Statewide Medicaid Managed Care (SMMC) Managed Care Plan
Report Guide
Effective 05-13-2021

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Chapter 1: General Overview

Purpose of Report Guide

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

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

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

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

Chapter 2, General Reporting Requirements, covers the general report submission and certification requirements for the health plans and the Dental Plans. After these introductory chapters are report summaries that cover specific report certification information and specific individual report instructions.

Each report summary, and any accompanying report template(s), are located directly below the Report Guide, listed in alphabetical order by the name of the report, on the Report Guide webpage http://ahca.myflorida.com/Medicaid/statewide_mc/plans_FY18-23.shtml.

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

- ➢ Benefit type(s) that are required to provide the report.
- ➢ Report purpose.
- ➢ Report frequency requirements and due dates.
- ➢ Report code and submission requirements.
- ➢ Specific instructions and requirements for completion, including any variances specific to a particular Managed Care Plan or Dental Plan.

Reading this Report Guide will produce the following four results:

- An understanding of the Managed Care Plan's and Dental 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 and Dental Plans to the Agency.

This Report Guide is referenced in each Managed Care Plan's and Dental Plan's Contract with the Agency, and each report is summarized in this Report Guide, the Report Summary, and the instructions included in each Report Template.

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

Report Guide Updates

As specified in each Managed Care Plan and Dental Plan Contract, the Agency reserves the right to modify reporting requirements periodically. The Agency will update the Report Guide through the issuance of one of the following types of plan communications:

- policy transmittal,
- contract interpretation, or
- report change notice.

Unless otherwise specified in the plan communication, updates to a report are effective ninety (90) days from the issue date of the plan communication. The Agency posts plan communications at http://ahca.myflorida.com/Medicaid/statewide_mc/plans_FY18-23.shtml.

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 and Dental Plan. The report templates can be found by using the link that is located above, in the "Report Guide Updates" section, to access the Agency website. For any report that has alternate template instructions listed under the "Report Template" section of the report summary, the alternate instructions must be followed by the Managed Care Plan and Dental Plan.

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

section labeled “Submission”. In such cases, the Dental Plans must use the designated file name instead of the standard file naming convention.

Chapter 2: General Reporting Requirements

General Report Certification Requirements

In addition to the specific report requirements found in subsequent report summaries and the SMMC Contract Submission Requirements Summary Chart, all Managed Care Plans and Dental 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 and Dental 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 and Dental 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)) under penalty of perjury. The Managed Care Plan and Dental Plan must submit its attestation at the same time it submits the certified data reports (see 42 CFR 438.606(c)).*

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

The attestation can simply state:

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

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

- If a Managed Care Plan or Dental Plan is submitting one weekly report and four quarterly reports at the same time on February 2, 2019, the Managed Care Plan or Dental Plan would submit one attestation listing all five reports being submitted.

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

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

Report Accuracy and Submission Timeliness

- The written delegation of authority must be submitted with the attestation and renewed each calendar year.

- The deadline for report submission referred to in the Contract provision is the actual time of receipt at the Agency bureau or location, not the date the file was postmarked or transmitted.

- If a reporting due date falls on a weekend or holiday, the report is due to the Agency on the following business day. State-recognized holidays can be found on the State of Florida's website at http://myflorida.com.

SFTP Site Access

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

- SMMC CY18-23 SFTP site.

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

Report Naming and Identification

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

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

- Provider Network File

- Suspected/Confirmed Fraud and Abuse Reporting

- Achieved Savings Rebate (ASR) Financial Reports

- Non-Special Needs (Non-SNP) Financial Reports

- Case Manager and Provider Training Report

- Provider Network and Qualifications Report

- Reports submitted directly to the Agency's Fiscal Agent or other delegated entities outside of the Agency that maintain their own file naming convention.

- Attestations must use the following naming convention: "ABCYYYYMMDDA", where ABC stands for the Managed Care Plan's or Dental Plan's three-character identifier from the Plan Identifier Table, YYYY stands for the four-digit year in which the report(s) are being submitted, MM stands for the two-digit month in which the report(s) are being submitted, DD stands for the two-digit day on which the report/attestation is submitted to the Agency, and A stands for the attestation. If multiple batches of reports and attestations are submitted in one day, a two-digit numeric indicator will be added after the "A". For example, if there are two batches of reports submitted at different times on February 2, 2019,

requiring two separate attestations, the naming convention of the first file would be – "ABCYYYYMMDDA" and the naming convention of the second file would be – "ABCYYYYMMDDA02".

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

SMMC PLAN IDENTIFIER TABLE	
Plan Identifier	**MMA Plan Name**
BST	Best Care Assurance d/b/a Vivida Health
NBD	Community Care Plan
PRS	Florida True Health d/b/a Prestige Health Choice
LHT	Lighthouse Health Plan
MCH	Miami Children's Health Plan
Plan Identifier	**MMA Specialty Plan Name**
SHP	Clear Health Alliance – HIV/AIDS Specialty Plan
STW	Staywell - SMI Specialty Plan
SUN	Sunshine State - Child Welfare Specialty Plan
MCC	Magellan Complete Care – SMI Specialty Plan
CMS	Children's Medical Services – CMS Specialty Plan
Plan Identifier	**LTC Plus Plan Name**
FCC	Florida Community Care (FCC)
Plan Identifier	**Comprehensive Plan Name**
COV	Coventry d/b/a Aetna Better Health of Florida
HUM	Humana Medical Plan
MOL	Molina Health Care of Florida
SHP	Simply Health Care Plan
SUN	Sunshine State Health Plan
URA	United Health Care Plan
STW	Wellcare of Florida d/b/a Staywell Health Plan
Plan Identifier	**Dental Plan Name**
DQT	DentaQuest of Florida
LIB	Liberty Dental Plan of Florida
MCA	Managed Care of North America

- The standard file naming convention is as follows:

  - The Managed Care Plan's or Dental 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 found in the report's Report Guide Chapter.
- For resubmissions: Two digits representing the submission number after the report code number.

- There are **NO** dashes, spaces or other characters between each field.

- For reports that require supplemental documents, the document must be submitted in a .zip file using the file naming convention for that report. This .zip file may not be password protected.

Resubmitted or Corrected Reports

- Resubmitted or corrected reports are accepted on or before the due date only. Resubmitted or corrected reports must be submitted with the same file name as the original report. **Exception**: If the resubmission is due to a correction needed for an incorrect file name, the file must be resubmitted using the correct file naming convention.

- Resubmissions after a report due date are only accepted when the Agency or Agency designee requests a resubmission of a report previously submitted. The Managed Care Plan or Dental Plan shall submit the report using the original naming convention with the addition of a two-digit numeric indicator after the report code number to indicate subsequent submissions. For example, the naming convention of the first report submitted on October 30, 2019 would be (ABC201910CM090145); the naming convention of the second report submitted on November 3, 2015 would be (ABC201910CM09014502) – with the addition of the numeric value '02" after the report code number.

- Submission of multiple variable reports on the same day will be accepted. The Managed Care Plan or Dental Plan shall submit the report using the variable report naming convention with the addition of a numeric indicator after the report code number to indicate subsequent submissions. For example, the naming convention of the first variable report submitted on October 30th would be (ABC201910CV300159); the naming convention of the second variable report submitted on October 30th would be (ABC201910CV3015902) – with the addition of the numeric value "02" after the report code number.

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

- Examples of standard file naming conventions are provided at the end of this chapter.

For any report that has a designated file name listed in the individual Report Guide chapter under the section labeled "Submission", the designated file name must be used instead of the standard

file naming convention. Please submit all such reports and their accompanying attestations in the file formats designated within the "Submission" sections of the report chapters.
Some reports will require the use of a two-digit numeric county code. The two-digit numeric county codes to be used for all such reports are provided on the County Code Table in following pages.

General Submission and Size Limits

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

1. The Managed Care Plan or Dental 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 or Dental Plan must discuss potential alternative delivery methods with its Agency contract manager.

Additional Reporting Format Instructions

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

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

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

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

Report Year Type Table	
Report Year Type	**Report Year Period**
K = Contract	10/01 – 09/30
F = Federal	10/01 – 09/30

Report Year Type Table	
Report Year Type	**Report Year Period**
R = Rate	10/01 – 09/30
S = State	07/01 – 06/30
C = Calendar	01/01 – 12/31

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

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

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

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File Naming Convention Examples

Example: File Name **ABC201910KA180139 =**

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

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

Example: File Name **ABC201904CQ010102=**

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

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

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

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

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