers,
 - c. Reviews of the consistency of enrollee service authorizations performed by case managers, and
 - d. The development and implementation of continuous improvement strategies to address identified deficiencies.
2. The annual roll-up is separate from the fourth quarter report; however, both are due as specified under Frequency and Due Dates. The annual roll-up contains cumulative results from all calendar quarters.

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 22: Case Manager Caseload Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS Plan

REPORT PURPOSE:

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

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 SMMC SFTP site:

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

INSTRUCTIONS:

1. The Managed Care Plan must submit the Case Manager Caseload Report in the format and layout specified in the report template.
2. For the reporting month, the report must include the following on the Case Manager Caseloads tab:
 - Case Manager First Name
 - Case Manager Last Name
 - Enrollee Last Name
 - Enrollee's Medicaid ID (ten digits)
 - Type of Case Management Provided to Enrollee – Select one of the options below from the drop down menu to classify the type of case management based on the enrollee's residential setting:

- i. Community Only: Select this option for individuals age 18 and older, who live in a private residence, ALF, or Adult Family Care Home and are NOT receiving private duty nursing services.
- ii. Community ages 18-20 with private duty nursing (PDN): Select this option if the enrollee is residing in the community, is age 18-20, and is receiving private duty nursing services.
- iii. Community - PDO: Select this option if the enrollee is residing in the community and has elected to receive services through the Participant Directed Option (PDO).
- iv. Nursing Facility – 21 and older: Select this option for individuals who are residing in a skilled nursing facility who are age 21 and older.
- v. Nursing Facility – ages 18-20: Select this option for individuals who are residing in a skilled nursing facility and are between the ages of 18 and 20.
- vi. Mixed – 21 and older: Select this option if all individuals in the case manager’s caseload are over the age of 21, but reside in both the community and facilities.
- vii. Mixed – ages 18-20 with private duty nursing (PDN): Select this option if the case manager has a mixed caseload that includes individuals ages 18-20 that are receiving private duty nursing services (PDN).
- viii. Mixed – ages 18-20 in nursing facility: Select this option if the case manager has a mixed caseload that includes one or more individuals age 18-20 residing in a nursing facility.
- ix. Mixed – PDO: Select this option if the case manager has a mixed caseload that includes individuals who elected to receive services through the Participant Directed Option (PDO).

Caseload Summary Tab:

The number of case managers reported on the Caseload Summary tab should match the number of case managers reported on the Case Manager Caseloads tab.

For each section (Community Caseload, Facility Caseload, Mixed Caseload):

- Enter the first and last names of the case managers.
- Next to each case manager’s name, enter the total number of enrollees assigned to that case manager.
- Enter the calculated average number of enrollees managed by each type of case manager (Community, Facility, Mixed).

Case managers that have enrollees ages 18-20 who are receiving private duty nursing, or nursing facility services, should report these enrollees in the newly designated area located at the end of the Caseload Summary tab 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: Denial, Reduction, Termination or Suspension of Services Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

- | | <u>Plan Type</u> |
|-------------------------------------|------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input type="checkbox"/> | MMA HMO |
| <input type="checkbox"/> | MMA Capitated PSN |
| <input type="checkbox"/> | MMA Specialty Plan |
| <input type="checkbox"/> | MMA CMS 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 benefits.

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 SMMC SFTP site:

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

INSTRUCTIONS:

1. The Managed Care Plan must create the Denial, Reduction, Termination or Suspension of Services Report in the format and layout specified in the report template.
2. For the reporting month, the report must include the following, as specified by tab, that occurs during the reporting month:

Denial of Services Tab:

- Enrollee's Last Name
- Enrollee's First Name
- Enrollee's Medicaid ID Number (10 digits)
- Requested Services (service name must be identical to service names as listed in Attachment II, Exhibit II-B, Section V, Covered Services)
- Type of Request as defined by 42 CFR 438.210 (the following codes shall be used to identify the request type: Standard = ST, Standard Extended = SE, Expedited = EX, Extended Expedited = EE)
- Date request was received (MM/DD/YYYY)
- Date Notice of Action was sent to the enrollee (MM/DD/YYYY)
- Number of days between request and the notice of action being sent (business or calendar days according to Attachment II, Section VII.G.5)
- Reason for denial using the numerical denial code specified in the template

Reduction of Services Tab:

- Enrollee's Last Name
- Enrollee's First Name
- Enrollee's Medicaid ID Number (10 digits)
- Previously Authorized Service (service name must be identical to service names as listed in Attachment II, Exhibit II-B, Section V, Covered Services)
- Previously Authorized Service amount and frequency
- New Service amount and frequency
- Date of service reduction (MM/DD/YYYY)
- Date Notice of Action was sent to the enrollee (MM/DD/YYYY)
- Number of days between request and the notice of action being sent (business or calendar days according to Attachment II, Section VII.G.5)
- 42 CFR 431.213 exception reference (insert the corresponding letter from the CFR identifying which exception applies to this case. Acceptable responses are letters a-h. If the exception applied falls under 42 CFR 431.214, the reason code for "other" should be used and this column should be left blank) *
- Reason for reduction using the numerical reduction code specified in the template
- If the reduction is the result of an enrollee request, enter the date the request was received (MM/DD/YYYY). If not applicable, leave the field blank

Termination of Services Tab:

- Enrollee's Last Name
- Enrollee's First Name
- Enrollee's Medicaid ID Number (10 digits)
- Previously Authorized Service (service name must be identical to service names as listed in Attachment II, Exhibit II-B, Section V, Covered Services)
- Previously Authorized Service amount and frequency

- Date of service termination (MM/DD/YYYY)
- Date Notice of Action was sent to the enrollee (MM/DD/YYYY)
- Number of days between request and the notice of action being sent (business or calendar days according to Attachment II, Section VII.G.5)
- 42 CFR 431.213 exception reference (insert the corresponding letter from the CFR identifying which exception applies to this case. Acceptable responses are letters a-h. If the exception applied falls under 42 CFR 431.214, the reason code for “other” should be used and this column should be left blank) *
- Reason for termination using the numerical termination code specified in the template
- If the termination is the result of an enrollee request, enter the date the request was received (MM/DD/YYYY). If not applicable, leave the field blank

Suspension of Services Tab:

- Enrollee’s Last Name
- Enrollee’s First Name
- Enrollee’s Medicaid ID Number (10 digits)
- Previously Authorized Service (service name must be identical to service names as listed in Attachment II, Exhibit II-B, Section V, Covered Services)
- Previously Authorized Service amount and frequency
- Date notification was received (MM/DD/YYYY)
- Date Notice of Action was sent to the enrollee (MM/DD/YYYY)
- Number of days between request and the notice of action being sent (business or calendar days according to Attachment II, Section VII.G.5)
- 42 CFR 431.213 exception reference (insert the corresponding letter from the CFR identifying which exception applies to this case. Acceptable responses are letters a-h. If the exception applied falls under 42 CFR 431.214, the reason code for “other” should be used and this column should be left blank) *
- Reason for suspension using the numerical suspension code specified in the template

*Note: The references from 42 CFR 431.213 are below. If an applicable exception applies, the corresponding letter shall be inserted into the corresponding column on the report. If there is no applicable CFR exception, the field shall be left blank.

Section 431.213 Exceptions from advance notice.

The Agency may mail a notice not later than the date of action if – (a) The Agency has factual information confirming the death of a recipient; (b) The Agency receives a clear written statement signed by the recipient that – (1) He no longer wishes services; or (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; (c) The recipient has been admitted to an

institution where he is ineligible under the plan for further services; (d) The recipient's whereabouts are unknown and the post office returns Agency mail directed to him indicating no forwarding address (See s.431.231 (d) of this subpart for procedure if the recipient's whereabouts become known); (e) The Agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory or commonwealth; (f) A change in the level of medical care is prescribed by the recipient's physician; (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or (h) The date of action will occur in less than 10 days, in accordance with s.483.12(a)(5)(ii), which provides exceptions to the 30 day notice requirements of s.483.12(a)(5)(i).

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: Enrollee Roster and Facility Residence Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

| | <u>Plan Type</u> |
|-------------------------------------|------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input type="checkbox"/> | MMA HMO |
| <input type="checkbox"/> | MMA Capitated PSN |
| <input type="checkbox"/> | MMA Specialty Plan |
| <input type="checkbox"/> | MMA CMS Plan |

REPORT PURPOSE:

The purpose of this report is to provide information on the current physical location of each enrollee receiving LTC benefits. 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, by the fifteenth (15th) calendar day.

SUBMISSION:

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

- 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, including all Medicaid Pending and SIXT enrollees, and the facility in which they are currently residing, if applicable.

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 25: Missed Services Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 benefits 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 following to the SMMC SFTP site:

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

INSTRUCTIONS:

1. The Managed Care Plan shall create the Missed Services Report in the format and layout specified in the report template. A missed service is defined as any authorized facility or non-facility covered service unit that was not provided as authorized and/or on the scheduled date and time.
2. Data to be reported includes, but is not limited to the following:
 - Enrollee's full name (last, first)
 - Enrollee's Medicaid ID (ten (10) digits)
 - Region (select from the drop down menu on the template)
 - County of Residence (select from the drop down menu on the template)
 - Provider Name

- Authorized service type (select from the drop down menu on the template)
- Number of authorized service units for the reported month: insert the total number of authorized service units for this service for the month
- Number of missed service units per date missed: insert the number of authorized service units that were not provided as authorized and/or on the scheduled date and time per day
- Percentage of missed service units per date missed (calculate the total percentage of service units that were missed by using the following formula: Number of Missed Service Units / Authorized Service Units)
- Reason for missed service (missed service codes are provided on the instruction tab of the template)
- Date of missed service(s)
- Date Managed Care Plan was notified of missed service
- Date services resumed
- Explanation and resolution of missed services

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: Participant Direction Option (PDO) Roster Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

- | | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input type="checkbox"/> | MMA HMO |
| <input type="checkbox"/> | MMA Capitated PSN |
| <input type="checkbox"/> | MMA Specialty Plan |
| <input type="checkbox"/> | MMA CMS 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 benefits. 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 following to the SMMC SFTP site:

- 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 should 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.
5. PDO Roster tab:
 - Managed Care Plan Name
 - Reporting Date (MM/DD/YYYY)
 - Enrollee's Last Name
 - Enrollee's First Name
 - Enrollee's Medicaid ID number (10 digits)
 - Region: select the region from the drop down menu
 - County of Residence: select the county from the drop down menu
 - PDO Services Received: place an "X" in the appropriate box(es)
 - PDO Enrollment Status: select the enrollee's status from the drop down menu
 - PDO Enrollment Date: insert the enrollee's date of enrollment for PDO
 - PDO Disenrollment Date: insert the date the enrollee was disenrolled from PDO
 - PDO Disenrollment Reason: select the reason for disenrollment from the drop down menu (if "other" is selected, please include a description in the comments section)
 - Comments

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 27: Patient Responsibility Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

| | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input type="checkbox"/> | MMA HMO |
| <input type="checkbox"/> | MMA Capitated PSN |
| <input type="checkbox"/> | MMA Specialty Plan |
| <input type="checkbox"/> | MMA CMS Plan |

REPORT PURPOSE:

The purpose of this report is to provide a comparison of the total cost of home and community-based services (HCBS) to the enrollee's assigned patient responsibility amount for the prior calendar year, for enrollees receiving LTC benefits.

FREQUENCY & DUE DATES:

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

SUBMISSION:

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

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

INSTRUCTIONS:

1. The Managed Care Plan must create the Patient Responsibility Report in the format and layout specified in the report template.
2. Data to be reported includes the following:
 - Enrollee's name (last, first)
 - Enrollee's Medicaid ID (ten digits)
 - Total patient responsibility amount
 - Total cost of home and community-based services enrollee received
 - Service(s) for which the Managed Care Plan and enrollee agreed that patient responsibility was/would be applied
 - Total cost of other Medicaid services enrollee received via the Managed Care Plan

- Is the total cost of the HCBS received greater than or equal to the enrollee's patient responsibility amount?

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: Unable to Locate/Contact Enrollee Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

- | | <u>Plan Type</u> |
|-------------------------------------|-------------------------|
| <input checked="" type="checkbox"/> | Comprehensive LTC Plan |
| <input type="checkbox"/> | MMA HMO |
| <input type="checkbox"/> | MMA Capitated PSN |
| <input type="checkbox"/> | MMA Specialty Plan |
| <input type="checkbox"/> | MMA CMS Plan |

REPORT PURPOSE:

The purpose of this report is to formalize and establish LTC plans' reporting of enrollees receiving LTC benefits whom the plans are unable to locate and/or contact as indicated in the LTC Contract/ Exhibit.

FREQUENCY & DUE DATES:

This report is due monthly, within five (5) calendar 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 SMMC SFTP site:

- LTC Plan Unable to Locate/Contact Enrollee 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 locate or contact the enrollee within any 60- day period, which includes the reporting month. The enrollee shall remain on the Unable to Locate/Contact Enrollee Report until located/contacted or disenrolled.

The Managed Care Plan shall report the following to the Agency in accordance with the format set forth in the Unable to Locate/Contact Enrollee Report Template:

- 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 Middle Initial
- Enrollee's DOB (Date of Birth) (MM/DD/YYYY)
- County
- Last Known Address
- Last Known Address2
- City
- State (two-character identifier)
- Zip Code (five (5) digits)
- Able to Locate? Y or N
- Location of Enrollee (n/a if unable to locate)
- Able to Contact? Y or N
- Date of Last Contact
- Date of Death, if applicable
- Last Date that services were provided
- Comments; Demonstration of Attempts to Contact or Locate

The Managed Care Plan shall report monthly all of the above information in the report template provided for each enrollee the plan is unable to locate and/or contact in any 60-day period, which includes the reporting month. One Excel workbook shall be submitted for each plan. The plan shall insert additional rows as necessary to completely report on all enrollees whom it has been unable to locate and/or contact.

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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Section Four: Managed Medical Assistance Reports

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Chapter 29: CHCUP (CMS-416) and FL 80% Screening

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 Child Health Check Up (CHCUP) screening and participation, for enrollees receiving MMA benefits.

FREQUENCY & DUE DATES:

The Audited CHCUP (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 SMMC SFTP site:

- For the Audited CHCUP (CMS-416) and FL 80% Screening Ratio Report:
 - a. The completed Audited CHCUP and FL 80% Screening Ratio Agency-supplied templates submitted as an Excel file and named: A-CHCUP-***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-CHCUP-ABC1314.xls").
 - b. The independent auditor's report summary and letter of opinion, which must be submitted as a PDF file and named AO-CHCUP-***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-CHCUP-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 CHCUP report. Note: the audited CHCUP 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 should 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 CHCUP services, referrals and dental services in the appropriate lines.
4. Count only CHCUPs that were completed when eligibles were enrollees of the reporting HMO/PSN. Do not count CHCUPs 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" CHCUP screening. (A catch-up CHCUP 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 should 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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Chapter 30: ER Visits for Enrollees without PCP Appointment Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 benefits who have not had at least one appointment with their primary care provider since the beginning of their enrollment in the plan, in accordance with Exhibit II-A, Sections V. and XIV. of the SMMC contract.

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 following to the SMMC SFTP site:

- ER Visits for Enrollees without PCP 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 Appointment Report Template provided at the link 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.

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Chapter 31: Healthy Behaviors Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 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 SMMC SFTP site:

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

INSTRUCTIONS:

1. The Managed Care Plan must report only newly enrolled individuals in Healthy Behaviors programs for each reporting quarter. Quarterly reporting of enrollee participation in Healthy Behaviors programs must be unduplicated 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.

3. For the reporting quarter, the report must include but not be limited to:

- Plan Name
- Plan Type
- Plan Medicaid ID (seven (7) -digit)
- Reporting Quarter: Quarter for which data is being reported
- Reporting Year
- Report Submission Date
- Report Submitted By- Name of person submitting report
- Number of recipients enrolled in Medically Approved Smoking Cessation Program, Medically Directed Weight Loss Program, Medically Approved Alcohol or Substance Abuse Recovery Program and Other Approved Program(s)
- Number of recipients by gender (Males/Females) enrolled in Medically Approved Smoking Cessation Program, Medically Directed Weight Loss Program, Medically Approved Alcohol or Substance Abuse Recovery Program and Other Approved Program(s)
- Number of recipients by age (0-20, 21-40, 41-60, over 60) enrolled in Medically Approved Smoking Cessation Program, Medically Directed Weight Loss Program, Medically Approved Alcohol or Substance Abuse Recovery Program and Other Approved Program(s)
- List Type of Incentive/Reward and Value of Incentive/Reward for each program: Medically Approved Smoking Cessation Program, Medically Directed Weight Loss Program, Medically Approved Alcohol or Substance Abuse Recovery Program and Other Approved Program(s)

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.

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Chapter 32: Hernandez Settlement Agreement Survey

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 SMMC 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 33: Hernandez Settlement Ombudsman Log

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 SMMC 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 34: PLACEHOLDER for PCP Appointment Report

UNDER DEVELOPMENT

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Chapter 35: Timely Access/PCP Wait Times Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 its participating PCP offices' average appointment wait times through a statistically valid sample, and to ensure these PCP offices are held accountable to contractually obligated standards for enrollees receiving MMA benefits (See Contract Attachment II, Exhibit II-A, Section VI, Provider Network).

FREQUENCY & DUE DATES:

This report is due annually, on or before February 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 SMMC SFTP site:

- The completed report using the Agency-supplied template, which must be submitted as an XLS 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 submit the completed report using the Agency's supplied template (see the "Report Template" section of this chapter).
 - a. On the Cover Sheet of the report template, the Managed Care Plan must:
 - Indicate which calendar year is being reported; and
 - Submit the methodology used to determine a "statistically valid" sample.
 - b. On the PCP Wait Times Sheet of the report template, the Managed Care Plan must:
 - Indicate the PCP information and the number of calendar days for PCP

services and referrals to specialists for covered services.

2. The Managed Care Plan must refer to Exhibit II-A, Section VI of the Managed Care Plan Contract for pertinent wait time definitions.

VARIATIONS BY MANAGED CARE PLAN TYPE:

No variations

REPORT TEMPLATE:

The Agency's template consists of the following:

- A Cover Sheet; and
- A PCP Wait Times worksheet.

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 36: Supplemental HIV/AIDS Report

SMMC PLAN TYPES

The following Managed Care Plans may submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMS 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 SMMC SFTP Site:

- 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 is 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 37: Residential Psychiatric Treatment Report

SMMC PLAN TYPES

The following Managed Care Plans must submit this report:

Plan Type

- Comprehensive LTC Plan
- MMA HMO
- MMA Capitated PSN
- MMA Specialty Plan
- MMA CMSN Plan

REPORT PURPOSE:

The purpose of this report is to provide the Agency information regarding enrollees under the age of twenty-one (21) years who are receiving residential psychiatric treatment.

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 SMMC 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.