Health Plan Report Guide
(for use with the September 1, 2012 Medicaid Health Plan Contract, NOT for use with the Statewide Medicaid Managed Care Contracts)

Effective 01/01/2014
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>TABLE OF CONTENTS</td>
<td>2</td>
</tr>
<tr>
<td>CHAPTER 1</td>
<td>5</td>
</tr>
<tr>
<td>GENERAL OVERVIEW</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER 2</td>
<td>16</td>
</tr>
<tr>
<td>GENERAL REPORTING REQUIREMENTS</td>
<td>16</td>
</tr>
<tr>
<td>CHAPTER 3</td>
<td>30</td>
</tr>
<tr>
<td>AUDITED ANNUAL AND UNAUDITED QUARTERLY FINANCIAL REPORTS</td>
<td>30</td>
</tr>
<tr>
<td>CHAPTER 4</td>
<td>34</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH - ANNUAL PROVIDER AUDIT REPORT</td>
<td>34</td>
</tr>
<tr>
<td>CHAPTER 5</td>
<td>36</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH ANNUAL 80/20 EXPENDITURE REPORT</td>
<td>36</td>
</tr>
<tr>
<td>CHAPTER 6</td>
<td>41</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH - CRITICAL INCIDENT REPORT - INDIVIDUAL</td>
<td>41</td>
</tr>
<tr>
<td>CHAPTER 7</td>
<td>44</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH - CRITICAL INCIDENT REPORT - SUMMARY</td>
<td>44</td>
</tr>
<tr>
<td>CHAPTER 8</td>
<td>46</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH - ENCOUNTER DATA REPORT</td>
<td>46</td>
</tr>
<tr>
<td>CHAPTER 9</td>
<td>50</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH – ENROLLEE SATISFACTION SURVEY SUMMARY</td>
<td>50</td>
</tr>
<tr>
<td>CHAPTER 10</td>
<td>52</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH - FARS/CFARS REPORTS</td>
<td>52</td>
</tr>
<tr>
<td>CHAPTER 11</td>
<td>55</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH – PHARMACY ENCOUNTER DATA REPORT</td>
<td>55</td>
</tr>
<tr>
<td>CHAPTER 12</td>
<td>58</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH REQUIRED STAFF/PROVIDERS REPORT</td>
<td>58</td>
</tr>
<tr>
<td>CHAPTER 13</td>
<td>61</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH – STAKEHOLDERS’ SATISFACTION SURVEY – SUMMARY</td>
<td>61</td>
</tr>
<tr>
<td>CHAPTER 14</td>
<td>63</td>
</tr>
<tr>
<td>CHCUP (CMS-416) &amp; FL 60% SCREENING REPORT</td>
<td>63</td>
</tr>
<tr>
<td>CHAPTER 15</td>
<td>66</td>
</tr>
<tr>
<td>CLAIMS AGING REPORT &amp; SUPPLEMENTAL FILING REPORT</td>
<td>66</td>
</tr>
<tr>
<td>CHAPTER 16</td>
<td>69</td>
</tr>
<tr>
<td>CODE 15 – CRITICAL INCIDENT REPORT</td>
<td>69</td>
</tr>
<tr>
<td>CHAPTER 17</td>
<td>71</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>PAGE</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>18</td>
<td>COMMUNITY OUTREACH HEALTH FAIRS/PUBLIC EVENTS NOTIFICATION</td>
</tr>
<tr>
<td>19</td>
<td>COMMUNITY OUTREACH REPRESENTATIVE REPORT</td>
</tr>
<tr>
<td>20</td>
<td>COMPLAINTS, GRIEVANCES, AND APPEALS REPORT</td>
</tr>
<tr>
<td>21</td>
<td>CRITICAL INCIDENT REPORT</td>
</tr>
<tr>
<td>22</td>
<td>CRITICAL INCIDENT SUMMARY REPORT</td>
</tr>
<tr>
<td>23</td>
<td>CULTURAL COMPETENCY PLAN (AND ANNUAL EVALUATION)</td>
</tr>
<tr>
<td>24</td>
<td>CUSTOMIZED BENEFIT NOTIFICATIONS REPORT</td>
</tr>
<tr>
<td>25</td>
<td>ENHANCED BENEFITS REPORT</td>
</tr>
<tr>
<td>26</td>
<td>HERNANDEZ SETTLEMENT AGREEMENT LOG</td>
</tr>
<tr>
<td>27</td>
<td>HERNANDEZ SETTLEMENT AGREEMENT SURVEY</td>
</tr>
<tr>
<td>28</td>
<td>INPATIENT DISCHARGE REPORT</td>
</tr>
<tr>
<td>29</td>
<td>INSOLVENCY PROTECTION MULTIPLE SIGNATURES AGREEMENT FORM</td>
</tr>
<tr>
<td>30</td>
<td>INVOLUNTARY DISENROLLMENT REPORT</td>
</tr>
<tr>
<td>31</td>
<td>MEDICAID REDETERMINATION NOTICE SUMMARY REPORT</td>
</tr>
<tr>
<td>32</td>
<td>MEDICAID SUPPLEMENTAL HIV/AIDS REPORT</td>
</tr>
<tr>
<td>33</td>
<td>MPI - ANNUAL FRAUD AND ABUSE ACTIVITY REPORT</td>
</tr>
<tr>
<td>34</td>
<td>MPI - QUARTERLY FRAUD AND ABUSE ACTIVITY REPORT</td>
</tr>
<tr>
<td>35</td>
<td>MPI - SUSPECTED/CONFIRMED FRAUD AND ABUSE REPORTING</td>
</tr>
</tbody>
</table>
Chapter 1

General Overview

About Florida Medicaid and the Agency for Health Care Administration

The Agency for Health Care Administration (referred to as “Agency” or “AHCA”) seeks to provide better health care for all Floridians and is the agency that oversees Florida’s Medicaid program. Medicaid is a state and federal partnership providing health care for children, elders and disabled adults with low incomes. Florida began offering Medicaid in 1970. Core services are available through Medicaid in all states as required by federal law. Each state may offer optional services, which require legislative approval.

Florida Medicaid Managed Care

Medicaid services are available on a fee-for-service basis statewide. Several managed care programs also serve Medicaid participants. They help coordinate care and hold down the cost of health care. Medicaid’s managed care programs include the MediPass primary care case management program, health maintenance organizations (HMOs), provider service networks (PSNs), prepaid dental program, prepaid mental health plan program, disease management programs, nursing home diversion program, and the minority physician network program.

About Medicaid Health Plans

Health plans provide the necessary resources and provider networks to deliver covered Medicaid services. The Agency manages the health plan contracts and their methods of service delivery. The Agency works closely with health plans to prevent or report any fraud and abuse of Medicaid. Contract requirements vary depending on the type of health plan. Some Florida counties participate in a Medicaid Reform pilot testing new ways to deliver Medicaid services. This Report Guide covers ten types of health plans participating in Florida Medicaid:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Non-Reform FFS PSN Capitated for Behavioral Health
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

This Report Guide is not to be used with the Statewide Medicaid Managed Care Contracts.
Purpose of Report Guide

The Report Guide is a companion to each health plan’s contract with AHCA. It provides details of plan reporting requirements including instructions, templates, and submission directions. Chapter 2, General Report Information and Certification, covers the general AHCA report certification requirements. After these introductory chapters, the remaining chapters cover general certification information and specific individual report formats.

Each remaining chapter discusses an individual specific report. Within each individual report chapter, the following report-specific items are covered:

- Health 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 format and any variances specific to a particular health plan type.
- Report template.

Reading this guide should produce the following four results:

- An understanding of which health plans are responsible for the submission of which reports.
- A clear concept of what each report requires and how it is best fulfilled.
- A specific report format to maintain consistency in the data flow.
- A single location for all format requirements for all contractual non-X-12 reports that must be submitted by health plans to the Agency.

This guide is referenced in each of the plan contracts in Attachment II, Section XII, along with a brief summary of reporting requirements. All of the reports within the guide are a contractual obligation of the health plan to the Agency, and plans are responsible for their accurate completion and timely submission. Non-compliant health plans are subject to sanctions.

Sanctions

As described in 42 CFR 438.700, the Agency may impose sanctions on a health plan if it determines that the plan has not complied with contract terms. As specified in the model health plan contract Attachment II, Section I, each day a violation continues is considered a separate violation.

If the health plan fails to submit required reports accurately and on time, the Agency may apply a fine of $200 per day per report in accordance with the health plan contract.
and Rule 59A-12.0073, F.A.C. Other possible sanctions for contract violation are also included in Attachment II, Section XIV of the health plan’s contract.

**Liquidated Damages**

In accordance with the health plan contract, the Agency is entitled to liquidated damages as a result of the health plan’s breach or failure to meet contract responsibilities. Specific liquidated damages for contract reporting violations are specified in Attachment II, Section XVII, of the Health Plan Contract.

**Report Guide Updates**

As specified in each health plan contract, the Agency reserves the right to modify reporting requirements with a 90-calendar-day written notice to the health plan, unless otherwise required by law. The Agency will post updates to the guide on the AHCA website at: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml

In general, the Report Guide may change on a calendar quarter basis. Changes in templates between Report Guide postings are provided on the website above under the heading, Templates (see snapshot below).
Summary Table of Health Plan Reports (non X-12 Reports)

The table below lists the following health plan reports required by the Agency. For each of the chapters in the Report Guide, please refer to this table for specific contract cites. Additional reporting requirements are specified in the Medicaid Health Plan Contract.

SUMMARY OF REPORTING REQUIREMENTS

Health plan reports required by the Agency and included in this Report Guide are as follows:

<table>
<thead>
<tr>
<th>Report Guide Chapter</th>
<th>Report Name</th>
<th>Health Plan Type</th>
<th>Frequency</th>
<th>Submit To</th>
<th>Contract Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 3</td>
<td>Audited Annual and Unaudited Quarterly Financial Reports</td>
<td>All Health Plans except CCC</td>
<td>Audited - Annually by April 1&lt;sup&gt;st&lt;/sup&gt; for each calendar year; Unaudited – Quarterly, forty-five (45) calendar days after end of each reported quarter</td>
<td>BMHC</td>
<td>Section XV</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Behavioral Health – Annual Provider Audit Report</td>
<td>All Health Plans</td>
<td>Annually, by October 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td>Chapter 5</td>
<td>Behavioral Health Annual 80/20 Expenditure Report</td>
<td>NR HMO; NR Cap PSN; NR HIV/AIDS; NR FFS PSN - BH CAP</td>
<td>Annually, by April 1&lt;sup&gt;st&lt;/sup&gt;; Supplemental file due February 1 of the following year for plans that reported IBNR</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td>Chapter 6</td>
<td>Behavioral Health Critical Incident Report - Individual</td>
<td>All Health Plans</td>
<td>Immediately, no later than twenty-four (24) hours after occurrence or knowledge of incident</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td>Chapter 7</td>
<td>Behavioral Health Critical Incident Report - Summary</td>
<td>All Health Plans</td>
<td>Monthly, by the 15&lt;sup&gt;th&lt;/sup&gt;</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td>Report Guide Chapter</td>
<td>Report Name</td>
<td>Health Plan Type</td>
<td>Frequency</td>
<td>Submit To</td>
<td>Contract Section</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Chapter 8</td>
<td>Behavioral Health - Encounter Data Report</td>
<td>NR HMO; NR Cap PSN; Ref HMO; Ref Cap PSN; Ref HIV/AIDS; NR HIV/AIDS; NR FFS PSN - BH CAP</td>
<td>Quarterly, forty-five (45) calendar days after end of reporting quarter</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health - Enrollee Satisfaction Survey Summary</td>
<td>All Health Plans</td>
<td>Annually by March 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>BMHC behavioral health analyst</td>
<td>Section VI</td>
</tr>
<tr>
<td>Chapter 10</td>
<td>Behavioral Health - FARS/CFARS</td>
<td>All Health Plans</td>
<td>Semi-Annually, August 15&lt;sup&gt;th&lt;/sup&gt; and February 15&lt;sup&gt;th&lt;/sup&gt;</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td>Chapter 11</td>
<td>Behavioral Health – Pharmacy Encounter Data Report</td>
<td>NR HMO; NR Cap PSN; Ref HMO; Ref Cap PSN; Ref HIV/AIDS; NR HIV/AIDS</td>
<td>Quarterly, forty-five (45) calendar days after end of reporting quarter</td>
<td>BMHC</td>
<td>Section V and Section VI</td>
</tr>
<tr>
<td>Chapter 12</td>
<td>Behavioral Health - Required Staff/Providers Report</td>
<td>All Health Plans</td>
<td>Quarterly, forty-five (45) calendar days after end of reporting quarter for Health Plans operating less than one (1) year; Annually, by August 15&lt;sup&gt;th&lt;/sup&gt;, for all other Health Plans</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td>Chapter 13</td>
<td>Behavioral Health - Stakeholders’ Satisfaction Survey - Summary</td>
<td>All Health Plans</td>
<td>Annually, by March 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>BMHC</td>
<td>Section VI</td>
</tr>
<tr>
<td>Chapter 14</td>
<td>CHCUP (CMS-416) &amp; FL 60% Screening (Child Health Check Up report)</td>
<td>All Health Plans</td>
<td>Annually, unaudited by January 15&lt;sup&gt;th&lt;/sup&gt; for prior federal fiscal year; Annually, audited report by October 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>BMHC</td>
<td>Section V</td>
</tr>
<tr>
<td>Report Guide Chapter</td>
<td>Report Name</td>
<td>Health Plan Type</td>
<td>Frequency</td>
<td>Submit To</td>
<td>Contract Section</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------</td>
<td>------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Chapter 15</td>
<td>Claims Aging Report &amp; Supplemental Filing Report</td>
<td>All Health Plans</td>
<td>Quarterly, forty-five (45) calendar days after end of reporting quarter; Capitated Plans, optional supplemental filing – one-hundred and five (105) calendar days after end of reporting quarter</td>
<td>BMHC</td>
<td>Section X</td>
</tr>
<tr>
<td>Chapter 16</td>
<td>Code 15 – Critical Incident Report</td>
<td>All Health Plans</td>
<td>Within fifteen (15) calendar days of the Health Plan receiving notification of the injury</td>
<td>BMHC Plan Analyst via copy of HQA online form</td>
<td>Section VIII</td>
</tr>
<tr>
<td>Chapter 17</td>
<td>Community Outreach Health Fairs/Public Events Notification</td>
<td>All Health Plans</td>
<td>Monthly, no later than 20th calendar day of month before event month; amendments two (2) weeks before event.</td>
<td>BMHC</td>
<td>Section IV</td>
</tr>
<tr>
<td>Chapter 18</td>
<td>Community Outreach Representative Report</td>
<td>All Health Plans</td>
<td>Two (2) weeks before activity Quarterly, forty-five (45) calendar days after end of reporting quarter</td>
<td>BMHC</td>
<td>Section IV</td>
</tr>
<tr>
<td>Chapter 19</td>
<td>Complaints, Grievance, and Appeals Report</td>
<td>All Health Plans</td>
<td>Quarterly, fifteen (15) calendar days after end of quarter</td>
<td>BMHC</td>
<td>Section IX</td>
</tr>
<tr>
<td>Chapter 20</td>
<td>Critical Incident Report</td>
<td>All Health Plans</td>
<td>Immediately upon occurrence and within twenty-four (24) hours of detection or notification</td>
<td>BMHC</td>
<td>Section VIII</td>
</tr>
<tr>
<td>Report Guide Chapter</td>
<td>Report Name</td>
<td>Health Plan Type</td>
<td>Frequency</td>
<td>Submit To</td>
<td>Contract Section</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------------</td>
</tr>
<tr>
<td>Chapter 21</td>
<td>Critical Incident Summary</td>
<td>All Health Plans</td>
<td>Monthly, by the fifteenth (15th) calendar day of the month following the report month</td>
<td>BMHC</td>
<td>Section VIII</td>
</tr>
<tr>
<td>Chapter 22</td>
<td>Cultural Competency Plan (and Annual Evaluation)</td>
<td>All Health Plans</td>
<td>Annually, June 1st</td>
<td>BMHC</td>
<td>Section VIII</td>
</tr>
<tr>
<td>Chapter 23</td>
<td>Customized Benefit Notifications Report</td>
<td>Ref HMO; Ref Cap PSN; HIV/AIDS</td>
<td>Monthly, fifteen (15) calendar days after end of reporting month</td>
<td>BMHC</td>
<td>Section V, Exhibit 5</td>
</tr>
<tr>
<td>Chapter 24</td>
<td>Enhanced Benefits Report</td>
<td>Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; Ref HIV/AIDS</td>
<td>Monthly, ten (10) calendar days after end of reporting month</td>
<td>BMHC</td>
<td>Section V and Exhibit 4</td>
</tr>
<tr>
<td>Chapter 25</td>
<td>Hernandez Settlement Ombudsman Log</td>
<td>NR HMO; NR FFS PSN*; NR Cap PSN; Ref HMO; Ref FFS PSN*; Ref Cap PSN; CCC*; Ref HIV/AIDS; NR HIV/AIDS</td>
<td>Quarterly, fifteen (15) calendar days after end of reporting quarter</td>
<td>BMHC</td>
<td>Section V</td>
</tr>
</tbody>
</table>

* If the FFS Health Plan has authorization requirements for prescribed drug services
<table>
<thead>
<tr>
<th>Report Guide Chapter</th>
<th>Report Name</th>
<th>Health Plan Type</th>
<th>Frequency</th>
<th>Submit To</th>
<th>Contract Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 26</td>
<td>Hernandez Settlement Agreement Survey</td>
<td>NR HMO; NR FFS PSN*; NR Cap PSN; Ref HMO; Ref FFS PSN*; Ref Cap PSN; CCC*; Ref HIV/AIDS; NR HIV/AIDS</td>
<td>Annually, on August 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>BMHC</td>
<td>Section V</td>
</tr>
<tr>
<td></td>
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<td>* If the FFS Health Plan has authorization requirements for prescribed drug services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chapter 27</td>
<td>Inpatient Discharge Report</td>
<td>NR HMO; NR Cap PSN; Ref HMO; Ref Cap PSN; Ref HIV/AIDS; NR HIV/AIDS</td>
<td>Quarterly, thirty (30) calendar days after end of reporting quarter</td>
<td>BMHC</td>
<td>Section V</td>
</tr>
<tr>
<td>Chapter 28</td>
<td>Insolvency Protection Multiple Signatures Agreement Form</td>
<td>NR HMO; NR FFS PSN*; NR Cap PSN; Ref HMO; Ref Cap PSN; Ref HIV/AIDS; NR HIV/AIDS; Ref FFS PSN</td>
<td>Annually, by April 1&lt;sup&gt;st&lt;/sup&gt;; Thirty (30) calendar days after any change</td>
<td>BMHC</td>
<td>Section XV, Exhibit 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*If the FFS health plan is approved for capitated behavioral health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chapter 29</td>
<td>Involuntary Disenrollment Report</td>
<td>Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; Ref HIV/AIDS</td>
<td>Monthly, first Thursday of month</td>
<td>Choice Counseling Vendor</td>
<td>Section III and Exhibit 3</td>
</tr>
<tr>
<td>Chapter 30</td>
<td>Medicaid Redetermination Notice Summary Report</td>
<td>All Health Plans that participate per Health Plan Contract, Attachment I</td>
<td>Quarterly, forty-five (45) calendar days after end of reporting quarter</td>
<td>BMHC</td>
<td>Section IV</td>
</tr>
<tr>
<td>Report Guide Chapter</td>
<td>Report Name</td>
<td>Health Plan Type</td>
<td>Frequency</td>
<td>Submit To</td>
<td>Contract Section</td>
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</tr>
<tr>
<td>Chapter 31</td>
<td>Medicaid Supplemental HIV/AIDS Report (optional)</td>
<td>Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; Ref HIV/AIDS; NR HIV/AIDS</td>
<td>Monthly, by second Thursday of month</td>
<td>BMHC</td>
<td>Section XIII, Exhibit 13</td>
</tr>
<tr>
<td>Chapter 32</td>
<td>MPI – Annual Fraud &amp; Abuse Activity Report</td>
<td>All Health Plans</td>
<td>Annually, by September 1st</td>
<td>MPI</td>
<td>Section X</td>
</tr>
<tr>
<td>Chapter 33</td>
<td>MPI – Quarterly Fraud &amp; Abuse Activity Report</td>
<td>All Health Plans</td>
<td>Quarterly, fifteen (15) calendar days after the end of reporting quarter</td>
<td>MPI</td>
<td>Section X</td>
</tr>
<tr>
<td>Chapter 34</td>
<td>MPI - Suspected/Confirmed Fraud &amp; Abuse Reporting</td>
<td>All Health Plans</td>
<td>Within fifteen (15) calendar days of detection</td>
<td>MPI</td>
<td>Section X</td>
</tr>
<tr>
<td>Chapter 35</td>
<td>Newborn Enrollment Report</td>
<td>NR FFS PSN; Ref FFS PSN; CCC</td>
<td>Weekly, on Wednesday</td>
<td>Medicaid Area Office</td>
<td>Section III and Exhibit 3</td>
</tr>
<tr>
<td>Chapter 36</td>
<td>PCP Wait Times Report</td>
<td>All Health Plans</td>
<td>Annually, by February 1st</td>
<td>BMHC</td>
<td>Section VII</td>
</tr>
<tr>
<td>Chapter 37</td>
<td>Performance Measures</td>
<td>All Health Plans</td>
<td>Annually, on July 1st</td>
<td>BMQM</td>
<td>Section VIII and Exhibit 5</td>
</tr>
<tr>
<td>Chapter 38</td>
<td>Pharmacy Navigator Report</td>
<td>Ref HMO; Ref Cap PSN; Ref HIV/AIDS</td>
<td>Annually, by December 1st</td>
<td>Choice Counseling Vendor</td>
<td>Section V</td>
</tr>
<tr>
<td>Chapter 39</td>
<td>Provider Network File</td>
<td>All Health Plans</td>
<td>Monthly, first Thursday of month (optional weekly submissions each Thursday for remainder of month)</td>
<td>AHCA Choice Counseling Vendor and Medicaid fiscal agent</td>
<td>Section VII</td>
</tr>
<tr>
<td>Chapter 40</td>
<td>Provider Termination and New Provider Notification Report</td>
<td>All Health Plans</td>
<td>Summary of new and terminated providers due monthly, by the fifteenth (15th) calendar day of the month following the reporting month</td>
<td>BMHC</td>
<td>Section VII</td>
</tr>
</tbody>
</table>
### Chapter 41

**Quarterly and Annual Medical Loss Ratio Reports**

<table>
<thead>
<tr>
<th>Health Plan Type</th>
<th>Frequency</th>
<th>Submit To</th>
<th>Contract Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ref HMO; Ref Cap PSN; Ref HIV/AIDS</td>
<td>Annually, seven (7) months after the end of the reporting year</td>
<td>BMHC</td>
<td>Section II</td>
</tr>
<tr>
<td></td>
<td>Quarterly, seven (7) months after the end of the reporting quarter</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Chapter 42**

**Subcontractors and Affiliates Report**

<table>
<thead>
<tr>
<th>Health Plan Type</th>
<th>Frequency</th>
<th>Submit To</th>
<th>Contract Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Health Plans</td>
<td>Quarterly, within fifteen (15) calendar days after the end of the reporting period</td>
<td>BMHC</td>
<td>Section XVI</td>
</tr>
</tbody>
</table>

NR HMO = Non-Reform health maintenance organization, includes health plans covering Frail/Elderly Program services as specified in the Health Plan Contract, Attachment I
Ref HMO = Reform health maintenance organization
Ref Cap PSN = Reform capitated provider service network
Ref FFS PSN = Reform fee-for-service provider service network
NR Cap PSN = Non-Reform capitated provider service network
NR FFS PSN = Non-Reform fee-for-service provider service network
CCC = Specialty plan for children with chronic conditions
Ref HIV/AIDS = Reform HMO specialty plan for recipients living with HIV/AIDS
NR HIV/AIDS = Non-Reform HMOs that Specialize in HIV/AIDS
NR FFS PSN - BH CAP = Non-Reform FFS PSN Capitated for Behavioral Health

### Websites of Interest

The following websites offer more information on Medicaid and the health plans that serve its recipients:

**Agency for Health Care Administration (AHCA):**

http://ahca.myflorida.com/index.shtml

**Bureau of Managed Health Care (BMHC) secure FTP site:**

IP address: sftp.ahca.myflorida.com, port 2222

**Disclosure of Ownership and interest/CMS 1513 form:**


**EDS X-12 Florida Companion Guides:**

Florida Health Finder (Listing of Hospital IDs):
http://www.floridahealthfinder.gov/FacilityLocator/FacilitySearch.aspx

Non-Reform HMO Health Plan Application (same as standard Reform health plan application):
http://ahca.myflorida.com/Medicaid/managed_care/index.shtml

Non-Reform PSN Health Plan Application:
http://ahca.myflorida.com/Medicaid/managed_care/index.shtml

Reform Health Plan Application:
http://ahca.myflorida.com/Medicaid/managed_care/index.shtml

Health Plan Model Contract:
http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml

Managed Care:
http://ahca.myflorida.com/MCHQ/Managed_Health_Care/

Medicaid Reform:
http://ahca.myflorida.com/Medicaid/medicaid_reform/

Medicaid Encounter Data System (MEDS) Companion Guide:
http://ahca.myflorida.com/medicaid/meds/index.shtml

Medicaid Encounter Data System’s secure FTP site:
IP address: sftp.ahca.myflorida.com, port 2233

Medicaid Program Integrity (MPI):

MPI secure FTP site:
Host Name: sftp.ahca.myflorida.com, port 2232

National Council for Prescription Drug Programs (NCPDP) Companion Guide:
http://ahca.myflorida.com/Medicaid/meds/ncpdp.shtml

Provider Service Network (PSN):
http://ahca.myflorida.com/Medicaid/psn/

Quality in Managed Care:
http://ahca.myflorida.com/Medicaid/quality_mc/

Statewide Medicaid Managed care Program:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml
Chapter 2

General Reporting Requirements

General Report Certification Requirements
In addition to the specific report requirements found in subsequent chapters, all health plans are responsible for fulfilling basic requirements that apply to all submissions. These include:

- Assuring the accuracy, completeness, and timely submission of each report.
- Submitting a certification at the same time it submits the specific report, signed by the chief executive officer (CEO), chief financial officer (CFO), or a direct report with written delegated authority certifying that all data submitted are accurate, truthful, and complete to the best of the official’s knowledge, and that all documents submitted are accurate, truthful, and complete. See 42 CFR 438.606(a) and (b).

Some chapters have designated file names and/or formats for these federally required certifications (also referred to as “attestations”). However, for chapters where a file name and/or format is not designated, plans must create and submit a PDF file with a file name that includes the word “attestation” and the date it is being submitted. The attestation can simply state:

“I, <<NAME OF PLAN OFFICIAL>>, certify that all data submitted for <<Report Name and Report Period>> are accurate, truthful, and complete to the best of my knowledge, and that all documents submitted are accurate, truthful, and complete.”

The page should be on health plan letterhead, signed by the official referenced on the certification itself, and it should include the official’s specific title. The certification PDF file should be submitted to the same person, location, and in the same manner as the report submission unless the specific report chapter indicates otherwise.

- If a direct report is submitting the data, the certification must be accompanied by a pdf copy of the written delegation of authority. A sample delegation of authority letter is provided by the Agency at:

  http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Forms/SAMPLE_DELEGATION_LTR-4-6-11.pdf

- The health plan shall submit its certification (and delegation of authority if applicable) at the same time its submits the certified data reports. These must be scanned and submitted electronically to the Agency in PDF format with the certified data reports (see 42 CFR 438.606(c)).
Report Accuracy and Submission Timeliness
As specified in Attachment II, Section XII, of the health plan contract, timeliness and accuracy are measured as follows:

- Unless otherwise specified by the health plan’s contract or in the applicable Report Guide chapter, a report is considered accurate when the error ratio does not exceed three percent for the total records submitted.

- Deadline for submission is the actual time of receipt at the Agency and not the date the file was postmarked or transmitted (as specified in Attachment II, Section XII, A.1.d. of health plan model contract).

- If a due date falls on a weekend or holiday, the report is due to the Agency on the following business day.

- All quarterly reports are based on the calendar year unless otherwise specified in the individual report chapter.

Note: The health plan may not alter or change report templates in any way.

Report Naming and Identification
A new report naming convention has been established for all reports and attestations (including supporting submission documents) with the following exceptions:

- Audited Annual and Unaudited Quarterly Financial Reports
- Behavioral Health Annual 80/20 Expenditure Report
- Behavioral Health – Critical Incident Report – Individual
- CHCUP (CMS – 416) & FL 60% Screening Report
- Initial Insolvency Protection Multiple Signatures Agreement Form
- Enhanced Benefits Report
- Insolvency Protection Multiple Signatures Agreement Form
- Involuntary Disenrollment Report
- MPI – Quarterly Fraud and Abuse Activity Report
- MPI – Suspected/Confirmed Fraud and Abuse Reporting
- Newborn Enrollment Report
- Pharmacy Navigator Report
- Provider Network File
- Quarterly and Annual Medical Loss Ratio Reports
- Reports submitted directly to the Agency’s Fiscal Agent or other delegated entities outside of the Agency will maintain their current file naming convention.

This new file naming convention is required in order to maintain submission validity, and to assist in Agency organizational efforts.

The new file naming convention will use the existing plan name identifier (see Plan Identifier Table) as well as a unique 4-digit number (see Report Code Identifier) assigned to each report, attestation and submission document. There is also a new code for the frequency of each report (see Report Frequency Code). These codes are provided in the Report Code Identifier Table and the Report Frequency Code Table,
respectively, after the Plan Identifier Table later in Chapter 2. The plan name identifiers, report code identifiers, report year type identifiers and report frequency codes are all used as part of the new file naming convention.

➢ The new file naming convention is as follows:

- The health 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 = C
- 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)
- Four-digit report code identifier from the Report Code Identifier Table

Example: File Name **ABC201108CA100066** =

ABC Health Plan
2010 Hernandez Settlement Agreement Survey due August 1, 2011

- Health Plan’s three-character identifier = ABC
- Four-digit year in which report is due = 2011
- Two-digit month in which report is due = 08
- One-character identifier for report’s year type from the Report Year Type Table = C
- 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) = 10 (Reporting Data Period 2010)
- Four-digit report code identifier for the Hernandez Settlement Agreement Survey = 0066

Example: File Name **ABC201202CQ040003** =

ABC Health Plan
4th Quarter 2011 Behavioral Health Encounter Data Report due February 15, 2012

- Health Plan’s three-character identifier = ABC
- Four-digit year in which report is due = 2012
- Two-digit month in which report is due = 02
- One-character identifier for report’s 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) = 04 (Reporting Data Period 4th Quarter ending 12/31/11)
• Four-digit report code identifier for the Behavioral Health Encounter Data Report = 0003

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 is not password protected.

Example: File Name ABC201112CM110064.xls =

ABC Health Plan

• Health Plan’s three-character identifier = ABC
• Four-digit year in which report is due = 2011
• Two-digit month in which report is due = 12
• 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) = 11 (November reporting period)
• Four-digit report code identifier for the Provider Termination and New Provider Notification Report = 0064

Attachments that are required with this report will be as follows: ABC201112CM110064.zip

➢ There are NO dashes, spaces or other characters between each field

➢ Resubmitted or corrected filings must be submitted with the same file name as the original report. The only exception to this is if the resubmission is due to a correction needed for an incorrect file name; in this circumstance, the file name must be the correct file name using the new file naming convention.

➢ **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 2011, but filed in January 2012, must state the year 2011 in the file name (not January 2012).

➢ The Agency will allow the health plan to submit a one-time file-naming-convention correction without penalty.

Any report that does not require the new file naming convention shall have a designated file name which can be found within the individual Report Guide chapters, under the section labeled “Submission.” Please submit all such reports and their accompanying
attestations in the file formats designated within the “Submission” sections. It is important to follow the file naming designations specified in the individual report chapters in order to maintain submission validity, and to assist in organizational efforts.

Most of the report file names not using the new file naming convention require the use of the unique alphabetic 3-character plan identifier, and some will require a 2-digit numeric county code. These two characteristics are charted for your convenience on the following pages.

**General Submission and Size Limits**

For all reports, in addition to following the designated file naming convention and format, two other considerations should be taken:

1. For reports or documents emailed to the Agency, the Agency’s email server security protocol allows documents with the “.zip” file extension; however, the file must be within the size limit listed below.

2. For reports or documents emailed to the Agency, there is a ten megabyte size limit on Agency servers. If larger files must be sent, health plans should discuss potential alternative delivery methods with the intended recipient at the Agency.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK
**PLAN IDENTIFIER TABLE**

<table>
<thead>
<tr>
<th>Plan Identifier</th>
<th>Plan Name Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMG</td>
<td>Amerigroup</td>
</tr>
<tr>
<td>BET</td>
<td>Better Health</td>
</tr>
<tr>
<td>CAP</td>
<td>Care Access PSN</td>
</tr>
<tr>
<td>CBN</td>
<td>CMS - Broward North</td>
</tr>
<tr>
<td>CBS</td>
<td>CMS - Broward South</td>
</tr>
<tr>
<td>CFL</td>
<td>CareFlorida</td>
</tr>
<tr>
<td>CHA</td>
<td>Clear Health Alliance</td>
</tr>
<tr>
<td>CMD</td>
<td>CMS - Duval</td>
</tr>
<tr>
<td>FCA</td>
<td>First Coast Advantage</td>
</tr>
<tr>
<td>CEN</td>
<td>First Coast Advantage Central</td>
</tr>
<tr>
<td>UFS</td>
<td>First Coast Advantage LLC</td>
</tr>
<tr>
<td>FHC</td>
<td>Florida Healthcare Plus, Inc.</td>
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<td>FTH</td>
<td>Florida True Health</td>
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<tr>
<td>FRE</td>
<td>Freedom</td>
</tr>
<tr>
<td>HEA</td>
<td>HealthEase</td>
</tr>
<tr>
<td>HUM</td>
<td>Humana Family</td>
</tr>
<tr>
<td>IHP</td>
<td>Integral Health Plan</td>
</tr>
<tr>
<td>JMH</td>
<td>Jackson Memorial Hospital</td>
</tr>
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<td>MCC</td>
<td>Magellan Complete Care, LLC</td>
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<tr>
<td>MFL</td>
<td>Medica Health Plans of Florida Inc.</td>
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<tr>
<td>MHS</td>
<td>Memorial HealthCare System-SFCCN</td>
</tr>
<tr>
<td>MOL</td>
<td>Molina Healthcare of Florida</td>
</tr>
<tr>
<td>NBD</td>
<td>North Broward Hospital District-SFCCN</td>
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<tr>
<td>PHC</td>
<td>Positive Healthcare Florida</td>
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<tr>
<td>PHP</td>
<td>Personal Health Plan</td>
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<tr>
<td>PHT</td>
<td>Public Health Trust of Miami-Dade County-SFCCN</td>
</tr>
<tr>
<td>PRE</td>
<td>Preferred Medical Plan</td>
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<td>PRS</td>
<td>Prestige Health Choice</td>
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<td>SAL</td>
<td>Salubris LLC</td>
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<td>SHP</td>
<td>Simply Healthcare Plans, Inc.</td>
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<td>STW</td>
<td>Staywell Health/Wellcare HMO</td>
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<td>SUN</td>
<td>Sunshine State Healthplan</td>
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<td>UnitedHealthcare of Florida</td>
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<td>Buena Vista</td>
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<td>VSF</td>
<td>Vista HealthPlan of South Florida</td>
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<tr>
<td>WEC</td>
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</tbody>
</table>

*Note: The three-character identifiers for the Chapter 22 Enhanced Benefits Report differ from the above identifiers. See the Enhanced Benefits chapter for its identifier list.*
<table>
<thead>
<tr>
<th>Report Code Identifier Table</th>
</tr>
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<tbody>
<tr>
<td><strong>Report Name</strong></td>
</tr>
<tr>
<td>Behavioral Health – Annual Provider Audit Report</td>
</tr>
<tr>
<td>• Behavioral Health – Annual Provider Audit Report</td>
</tr>
<tr>
<td>• Behavioral Health – AHCA-approved annual provider audit schedule for the previous year</td>
</tr>
<tr>
<td>• Behavioral Health – Annual Provider Audit Report Attestation</td>
</tr>
<tr>
<td>Behavioral Health Critical Incident Report - Summary</td>
</tr>
<tr>
<td>Behavioral Health Critical Incident Report – Summary Attestation</td>
</tr>
<tr>
<td>Behavioral Health Encounter Data Report</td>
</tr>
<tr>
<td>Behavioral Health Encounter Data Report Attestation</td>
</tr>
<tr>
<td>Behavioral Health - Enrollee Satisfaction Survey Summary</td>
</tr>
<tr>
<td>• Behavioral Health - Enrollee Satisfaction Survey Summary Survey Tool</td>
</tr>
<tr>
<td>• Behavioral Health - Enrollee Satisfaction Survey Summary Methodology Used and Results</td>
</tr>
<tr>
<td>• Behavioral Health - Enrollee Satisfaction Survey Summary Attestation</td>
</tr>
<tr>
<td>Behavioral Health - FARS/CFARS</td>
</tr>
<tr>
<td>Behavioral Health - FARS/CFARS Attestation</td>
</tr>
<tr>
<td>Behavioral Health - Pharmacy Encounter Data Report</td>
</tr>
<tr>
<td>Report Code Identifier Table</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Report Name</strong></td>
</tr>
<tr>
<td>Behavioral Health - Pharmacy Encounter Data Report Attestation</td>
</tr>
<tr>
<td>Behavioral Health - Required Staff/ Providers Report</td>
</tr>
<tr>
<td>Behavioral Health - Required Staff/ Providers Report Attestation</td>
</tr>
<tr>
<td>Behavioral Health - Stakeholders’ Satisfaction Survey - Summary</td>
</tr>
<tr>
<td>Behavioral Health - Stakeholders’ Satisfaction Survey - Summary</td>
</tr>
<tr>
<td>Behavioral Health - Stakeholders’ Satisfaction Survey Tool</td>
</tr>
<tr>
<td>Behavioral Health - Stakeholders’ Satisfaction Survey – Methodology Used</td>
</tr>
<tr>
<td><strong>Claims Aging Report &amp; Supplemental Filing Report</strong></td>
</tr>
<tr>
<td>Reform Capitated Claims Aging Report</td>
</tr>
<tr>
<td>Non-Reform Capitated Claims Aging Report</td>
</tr>
<tr>
<td>Reform Fee-for-Service Claims Aging Report</td>
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<tr>
<td>Non-Reform Fee-for-Service Claims Aging Report</td>
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<tr>
<td>Claims Aging Report Attestation</td>
</tr>
<tr>
<td>Reform Capitated Supplemental Filing Report</td>
</tr>
<tr>
<td>Non-Reform Capitated Supplemental Filing Report</td>
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<tr>
<td>Supplemental Filing Report Attestation</td>
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<tr>
<td>Report Name</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Code 15 – Critical Incident Report</td>
</tr>
<tr>
<td>Code 15 – Critical Incident Report Attestation</td>
</tr>
<tr>
<td>Community Outreach Health Fairs/Public Events Notification</td>
</tr>
<tr>
<td>• Community Outreach Health Fairs/Public Events Notification Report</td>
</tr>
<tr>
<td>• Amendment to a reported event change</td>
</tr>
<tr>
<td>• Community Outreach Health Fairs/Public Events Notification Report Attestation</td>
</tr>
<tr>
<td>Community Outreach Representative Report</td>
</tr>
<tr>
<td>Community Outreach Representative Report Attestation</td>
</tr>
<tr>
<td>Complaints, Grievances, and Appeals Report</td>
</tr>
<tr>
<td>• Reform Complaints, Grievances, and Appeals Report</td>
</tr>
<tr>
<td>• Non-Reform Complaints, Grievances, and Appeals Report</td>
</tr>
<tr>
<td>• Complaints, Grievance, and Appeals Report Attestation</td>
</tr>
<tr>
<td>Critical Incident Report</td>
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<td>Critical Incident Report Attestation</td>
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<tr>
<td>Critical Incident Summary Report</td>
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<td>Critical Incident Summary Report Attestation</td>
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<tr>
<td>Report Name</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Cultural Competency Plan (and Annual Evaluation)</strong></td>
</tr>
<tr>
<td>• Cultural Competency Plan</td>
</tr>
<tr>
<td>• Annual Evaluation for Previous Contract Year for Reform</td>
</tr>
<tr>
<td>• Annual Evaluation for Previous Contract Year for Non-Reform</td>
</tr>
<tr>
<td>• Cultural Competency Plan (and Annual Evaluation) Attestation</td>
</tr>
<tr>
<td><strong>Customized Benefit Notifications Report</strong></td>
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<td>Customized Benefit Notifications Report Attestation</td>
</tr>
<tr>
<td><strong>Hernandez Settlement Agreement Log</strong></td>
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<tr>
<td>• Reform Hernandez Settlement Agreement Log</td>
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<tr>
<td>• <em>Non-Reform Hernandez Settlement Agreement Log</em></td>
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<tr>
<td>• Hernandez Settlement Agreement Log Attestation</td>
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<tr>
<td><strong>Hernandez Settlement Agreement Survey</strong></td>
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<td>Hernandez Settlement Agreement Survey Attestation</td>
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<tr>
<td><strong>Inpatient Discharge Report</strong></td>
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<td>Inpatient Discharge Report Attestation</td>
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<tr>
<td><strong>Medicaid Redetermination Notice Summary Report</strong></td>
</tr>
<tr>
<td>• Reform Medicaid Redetermination Notice Summary Report</td>
</tr>
<tr>
<td>• Non-Reform Medicaid Redetermination Notice Summary Report</td>
</tr>
<tr>
<td>Report Name</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medicaid Redetermination Notice Summary Report Attestation</td>
</tr>
<tr>
<td>Medicaid Supplemental HIV/AIDS Report</td>
</tr>
<tr>
<td>Medicaid Supplemental HIV/AIDS Report Attestation</td>
</tr>
<tr>
<td>MPI – Annual Fraud and Abuse Activity Report</td>
</tr>
<tr>
<td>MPI – Annual Fraud and Abuse Activity Report Attestation</td>
</tr>
<tr>
<td>PCP Wait Times Report</td>
</tr>
<tr>
<td>Reform PCP Wait Times Report</td>
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<tr>
<td>Non-Reform PCP Wait Times Report</td>
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<tr>
<td>Reform PCP Wait Times Report Attestation</td>
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<tr>
<td>Non-Reform PCP Wait Times Report Attestation</td>
</tr>
<tr>
<td>Performance Measures</td>
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<tr>
<td>Performance Measures Attestation</td>
</tr>
<tr>
<td>HEDIS Auditor Certification with Audit Review Table</td>
</tr>
<tr>
<td>Provider Termination and New Provider Notification Report</td>
</tr>
<tr>
<td>Provider Termination and New Provider Notification Report</td>
</tr>
<tr>
<td>Subcontractors and Affiliates Report</td>
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<td>Subcontractors and Affiliates Report Attestation</td>
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## Report Year Type Table

<table>
<thead>
<tr>
<th>Report Year Type</th>
<th>Report Year Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>K = Contract</td>
<td>09/01 – 08/31</td>
</tr>
<tr>
<td>F = Federal</td>
<td>10/01 – 09/30</td>
</tr>
<tr>
<td>S = State</td>
<td>07/01 – 06/30</td>
</tr>
<tr>
<td>C = Calendar</td>
<td>01/01 – 12/31</td>
</tr>
</tbody>
</table>

## Frequency Code Table

<table>
<thead>
<tr>
<th>Report Frequency</th>
<th>Reporting Data Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annually = A</td>
<td>Last two digits of year’s data being reported</td>
</tr>
<tr>
<td>Semi-annually = S</td>
<td>01 or 02 for first or second data period being reported</td>
</tr>
<tr>
<td>Quarterly = Q</td>
<td>Two digits for quarter of data being reported (01, 02, 03, 04)</td>
</tr>
<tr>
<td>Monthly = M</td>
<td>Two-digit month of data being reported</td>
</tr>
<tr>
<td>Variable = V</td>
<td>Two-digit day of submission date (01-31)</td>
</tr>
</tbody>
</table>

REMINDER OF PAGE INTENTIONALLY LEFT BLANK
<table>
<thead>
<tr>
<th>COUNTY NAME</th>
<th>COUNTY ID</th>
<th>AHCA AREA</th>
<th>DCF CIRCUIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alachua</td>
<td>01</td>
<td>03</td>
<td>08</td>
</tr>
<tr>
<td>Baker</td>
<td>02</td>
<td>04</td>
<td>08</td>
</tr>
<tr>
<td>Bay</td>
<td>03</td>
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Chapter 3
Audited Annual and Unaudited Quarterly Financial Reports

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with unaudited quarterly financial statements, an audited annual financial statement, an audited annual report and a letter of opinion from an independent auditor (certified public accountant unaffiliated with the health plan).

FREQUENCY & DUE DATES:

➢ Unaudited financial statements are due quarterly, within 45 calendar days after the end of each reported quarter.

➢ Audited financial statement, audited annual report and the letter of opinion from an independent auditor are due annually, on or before April 1 following the end of each reported calendar year.

SUBMISSION:

The health plan shall submit the following, via a single, non-secure email to the Agency’s Bureau of Managed Health Care (BMHC) mailbox at MMCFIN@ahca.myflorida.com:

➢ For the unaudited quarterly submissions:

   a. The completed and accurate financial statement report template, which shall be submitted as an XLS file and named F***YYQ#.xls, where *** is the health 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 Health Plan’s submission for the 1st quarter of 2013 would be named “FABC13Q1.xls”).
b. The jurat page (included in the financial statement report template), which shall be submitted as a PDF file and named F***YYQ#-jurat.pdf, where *** is the health 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. This jurat page must be signed only by the health plan’s CEO. **Delegate signatures will not be accepted.**

c. The attestation (see Chapter 2) for the completed and accurate financial statement report template, which shall be submitted with the certified data as a PDF file and named F***YYQ#-cert.pdf, where *** is the health 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. This attestation must be signed by the health plan’s CEO, chief financial officer (CFO), or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify report.

If a health plan is non-Reform and Reform, the above mentioned submissions should be combined into a single filing (see the “Instructions” section of this chapter).

➢ For the audited annual submissions:

a. The completed and accurate financial statement report template showing any corrections made by the independent auditor, which shall be submitted as an XLS file and named AF***YYYY.xls, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), and YYYY are the four digits of the calendar year being reported.

b. The jurat page (included in the financial statement report template), which shall be submitted as a PDF file and named AF***YYYY-jurat.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), and YYYY are the four digits of the calendar year being reported. This jurat page must be signed only by the health plan’s CEO. **Delegate signatures will not be accepted.**

c. The attestation (see Chapter 2) for the completed and accurate financial statement report template, which shall be submitted with the certified data as a PDF file and named AF***YYYY-cert.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), and YYYY are the four digits of the calendar year being reported. This attestation must be signed by the health plan’s CEO, CFO, or a direct report with written delegated authority certifying that all data and documents submitted are...
accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify report.

d. The independent auditor’s financial report and letter of opinion, which shall be submitted as a PDF file and named AFO***YYYY.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), and YYYY are the four digits of the calendar year being reported.

If a health plan is non-Reform and Reform, the above mentioned submissions should be combined into a single filing (see the “Instructions” section of this chapter).

Questions regarding the submission of this financial report should be directed to the BMHC’s Financial Analyst via email at: MMCFIN@ahca.myflorida.com prior to the specified due date.

INSTRUCTIONS:

1. The health plan shall complete the financial reporting submission requirements using the Excel file template, provided at the Agency’s website specified in the Report template section, to report the following sets of financial data:

> Balance Sheet;
> Statement of Revenues and Expenses;
> Statement of Cash Flow; and
> Footnotes.

It is the responsibility of the health plan to use the most current financial statement report template supplied by the Agency. The Agency will provide the most recent template within the first quarter of each reporting year.

2. The health plan must file a combined financial statement report for its unaudited quarterly and audited annual statements. These combined financial statement(s) should be submitted and emailed as one report (including both non-Reform and Reform data).

3. The health plan shall use generally accepted accounting principles (GAAP) in preparing all financial statements; however, if the health plan is also required to file with the State of Florida Office of Insurance Regulation, then the annual financial statement and the annual independent auditor’s financial report may be submitted using statutory accounting.

4. The health plan shall submit financial statements that are specific to the operations of the health plan rather than to a parent or umbrella organization.
VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

No alterations or duplications shall be made to the report template by the health plan. The Agency-supplied unaudited quarterly financial statement report template and audited annual financial statement report template can be found at:

http://www.ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912. shtml

The Agency’s template consists of the following:

- A financial workbook to report financial data, which includes an instructions page, and
- A jurat page.
Chapter 4

Behavioral Health - Annual Provider Audit Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMO that SpecializesNon-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with the results of the health plan’s behavioral health annual (contract year) provider audit, pursuant to Attachment II, Section VI, of the health plan’s contract.

FREQUENCY & DUE DATES:

➢ Due annually October 1 after the end of the contract year being reported.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) via email to mmcdatalahca.myflorida.com:

➢ The Behavioral Health - Annual Provider Audit Report.
➢ The Agency-approved annual provider audit schedule for the previous contract year.
➢ A report attestation (see Chapter 2).
INSTRUCTIONS:

1. The health plan’s completed Provider Annual Audit Report shall, at a minimum, address the administrative, programmatic, and clinical elements identified and meet the minimum standards outlined below.

   a. Administrative compliance with:
      (1) Contractual financial requirements as applicable
      (2) Provider/Facility contract
      (3) Claims submission
      (4) Encounter data
      (5) Credentialing requirements

   b. Programmatic compliance with:
      (1) Requirements of the Community Behavioral Health Services Coverage and Limitations Handbook
      (2) Agency Health Plan Contract
      (3) Staffing requirements

   c. Clinical record compliance with:
      (1) Utilization of the standardized Agency-approved record review tools.
      (2) Number of charts reviewed per health plan

2. Should there be any correction action plan, the health plan must identify the provider(s), plans for follow-up and resolution.

3. The report attestation must include an attestation that the health plan coordinated the audit schedule with the providers being audited.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT GUIDE TEMPLATE

The Agency supplied behavioral health annual (contract year) provider audit template can be found on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml

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Chapter 5

Behavioral Health Annual 80/20 Expenditure Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Non-Reform Fee-for-Service PSN - Capitated for Behavioral Health

REPORT PURPOSE:

To provide the Agency with a breakdown of expenditures related to the provision of community behavioral health and targeted case management services as required under Florida Statutes. Per s. 409.912, F.S, the health plan is contractually obligated to expend 80% of the capitation rate paid to the health plan by the Agency for the provision of community behavioral health services for each calendar year. In the event the health plan expends less than 80% of the capitation rate, the health plan shall refund the difference to the Agency.

FREQUENCY & DUE DATES:

➢ Due annually on or before April 1 following the end of each reported calendar year.

SUBMISSION:

The health plan shall submit the following via a single, non-secure email to the Agency’s Bureau of Managed Health Care (BMHC) mailbox at MMCDATA@ahca.myflorida.com (if no refund is due to the Agency) or via mail at the following address (if a refund is due to the Agency):

Agency for Health Care Administration
Bureau of Managed Health Care
Attn: Hazel Greenberg (BH 80/20)
2727 Mahan Drive, MS# 26
Tallahassee, FL 32308

➢ The completed 80/20 report template (included in the template document), which shall be submitted via hard copy or as a PDF file and named using the naming convention, 80-20***YYYY.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), and YYYY is the calendar year being reported.
The attestation (see Chapter 2) for the completed 80/20 report template and for the back-up encounter data (included in the template document), which shall be submitted with the certified data via hard copy or as a PDF file and named 80-20***YYYY-cert.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2) and YYYY is the calendar year being reported. This attestation must be signed by the health plan’s chief executive officer (CEO), chief financial officer (CFO) or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete to the best of the official’s knowledge. Such delegations of authority must be attached to the submitted signed attestation to certify report.

Any applicable refund due (make check payable to the Agency for Health Care Administration).

The health plan shall submit the following via the Agency’s BMHC secure FTP site:

The back-up encounter data, which shall be submitted as a TXT file and named using the naming convention, E80-20***YYYY.txt, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2) and YYYY is the calendar year being reported.

The attestation (see Chapter 2) for the completed 80/20 report template and for the back-up encounter data (included in the template document), which shall be submitted with the certified data as a PDF file and named 80-20***YYYY-cert.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2) and YYYY is the calendar year being reported. This attestation must be signed by the health plan’s CEO, CFO or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete to the best of the official’s knowledge. Such delegations of authority must be attached to the submitted signed attestation to certify report.

**INSTRUCTIONS:**

1. The health plan shall submit the completed 80/20 report template, signed attestation, backup encounter data and any refund due for the calendar year being reported, in the following manner:

   a. The health plan must use the Agency’s supplied template and encounter filing instructions (see the “Report Template” section of this chapter).

   b. The report must contain non-Reform data only.

   c. The health plan must report all non-Reform expenditures, for the calendar year being reported, only for the specified community mental health/substance abuse
services and mental health targeted/intensive targeted case management codes listed under 2. below.

d. Any health plan that expended less than 80% of the non-Reform capitation paid to the health plan by the Agency on community mental health/substance abuse services and mental health targeted/intensive targeted case management services must refund the difference to the Agency at the same time the template is filed.

e. The health plan may include incurred but not reported (IBNR) expenditures as long as the health plan included the IBNR in reporting all prior year reports. If a health plan is reporting IBNR for the first time, it must continue to report IBNR in all subsequent filings.

f. Any health plan that includes IBNR is required to reconcile the IBNR with 80/20 reported data by February 1 of the following year in which the 80/20 was filed (i.e., 80/20 filed April 1, 2013, reconciliation of IBNR due by February 1, 2014). Health plans shall follow the same filing instructions and use the same template for the calendar year being reported for the IBNR reconciliation as outlined above (see the “Submission” section of this chapter). Any applicable refund due for the IBNR reconciliation will be the difference of the amount of refund owed to the Agency less what was previously paid to the Agency in April. The Agency will compare both report submissions to verify the amount owed.

2. The backup encounter data shall be developed in an ASCII flat fixed record length text file in the format described in the template table (see the “Report Template” section of this chapter).

The health plan shall use the following when completing the encounter data file:

a. Diagnostic Criteria

All provider claims are restricted to claims for enrollees with an ICD-9-CM diagnosis code of 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4, 312.81 through 314.9 and 315.9.

b. Community Mental Health Services


- Use procedure code H0004 - federally qualified health centers only
c. Community Substance Abuse Services

Use procedure code H0001, H0001HN, H0001HO, H0001TS, H0047, H2010HF, H2012HF, T1007, T1007TS, T1015HF or T1023HF.

d. Mental Health Targeted Case Management

Use procedure code T1017HA (children) or T1017 (adults).

e. Mental Health Intensive Targeted Case Management

Use procedure code T1017HK (adults).

f. The health plan shall use the following file layout (on the next page):

**Behavioral Health Annual Expenditure Report (80/20) (E80-20***YYYY.txt)**

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<td>9-digit Medicaid ID of the health plan in which enrollee was enrolled on the first date of service</td>
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<tr>
<td></td>
<td></td>
<td>32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>68</td>
</tr>
<tr>
<td></td>
<td></td>
<td>91</td>
</tr>
<tr>
<td>Provider ID Type</td>
<td>1</td>
<td>Type of unique identifier for the direct service provider:</td>
</tr>
<tr>
<td>-----------------</td>
<td>---</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>A</td>
<td>AHCA ID</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>NPI (National Provider Identifier)</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Medicaid Provider ID</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>Professional License Number</td>
<td></td>
</tr>
<tr>
<td>Provider ID</td>
<td>10</td>
<td>Unique identifier for the direct service provider</td>
</tr>
<tr>
<td>Amount Paid</td>
<td>10</td>
<td>Costs associated with the claim. Format with an explicit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>decimal point and 2 decimal places but no explicit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>commas.</td>
</tr>
<tr>
<td>Claim Paid Date</td>
<td>10</td>
<td>The date of the claim/capitation payment to the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>provider (check/warrant date). Use mm/dd/ccyy format</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(please include the “/”).</td>
</tr>
<tr>
<td>Claim Reference Number</td>
<td>25</td>
<td>The Health Plan’s internal unique claim record identifier.</td>
</tr>
</tbody>
</table>

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The Agency’s Behavioral Health 80/20 Refund template and encounter data filing instructions are emailed to the health plan’s compliance contact each February. No alterations or duplications shall be made to the template by the health plan. Each plan may request a copy of its respective template via email to: MMCDATA@ahca.myflorida.com.

The Agency’s template consists of the following:

1. A cover letter explaining the requirements and providing a list of acceptable procedure, diagnosis, and revenue codes that the health plan may use in reporting expenditures;

2. A financial worksheet containing the amount of capitation paid to the health plan for the calendar year being reported for the acceptable codes listed in the Agency’s cover letter. This financial worksheet will calculate the percentage of expenditures to the amount of capitation received; and

3. An attestation certifying the accuracy, truthfulness and completion of both the financial worksheet and the back-up encounter data.

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Chapter 6

Behavioral Health - Critical Incident Report - Individual

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-For-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with data regarding behavioral health critical incidents involving health plan enrollees.

FREQUENCY & DUE DATES:

➢ Due immediately to the Agency, no later than 24 hours after occurrence or knowledge of the incident.

SUBMISSION:

The health plan shall report events immediately to the Agency’s Bureau of Managed Health Care behavioral health plan analyst via <encrypted> email with the subject line: CRITICAL INCIDENT.

INSTRUCTIONS:

1. The health plan shall report the following events to the Agency in accordance with the format set forth in the Critical Incident - Individual table of the Report Template section:

   a. Death of an enrollee while the enrollee is in a facility operated or contracted by the health plan or in an acute care facility due to one of the following:

      (1) Suicide;

      (2) Homicide;
(3) Abuse;

(4) Neglect; or

(5) An accident or other incident that occurs while the enrollee is in a facility operated or contracted by the health plan or in an acute care facility.

b. Enrollee injury or illness – A medical condition that requires medical treatment by a licensed health care professional and which is sustained, or allegedly is sustained, due to an accident, act of abuse, neglect or other incident occurring while an enrollee is in a facility operated or contracted by the health plan or while the enrollee is in an acute care facility.

c. Sexual battery while the enrollee is in a facility operated or contracted by the health plan or in an acute care facility – An allegation of sexual battery, as determined by medical evidence or law enforcement involvement, by:

(1) An enrollee on another enrollee;

(2) An employee of the health plan, a provider or a subcontractor, an enrollee; and/or

(3) An enrollee on an employee of the health plan, a provider or a subcontractor.

d. The health plan shall report if one or more of the following events occur:

(1) Medication errors in an acute care setting; and/or

(2) Medication errors involving children/adolescents in the care or custody of DCF.

e. Enrollee suicide attempt – An act which clearly reflects an attempt by an enrollee to cause his or her own death while an enrollee is in a facility operated or contracted by the health plan or while the enrollee is in an acute care facility, which results in bodily injury requiring medical treatment by a licensed health care professional.

f. Altercations requiring medical intervention – Any untoward or adverse event that requires medical intervention other than minimal first aid treatment occurring while an enrollee is in a facility operated or contracted by the health plan or while the enrollee is in an acute care facility.

g. Enrollee escape – To leave a locked or secured facility operated or contracted by the health plan or an acute care facility without notice or permission.
h. Enrollee elopement – To leave a facility operated or contracted by the health plan, an acute care facility, vehicle or supervised activity that would endanger an enrollee’s personal safety.

2. The definitions of reportable critical incidents apply to the health plan, providers (participating and non-participating) and any subcontractors/delegates providing services to enrollees.

3. The state’s “Operating Procedures” establish both DCF procedures and guidelines for reporting information relating to the incidents specified in this chapter (see CF Operating Procedure No. 215-6, November 1, 1998).

4. The critical incident reporting requirements set forth in this section do not replace the abuse, neglect and exploitation reporting system established by the state.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

*Click here to download the template: Report Template - Behavioral Health - Critical Incident Indiv.xls*
Chapter 7

Behavioral Health - Critical Incident Report - Summary

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-For-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with summary data regarding behavioral health critical incidents involving health plan enrollees.

FREQUENCY & DUE DATES:

- Due to the Agency by the 15th calendar day of every month.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) via the Secure Transfer Protocol (SFTP) site:

- A monthly summary of Critical Incidents Reports.
- A report attestation (see Chapter 2).

INSTRUCTIONS:

1. The State’s “Operating Procedures” establish both Department of Children and Families procedures and guidelines for reporting information relating to the incidents specified in this chapter (see CF Operating Procedure No. 215-6, November 1, 1998).

2. The critical incident reporting requirements set forth in this section do not replace the abuse, neglect and exploitation reporting system established by the state.
3. The health plan shall submit a summary of the previous calendar month’s incidents as indicated and shall submit it in the format found in the Report Template section of this chapter.

4. This report includes data for Reform and non-Reform, separated by AHCA area as specified by multiple tabs within the Excel template.

5. The health plan should fill in the template with zeros if no incidents occurred within the report month.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

Click here to download the template: Report Template - Behavioral Health - Critical Incidents Summary.xls
Chapter 8
Behavioral Health - Encounter Data Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Non-Reform Fee-for-Service PSN - Capitated for Behavioral Health

REPORT PURPOSE:

To provide confirmation to the Agency that the Behavioral Health Encounter Data Report is an electronic representation of the health plan’s complete listing of behavioral health services provided during the report period.

FREQUENCY & DUE DATES:

- Due quarterly within forty-five calendar days after the end of the quarter being reported.
- The report shall contain data for the entire quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) via the Secure File Transfer Protocol (SFTP) site:

- The Behavioral Health Encounter Data Report.
- A report attestation (see Chapter 2).
- One report shall be submitted containing both Reform and non-Reform data.

INSTRUCTIONS:

1. The Behavioral Health Encounter Data Report shall be developed in an ASCII flat fixed record length text file in the format described in the template table found in the “Report Template” section of this chapter.
2. The health plan shall use the following when completing the report:

   a. Diagnostic criteria all provider claims are restricted to claims for enrollees with an ICD-9-CM diagnosis code of 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4, 312.81 through 314.9 and 315.9.

   b. Provider and Coding Criteria

      (1) Inpatient hospital services for psychiatric conditions – Provider Type 01, Claim Input Indicator “I” – Use Revenue Center Codes 0114, 0124, 0134, 0144, 0154, or 0204 on the UB-04 or 837-I.

      (2) Outpatient hospital services for psychiatric conditions – Provider Type 02, Claim Input Indicator “O” – Use Revenue Center Codes 0450, 0513, 0901, 0914, or 0918 on the UB-04 or 837-I.

   c. Community Mental Health Services


      (2) Use procedure code H0004 - federally qualified health centers only

Psychiatric Physician Services – Provider Type 25 (MD) or 26 (DO) with a specialty code of "042" Psychiatrist, "043" Child Psychiatrist, or "044" Psychoanalysis – All Claim Input Indicators submitted by these specialists apply.

   d. Community Substance Abuse Services

      (1) Use Procedure Code H0001, H0001HN, H0001HO, H0001TS, H0047, H2010HF, H2012HF, T1007, T1007TS, T1015HF or T1023HF.

   e. Mental Health Targeted Case Management

      (1) Procedure code T1017 (adults) or T1017HA (children).

   f. Mental Health Intensive Targeted Case Management

      (1) Procedure code T1017HK (adults).

   g. Advanced Nurse Practitioner – Provider Type 30 (ARNP) with a specialty code of “076” – Clinical Nurse Specialist – All Claim Input Indicators submitted by these specialists apply.
VARIATIONS BY HEALTH PLAN TYPE:

No variations.

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# REPORT TEMPLATE:

## Behavioral Health Encounter Data

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Field Length</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid ID</td>
<td>10</td>
<td>First 10 digits of the enrollee Medicaid ID number</td>
</tr>
<tr>
<td>Plan ID</td>
<td>9</td>
<td>9 digit Medicaid ID of the health plan in which enrollee was enrolled on the first date of service</td>
</tr>
<tr>
<td>Service Type</td>
<td>1</td>
<td>Hospital Inpatient&lt;br&gt;C CSU&lt;br&gt;O Hospital Outpatient&lt;br&gt;P Physician (MD or DO)&lt;br&gt;A Advanced Nurse Practitioner, ARNP&lt;br&gt;H Comm. Mental Health, Mental Health Practitioner&lt;br&gt;T Targeted Case Management&lt;br&gt;L Locally Defined or Optional Service</td>
</tr>
<tr>
<td>Date of Service</td>
<td>10</td>
<td>For Inpatient and CSU encounters, this equals the admit date. Use mm/dd/ccyy format (please include the “/”).</td>
</tr>
<tr>
<td>Revenue Code</td>
<td>4</td>
<td>Use only for Hospital Inpatient and Hospital Outpatient Encounters</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>5</td>
<td>5 digit CPT or HCPCS Procedure Code (For Inpatient Claims only, use the ICD9-CM Procedure Code.)</td>
</tr>
<tr>
<td>Procedure Modifier 1</td>
<td>2</td>
<td>2-character procedure code modifier, if applicable.</td>
</tr>
<tr>
<td>Procedure Modifier 2</td>
<td>2</td>
<td>2-character procedure code modifier, if applicable.</td>
</tr>
<tr>
<td>Units of Service</td>
<td>3</td>
<td>For Inpatient and CSU encounters, report the number of covered days. For all other encounters, use the units of service for paid claims referenced in the appropriate Medicaid Coverage and Limitations Handbook.</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>6</td>
<td>Primary Diagnosis Code. Format with the explicit decimal point in appropriate codes.</td>
</tr>
<tr>
<td>Provider Type</td>
<td>2</td>
<td>01 General Hospital&lt;br&gt;02 Special Hospital/Outpatient Rehab&lt;br&gt;05 Community Alcohol Drug Mental Health&lt;br&gt;07 Mental Health Practitioner&lt;br&gt;08 District Schools&lt;br&gt;25 Physician (MD)&lt;br&gt;26 Physician (DO)&lt;br&gt;30 Advanced Registered Nurse Practitioner&lt;br&gt;31 Registered Nurse&lt;br&gt;32 Social Worker/Case Worker&lt;br&gt;66 Rural Health Clinic&lt;br&gt;68 Federally Qualified Health Center&lt;br&gt;91 Case Management Agency</td>
</tr>
<tr>
<td>Provider ID Type</td>
<td>1</td>
<td>Type of unique identifier for the direct service provider: A = AHCA ID N = NPI (National Provider Identifier) M = Medicaid Provider ID L = Professional License Number</td>
</tr>
<tr>
<td>Provider ID</td>
<td>10</td>
<td>Unique identifier for the direct service provider</td>
</tr>
<tr>
<td>Amount Paid</td>
<td>10</td>
<td>Costs associated with the claim. Format with an explicit decimal point and 2 decimal places but no explicit commas. Optional.</td>
</tr>
<tr>
<td>Claim Paid Date</td>
<td>10</td>
<td>The date of the claim/capitation payment to the provider (check/warrant date). Use mm/dd/ccyy format (please include the “/”).</td>
</tr>
<tr>
<td>Claim Reference Number</td>
<td>25</td>
<td>The health plan’s internal unique claim record identifier.</td>
</tr>
</tbody>
</table>
Chapter 9

Behavioral Health – Enrollee Satisfaction Survey Summary

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-For-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with a gauge of behavioral health effectiveness through enrollee satisfaction survey response in all service areas in which the health plan provides behavioral health services.

FREQUENCY & DUE DATES:

- Due annually by March 1 following the calendar year being reported.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following in an email to its Agency Bureau of Managed Health Care (BMHC) Behavioral Health (BH) plan analyst to the mailbox mmccdata@ahca.myflorida.com:

- A copy of the survey tool, the methodology used, and the results.
- A report attestation (see Chapter 2).

INSTRUCTIONS:

1. The health plan shall complete the Enrollee Satisfaction Survey Summary in accordance with the template set forth in the Report Template section of this chapter, and submit it to the Agency as directed above.

2. The health plan must report Reform data separate from non-Reform data in separate tabs.
3. The survey questions and the response categories in the template must match the survey tool approved previously by BMHC pursuant to Attachment II, Exhibit 6, of the health plan contract.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE**

Enrollee Satisfaction Survey Summary

![Enrollee Satisfaction Survey Summary](Report Template - Behavioral Health - Enrollee Satisfaction Survey.xls)

Click here to download the template: Report Template - Behavioral Health - Enrollee Satisfaction Survey.xls

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Chapter 10

Behavioral Health - FARS/CFARS Reports

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-For-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with assurance that all behavioral health care providers administer functional assessments using the Functional Assessment Rating Scales (FARS) for all enrollees age of 18 and up, and Child Functional Assessment Rating Scale (CFARS) for all enrollees under the age of 18.

FREQUENCY & DUE DATES:

Due semi-annually:

- The required file for assessments performed in the months of January through June is due to the Agency no later than August 15.
- The required file for assessments performed in the months of July through December is due to the Agency no later than February 15.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site:

- FARS/CFARS reports.
- A report attestation (see Chapter 2).
INSTRUCTIONS:

- The health plan shall submit the FARS/CFARS Reports in an ASCII flat fixed record length text file and in concurrence with the table template set forth in the "Report Template" section of this chapter.

- The definitions of the FARS and CFARS domains (as well as related functional scales and subscales for each domain) are available on the Florida Mental Health Institute web site link: http://outcomes.fmhi.usf.edu.

For example, the following are domains and functional scales for FARS and CFARS:

<table>
<thead>
<tr>
<th>Domains</th>
<th>Functional Scales</th>
<th>FARS</th>
<th>CFARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>Hyper Affect</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Thought Process</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Cognitive Performance</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Medical/Physical</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Activity of Daily Living</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Ability to Care for Self</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Emotionality</td>
<td>Depression</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Traumatic Stress</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Relationships</td>
<td>Interpersonal Relations</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Family Relations</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Family Environment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Socio-Legal</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Work or School</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Danger to Others</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Hyper Activity</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Cognitive Performance</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Behavior in Home Setting</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Personal Safety</td>
<td>Substance Use</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Danger to Self</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Security Management Needs</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Socio-Legal</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

VARIATIONS BY HEALTH PLAN TYPE:

No variations.
### REPORT TEMPLATE:

**FARS/CFARS Reporting**

<table>
<thead>
<tr>
<th>Data Element Name</th>
<th>Length</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient Identification Number</td>
<td>10</td>
<td>10-Digit Medicaid Identification Number of Enrollee.</td>
</tr>
<tr>
<td>Recipient Date of Birth</td>
<td>8</td>
<td>Enrollee’s date of birth in CCYYMMDD format, e.g., 20010101.</td>
</tr>
<tr>
<td>Recipient First Name</td>
<td>15</td>
<td>Enrollee’s first name.</td>
</tr>
<tr>
<td>Recipient Last Name</td>
<td>15</td>
<td>Enrollee’s last name.</td>
</tr>
<tr>
<td>Plan Identification Number</td>
<td>9</td>
<td>9-Digit Medicaid Plan Identification Number.</td>
</tr>
<tr>
<td>Contractor Identification Number</td>
<td>10</td>
<td>10-digit Federal Tax Identification Number or National Provider Identifier (NPI) of the provider conducting the assessment.</td>
</tr>
<tr>
<td>Contract Number</td>
<td>5</td>
<td>Up to 5-digit alpha-numeric number of the Department of Children and Families contract responsible for serving the enrollee being evaluated through FUNCTIONAL ASSESSMENT RATING SCALE or CHILDREN’S FUNCTIONAL ASSESSMENT RATING SCALE. If the provider does not have a contract, enter “00000”.</td>
</tr>
<tr>
<td>Assessment Type</td>
<td>1</td>
<td>1-digit code to designate the type of functional assessment that was done, i.e., “F” = FUNCTIONAL ASSESSMENT RATING SCALE or “C” = CHILDREN’S FUNCTIONAL ASSESSMENT RATING SCALE</td>
</tr>
<tr>
<td>Assessment Purpose</td>
<td>1</td>
<td>1-digit code to designate the purpose for doing the assessment, i.e., “1” = Initial assessment at time of admission into provider agency; “2” = every 6-month after admission, or “3” = assessment at time of discharge from provider agency</td>
</tr>
<tr>
<td>Assessment Date</td>
<td>8</td>
<td>Date of assessment in CCYYMMDD format, e.g., 20060812.</td>
</tr>
<tr>
<td>Disability Score</td>
<td>2</td>
<td>Sum of the assessment scores for all the scales in the Disability domain.</td>
</tr>
<tr>
<td>Emotionality Score</td>
<td>2</td>
<td>Sum of the assessment score for all the scales in the Emotionality domain.</td>
</tr>
<tr>
<td>Relationship Score</td>
<td>2</td>
<td>Sum of the assessment score for all the scales in the Relationships domain.</td>
</tr>
<tr>
<td>Safety Score</td>
<td>2</td>
<td>Sum of the assessment score for all the scales in the Personal Safety domain.</td>
</tr>
<tr>
<td>Overall Assessment Score</td>
<td>3</td>
<td>Sum of ALL domain scores.</td>
</tr>
<tr>
<td>Rater FMHI Certification Number</td>
<td>9</td>
<td>Optional 9-Digit FMHI Certification ID of the staff member conducting the assessment. This is the ID number assigned upon successful completion of the CFARS or FARS Rater Certification Test.</td>
</tr>
<tr>
<td>Provider Local Information</td>
<td>20</td>
<td>Optional local information that can be used by the Provider agency to identify or track client’s other information for reporting purposes.</td>
</tr>
</tbody>
</table>
Chapter 11

Behavioral Health – Pharmacy Encounter Data Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with an accurate electronic representation of the health plan’s complete listing of behavioral health prescription services administered during the quarter being reported.

FREQUENCY & DUE DATES:

➢ Due quarterly to the Agency within forty-five calendar days after the end of the quarter being reported.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site:

➢ The Behavioral Health Pharmacy Encounter Data Report.

➢ A report attestation (see Chapter 2).

➢ Reform and non-Reform populations should be combined into one report.

INSTRUCTIONS:

1. The health plan shall submit the Behavioral Health Pharmacy Encounter Data Report in an ASCII flat fixed record length text file, and shall use the format outlined in the “Report Template” section of this chapter.

2. The health plan shall use the behavioral health related therapeutic class codes listed in the following table:
## BEHAVIORAL HEALTH RELATED THERAPEUTIC CLASS CODES

<table>
<thead>
<tr>
<th>Class Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5B</td>
<td>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</td>
</tr>
<tr>
<td>H7B</td>
<td>ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS</td>
</tr>
<tr>
<td>C0D</td>
<td>ANTI-ALCOHOLIC PREPARATIONS</td>
</tr>
<tr>
<td>H2F</td>
<td>ANTI-ANXIETY DRUGS</td>
</tr>
<tr>
<td>H4B</td>
<td>ANTICONVULSANTS</td>
</tr>
<tr>
<td>H2J</td>
<td>ANTIDEPRESSANTS O.U.</td>
</tr>
<tr>
<td>Z2A</td>
<td>ANTIHISTAMINES</td>
</tr>
<tr>
<td>H2M</td>
<td>ANTI-MANIA DRUGS</td>
</tr>
<tr>
<td>H6B</td>
<td>ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC</td>
</tr>
<tr>
<td>H6A</td>
<td>ANTIPARKINSONISM DRUGS, OTHER</td>
</tr>
<tr>
<td>L3P</td>
<td>ANTI-PRURITICS, TOPICAL</td>
</tr>
<tr>
<td>H7R</td>
<td>ANTIPSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES</td>
</tr>
<tr>
<td>H7X</td>
<td>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</td>
</tr>
<tr>
<td>H7U</td>
<td>ANTIPSYCHOTICS, DOPAMINE &amp; SEROTONIN ANTAGONISTS</td>
</tr>
<tr>
<td>H7T</td>
<td>ANTIPSYCHOTICS, ATYPICAL, DOPAMINE, &amp; SEROTONIN ANTAG</td>
</tr>
<tr>
<td>H7P</td>
<td>ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES</td>
</tr>
<tr>
<td>H7O</td>
<td>ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES</td>
</tr>
<tr>
<td>H7S</td>
<td>ANTIPSYCHOTICS, DOPAMINE ANTAGONIST, DIHYDROINDOLONES</td>
</tr>
<tr>
<td>H2L</td>
<td>ANTI-PSYCHOTICS, NON-PHENOTHIAZINES</td>
</tr>
<tr>
<td>H2G</td>
<td>ANTI-PSYCHOTICS, PHENOTHIAZINES</td>
</tr>
<tr>
<td>H2D</td>
<td>BARBITURATES</td>
</tr>
<tr>
<td>U6W</td>
<td>BULK CHEMICALS</td>
</tr>
<tr>
<td>H2A</td>
<td>CENTRAL NERVOUS SYSTEM STIMULANTS</td>
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<tr>
<td>C6M</td>
<td>FOLIC ACID PREPARATIONS</td>
</tr>
<tr>
<td>H2C</td>
<td>GENERAL ANESTHETICS, INJECTABLE</td>
</tr>
<tr>
<td>H7J</td>
<td>MAOIS - NON-SELECTIVE &amp; IRREVERSIBLE</td>
</tr>
<tr>
<td>H2H</td>
<td>MONOAMINE OXIDASE (MAO) INHIBITORS</td>
</tr>
<tr>
<td>H3T</td>
<td>NARCOTIC ANTAGONISTS</td>
</tr>
<tr>
<td>H7D</td>
<td>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)</td>
</tr>
<tr>
<td>S2B</td>
<td>NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE</td>
</tr>
<tr>
<td>H2E</td>
<td>SEDATIVE-HYPNOTICS, NON-BARBITURATE</td>
</tr>
<tr>
<td>H2S</td>
<td>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)</td>
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<tr>
<td>H7E</td>
<td>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBATORS (SARIS)</td>
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<tr>
<td>H7C</td>
<td>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)</td>
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<tr>
<td>H7N</td>
<td>SMOKING DETERRENTS, OTHER</td>
</tr>
<tr>
<td>H2X</td>
<td>TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATIONS</td>
</tr>
<tr>
<td>H2W</td>
<td>TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATIONS</td>
</tr>
<tr>
<td>H2U</td>
<td>TRICYCLIC ANTIDEPRESSANTS &amp; REL. NON-SEL. RU-INHIB</td>
</tr>
<tr>
<td>H2V</td>
<td>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY</td>
</tr>
</tbody>
</table>

### VARIATIONS BY HEALTH PLAN TYPE:

No variations.
**REPORT TEMPLATE:**

**Behavioral Health Pharmacy Encounter Data**

<table>
<thead>
<tr>
<th>Data Element Name</th>
<th>Length</th>
<th>Data Type</th>
<th>Start Column</th>
<th>End Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECIP_ID</td>
<td>10</td>
<td>Character</td>
<td>1</td>
<td>10</td>
<td>Medicaid Identification Number of Beneficiary</td>
</tr>
<tr>
<td>NDC</td>
<td>11</td>
<td>Character</td>
<td>11</td>
<td>21</td>
<td>National Drug Code Identification Number of the Dispersed Medication</td>
</tr>
<tr>
<td>CLASS</td>
<td>3</td>
<td>Character</td>
<td>22</td>
<td>24</td>
<td>Therapeutic Class Code (see Behavioral Health Related Therapeutic Class Code Listing)</td>
</tr>
<tr>
<td>QUANT</td>
<td>8</td>
<td>Numeric</td>
<td>25</td>
<td>32</td>
<td>Quantity of Drug Dispensed</td>
</tr>
<tr>
<td>DOS</td>
<td>10</td>
<td>Character</td>
<td>33</td>
<td>42</td>
<td>Date of Service (mm/dd/ccyy -please include the “/”)</td>
</tr>
<tr>
<td>PLAN_ID</td>
<td>9</td>
<td>Character</td>
<td>43</td>
<td>51</td>
<td>9-digit Medicaid Provider Number of the health plan</td>
</tr>
<tr>
<td>RX_NUM</td>
<td>7</td>
<td>Character</td>
<td>52</td>
<td>58</td>
<td>Prescription Identification Number</td>
</tr>
<tr>
<td>*DEA</td>
<td>9</td>
<td>Character</td>
<td>59</td>
<td>67</td>
<td>9 digit DEA Number of Prescriber, required for all medications in DEA classes 2 through 5.</td>
</tr>
<tr>
<td>PROV_ID_TYPE</td>
<td>1</td>
<td>Character</td>
<td>68</td>
<td>68</td>
<td>Type of unique identifier for the Prescriber: N = NPI (National Provider Identifier) L = Professional License Number</td>
</tr>
<tr>
<td>PROV_ID</td>
<td>10</td>
<td>Character</td>
<td>69</td>
<td>78</td>
<td>Unique identifier for the Prescriber</td>
</tr>
<tr>
<td>PHARM_ID</td>
<td>7</td>
<td>Character</td>
<td>79</td>
<td>85</td>
<td>Dispensing Pharmacy’s 7-Character National Association of Boards of Pharmacy Number (NABP) / NCDBP ID.</td>
</tr>
</tbody>
</table>

**NOTE:** The DEA number of the prescribing physician is required for all dispensed medications in DEA classes 2 through 5 (controlled substances). If the prescribed medication is not in these DEA classes, this field should be filled with nine spaces to maintain record-length integrity.

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Chapter 12

Behavioral Health Required Staff/Providers Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-For-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with adequate assurances that the health plan has the capacity to provide covered services to all enrollees up to the maximum enrollment level in each county, including assurances that the health plan:

1. Offers an appropriate range of accessible behavioral services such that the health plan can meet the needs of the maximum enrollment level in each county, and

2. Maintains a sufficient number, mix and geographic distribution of providers, including providers who are accepting new Medicaid patients as specified in Section 1932(b)(7) of the Social Security Act, as enacted by Section 4704(a) of the Balanced Budget Act of 1997.

FREQUENCY & DUE DATES:

➢ Due annually to the Agency by August 15 if the health plan has been in existence a year or more.

➢ Due quarterly to the Agency within forty-five calendar days after the end of the quarter being reported if the health plan has been in existence less than one year.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site:
- A Staff/Providers Report in accordance with the template found in the “Report Template” section below.

- A report attestation (see Chapter 2).

**INSTRUCTIONS:**

1. The health plan shall submit the total number of staff/provider positions for those professionals listed in the Behavioral Health Required Staff/Providers Report Template on an annual/quarterly basis (see Frequency & Due Dates) by completing the reporting template below. This report must reflect the health plan’s behavioral health staffing in the month of June (or the last month of the quarter for health plans that have been in business less than one year).

2. A separate report must be provided for each AHCA Medicaid area of operation. A template is provided in the form of a workbook with a separate worksheet for reporting the individual AHCA Medicaid areas (and divided by Reform and non-Reform data).

3. Regardless of report submission requirements, health plans are still required to notify the Agency if they experience a deficit in any staffing area that may cause a delay in enrollee access to services.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

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### Behavioral Health – Required Staff/Providers Report

<table>
<thead>
<tr>
<th>Positions</th>
<th>Total</th>
<th>Non Clinical Specialties</th>
<th>Therapeutic Specialty Areas With 2 Years Clinical Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Brain Injuries, Head Injuries, Accident &amp; Poisoning</td>
</tr>
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<td>Ear Infections, Nasal Diseases</td>
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<td></td>
<td>Cardiovascular Disease, Pneumonia, Shock</td>
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<td>Gastrointestinal Disease, Nephritis</td>
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<td>Spinal Disorders, Injuries</td>
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<td>Neurological Disease, Mental Health</td>
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<td>Infectious Disease, Urological Disease</td>
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<td>Allergies, Dermatology</td>
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<td>Sexual Health, Reproductive Disease</td>
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<td>Oncology, Hematology</td>
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<td>Endocrinology, Diabetes</td>
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<td>Pulmonary Disease, Sleep Disorders</td>
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<td>Immunology, Immunizations</td>
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<td>Obstetrics, Gynecology</td>
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<td>Gastroenterology, Gastrointestinal Disease</td>
</tr>
</tbody>
</table>

The report is due within forty-five (45) calendar days after June 30 (or 15 August), and will reflect the health plan’s behavioral health staffing as of the month of June.

Click here to download the template: Report Template - Behavioral Health - Required Staff-Providers.xls
Chapter 13

Behavioral Health – Stakeholders’ Satisfaction Survey – Summary

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-For-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with the summary results of the health plan’s behavioral health services Stakeholders’ Satisfaction Survey.

FREQUENCY & DUE DATES:

- Due annually by March 1 after the end of the calendar year being reported.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) at mmcddata@ahca.myflorida.com:

- Stakeholders’ Satisfaction Survey Summary in accordance with the template found in the Report Template section below.
- A copy of the survey tool and the methodology used.
- A report attestation (see Chapter 2).

INSTRUCTIONS:

1. The health plan must report Reform data separate from non-Reform data; separate worksheets-tabs are provided in the template.
2. The survey questions and the response categories in the template must match the survey tool approved previously by BMHC pursuant to Attachment II, Exhibit 6, of the health plan contract.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

Stakeholders’ Satisfaction Survey Summary

![Stakeholders’ Satisfaction Survey Summary Table]

*Click here to download the template: Report Template - Behavioral Health - Stakeholder Satisfaction Survey.xls*

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Chapter 14

CHCUP (CMS-416) & FL 60% Screening Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with data documenting the health plan's program and compliance with federal and state statutory requirements regarding Child Health Check Up (CHCUP) screening and participation.

FREQUENCY & DUE DATES:

- Due annually – Unaudited CHCUP (CMS-416) and FL 60% Screening Ratio Report, on or before January 15 following the reported federal fiscal year (October 1 through September 30).

- Due annually – the Audited CHCUP (CMS-416) and FL 60% Screening Ratio Report, the Audited Report, and the Auditor’s Letter of Opinion on or before October 1.

SUBMISSION:

The health plan shall submit the following in an email to the Agency Bureau of Managed Health Care (BMHC) mailbox – mmcdata@ahca.myflorida.com:

- The Unaudited CHCUP and FL 60% Screening Ratio Agency-supplied templates, with the file named: UA-CHCUP-***yyy.xls, where “***” represents the plan’s three letter plan identifier and “yyyy” represents the federal fiscal year being reported.
➢ The Audited CHCUP and FL 60% Screening Ratio Agency-supplied templates with the file named: A-CHCUP-***yyyy.xls, where “***” represents the plan’s three letter plan identifier and “yyyy” represents the federal fiscal year being reported.

➢ The auditor’s report and opinion letter is due with the audited CHCUP and FL 60% Screening templates with the file named: A-CHCUP-***yyyy.pdf, where “***” represents the plan’s three letter plan identifier and “yyyy” represents the federal fiscal year being reported.

INSTRUCTIONS:

1. Reform and non-Reform data shall be filed as one template. Check the appropriate box indicating if the reported data is Reform only, non-Reform only, or combined (Reform & non-Reform).

2. 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.

3. 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.

4. Services provided to individuals prior to them turning 21 during the report year shall be counted in the 19-20 Yr 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.

5. Count only CHCUPs that were completed when eligibles were members of the reporting HMO/PSN. Do not count CHCUPs performed by other HMOs, PSNs or fee-for-service providers such as MediPass.

6. Do not count MediKids populations in the data reported.

7. 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.

8. All fields in the templates must be completed according to the services required under contract.
9. 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.

10. 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 HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The CHCUP (CMS-416) & FL 60% Screening Ratio Report Agency-supplied template is emailed to the health plan’s compliance contact each November. The template can be found on the Bureau of Managed Care’s Medicaid Health Plan Information webpage at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/CHCUP_CMS-416-FL_60-percent_SCREENING.xls

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Chapter 15

Claims Aging Report & Supplemental Filing Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS
✓ Reform Specialty Plan for Children with Chronic Conditions

REPORT PURPOSE:

To provide the Agency with assurance that claims are processed and payment systems comply with the State requirements set forth in 42 CFR 447.45, 42 CFR 447.46, and Chapters 641 and 409, F.S.

FREQUENCY & DUE DATES:

➢ Due quarterly, within 45 calendar days after the end of each reported quarter.

➢ For capitated health plans, the optional Supplemental Report is due within 105 calendar days after the end of each reported quarter.

SUBMISSION:

The health plan shall submit the following via a single non-secure email to the Agency’s Bureau of Managed Health Care (BMHC) mailbox at MMCCLMS@ahca.myflorida.com:

➢ For the quarterly submissions:

   a. The completed claims aging report template, which shall be submitted as an XLS file and named using the file naming convention as described in Chapter 2 of this guide.

   b. The attestation (see Chapter 2) for the completed claims aging report template, which shall be submitted with the certified data as a PDF file and named using the file naming convention as described in Chapter 2 of this guide. This attestation must be signed by the health plan’s chief executive
officer (CEO), chief financial officer (CFO) or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify report.

If a health plan is non-Reform and Reform, the above mentioned submissions must be emailed separately (see the “Instructions” section of this chapter).

➢ For the optional supplemental submissions (capitated health plans only):

a. The completed claims aging supplemental filing report template, which shall be submitted as an XLS file and named using the file naming convention as described in Chapter 2 of this guide.

b. The attestation (see Chapter 2) for the completed claims aging supplemental filing report template, which shall be submitted with the certified data as a PDF file and named using the file naming convention as described in Chapter 2 of this guide. This attestation must be signed by the health plan’s CEO, CFO or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete. Such delegations of authority must be attached to the submitted signed attestation to certify report.

If a health plan is serving non-Reform and Reform populations, the above mentioned submissions must be emailed separately (see the “Instructions” section of this chapter).

**INSTRUCTIONS:**

1. The health plan shall complete the quarterly Claims Aging Report(s) and, if applicable, Claims Aging Supplemental Filing Report(s), using the appropriate report template (specific to health plan type) 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 received, paid and denied during the reporting period (see template).

5. The health plan must file **separate reports in separate emails** for Reform and non-Reform data, respectively.
6. Fee-for-service health plans that receive capitation from the Agency for covered services, or that sub-capitate for covered services, must report such claims as specified for capitated claims reporting in the reporting template for fee-for-service health plans.

7. If the capitated health plan chooses to file a Claims Aging Supplemental Filing Report, it may report claims received during the reported quarter and processed within 90 calendar days of receipt. The supplemental reporting is voluntary on the part of the capitated health plan.

**VARIATIONS BY HEALTH PLAN TYPE:**

Templates and reporting requirements are unique to specific health plan types (fee-for-service health plans have one template; capitated health plans have another – see the “Report Templates” section of this chapter).

**REPORT TEMPLATE:**

No alterations or duplications shall be made to the report template by the health plan. The Agency-supplied claims aging report template for capitated health plans (for the required quarterly and optional supplemental submission) can be found at:

http://www.ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml

The Agency-supplied claims aging template for fee-for-service health plans can be found at:

http://www.ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_prov_0912.shtml
Chapter 16

Code 15 – Critical Incident Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

The purpose of this report is to monitor all health plan’s critical and adverse incident reporting and management system and proactive steps for critical events that negatively impact the health, safety, or welfare of enrollees. Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents. Such systems shall be for critical and adverse incidents that occur in all service delivery settings applicable to enrollees.

FREQUENCY & DUE DATES:

➢ Due within 15 calendar days following the incident.

SUBMISSION:

Using the file naming convention described in Chapter 2, the health plan shall submit the following to the Agency’s BMHC plan analyst:

➢ Critical Incident Code 15 using the Division of Health Quality Assurance’s online Code 15 to document and report the incident.

➢ The report attestation (see Chapter 2).

INSTRUCTIONS:

1. The Health Plan shall utilize the Critical Incident Code 15 report as posted online by the Division of Health Quality Assurance.
2. For the incident, the report shall include but not be limited to:

- Enrollee’s full name
- Enrollee’s Medicaid ID
- Reporting date
- Date of incident
- Address of incident
- Name of facility (if applicable)
- Facility Unit, if hospital, if applicable; or
- Other Health Care Provider: Abortion Clinic, Ambulatory Surgical Center, Assisted Living Facility, Doctor’s Office, Home Health, Nursing Home, or other type of provider.
- ICD 9 or ICD 10 Code and ICD 9 CM Code for Admitting Diagnosis; Accident, event or specific agent that caused event; resulting injury
- Incident details
- Outcome of the incident, including current status of the enrollee
- List of license number of personnel and capacity in which they were directly involved with this incident.
- List of license numbers of witnesses
- Date resolved
- Analysis of this incident
- Describe corrective or proactive action taken

**VARIATIONS BY HEALTH PLAN TYPE:**

While PSNs cannot submit the Code 15 report directly to HQA through the online process, the PSNs can download the Code 15 form for submission to BMHC.

**REPORT TEMPLATE:**

The template to be used for the Code 15 report can be found online at:


The Agency-supplied template must be used as specified in the Report Guide. The Agency-supplied template to be used for this report can be found on the Bureau of Managed Care Medicaid Health Plan Information webpage at:


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Chapter 17
Community Outreach Health Fairs/Public Events Notification

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with notification of health plan participation at health fairs and public events.

FREQUENCY & DUE DATES:

- Due monthly, no later than the 20th calendar day of the month prior to the event month.
- Amendments to the report are due no later than two weeks prior to the event (variable).

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the BMHC email box: mmcdata@ahca.myflorida.com

- An outreach/public event report using the Agency-supplied template. The month used in the naming convention will represent the month the event will occur.
- An amendment to a reported event when there is a change in time, location, date or cancellation of the event. The month used in the naming convention will be the same month the event was originally scheduled to occur.
- A report attestation (see Chapter 2).
INSTRUCTIONS:

The health plan shall submit Reform and non-Reform events on the same template. If no events are planned in any month, the health plan must file the template indicating “none” on the first line of the template.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The template is located on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/COMMUNITY_OUTREACH_HEALTH_FAIRS_PUBLIC_EVENTS_NOTIFICATION.xls

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Chapter 18
Community Outreach Representative Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To ensure health plans register each community outreach representative with the Agency as required in Attachment II, Section IV, of the model health plan contract.

FREQUENCY & DUE DATES:

➢ Due two weeks prior to any outreach activities to be performed by the representative (variable).

➢ Due quarterly – Within 45 calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following in an email to the Agency Bureau of Managed Health Care (BMHC) mailbox – mmcdata@ahca.myflorida.com:

➢ A file in the template supplied within this chapter.

➢ A report attestation (see Chapter 2). This attestation must include an attestation specifically addressing the accuracy and completeness of both Reform and non-Reform submissions (when applicable).

INSTRUCTIONS:

1. The Community Outreach Representative Registration Template is an Excel workbook consisting of three worksheets:
a. Instructions for the completion of the template.


c. Representative Activity – Community outreach representative information including any change in status.

2. The health plan may submit Reform and non-Reform data together in the same file.

3. In the event that there are no representative activities to report for a quarter, a blank report must still be submitted along with an attestation.

**VARIATIONS BY HEALTH PLAN TYPE:**

For the Specialty Plan for Children with Chronic Conditions, this registration includes only those community outreach representatives that represent the CMS PSN.

**REPORT TEMPLATE:**

The template is available on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page:


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Chapter 19
Complaints, Grievances, and Appeals Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Reform Specialty Plan for Children with Chronic Conditions

REPORT PURPOSE:

To provide the Agency with a quarterly record of all complaints, grievances and appeals in accordance with the terms of the contract.

FREQUENCY & DUE DATES:

- Due quarterly; 15 calendar days from the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site:

1. For Reform populations, one report of complaints, grievances and appeals using the template supplied in this chapter and including Reform data only.

2. For non-Reform populations, one report of complaints, grievances and appeals using the template supplied in this chapter and including non-Reform data only.

3. A report attestation (see Chapter 2). This attestation must specifically address the accuracy and completeness of both Reform and non-Reform submissions (where applicable).
INSTRUCTIONS:

1. The health plan must file separate reports using the template provided for Reform and non-Reform data.

2. The template consists of seven worksheets (four of which are quarterly representations):
   a. Instructions – explains how to complete the template.
   b. Codes – provides report definitions and codes explaining the types of complaints, grievances, appeals and dispositions.
   c. Quarter 1 – Quarter 4 – Each quarter has a separate worksheet for reporting complaints, grievances, and appeals received by the health plan during the reporting quarter.
   d. Summary – No data can be entered into the summary worksheet. As the health plan completes each quarterly worksheet, the data is captured and reported in the aggregate on the Summary worksheet.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Complaints, Grievances & Appeals Report template can be found on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/COMPLAINTS-GRIEVANCES-APPEALS_REPORT.xls

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Chapter 20

Critical Incident Report

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

The purpose of this report is to monitor all health plan’s critical and adverse incident reporting and management system for critical events that negatively impact the health, safety, or welfare of enrollees.

FREQUENCY & DUE DATES:

➢ 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 health plan shall submit the following via secure, encrypted email to the Agency’s BMHC plan analyst:

➢ Critical Incident Report using the template provided.

➢ The report attestation (see Chapter 2).

INSTRUCTIONS:

1. The health plan shall create and submit the Critical Incident Report in the format and layout specified in the report template for critical incidents reported.

2. The report shall include the following:
   • Enrollee’s full name
   • Enrollee’s Medicaid ID
- Reporting date
- Date of incident
- Address of incident
- County
- Name of facility (if applicable)
- Facility Unit, if hospital, if applicable; or
- Other Health Care Provider: Abortion Clinic, Ambulatory Surgical Center, Assisted Living Facility, Doctor’s Office, Home Health, Nursing Home, or other type of provider.
- ICD 9 or ICD 10 Code for Admitting Diagnosis
- Incident type
- Incident details
- Outcome of the incident, including current status of the enrollee (From the following: Death, fetal death, brain damage, spinal damage, surgical procedure performed on the wrong site, surgical procedure performed on wrong patient, wrong surgical procedure performed, surgical procedure unrelated to patient’s diagnosis, surgical procedure to remove foreign objects remaining from a surgical procedure, surgical repair of injuries from a planned surgical procedure, abuse/neglect/exploitation, altercation with law enforcement, elopement, missing, major medication injuries).
- List of license number of personnel and capacity in which they were directly involved with this incident.
- List of license numbers of witnesses
- Date resolved

3. Adverse incidents to be reported include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents that occur in all service delivery settings applicable to enrollees.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency-supplied template must be used as specified in the Report Guide. The Agency-supplied template to be used for this report can be found on the Bureau of Managed Care Medicaid Health Plan Information webpage at:

Chapter 21

Critical Incident Summary Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

The purpose of this report is to provide a summary of the Health Plan’s critical and adverse incidents reported during the prior month. See Critical Incident Report, Chapter 22.

FREQUENCY & DUE DATES:

- Due monthly, by the fifteenth (15th) calendar day of the month following the reporting month.

SUBMISSION:

Using the file naming convention described in Chapter 2, the health plan shall submit the following to the Agency’s BMHC SFTP site:

- Critical Incident Summary Report using the template provided.
- The report attestation (see Chapter 2).

INSTRUCTIONS:

1. The Health Plan shall create the Critical Incident Summary Report in the format and layout specified in the report template.

2. For the reporting period, the report shall include the number of events by outcome during the reporting period, and rolled up for quarter and year.
3. Adverse incidents may include events involving abuse, neglect, exploitation, major illness or injury, involvement with law enforcement, elopement/missing, or major medication incidents. Such systems shall be for critical and adverse incidents that occur in all service delivery settings applicable to enrollees.

4. The first Critical Incident Summary Report will be due February 15, 2014, for the January 2014 report month.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE

The Agency-supplied template must be used as specified in the Report Guide. The Agency-supplied template to be used for this report can be found on the Bureau of Managed Care Medicaid Health Plan Information webpage at:


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Chapter 22
Cultural Competency Plan (and Annual Evaluation)

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with assurance of the health plan’s compliance with 42 CFR 438.206, which requires the health plan to have a comprehensive written Cultural Competency Plan (CCP) describing how the health plan will ensure services are provided in a culturally competent manner to all enrollees. The program goal is to describe how providers, health plan employees, and systems will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms, and respects the worth of the individual enrollees and protects and preserves the dignity of each.

FREQUENCY & DUE DATES:

- Due annually June 1 to the Agency for approval. The approved plan must be implemented by September 1 of each contract year. In addition, the health plan must submit an annual evaluation of its cultural competency plan’s effectiveness during the previous contract year as part of its annual submission for the Agency’s review.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) via email to mmcdeta@ahca.myflorida.com or by CD/DVD standard mail submission to 2727 Mahan Drive, Mail Stop 26, Tallahassee FL 32308:

- The CCP for the coming year.
- The annual evaluation of the health plan’s CCP effectiveness for the Reform population for the previous contract year.

- The annual evaluation of the health plan’s CCP effectiveness for the non-Reform population for the previous contract year.

- A report attestation (see Chapter 2).

**INSTRUCTIONS:**

1. The health plan shall submit its annual CCP including its evaluation of the effectiveness of its previous contract year's CCP. The evaluation may include results from the CAHPS or other comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances, member appeals, provider feedback and health plan employee surveys. The health plan must also track and trend any issues identified in the evaluation, and implement interventions to improve the provision of services. A description of the evaluation, its results, the analysis of the results, and interventions to be implemented must be described in the annual CCP.

2. The health plan may file one CCP combining both Reform and non-Reform information. However, the health plan must submit two separate evaluation reports, one for Reform and one for non-Reform if it serves both Reform and non-Reform.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE**

The CCP should be developed in narrative form, but may include data sets and graphical representations where necessary.

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Chapter 23

Customized Benefit Notifications Report

PLAN TYPES:

Health plans that must submit this report:

- Reform HMOs
- Reform Capitated PSNs
- Reform HMO specialty plan for recipients living with HIV/AIDS

REPORT PURPOSE:

HMOs and capitated PSNs may choose to offer a customized benefit package for their Reform enrollees as provided for in the health plan contract, Attachment II, Section V, Exhibit 5, and Attachment I. The customized benefit package may limit the coverage for some state plan services. As part of the customized benefit package, the capitated health plan may vary the dollar amount or unit amount of certain Medicaid state plan services. Such customized benefit packages must be approved annually by the Agency through the Bureau of Health Systems Development. For those plans that offer a customized benefit package, this report provides the Agency with verification that the capitated health plan has mailed notices to affected Reform enrollees as they begin to reach their maximum annual dollar limits for any service restricted by the Customized Benefit Package dollar amount.

FREQUENCY & DUE DATES:

- Due monthly, by the 15th calendar day of the month following the end of the reported month.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site:

- A completed report using the template supplied in this chapter.

- A report attestation (see Chapter 2). This attestation must specifically address the accuracy and completeness of the submitted Reform data.

- If no Reform enrollees have reached the specified percentage (50%, 75%, or 100%) of their annual limits, the health plan must still provide a attestation letter indicating no Reform enrollees have reached the specified percentages for benefit limits for the report month.
INSTRUCTIONS:

1. The health plan shall complete and submit a Customized Benefit Notifications Report, along with copies of each notification letter (in a pdf format), using the report template located on the Agency website (see link to template in the “Report Template” section of this chapter).
   a. Note: maximum benefit levels are contract year limits and begin every September 1.
   b. Note: number of Reform enrollees is reported by benefit type being exhausted.

2. The affected health plan shall complete the Customized Benefit Notifications Report for any Reform service which is restricted by a dollar amount that is more restrictive than Medicaid fee-for-service limits.

3. The Customized Benefit Notifications Report shall include the following:
   a. Number of Reform enrollees sent notification letters when they have reached 50% of any maximum annual dollar amount limit established by the health plan.
   b. Number of Reform enrollees sent notification letters when they have reached 75% of any maximum annual dollar amount limit established by the health plan.
   c. Number of Reform enrollees sent notification letters when they have reached the maximum dollar amount established by the health plan for a benefit.

4. The health plan must provide the report attestation with each monthly submission (see the Submission section of this Chapter).

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Customized Benefit Notifications Report Agency-supplied template to be used for this report can be found on the Bureau of Managed Care Medicaid Health Plan Information webpage at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/CUSTOMIZED_BENEFIT_NOTIFICATIONS_REPORT.xls
Chapter 24
Enhanced Benefits Report

PLAN TYPES:

Health plans that must submit this report:

- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with a monthly list of all Reform enrollees’ completed and/or approved healthy behaviors.

FREQUENCY & DUE DATES:

- Due monthly by the 10th calendar day of the month following the reported month.

SUBMISSION:

The health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site*:

- One Enhanced Benefit Report with the file name C_^^^_YYMMDD.txt replacing ^^^ with the health plan’s three-character approved abbreviation (located on the last page of this chapter) and replacing ‘YYMMDD’ with the two-digit year, two-digit month, and two-digit day the data was recorded.

- A report attestation (see Chapter 2); the attestation shall be named C_^^^_YYMMDD_cert.pdf following the same naming convention above.

* The Choice Counseling Unit is responsible for reviewing the reports for accuracy and timeliness, and will retrieve the reports from the BMHC site to do so.

INSTRUCTIONS:

1. The health plan shall submit a monthly report (flat text file) of all healthy behaviors for the prior month or up to one year from the date of service/completion for the following procedure codes in the prescribed format below.
2. For maintenance drugs, use the following maintenance drug links to get the NDC codes:

   a. **Maintenance Drug Links**
      
      List [924KB PDF]  
      List [2.10KB Microsoft Excel]

3. The health plan should fill in the text file with all zeros if there is no data to report for a specific month.

4. Questions regarding this report may be sent by email to: [enhancedbenefit@ahca.myflorida.com](mailto:enhancedbenefit@ahca.myflorida.com).

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The Enhanced Benefits Report template can be found at:


**EBIS Credit File Validator**

The EBIS Credit File Validator was created to assist health plans to validate the health plan enhanced benefits credit file. The validator software can be found under the header EBIS Credit File Validator at:


**Health Plan Enhanced Benefits Credit File Layout**

The record length is 90 bytes. File to include header record, detail records and trailer record. Record fields are TAB delimited.

**Format of the header record:**

Bytes 01 – 01 Character ‘H’ indicating header  
02 – 02 Character TAB delimiter  
03 – 12 First of the month date to be processed, CCYY-MM-DD  
13 – 13 Character TAB delimiter  
14 – 15 Numeric 2 whole digits  
   File Type 01 = Health Plan Enhanced Benefit Credit Import  
16 – 16 Character TAB delimiter  
17 - 87 Character, spaces  
88 - 88 Character TAB delimiter  
89-89 Line Feed character  
90-90 Carriage Return character
Format of each detail record:
Bytes 01 – 01 Character ‘D’ indicating detail

02 – 02 Character TAB delimiter
03 – 11 Character, 9 Plan ID
12 – 12 Character TAB delimiter
13 – 21 Character, 9 Recipient ID
22 – 22 Character TAB delimiter
23 – 32 CCYY-MM-DD Date of Birth
33 – 33 Character TAB delimiter
34 – 38 Character, 5 Procedure Code
39 – 39 Character TAB delimiter
40 – 49 CCYY-MM-DD Date of Paid Claim / Date HP received EB Universal Form
50 – 50 Character TAB delimiter
51 – 61 Character, 11 NDC
62 – 62 Character TAB delimiter
63 – 67 Character, 5 GCN
68 – 68 Character TAB delimiter
69 – 72 Numeric, 4 Quantity
73 – 73 Character TAB delimiter
74 – 76 Numeric, 3 Day Supply
77 – 77 Character TAB delimiter
78 – 87 CCYY-MM-DD Date of Service / End Date on the EB Universal Form
88 – 88 Character TAB delimiter
89 – 89 Line Feed Character
90 – 90 Carriage Return Character

Format of the trailer record:
Bytes 01 – 01 Character ‘T’ indicating trailer

02 – 02 Character TAB delimiter
03 – 09 Total number of detail records, Sign Leading Separate 7 whole Digits
10 – 10 Character TAB delimiter
11 – 87 Character, spaces
88 -88 Character TAB delimiter
89 – 89 Line Feed Character
90 – 90 Carriage Return Character

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For Reporting Healthy Behaviors

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Chapter 25
Hernandez Settlement Agreement Log

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs*
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs*
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Reform Specialty Plan for Children with Chronic Conditions*

*Only FFS PSNs that have authorization requirements for prescribed drug services must submit this report.

REPORT PURPOSE:

To provide the Agency with details regarding any enrollee issues related directly to the settlement agreement et.al. v. Medows (Case number 02-20964 Civ-Gold/Simonton), commonly referred to as the Hernandez Settlement Agreement (HSA).

HSA explained:

*If a health plan has authorization requirements for prescribed drug services, the health plan shall comply with all aspects of the Settlement Agreement- Hernandez, et.al. v. Medows (Case number 02-20964 Civ-Gold/Simonton. An HSA situation arises when an Enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive his/her prescription as a result of: 1. An unreasonable delay in filling the prescription; 2. A denial of the prescription; 3. The reduction of a prescribed good or service; and/or 4. The termination of a prescription.*

FREQUENCY & DUE DATES:

- Due quarterly – 15 calendar days after the end of the reported quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site:

- The Agency supplied HSA Template.
A report attestation (see Chapter 2). This attestation must include an attestation specifically addressing the accuracy and completeness of both Reform and non-Reform submissions (when applicable).

**INSTRUCTIONS:**

1. The health plan shall maintain a log of all correspondence and communications from enrollees relating to the HSA Ombudsman process using the provided Agency template.

2. The health plan must file separate reports for Reform and non-Reform data.

3. The template has five spreadsheets — one plan info sheet, and four quarterly spreadsheets.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The HSA Log Template may be found on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page:


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Chapter 26
Hernandez Settlement Agreement Survey

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs*
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs*
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Reform Specialty Plan for Children with Chronic Conditions*

*Only FFS PSNs that have authorization requirements for prescribed drug services must submit this report.

REPORT PURPOSE:

To provide the Agency with annual HSA surveys conducted by the health plan on no less than 5% of all participating pharmacy locations in an effort to ensure compliance with the HSA.

HSA explained:

If a health plan has authorization requirements for prescribed drug services, the health plan shall comply with all aspects of the Settlement Agreement - Hernandez, et.al. v. Medows (Case number 02-20964 Civ-Gold/Simonton. An HSA situation arises when an Enrollee attempts to fill a prescription at a participating pharmacy location and is unable to receive his/her prescription as a result of: 1. An unreasonable delay in filling the prescription; 2. A denial of the prescription; 3. The reduction of a prescribed good or service; and/or 4. The termination of a prescription.

FREQUENCY & DUE DATES:

- Due annually, on or before August 1 of each year.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following in an email to the Agency Bureau of Managed Health Care (BMHC) email box – mmcddata@ahca.myflorida.com:

- The HSA survey template.
A report attestation (see Chapter 2). This attestation shall specifically address the accuracy and completeness of the report.

**INSTRUCTIONS:**

1. The health plan shall conduct HSA surveys of no less than 5% of all participating pharmacy locations.

2. The health plan shall not include any participating pharmacy locations that the health plan found to be in complete compliance with the HSA requirements within the previous 12 months.

3. The health plan shall 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 with one month of the health plan’s HSA training to ensure compliance.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The HSA Survey Template can be found on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/HERNANDEZ_SETTLEMENT_AGREEMENT_SURVEY.xls

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Chapter 27

Inpatient Discharge Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency, for use in county billing, with an accurate electronic representation of the health plan’s complete listing of all Medicaid enrollees discharged from inpatient hospitalization during the quarter being reported or unreported from previous quarters.

FREQUENCY & DUE DATES:

- Due quarterly to the Agency within thirty calendar days following the end of the quarter being reported.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (SFTP) site:

- The Inpatient Discharge Report.
- A report attestation (see Chapter 2).
- Reform and non-Reform populations should be combined into one report.

INSTRUCTIONS:

1. The health plan shall submit the Inpatient Discharge Report in an ASCII flat fixed record length text file, and shall use the format outlined in the “Report Template” section of this chapter.

2. Inpatient psychiatric care will be identified as an Admit Type of “2,” restricted to claims for enrollees with a primary ICD-9CM diagnosis code of 290 through 290.43,
290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, and 315.31.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Type</th>
<th>Width</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAN_ID</td>
<td>Character</td>
<td>9</td>
<td>9-Digit Medicaid provider number of health plan</td>
</tr>
<tr>
<td>RECIP_ID</td>
<td>Character</td>
<td>10</td>
<td>10-Digit Medicaid ID number of plan member</td>
</tr>
<tr>
<td>RECIP_LAST</td>
<td>Character</td>
<td>20</td>
<td>Last name of plan member</td>
</tr>
<tr>
<td>RECIP_FIRS</td>
<td>Character</td>
<td>10</td>
<td>First name of plan member</td>
</tr>
<tr>
<td>RECIP DOB</td>
<td>Date</td>
<td>10</td>
<td>Plan member’s date of birth, mm/dd/yyyy</td>
</tr>
<tr>
<td>AHCA_ID</td>
<td>Character</td>
<td>8</td>
<td>AHCA ID Number of admitting hospital</td>
</tr>
<tr>
<td>HOSP NAME</td>
<td>Character</td>
<td>60</td>
<td>Please use upper case only.</td>
</tr>
<tr>
<td>ADMIT</td>
<td>Date</td>
<td>10</td>
<td>Date of Admission, mm/dd/yyyy</td>
</tr>
<tr>
<td>DISCH</td>
<td>Date</td>
<td>10</td>
<td>Date of Discharge, mm/dd/yyyy</td>
</tr>
<tr>
<td>ADMIT TYPE</td>
<td>Character</td>
<td>1</td>
<td>Indicates the Type of Admission. 1=General Acute Care 2=Inpatient Psychiatric</td>
</tr>
<tr>
<td>TPL</td>
<td>Numeric</td>
<td>7</td>
<td>Amount paid by third party (whole dollars)</td>
</tr>
<tr>
<td>DIAG1</td>
<td>Character</td>
<td>7</td>
<td>Primary ICD-9 Diagnosis with the explicit decimal point in appropriate codes.</td>
</tr>
<tr>
<td>DIAG2</td>
<td>Character</td>
<td>7</td>
<td>Secondary ICD-9 Diagnosis (if applicable) with the explicit decimal point in appropriate codes.</td>
</tr>
<tr>
<td>DIAG3</td>
<td>Character</td>
<td>7</td>
<td>Tertiary ICD-9 Diagnosis (if applicable) with the explicit decimal point in appropriate codes.</td>
</tr>
<tr>
<td>PROC1</td>
<td>Character</td>
<td>5</td>
<td>For a surgical or obstetrical admission, the principal ICD-9 Procedure Code</td>
</tr>
<tr>
<td>PROC2</td>
<td>Character</td>
<td>5</td>
<td>For a surgical or obstetrical admission, the secondary ICD-9 Procedure Code</td>
</tr>
<tr>
<td>PROC3</td>
<td>Character</td>
<td>5</td>
<td>For a surgical or obstetrical admission, the tertiary ICD-9 Procedure Code</td>
</tr>
</tbody>
</table>

*Note: The 8 character AHCA hospital ID # can be located on the Florida Health Finder website at: [http://www.floridahealthfinder.gov/FacilityLocator/FacilitySearch.aspx](http://www.floridahealthfinder.gov/FacilityLocator/FacilitySearch.aspx)
Chapter 28

Insolvency Protection Multiple Signatures Agreement Form

PLAN TYPES:

Health plans that must submit this form:

- Non-Reform FFS PSNs*
- Non-Reform HMOs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS

*Non-Reform FFS PSNs Approved to Subcapitate for Services or Capitated for Behavioral Health Services

REPORT PURPOSE:

To provide the Agency with confirmation of a health plan’s required restricted insolvency protection account with a federally guaranteed financial institution that is licensed to do business in Florida.

FREQUENCY & DUE DATES:

- Due immediately upon the health plan filing an application for a Medicaid contract with the Agency (in accordance with the application filing instructions).

- Due annually on or before April 1. If the authorized persons on file with the Agency remain the same, the health plan shall submit an annual attestation to this effect.

- Due within thirty (30) calendar days of any changes to the authorized persons on file with the Agency.

SUBMISSION:

- For the initial submission to the Agency during the application process or subsequent notification of any changes to the authorized persons on file with the Agency, the health plan shall submit the following via mail to the Agency’s Bureau of Managed Health Care (BMHC) at the following address:
Agency for Health Care Administration  
Bureau of Managed Health Care  
Attn: Hazel Greenberg (MSVA)  
2727 Mahan Drive, MS# 26  
Tallahassee, FL 32308

1. The original completed Multiple Signature Verification Agreement form with original signatures (in blue ink) of the authorized persons. This form must contain the following to be considered complete:

- The signatures of the health plan’s authorized person and the bank official executing the agreement as of the date shown in paragraph one on the first page of the form.

- The certificate of authority must be signed by the Secretary of the health plan and sealed with the health plan’s corporate seal; and

- The authorized signatures portion must be completed by the health plan with the signatures of at least two of the health plan’s authorized persons.

2. A copy of the health plan’s most current bank statement.

- For the annual submissions, the health plan shall submit the following via a single, non-secure email to the Agency’s BMHC mailbox at – MMMCFIN@ahca.myflorida.com:

  1. An attestation (see Chapter 2) stating that no changes have been made to the health plan’s designated persons on file with the Agency, which shall be submitted as a PDF file and named insolvencyverification-***-MMYYYY-attestation.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), MM is the two-digit month in which the report is due, and YYYY are the last four digits of the calendar year in which the report is due. This attestation must be signed by the health plan’s CEO, CFO or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete to the best of the official’s knowledge. Such delegations of authority must be attached to the submitted signed attestation to certify the report.

  2. A copy of the health plan’s most current bank statement (from February of the calendar year in which the report is due), which shall be submitted as a PDF file and named insolvencyverification-***MMYYYY-bank statement.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), MM is the two-digit month in which the report is due, and YYYY are the four digits of the calendar year in which the report is due.

- Questions regarding the submission of the Multiple Signature Verification Agreement form and/or current bank statement should be directed to the BMHC’s Financial...
Analyst via email at: MMCFIN@ahca.myflorida.com prior to the specified due date.

INSTRUCTIONS:

1. The health plan shall deposit into the account 5% of the capitation payments made by the Agency each month until a maximum total of 2% of the annualized total current contract amount is reached. This provision shall remain in effect as long as the health plan continues to contract with the Agency.

2. The restricted insolvency protection account may be drawn upon with the authorized signatures of two persons designated by the health plan and two representatives of the Agency.

3. The health plan must have the form signed by the health plan’s designated persons and the bank official, and the form must be sealed with the health plan’s corporate seal. Include a copy of the most current bank statement.

4. Once the BMHC receives the original signed form, the Agency representatives’ signatures will be obtained. Then, BMHC will mail the completed form with original signatures via certified mail to the bank official named in the document and a copy will also be mailed to the health plan’s compliance officer.

5. The multiple signature process must be repeated whenever a change is made to the health plan’s designated persons.

6. The health plan must submit an attestation on or before April 1 of each year stating that no changes have been made to the health plan’s designated persons on file with the Agency.

7. For specific contract cites, see Chapter 1, Summary Table of Health Plan Reports.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

A copy of the Multiple Signatures Agreement Form to be used may be found at:


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Chapter 29

Involuntary Disenrollment Report

PLAN TYPES:

Health plans that must submit this report:

✔ Reform HMOs
✔ Reform Fee-for-Service PSNs
✔ Reform Capitated PSNs
✔ Reform Specialty Plan for Children with Chronic Conditions
✔ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

The purpose of this Reform Involuntary Disenrollment Report file is to enable disenrollment requests that are initiated by the Reform health plan for affected Reform enrollees.

FREQUENCY & DUE DATES:

➢ This file is to be submitted by the health plan for affected Reform enrollees on the 1st Thursday of each month.

SUBMISSION:

The health plan shall submit the following to the Agency’s choice counseling vendor Secure File Transfer Protocol (SFTP) site server:

NOTE: prior to and through June 18, 2010, plans must submit the report to the Agency’s current choice counseling vendor in concurrence with the ongoing submission to the new choice counseling vendor that becomes effective June 18, 2010. Submission information for the vendor previous to June 18, 2010, is located in the April 1, 2010 Report Guide.


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: 63.240.123.156 (only if required for firewall rules, everyone should use the URL)

Port: 22

➢ A fixed length text file with Reform recipient disenrollments, with the following naming convention: ***_DIS_YYMM.dat, where *** represents the unique alphabetic three-character plan identifier and YYMM represents the year and month of the disenrollment file submittal.
The files will be placed in the location specified by the choice counseling/enrollment broker.

Plans needing technical assistance for submitting the Involuntary Disenrollment Report to the Reform Choice Counselor’s sftp directory should contact the following helpdesk for assistance: AHSFL-Helpdesk@automated-health.com. For more immediate concerns regarding the submission of the Involuntary Disenrollment Report, plans may contact 412-367-3030 ext 2900.

**INSTRUCTIONS:**

1. The health plans shall create the Reform Involuntary Disenrollment Report/File in the format and layout below. Acceptable reasons for disenrollments to be submitted in this file are listed in Attachment II, Exhibit 3, Section III, C.4.b., of the health plan contract.

2. For further instructions, see Involuntary Disenrollment File Layout Assumptions.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The following Reform Involuntary Disenrollment file layout is emailed by the Reform Choice Counselor/Enrollment Broker to the health plan’s compliance contact.

**Reform**

**Involuntary Disenrollment File Layout Assumptions**

1. This file runs on the first Thursday of each month. The file should process after the Daily File and after the Recon File have been processed but prior to the running of monthly exports to the Reform health plans.

2. All health plan files imported will be staged into one table and processed together. This table will be cleared prior to processing the files in the next month.

3. The health plan will send a county code of the recipient’s address. This is needed to determine if the recipient should be changed to the same plan in a different county or disenrolled.

4. All Reform health plans will send a file each month. The file will have zero transactions plus a trailer record if the health plan has no recipients to be disenrolled.
<table>
<thead>
<tr>
<th>Field Name in &lt;PlanCode&gt;_Dis&lt;MMYY&gt;</th>
<th>Text File Position</th>
<th>Field Length</th>
<th>Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;Plan Code&gt; from file name</td>
<td>N/A</td>
<td>N/A</td>
<td>Y</td>
<td>Pull three character plan code from filename.</td>
</tr>
<tr>
<td>Plan MEDICAID_ID</td>
<td>1</td>
<td>9</td>
<td>Y</td>
<td>9 digit Medicaid number assigned to the plan by the state for each county of service</td>
</tr>
<tr>
<td>RECIP_ID</td>
<td>10</td>
<td>9</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>CHECK_DIGIT</td>
<td>19</td>
<td>1</td>
<td>Y</td>
<td>10th digit of Medicaid ID</td>
</tr>
<tr>
<td>RECIP_FIRST_NAME</td>
<td>20</td>
<td>25</td>
<td>Y</td>
<td>Not validated in case of spelling difference of first name</td>
</tr>
<tr>
<td>RECIP_LAST_NAME</td>
<td>45</td>
<td>15</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>RECIPDOB</td>
<td>60</td>
<td>8</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>RECIP_COUNTY</td>
<td>68</td>
<td>2</td>
<td>Y</td>
<td>New county of residence for recipient if the reason for Disenrollment is a move out of county. Required if the system is to do an automated plan change to the same plan in the new county. <strong>DO NOT ENTER FOR OTHER THAN REASON 44 OR IF PLAN IS NOT A REFORM PLAN IN THE NEW COUNTY.</strong></td>
</tr>
<tr>
<td>DISENROLL_REASON</td>
<td>70</td>
<td>2</td>
<td>Y</td>
<td><strong>See Valid Reason Codes in this document</strong></td>
</tr>
<tr>
<td>NOTES</td>
<td>72</td>
<td>200</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK
### Trailer Record

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Field Positions</th>
<th>Field Length</th>
<th>Required</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trailer Record Text</td>
<td>1-41</td>
<td>41</td>
<td>Y</td>
<td>TRAILER RECORD, Import Disenrollment DATA</td>
</tr>
<tr>
<td>Record Count</td>
<td>42-48</td>
<td>7</td>
<td>Y</td>
<td>Count of records included in Plan Import File</td>
</tr>
<tr>
<td>System Process Date</td>
<td>49-56</td>
<td>8</td>
<td>Y</td>
<td>System Date, Format = mmddyyyy</td>
</tr>
<tr>
<td>Filler</td>
<td>57-81</td>
<td>25</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

**Valid REFORM Involuntary Disenrollment Reason Codes (USE 2 NUMBER REASON CODE IN FILE)**

<table>
<thead>
<tr>
<th>REASONCODE</th>
<th>REASON DESCRIPTION</th>
<th>SYSTEMUSE</th>
<th>ACTIVE</th>
<th>AHCAAPP R</th>
</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>IR ENROLLEE INELIGIBLE FOR PLAN ENROLLMENT</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

**AHCAAPP R = Requires AHCA approval before submittal or upon submittal, according to health plan contract requirements.**

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Chapter 30

Medicaid Redetermination Notice Summary Report

PLAN TYPES:

Health plans that must submit this report if they are approved by the Agency (see Attachment I of the health plan contract) to use Medicaid redetermination date data from their X12-834 enrollment files:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Reform Specialty Plan for Children with Chronic Conditions

REPORT PURPOSE:

To provide the Agency with data confirming the health plan’s use of Medicaid redetermination date data for its enrollees.

FREQUENCY & DUE DATES:

- Due quarterly 45 calendar days after the end of the reporting quarter.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following in an email to the Agency Bureau of Managed Health Care (BMHC) mailbox – mmcdatalahcmyflorida.com:

- A completed report using the Agency-supplied template.

- A report attestation (see Chapter 2). This attestation must specifically address the accuracy and completeness of both Reform and non-Reform submissions (when applicable).

INSTRUCTIONS:

1. The health plan, upon choosing and being approved by the Agency to participate in the Medicaid redetermination notice process, must submit to the Agency a completed quarterly summary report in accordance with Contract Attachment II, Sections IV and XII, using the template supplied in this chapter.
2. The Agency will transmit the Medicaid redetermination date information to the health plan through its X12-834 enrollment transactions.

3. If the health plan mails Medicaid redetermination date notices, it must report the number of notices mailed during the report months, the dates the letters were mailed to the enrollees, and the number of notices returned to the health plan.

4. If the health plan provides enrollees with automated voice messages, the health plan must report the number of automated calls made and the dates the calls were made during the report month.

5. The health plan must file separate reports for Reform and non-Reform data.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The Agency-supplied template to be used can be found on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/MEDICAID_REDETERMINATION_NOTICE_SUMMARY_REPORT.xls

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Chapter 31
Medicaid Supplemental HIV/AIDS Report

PLAN TYPES:

Health plans that may submit this report:

- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Non-Reform HMOs that Specialize in HIV/AIDS

REPORT PURPOSE:

To help ensure that the Agency maintains up-to-date records of all Medicaid recipients enrolled in applicable Medicaid health plans who have been diagnosed with HIV/AIDS – in particular, those that might not have been captured by the Agency’s monthly disease determination algorithm – and thus ensure that health plans are compensated at the proper rate. Submission of this report is optional for all applicable Medicaid health plans.

FREQUENCY & DUE DATES:

- Due monthly – if submitting this report, health plans must submit by the second Thursday of each month.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the Agency Bureau of Managed Health Care (BMHC) Secure File Transfer Protocol (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 due by close of business on the second Thursday of each month, and it must contain the following variables:

   a. Recipient ID – the member’s 10-digit Medicaid ID
   b. Recipient Date of Birth – the member’s date of birth in the format YYYYMMDD
c. HIV/AIDS Indicator – Indicates whether the member has HIV or AIDS. The values are 1 for HIV and 2 for AIDS.
d. Plan ID – the plan’s 9-digit provider Medicaid ID

2. The list submitted by the health plan must be a cumulative list of recipients and can contain only those who are currently enrolled in the health plan. Once a health plan has begun submitting recipients, it 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 the health plans for the following month’s enrolled population.

4. No file or attestation is due if the health plan chooses not to submit this supplemental data file. See Health Plan Contract Attachment II, Exhibit 13, for more information.

5. For plan-identified enrollees, documentation of completed lab testing as interpreted by a licensed physician must be included in the enrollee’s medical record prior to reporting the enrollee to the Agency as having an HIV or AIDS diagnosis. The health plan must provide the Agency with such enrollee’s test results upon request. The Agency will sample the submission file and request test results from a portion of the identified enrollee pool.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The file submitted must be a fixed-width text file. Below is an example of what a record on the file might look like:

1234567890198001012987654321

The above record indicates that the member with Recipient ID 1234567890 and birth date January 1, 1980 has AIDS (the HIV/AIDS indicator is equal to 2) and is enrolled in the health plan with a Medicaid health plan provider ID 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 at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/HIV-AIDS_Algorithm_Detail-03-06-09.xls
Chapter 32

MPI - Annual Fraud and Abuse Activity Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

This report is required by s. 409.91212, F.S., and provides the Agency’s Bureau of Medicaid Program Integrity with a summary annual report on the health 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: This report applies to the Medicaid product line for the September 1, 2012 Medicaid Health Plan Contract only. All dollar amounts are to be reported for any overpayment, fraud, or abuse acts. See definitions below and in managed care health plan contract, Attachment II.

As used in this report, the terms “overpayment(s),” “fraud,” and “abuse” are defined as follows:

**Overpayment:** Overpayment is defined per s. 409.913, F.S., as including any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

**Fraud:** Fraud is defined per s. 409.913, F.S., as an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

**Abuse:** Abuse is defined per s. 409.913, F.S., as provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards.
for health care. In addition, it includes recipient practices that result in unnecessary cost to the Medicaid program.

**FREQUENCY & DUE DATES:**

- Due annually by September 1. If the due date falls on a weekend or holiday, the report is due to MPI on the following business day.

**SUBMISSION:**

The health plan shall submit the following to the Agency’s Office of the Inspector General, Bureau of Medicaid Program Integrity’s MPI-MC Secure File Transfer Protocol (SFTP) site. Contact the Agency’s MPI Business Manager (MPI Site Administrator) for access information via MPIBusiness.Manager@ahca.myflorida.com:

- The health plan’s MPI - Annual Fraud and Abuse Activity Report. The health plan must use the file naming convention described in Chapter 2 with the following exception:

  For the report data period, indicate the last two digits of the state fiscal year ending the reporting period. For example, if the reporting period is for state fiscal year July 1, 2013 – June 30, 2014, the report data period would appear as 14. The following is a file name example:

  Example: File Name **ABC201409SA140056** =

  ABC Health Plan
  2013 – 2014 Annual Fraud and Abuse Activity Report due September 1, 2014

  - Health plan’s three-character identifier = ABC
  - Four-digit year in which report is due = 2014
  - Two-digit month in which report is due = 09
  - One-character identifier for the report’s year type from the Report Year Type Table = S
  - 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) = 14 (Reporting Data Period State Fiscal Year 2013 – 2014)
  - Four-digit report code identifier for the Annual Fraud and Abuse Activity Report= 0056

- A report attestation (see Chapter 2). The certification (and delegation of authority if applicable – see Chapter 2) must be scanned and submitted electronically to the MPI-MC SFTP site in PDF format with the certified data. If delegation of authority is required, then the signed delegation document must be scanned and combined with the report attestation as one electronic pdf file. The attestation must be named using the file naming convention described in Chapter.
2 with the exception described above for the report file naming convention (indicating, for the report data period, the last two digits of the state fiscal year ending the reporting period). Upload this pdf file through the web-based application to MPI-MC SFTP site. The written delegation of authority for this report must be contemporaneous and renewed each calendar year.

- The health plan shall report separately for Reform and non-Reform as applicable.
- Note: The health plan may not alter or change the report template in any way.

**INSTRUCTIONS:**

The health plan’s primary contact shall obtain access to the MPI-MC SFTP site through the Agency’s MPI Business Manager (or designated representative). The health plan user shall implement Agency-approved FTP client software, such as Filezilla, or utilize the web-transfer client provided by AHCA. Security credentials (a single user ID and password) will be provided via encrypted email once the user’s registration is approved. Use the appropriate host name for the MPI-MC SFTP site: sftp.ahca.myflorida.com, port 2232. The plan is responsible for plan user security and shall maintain the user security access for plan staff. The MPI-MC SFTP site is limited to submitting and retrieving electronic file information within the plan-specific folder. The plan password is reissued by email only to the approved registered user, 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 health plan shall successfully submit a test file within 10 calendar days after the password is issued and as requested by the Agency.

The registered user will be notified by email in the event of an account lock out due to multiple, incorrect password attempts. The primary 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 their AHCA MPI-MC Site Administrator (MPI Business Manager).

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 their AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPIBusiness.Manager@ahca.myflorida.com 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 health plan’s primary contact and must include the user’s full name, position title, and business email address. The health plan must submit the request by email to MPIBusiness.Manager@ahca.myflorida.com.
The health plan shall submit the MPI – Annual Fraud and Abuse Activity Report via the MPI-MC SFTP site to the plan-specific file folder in the following manner using the same format as the XLS template

Note: ** = A drop down selection box with pre-populated values (selections). Header fields on the template are numbered and header titles are abbreviated (below each number). There are some help boxes located throughout the template.

1. AHCA Contract Number: Enter the alpha-numeric Contract Number, assigned by the Agency that appears on the Agency’s contract with the health plan (report on separate lines for Reform and non-Reform populations).

2. Medicaid Contract Type**: For each line entry, select Reform or non-Reform as applicable.

3. State Fiscal Year**: Select the State Fiscal Year for the year being reported. Note: State Fiscal Years run from July 1 – June 30.

4. Health Plan Identifier: Provide the health plan’s three-alpha-character identifier.

5. Health Plan Medicaid Provider Number: Provide the primary Medicaid provider number of the health plan including leading zeroes when applicable. Only one line of entry is allowed. Field length is nine digits. Leading zeroes will be applied to any entry that is less than nine digits.

6. Total Overpayments Identified for Recovery: Report the total amount of all dollars identified as lost to overpayment, abuse, and fraud during the State Fiscal Year being reported. This amount shall include the dollar amount being reported in 6a. and 7. Report dollars and cents by entering numeric characters only. Do not input dollar signs ($), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no dollar losses attributable to overpayment, abuse or fraud were identified during the State Fiscal Year being reported, insert zero (0).

   a. Total Overpayments Recovered: Of the total amount of overpayment identified for recovery, report the amount of total dollars recovered attributable to overpayment, abuse, and fraud during the State Fiscal Year being reported. Report the total dollar amount of recoveries attributable to overpayment, abuse, and fraud during the State Fiscal Year being reported. Report dollars and cents by entering numeric characters only. Do not input dollar signs ($), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no recoveries of losses attributable to overpayment, abuse or fraud occurred during the State Fiscal Year being reported, insert zero (0).

7. Total Dollars Identified as Lost to Fraud and Abuse: Of the total amount of overpayments identified for recovery, report the portion of total overpayments identified for recovery which were identified as being lost only to fraud and abuse during the State Fiscal Year being reported. This amount shall include the dollar
amount being reported in 7a. Report the total dollar amount identified as lost to abuse and fraud during the State Fiscal Year being reported. Report dollars and cents by entering numeric characters only. Do not input dollar signs ($), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no dollar losses attributable to abuse and fraud were identified during the State Fiscal Year being reported, insert zero (0).

a. Total Dollars Lost to Fraud and Abuse That Were Recovered: Of the portion of dollars identified as being lost to fraud and abuse, report the amount of total dollar recovered attributable to being lost to fraud and abuse during the State Fiscal Year being reported. Report the total dollar amount of all recoveries of dollars lost to fraud and abuse made during the State Fiscal Year being reported. Report dollars and cents by entering numeric characters only. Do not input dollar signs ($), decimals or commas; only numeric characters are allowed. The field is formatted to automatically input dollar signs and decimals. If no recoveries of losses attributable to abuse and fraud have occurred, during the State Fiscal Year being reported insert zero (0).

8. Total Number of Referrals: Enter the total number of referrals made to the Agency’s Office of the Inspector General, Bureau of Medicaid Program Integrity, during the State Fiscal Year being reported.

9. Narrative Field: A narrative field is provided for other relevant information or comments regarding this report.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template must be used and renamed as specified in this Report Guide chapter (see Submission), saved in XLS format, and submitted as an electronic file. The Agency-supplied template to be used can be found on the Agency for Health Care Administration information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/MPI_Annual_Fraud_and_Abuse_Activity_Report-03-12-12.xlsx
Chapter 33

MPI - Quarterly Fraud and Abuse Activity Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

This report provides the Agency’s Office of the Inspector General, Bureau of Medicaid Program Integrity with a quarterly ongoing comprehensive fraud and abuse prevention activity report from the health plans regarding their investigative, preventive, and detective activity efforts. This report allows health plans to demonstrate their due diligence for fraud and abuse compliance, including utilization control; to safeguard against unnecessary or inappropriate use of Medicaid services, excess payments, and underutilization; assess quality, and take necessary corrective action to ensure program effectiveness. This report also allows the Agency to track and trend data across all health plans, including potential for aggregate feedback. This report is implemented as an adjunct tool in statewide surveillance for managed care fraud and abuse. This report is a supplemental comprehensive summary regarding the quarterly status, progression, and outcome of the health plan’s previously reported referrals of suspected/confirmed fraud and abuse.

Note: This summary report does not replace the health plan’s requirement to report all suspected/confirmed fraud and abuse within 15 calendar days of detection to Medicaid Program Integrity (as per contractual provisions for using the online complaint form through: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx).

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

FREQUENCY & DUE DATES:

- This report is due quarterly, within 15 calendar days after the end of the calendar quarter being reported.
SUBMISSION:

To comply with the MPI - Quarterly Fraud and Abuse Activity Report (QFAAR) requirements, the health plan shall submit the following:

- The web-based QFAAR report to the Agency Office of Inspector General, Bureau of Medicaid Program Integrity (MPI) via the web-based application site.

- A report attestation (see Chapter 2); the attestation shall be named MPI_QFAAR***yyQ*-cert.pdf (replacing *** with the health plan’s unique alphabetic three character plan identifier, replacing yy with the year, and replacing * with the number of the quarter being reported). The report attestation must accompany each report submission. If the report attestation is not signed by the CEO or CFO, a written delegation of authority signed by the CEO or CFO for the report attestation signatory must accompany the submission each time the report is submitted. The delegated signatory must be a direct report to the CEO or CFO. If delegation is required, then the signed delegation document must be scanned, combined with the report attestation as one pdf file and uploaded through the web-based application site. The written delegation of authority for this report must be contemporaneous and renewed each calendar year.

INSTRUCTIONS:

The health plan shall 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 Item 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 name. Complete the online registration form and click “submit.” After clicking the Submit button, if the user registered successfully, the user will be directed to the registration results page. 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. In addition, the health plan management approval must be obtained by signature of the health plan’s primary contact on the form. Both signatures are required for the user to request his/her access. The health plan primary contact’s signature on the user agreement is sufficient to request the health plan primary contact’s access. Mail or fax the completed form using the information listed on the form. 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 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.
4. 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 completing a new user agreement and select a name other than the prior user name.

5. The health plan’s primary contact must notify the Agency to request deactivation (termination of access/request to remove a user) of a health 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.

6. 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 health plan’s primary contact 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.

7. The health plan shall submit the MPI - Quarterly Fraud and Abuse Activity Report via MPI’s web-based application. The health plan shall first select its health plan name. Records may 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.

8. The health plan shall identify reporting for Reform and non-Reform as applicable.

   Note: On the web-based application, if “other” is selected for any data element, a narrative box will open. Input information in narrative box to describe or define what is meant by “other.” Detailed instructions are available through the web-based application.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied web-based application must be completed and used as specified in the Report Guide. This application can be found at:

## Chapter 34

### MPI - Suspected/Confirmed Fraud and Abuse Reporting

#### PLAN TYPES:

Health plans that must submit this report:

- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

#### REPORT PURPOSE:

For health plans to report all suspected or confirmed fraud and abuse under state and/or federal law relative to the health plan contract and/or Florida Medicaid. Failure to report instances of suspected or confirmed fraud and abuse is a violation of law and subject to the penalties provided by law. Notwithstanding any other provision of law, failure to comply with these reporting requirements will be subject to sanctions.

#### FREQUENCY & DUE DATES:

- Due within 15 calendar days of detection.

#### SUBMISSION:

The health plan shall complete and submit the following Agency electronic data entry complaint form online to the Agency’s Office of the Inspector General, Bureau of Medicaid Program Integrity (MPI):


#### INSTRUCTIONS:

Report suspected or confirmed fraud and abuse relative to the health plan’s contract and Florida Medicaid.

1. The narrative box of the complaint form is required to be completed by describing the suspected fraudulent or abusive activities (including background, persons
involved, events, dates, and locations). Be sure to include the who, what when, where, why and how of the situation. If additional information/documents are being submitted via MPI-MC SFTP site, indicate and identify the submission in the narrative box of the online complaint form.

2. All suspected or confirmed instances of provider fraud and abuse under state and/or federal law is to be reported to MPI within 15 calendar days of detection by filing the online report. The report shall contain at a minimum:

   a. The date reported (“Date reported” is the date the online report is submitted to MPI);
   
   b. The name of the health plan reporting;
   
   c. The health plan’s Florida Medicaid provider number;
   
   d. The name of the provider;
   
   e. The provider’s Florida Medicaid provider number; if the provider is not enrolled as Medicaid provider, state this information in narrative field.
   
   f. The provider’s NPI number;
   
   g. The provider type;
   
   h. The provider’s tax identification number;
   
   i. A description of the acts allegedly involving suspected fraud or abuse:

      (1) Source of complaint/detection tool utilized;

      (2) Nature of complaint;

      (3) If applicable, case closed due to:

         (a) Corrective action completed by provider;
         (b) Provider voluntarily left network;
         (c) Provider involuntarily terminated by health plan;
         (d) Other (specify).

   j. Potential overpayment identified;
   
   k. If known, actual overpayment identified;
   
   l. If applicable, overpayment collected or recouped from provider by health plan.
3. Reporting suspected or confirmed enrollee fraud and abuse:

   a. All suspected or confirmed instances of enrollee fraud and abuse under state and/or federal law is to be reported to MPI within 15 calendar days of detection by filing the online report. The report shall contain, at a minimum:
   
   b. The date reported (“Date reported” is the date the online report is submitted to MPI);
   
   c. The name of the health plan reporting;
   
   d. The health plan’s Florida Medicaid provider number;
   
   e. The name of the enrollee;
   
   f. The enrollee’s Health Plan identification number
   
   g. The enrollee’s Florida Medicaid identification number;
   
   h. A description of the acts allegedly involving suspected fraud or abuse:

       (1) Source of complaint/detection tool utilized;
       (2) Nature of complaint;
       (3) Potential amount of ineligible payment identified.

4. Reporting all suspected or confirmed instances of internal fraud and abuse relating to the provision of and payment for Medicaid services including, but not limited to fraud and abuse acts related to the health plan contract and/or Florida Medicaid that is other than provider and enrollee fraud and abuse (e.g. internal to the health plan – health plan employees/management, subcontractors, vendors, delegated entities):

5. The online report shall contain, at a minimum:

   a. The date reported (“date reported” is the date the online report is submitted to MPI);
   
   b. The name of the health plan reporting;
   
   c. The health plan’s Florida Medicaid provider number;
   
   d. The name of the individual or entity;
   
   e. The entity’s tax identification number;
   
   f. A description of the acts allegedly involving suspected fraud or abuse:
(1) Source of complaint/detection tool utilized;

(2) Nature of complaint (who, what, when, where, why, how);

(3) If applicable, case closed due to:

   (a) Corrective action completed by provider;
   (b) Provider voluntarily left network;
   (c) Provider involuntarily terminated by health plan;
   (d) Other (specify).

   g. Potential exposure/loss identified;

   h. If known, actual exposure/loss identified;

   i. If applicable, exposure/loss collected or recouped from individual or entity by
      the health plan.

6. The health plan may submit supplemental information via MPI-MC SFTP site.
   Reporting via the SFTP site is not a substitute for using the required online
   Medicaid Fraud and Abuse Complaint Form.

7. The health plan’s primary contact shall obtain access to MPI-MC SFTP site
   through the Agency’s MPI Business Manager (or designated representative) to
   upload electronic supplemental documentation. The health plan user shall
   implement Agency-approved FTP client software, such as Filezilla, or utilize the
   web-transfer client provided by AHCA. Security credentials (a single user ID and
   password) will be provided via encrypted email once the user’s registration is
   approved. Use the appropriate host name for the MPI-MC SFTP site: sftp.ahca.myflorida.com, port 2232. The plan is responsible for plan user
   security and shall maintain the user security access for plan staff. The MPI-MC
   SFTP site is limited to submitting and retrieving electronic file information
   within the plan-specific folder. The plan password reissued by email only to the
   approved registered user, and will expire every 90 days in accordance with
   AHCA 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 health plan shall successfully submit a test file within 10 calendar
   days after the password is issued and as requested by the Agency.

8. The registered user will be notified by email in the event of an account lock out
   due to multiple, incorrect password attempts. The primary 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 their AHCA MPI-MC
   Site Administrator (MPI Business Manager).
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 60 seconds. This form of lockout must be cleared by AHCA’s network staff. The external user must contact their AHCA Site Administrator (MPI Business Manager) for MPI reporting at MPIBusiness.Manager@ahca.myflorida.com 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 health plan’s primary contact and must include the user’s full name, position title, and business email address. The health plan must submit the request by email to MPIBusiness.Manager@ahca.myflorida.com.

11. Any additional supporting documentation must be HIPAA-compliant and may be submitted to MPI-MC SFTP site or by mail to:

AHCA Administrator, Intake Unit  
Medicaid Program Integrity  
Agency for Health Care Administration  
2727 Mahan Drive, MS #6, Tallahassee, FL 32308  
Phone: 850-412-4600

Agency Consumer Complaint Call Center: 1-888-419-3456

12. If reporting a provider that does not have a Medicaid provider number (enrolled or registered), the health plan shall include provider identifying information in narrative form.

13. An acknowledgement from the intake unit at MPI is generated for all online reporting received.

REPORT TEMPLATE:

MPI’s General Website is located at:  

Complaint report form available online at:  

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Chapter 35

Newborn Enrollment Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform Fee-for-Service PSNs
- Reform Fee-for-Service PSNs
- Reform Specialty Plan for Children with Chronic Conditions

REPORT PURPOSE:

To enroll a newborn, for whom an unborn activation was initiated, into the same PSN in which the mother is enrolled.

FREQUENCY & DUE DATES:

- Due each Wednesday.

SUBMISSION:

The health plan shall submit by email the following to the appropriate local Agency Area Office based on the county in which the newborn resides:

- A password protected Excel workbook, which shall be named: ***-WORKBOOK-Newborn-Enroll-YYMMDD.xls, where *** represents the individual health plan’s unique three-character ID, and YYMMDD represents the corresponding two-digit year, two-digit month, and two-digit day of the report.

- If there are no new cases for a particular week, the health plan shall send an e-mail to the local Agency Area Office contact indicating such.

INSTRUCTIONS:

1. See Section III, Attachment II, of the contract for pertinent information about unborn activation.

2. The health plan completes the Excel workbook in the file naming format above, to enroll only those newborns for which it has submitted unborn activation records. The workbook shall provide all the information required for the newborn’s enrollment into the health plan.
3. Prior to sending the workbook via email, the health plan must password-protect the Excel file. The password must be sent to the applicable area office in a separate email message.

4. The following is a list of Agency Area Office email addresses for submission:

   - Area 3-A: Donna Smith: Donna.Smith@ahca.myflorida.com
   - Area 3-B: Dorothy Pohleven: Dorothy.Pohleven@ahca.myflorida.com
   - Area 04: Bianka Cruz: Bianka.Cruz@ahca.myflorida.com
   - Area 09: Ivy Newton and Phyllis Sidersky: Ivy.Newton@ahca.myflorida.com and Phyllis.Sidersky@ahca.myflorida.com
   - Area 10: Alfreda Rodney and Ken Hamblin: Alfreda.Rodney@ahca.myflorida.com and Ken.Hamblin@ahca.myflorida.com
   - Area 11: Carmel Lovinsky and Dianna Chirino: lovinskc@ahca.myflorida.com and Dianna.Chirino@ahca.myflorida.com

5. If no newborns are reported, then indicate such by email to the Agency Area Office(s).

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency-supplied template to be used can be found on the Bureau of Managed Health Care Medicaid Health Plan Information webpage at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/NEWBORN_ENROLLMENT_REPORT.xls

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Chapter 36

PCP Wait Times Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Reform Specialty Plan for Children with Chronic Conditions

REPORT PURPOSE:

To provide the Agency with confirmation of the health 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 (see Contract Attachment II, Section VII).

FREQUENCY & DUE DATES:

- Due annually on or before February 1, following the reported calendar year.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following, via a single, non-secure email, to the Agency's Bureau of Managed Health Care (BMHC) mailbox at mmcdata@ahca.myflorida.com:

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

- The attestation (see Chapter 2) for the completed report, which shall be submitted with the certified data as a PDF file and named using the file naming convention as described in Chapter 2 of this guide. The attestation must be signed by the health plan's CEO, CFO or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete to the best of the official's knowledge. Such delegations of authority must be attached to the submitted signed attestation to certify report.
If a health plan is non-Reform and Reform, the above mentioned submissions must be emailed separately (see the “Instructions” section of this chapter).

INSTRUCTIONS:

1. The health plan shall 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 health plan shall:
      - Indicate which calendar year is being reported;
      - Indicate which population is being reported (Reform or non-Reform); and
      - Submit the methodology used to determine a “statistically valid” sample.
   b. On the PCP Wait Times Sheet of the report template, the health plan shall:
      - Indicate the PCP information and the number of calendar days for PCP services and referrals to specialists for covered services.

2. The health plan must file separate reports in separate emails for Reform and non-Reform, respectively.

3. The health plan shall refer to Attachment II, Section VII, of the health plan contract for pertinent wait time definitions.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

No alterations or duplications shall be made to the report template by the health plan. The Agency supplied template can be found on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Home_Care/MHMO/docs/Templates/2009-2012-Templates/PCP_WAIT_TIMES_REPORT.xls

The Agency’s template consists of the following:

- A Cover Sheet; and
- A PCP Wait Times worksheet.
Chapter 37

Performance Measures

PLAN TYPES:

Health plans that must submit this report:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To measure the health plan’s performance on specific Healthcare Effectiveness Data and Information Set (HEDIS) and Agency-defined indicators. This information is used to monitor and publicly report plan performance.

FREQUENCY & DUE DATES:

➢ Due annually by July 1.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to MRPM@ahca.myflorida.com:

➢ The Performance Measures Report.

➢ The HEDIS Auditor certification with Audit Review Table.

➢ For health plans reporting on both Reform and non-Reform populations, reports shall be filed as separate sheets in one Excel workbook.

➢ A report attestation (see Chapter 2). This attestation must include an attestation specifically addressing the accuracy and completeness of both Reform and non-Reform submissions (where applicable).
For health plans generating an Interactive Data Submission System (IDSS) file as part of their HEDIS process, the health plan shall submit the IDSS file.

**INSTRUCTIONS:**

The health plan must report the following performance measures each year to the Agency:

<table>
<thead>
<tr>
<th>HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Adolescent Well Care Visits – (AWC)</td>
</tr>
<tr>
<td>2  Adults’ Access to Preventive /Ambulatory Health Services – (AAP)</td>
</tr>
<tr>
<td>3  Ambulatory Care – (AMB)</td>
</tr>
<tr>
<td>4  Annual Dental Visits – (ADV)</td>
</tr>
<tr>
<td>5  Antidepressant Medication Management – (AMM)</td>
</tr>
<tr>
<td>6  BMI Assessment – (ABA)</td>
</tr>
<tr>
<td>7  Breast Cancer Screening – (BCS)</td>
</tr>
<tr>
<td>8  Cervical Cancer Screening – (CCS)</td>
</tr>
<tr>
<td>9  Childhood Immunization Status – (CIS) – Combo 2 and 3</td>
</tr>
<tr>
<td>10 Comprehensive Diabetes Care – (CDC)</td>
</tr>
<tr>
<td>• Hemoglobin A1c (HbA1c) testing</td>
</tr>
<tr>
<td>• HbA1c poor control</td>
</tr>
<tr>
<td>• HbA1c control (&lt;8%)</td>
</tr>
<tr>
<td>• Eye exam (retinal) performed</td>
</tr>
<tr>
<td>• LDL-C screening</td>
</tr>
<tr>
<td>• LDL-C control (&lt;100 mg/dL)</td>
</tr>
<tr>
<td>• Medical attention for nephropathy</td>
</tr>
<tr>
<td>11 Controlling High Blood Pressure – (CBP)</td>
</tr>
<tr>
<td>12 Follow-up Care for Children Prescribed ADHD Medication – (ADD)</td>
</tr>
<tr>
<td>13 Immunizations for Adolescents – (IMA)</td>
</tr>
<tr>
<td>14 Lead Screening in Children – (LSC)</td>
</tr>
<tr>
<td>15 Chlamydia Screening for Women – (CHL)</td>
</tr>
<tr>
<td>16 Pharyngitis – Appropriate Testing related to Antibiotic Dispensing – (CWP)</td>
</tr>
</tbody>
</table>
### HEDIS

<table>
<thead>
<tr>
<th>No.</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Prenatal and Postpartum Care – (PPC)</td>
</tr>
<tr>
<td>18</td>
<td>Use of Appropriate Medications for People With Asthma – (ASM)</td>
</tr>
<tr>
<td>19</td>
<td>Well-Child Visits in the First 15 Months of Life – (W15)</td>
</tr>
<tr>
<td>20</td>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)</td>
</tr>
<tr>
<td>21</td>
<td>Children and Adolescents’ Access to Primary Care – (CAP)</td>
</tr>
<tr>
<td>22</td>
<td>Call Abandonment – (CAB)</td>
</tr>
<tr>
<td>23</td>
<td>Call Answer Timeliness – (CAT)</td>
</tr>
</tbody>
</table>

### Agency-Defined Measures

<table>
<thead>
<tr>
<th>No.</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Follow-Up after Hospitalization for Mental Illness – (FHM)</td>
</tr>
<tr>
<td>25</td>
<td>Mental Health Readmission Rate – (RER)</td>
</tr>
<tr>
<td>26</td>
<td>Lipid Profile Annually – (LPA)</td>
</tr>
<tr>
<td>27</td>
<td>Use of Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARB) Therapy – (ACE)</td>
</tr>
<tr>
<td>28</td>
<td>Prenatal Care Frequency – (PCF)</td>
</tr>
<tr>
<td>29</td>
<td>Frequency of HIV Disease Monitoring Lab Tests – (CD4 and VL)</td>
</tr>
<tr>
<td>30</td>
<td>Highly Active Anti-Retroviral Treatment – (HAART)</td>
</tr>
<tr>
<td>31</td>
<td>HIV-Related Medical Visits – (HIVV)</td>
</tr>
<tr>
<td>32</td>
<td>Transportation Timeliness – (TRT)</td>
</tr>
<tr>
<td>33</td>
<td>Transportation Availability – (TRA)</td>
</tr>
</tbody>
</table>


2. Data must be aggregated by population. Reform and non-Reform populations must be reported separately.

3. For HEDIS and Agency-defined performance measures (PM), there is no rotation schedule. The health plan must calculate and report each PM each year.
4. Data must be reported for every required data field for each PM. However, when the denominator is less than 30, report "*" (asterisk) in the "rate" field. For data fields other than "rate," report all data elements, including the numerator and denominator.

5. Extensions to the due date may be granted by the Agency for a maximum of 30 days from the due date in response to a written request signed by the chief executive officer of the health plan or designee. For approval, the request must be received prior to the due date and the delay must be due to unforeseen and unforeseeable factors beyond the control of the reporting health plan. Extensions shall not be granted to verbal requests.

6. Data Specifications – Each health plan shall report the data elements described below for each of the required PMs.

   a. Health Plan Identification Number – The Medicaid ID number that identifies the plan, as assigned by the Agency for reporting purposes;
   b. Performance Measure Identifier – The character code of the PM as specified in the table above in parentheses after the PM name;
   c. Data Collection Method – The source of data and approach used in gathering the data for all PMs as specified by HEDIS or Agency definitions:
      1. Administrative method – Enter "1."
      2. Hybrid method – Enter "2."
   d. Eligible Enrollee Population – The number of enrollees meeting the criteria as specified by HEDIS or Agency definitions.
   e. Sample Size – Minimum required sample size as specified by HEDIS. This data element is not required if the administrative method is used. Leave blank (zero-fill) if c. above is 1.
   f. Denominator – If the administrative method is used, eligible member population minus exclusions, if any, as specified by HEDIS or Agency definitions. If the hybrid method is used, the sample size is the denominator or as specified by HEDIS or Agency definitions.
   g. Numerator – Number of numerator events from all data sources as specified by HEDIS or Agency definitions.
   h. Rate – Numerator divided by denominator times 100.00.
   i. Lower CI – Lower 95% confidence interval as specified by HEDIS. If the lower CI is less than zero, report 000.00. This statistic is to be calculated for all PMs.
   k. Upper CI – Upper 95% confidence interval as specified by HEDIS. If the upper CI exceeds 100, report 100.00. This statistic is to be calculated for all PMs.
   l. Format for Rate, Lower CI and Upper CI: Five digits with two decimal places required, right-justified; zero-fill leading digits; include decimal. Use the format: xxx.xx where x represents any digit and xxx is a value between 0 and 100.00.

7. All PMs must be certified by an NCQA-certified HEDIS auditor, to include both HEDIS and Agency-defined measures. The Auditor must certify the actual file submitted to the Agency. A statement of certification from the HEDIS Auditor that
includes report designations for each performance measure must accompany the health plan’s report submission.

8. A report, certification, or other information required for PM reporting is incomplete when it does not contain all data required by the Agency or when it contains inaccurate data. A report or certification is “false” if done or made with the knowledge of the preparer or a superior of the preparer that it contains information or data that is not true or not accurate.

9. A health plan that refuses to file, fails to timely file, or files a false or incomplete report or a report that cannot be certified, validated, or excludes other information required to be filed may be subject to administrative penalties pursuant to Section XIV, Sanctions, of the Health Plan Model Contract.

10. A report that contains an “NR” due to bias for any or all measures by the HEDIS Auditor shall be considered deficient and will be subject to administrative penalties pursuant to Section XIV, Sanctions, of the Health Plan Model Contract.

11. In the event that a performance measure is not applicable because it measures a Reform-only benefit and the health plan does not cover Reform populations, or because the health plan does not cover the service or the specific population being measured, the health plan should indicate, “NB,” when reporting that measure.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

The most recent template and Agency-defined measure specifications can be found at:


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Chapter 38
Pharmacy Navigator Report

PLAN TYPES:

Health plans that must submit this report:

☑ Reform HMOs
☑ Reform Capitated PSNs
☑ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency’s Reform choice counseling vendor with a completed Pharmacy Drug List for each health plan in the format to be required by the vendor.

Navigator is an application that, when loaded with the health plans’ formularies and the enrollee’s prescription drug history, can yield data useful both to state policy makers, choice counselors and/or the choice counseling vendor’s Special Needs Unit to assist recipients in making a health plan selection.

FREQUENCY & DUE DATES:

➢ Due annually, by December 1.

SUBMISSION:

The health plan shall submit the following to the Agency’s choice counseling vendor Secure File Transfer Protocol (SFTP) site server:

NOTE: prior to and through June 18, 2010, plans must submit the report to the Agency’s current choice counseling vendor in concurrence with the ongoing submission to the new choice counseling vendor that becomes effective June 18, 2010. Submission information for the vendor previous to June 18, 2010, is located in the April 1, 2010 Report Guide.


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: 63.240.123.156 (only if required for firewall rules, everyone should use the URL)

Port: 22
The PDL Navigator Report with the file name ***_CC_NAV_FILE_YYYYMM.dat. The file name shall follow the following rules:

a. *** is to be replaced with the health plan’s unique three-character alpha ID.

b. YYYYMM is to be replaced with the four-digit year and two-digit month being recorded.

c. CC shall represent the two-digit State of Florida county ID number if the health plan is submitting by county (‘CC’ may otherwise be excluded).

d. NAV represents the Program ID, and should remain constant (not replaced with anything).

e. FILE shall be replaced by the File Identifier:
   i. PI= Plan Information
   ii. DF= Drug Formulary
   iii. GL= Geographic Locator
   iv. PN= Pharmacy Network

A report attestation (see Chapter 2); the attestation shall be named ***_CC_NAV_FILE_YYYYMM_cert.pdf following the same naming convention above.

Plans needing technical assistance for submitting the Pharmacy Navigator Report to the Reform Choice Counselor’s sftp directory should contact the following helpdesk for assistance: AHSFL-Helpdesk@automated-health.com. For more immediate concerns regarding the submission of the Pharmacy Navigator Report, plans may contact 412-367-3030 ext 2900.

INSTRUCTIONS:

The health plan shall record all information requested on the report template. No cells may be left unanswered.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

A synopsis of the Pharmacy Navigator application can be found at: http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/Synopsis_of_the_Navigator_for_Reform_ChoiceCounseling.pdf
A naming convention example sheet can be found at: 

A list of frequently asked questions can be found at: 
http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/Navigator_Plan_Files_Questions-Answers-12-08-09.pdf

The Pharmacy Navigator file should be developed according to the template located on the following page.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK
### PLAN_INFORMATION_FILE

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Type(size)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTRACT_ID</td>
<td>Char(15)</td>
<td>Medicaid Contract ID</td>
</tr>
<tr>
<td>CONTRACT_NAME</td>
<td>Char(60)</td>
<td>Medicaid Contract Name</td>
</tr>
<tr>
<td>PLAN_NAME</td>
<td>Char(42)</td>
<td>Plan name</td>
</tr>
<tr>
<td>FORMULARY_ID</td>
<td>Char(18)</td>
<td>Unique Identifier assigned to formulary</td>
</tr>
<tr>
<td>STATE</td>
<td>Char(2)</td>
<td>2 character State code</td>
</tr>
<tr>
<td>COUNTY_CODE</td>
<td>Char(5)</td>
<td>5 character SSA State/County code; see Geographic Locater file</td>
</tr>
</tbody>
</table>

### BASIC_DRUGS_FORMULARY_FILE

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Type(size)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FORMULARY_ID</td>
<td>Char(18)</td>
<td>Unique Identifier assigned to formulary</td>
</tr>
<tr>
<td>FORMULARY_VERSION</td>
<td>9(5)</td>
<td>Version ID</td>
</tr>
<tr>
<td>CONTRACT_YEAR</td>
<td>Char(4)</td>
<td>Contract Year</td>
</tr>
<tr>
<td>NDC</td>
<td>Char(11)</td>
<td>11-digit NDC associated with the drug product (name/form/strength)</td>
</tr>
<tr>
<td>TIER_LEVEL_VALUE</td>
<td>9(2)</td>
<td>1 = Preferred 2 = Non-Preferred</td>
</tr>
<tr>
<td>QUANTITY_LIMIT_YN</td>
<td>Char(1)</td>
<td>Quantity Limits Apply to this NDC (Y/N)</td>
</tr>
<tr>
<td>QUANTITY_LIMIT_AMOUNT</td>
<td>9(6)</td>
<td>Quantity amount Limit</td>
</tr>
<tr>
<td>QUANTITY_LIMIT_DAYS</td>
<td>9(6)</td>
<td>Quantity day limit associated with this NDC</td>
</tr>
<tr>
<td>PRIOR_AUTHORIZATION</td>
<td>Char(1)</td>
<td>Prior authorization is necessary for this NDC (Y/N)</td>
</tr>
<tr>
<td>STEP_THERAPY_YN</td>
<td>Char(1)</td>
<td>Step Therapy is associated with the NDC (Y/N)</td>
</tr>
</tbody>
</table>

### GEOGRAPHIC_LOCATOR_FILE

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Type(size)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>COUNTY_CODE</td>
<td>Char(5)</td>
<td>5 character SSA State/County code</td>
</tr>
<tr>
<td>STATENAME</td>
<td>Char(20)</td>
<td>State name</td>
</tr>
<tr>
<td>COUNTY</td>
<td>Char(30)</td>
<td>County name</td>
</tr>
</tbody>
</table>

### PHARMACY_NETWORKS_FILE

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Type(size)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTRACT_ID</td>
<td>Char(15)</td>
<td>Medicaid Contract ID</td>
</tr>
<tr>
<td>PHARMACY_NUMBER</td>
<td>Char(22)</td>
<td>Pharmacy number: 5 zeroes followed by the pharmacy's 7 digit NABP pharmacy number</td>
</tr>
<tr>
<td>PHARMACY_ZIPCODE</td>
<td>Char(5)</td>
<td>ZIP code for pharmacy</td>
</tr>
<tr>
<td>PREFERRED</td>
<td>Char(1)</td>
<td>Is the pharmacy preferred? (Y/N)</td>
</tr>
<tr>
<td>PHARMACY_RETAIL</td>
<td>Char(1)</td>
<td>Is the pharmacy a retail outlet? (Y/N)</td>
</tr>
<tr>
<td>PHARMACY_MAIL</td>
<td>Char(1)</td>
<td>Is the pharmacy a mail order outlet? (Y/N)</td>
</tr>
<tr>
<td>IN_AREA_FLAG</td>
<td>9(1)</td>
<td>Pharmacy ZIP code places it in the plan service area (1=yes)</td>
</tr>
</tbody>
</table>
Chapter 39

Provider Network File

PLAN TYPES:

Health plans that must submit this file:

✓ Non-Reform HMOs
✓ Non-Reform Fee-for-Service PSNs
✓ Non-Reform Capitated PSNs
✓ Non-Reform HMOs that Specialize in HIV/AIDS
✓ Reform HMOs
✓ Reform Fee-for-Service PSNs
✓ Reform Capitated PSNs
✓ Reform Specialty Plan for Children with Chronic Conditions
✓ Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To supply the Agency and its agents with up to date provider network information. This report serves dual purposes. The choice counseling/enrollment broker contractor(s) loads this information into their system(s) for use in answering beneficiary questions and to enable primary care provider (PCP) selection at the time of voluntary plan enrollment. The agency uses the file to monitor the plan’s compliance with required provider network composition and PCP-to-member ratios and for other uses deemed pertinent.

Updated provider network information is available to the Choice Counseling/Enrollment Broker staff each Monday morning.

FREQUENCY & DUE DATES:

➢ Due monthly – The file must be submitted on the first Thursday of each month.

➢ Due weekly – Additional files may be submitted each week by close of business on Thursday.

➢ Beginning July 2011, as a result of the health plan’s receipt of a Provider Network Response File, the health plan may submit an optional complete refresh of the Provider Network File to the Agency’s choice counseling vendor by the Monday following the health plan’s prior submission (see instructions).
**SUBMISSION:**

1. Effective June 2011, health plans shall submit the following to the Agency’s choice counseling vendor’s Secure File Transfer Protocol (SFTP) site server and to the Florida Medicaid Web Portal for the MediKids population:

   - A combined Reform and non-Reform ASCII flat file that is a complete refresh of the provider information, with the file name: ***_PROVYYYYMMDD.dat (where *** represents the plan’s three character approved abbreviation and yyyymmdd represents the date of submittal).

   **Choice counseling vendor SFTP site:**
   
   **URL:** flftp.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

   **Florida Medicaid Web portal:**
   
   http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_SubmissionInformation/tabId/66/Default.aspx

2. All health plans shall submit the following to the Agency Bureau of Managed Health Care (BMHC) via the Secure Transfer Protocol (SFTP) site:

   - A signed attestation specifically addressing the accuracy and completeness of the Provider Network File submission, with the file name ***_PROVYYYYYMMAttestation.pdf (where *** represents the plan’s three character approved abbreviation, and YYYYMM represents the four-digit year and two-digit month of submission).

**INSTRUCTIONS:**

1. The health plan shall create the Provider Network Files in the format and layout below.

2. The health 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. The health plan may use the optional weekly file submission opportunity to ensure that the information presented to beneficiaries is the most current data available.
4. Effective November 2011, plans submitting Provider Network Files to the Agency’s choice counseling vendor will receive a Provider Network Response File (an error response file) the workday following the processing of the each submission. The process is as follows:

   a. The Agency’s choice counseling vendor will create the Provider Network Response File with the following naming convention ***_PROV_RESPYYYYMM.dat (where *** represents the plan’s three character approved abbreviation and yyyyymmdd represents the date of response), and place it in the health plan’s designated folder on the Choice Counseling SFTP site.

   b. The file will contain the same format as the Provider Network File, but also contain an extra field at the end for an error reason. (See “Provider Network Response File” link below.)

   c. Once the Provider Network Response File has been placed in the health plan’s folder, it will be the plan’s responsibility to review the file, fix any errors and resubmit a new, complete Provider Network File by the following Monday or by the next weekly submission.

   d. When the plan submits a new Provider Network File, it must be a full refresh of every record, not only the records with identified errors.

5. 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.

6. Plans needing technical assistance for transferring Provider Network Files to the Medicaid fiscal agent’s secure site should call EDI Services, 1-800-289-7799 Option 3 or 1-866-586-0961, 8 AM until 5 PM EST.

7. The Monday opportunity to resubmit the Provider Network File is only available for the Choice Counseling vendor, not the Medicaid fiscal agent.

**VARIATIONS BY HEALTH PLAN TYPE:**

See details in previous sections for variations.

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REPORT TEMPLATE:

The Agency-supplied Provider Network File Layout template is emailed to the health plan’s compliance contact when updated and can be found on the Agency’s Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2009-2012-Templates/PROVIDER_NETWORK_FILE_LAYOUT.pdf

The Agency-supplied Provider Network Response File layout can be found on the Agency’s Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Forms/FLHealthPlanExportFileFormats20130612.pdf

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Chapter 40

Provider Termination and New Provider Notification Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS
- Reform Specialty Plan for Children with Chronic Conditions

REPORT PURPOSE:

To provide the Agency with notice in the event of a suspension, termination, or withdrawal of medical and behavioral health providers from participation in the health plan’s network, to provide the Agency with notice of new providers, and to provide documentation that the health plan has performed enrollee notification in accordance with the provisions of the health plan Contract (see Attachment II, Section VII and Section X of the health plan contract).

FREQUENCY & DUE DATES:

- Due monthly, the 15th calendar day of the month following the report month.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following in an email to the Agency Bureau of Managed Health Care (BMHC) mailbox – mmcd@ahca.myflorida.com:

- A completed Provider Termination and New Provider Notification Report.

- A report attestation (see Chapter 2). This attestation must specifically address the accuracy and completeness of both Reform and non-Reform submissions (when applicable).
INSTRUCTIONS:

1. The health plan shall submit the report monthly using the Agency-supplied template. This submission must occur even when no provider terminations, suspensions, withdrawals, or new provider contracts occurred. The health plan shall indicate “none” in the first line of the report if there are no such changes.

2. The health plan shall report behavioral health terminations separately from medical provider terminations (see separate tabs).

3. The health plan shall report new/replacement medical and behavioral health providers in the “New Provider Information” tab.

4. The health plan must combine reports for Reform and non-Reform data.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Agency supplied template to be used can be found on the Bureau of Managed Health Care’s Medicaid Health Plan Information web page at:

Chapter 41

Quarterly and Annual Medical Loss Ratio Reports

PLAN TYPES:

Health plans that must submit this report:
- Reform HMOs
- Reform Capitated PSNs
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

To provide the Agency with unaudited quarterly and unaudited annual financial data showing the medical loss ratio (MLR) information for the waiver demonstration year (July 1 through June 30) for compliance with Special Terms and Conditions #14c of Florida’s Section 1115 Research and Demonstration Waiver (No. 11-W-00206/4) as approved by the Centers for Medicare and Medicaid Services on December 15, 2011.

The Agency shall calculate the MLR in a manner consistent with 45 C.F.R. Part 158 and s. 409.9122(21)(b) and (c), F.S.

FREQUENCY & DUE DATES:

- Due quarterly, no later than seven (7) months after the end of each reported quarter:
  - 1st quarter (July 1 - September 30) is due by April 30,
  - 2nd quarter (October 1 – December 31) is due by July 31,
  - 3rd quarter (January 1 – March 31) is due by October 31, and
  - 4th quarter (April 1 – June 30) is due by January 30.

- Due annually, no later than seven (7) months after the end of each reported year:
  - Annual report (July 1 – June 30) is due by January 30.

SUBMISSION:

- The health plan shall submit the following via a single, non-secure email to the Agency’s Bureau of Managed HealthCare (BMHC) mailbox at MMCFIN@ahca.myflorida.com

- For the quarterly submissions:
  a. The completed financial medical loss ratio worksheet, which shall be submitted as a PDF file and named using the naming convention,
MLR***YYQ#.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), YY are the last two-digits of the year being reported, and # is the one-digit of the quarter being reported (i.e., ABC Health Plan’s submission for the 3rd quarter of the reporting year July 1, 2012, through June 30, 2013, would be named “MLRABC12Q3.pdf”).

b. The attestation (see Chapter 2) for the completed financial medical loss ratio worksheet, which shall be submitted with the certified data as a PDF file and named MLR***YYQ#-cert.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), YY are the last two-digits of the year being reported, and # is the one-digit of the quarter being reported (i.e., ABC Health Plan’s submission for the 3rd quarter of the reporting year July 1, 2012 through June 30, 2013, would be named “MLRABC12Q3-cert.pdf”). This attestation must be signed by the health plan’s CEO, CFO or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete to the best of the official’s knowledge. Such delegations of authority must be attached to the submitted signed attestation to certify the report.

➢ For the annual submissions:

a. The completed financial medical loss ratio worksheet, which shall be submitted as a PDF file and named using the naming convention, MLR***YYYY.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), and YYYY are the four-digits of the year being reported (i.e., ABC Health Plan’s submission for the reporting year July 1, 2012, through June 30, 2013, would be named “MLRABC2012.pdf”).

b. The attestation (see Chapter 2) for the completed financial medical loss ratio worksheet, which shall be submitted with the certified data as a PDF file and named MLR***YYYY-cert.pdf, where *** is the health plan’s three-character identifier from the Plan Identifier Table (see Chapter 2), YYYY are the four-digits of the year being reported (i.e., ABC Health Plan’s submission for the reporting year July 1, 2012, through June 30, 2013, would be named “MLRABC2012-cert.pdf”). This attestation must be signed by the health plan’s CEO, CFO or a direct report with written delegated authority certifying that all data and documents submitted are accurate, truthful, and complete to the best of the official’s knowledge. Such delegations of authority must be attached to the submitted signed attestation to certify the report.

INSTRUCTIONS:

The health plan shall submit the completed financial worksheet for the calculation of the medical loss ratio in the following manner:

1. The health plan must use the Agency’s supplied template (see the “Report Template” section of this chapter). The appropriate box shall be checked
(quarterly/annual) by the health plan to identify the reporting period of the submitted report.

2. The report must contain Reform data only.

**VARIATIONS BY HEALTH PLAN TYPE:**

No variations.

**REPORT TEMPLATE:**

No alterations or duplications shall be made to the report template by the health plan. The Agency-supplied unaudited Quarterly Medical Loss Ratio template and the Annual Medical Loss Ratio template can be found at:


The Agency’s template consists of the following:

- A cover letter providing the information necessary for completion of this report;

- A financial worksheet used to calculate the medical loss ratio; and

- An attestation certifying the accuracy, truthfulness, and completion of the financial worksheet.

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Chapter 42

Subcontractors and Affiliates Report

PLAN TYPES:

Health plans that must submit this report:

- Non-Reform HMOs
- Non-Reform Fee-for-Service PSNs
- Non-Reform Capitated PSNs
- Non-Reform HMOs that Specialize in HIV/AIDS
- Reform HMOs
- Reform Fee-for-Service PSNs
- Reform Capitated PSNs
- Reform Specialty Plan for Children with Chronic Conditions
- Reform Specialty Plan for Recipients Living with HIV/AIDS

REPORT PURPOSE:

This report to the Agency’s Bureau of Managed Health Care (BMHC) provides a mechanism for health plans to report ownership and financial information for all subcontractors and affiliates to which the health 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 health plan’s subcontract or relationship with that entity. Entities already reported in the monthly Provider Network File shall not be included on this report.

FREQUENCY & DUE DATES:

- This report is due quarterly within 15 calendar days after the end of the reporting period.

SUBMISSION:

Using the file naming convention described in Chapter 2 of this guide, the health plan shall submit the following to the BMHC Secure File Transfer Protocol site:

- The health plan’s Subcontractors and Affiliates Report.
- A report attestation (see Chapter 2).
INSTRUCTIONS:

The health plan shall submit the report using the Agency’s template via BMHC’s 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 health plan for each business entity being reported unless instructions specify otherwise. If a field is not applicable, enter N/A. Entities already reported in the monthly Provider Network File shall not be included on this report.

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. Health Plan ID: Enter the health plan’s three-character identifier.
2. Health Plan Name: Enter the name of the Health Plan.
3. Health Plan Medicaid Provider Number: Provide the primary (base seven-digit) Medicaid provider number of the health plan including leading zeroes when applicable. Field length is seven digits. Leading zeroes will be applied to any entry that is less than 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 health plan’s subcontractor or affiliate being reported. Entities already reported in the monthly 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 health plan, an affiliate of the health 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 health 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 zeros.

14. Payment Methodology: Select the health plan’s payment method for the
    subcontractor/affiliate services from the drop-down box. Options are “Contingency
    Fee,” “Capitation” (per member), “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 health
      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 any services or functions under the health plan’s Medicaid contract obligation(s) to another entity.

18. Comments: This is an open text, narrative field, provided for other relevant information or comments regarding this report.

   a. This field may be used by a health plan operating in both Non-Reform and Reform areas. If the user enters the health plan’s primary base seven-digit identifier in field 3 to indicate a Non-Reform health plan, the user would then add the primary base seven-digit identifier for Reform in field 18 and list as Reform. This will capture both Non-Reform and Reform and will allow for the naming convention in Chapter 2 as a single report.

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1 For purposes of this report, “Subcontractor” means any person or entity with which the health plan has contracted or delegated administrative functions, services or responsibilities for providing services under this Contract, excluding those persons or entities reported by the health plan in the monthly 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 health 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 health 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.

VARIATIONS BY HEALTH PLAN TYPE:

No variations.

REPORT TEMPLATE:

The Subcontractors and Affiliates Report can be located at:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/Templates/2012-2015-Templates/MCO_Subcontractors_and_Affiliates_Report_092012.xlsx

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